WHY COMPENSATION MATTERS

Lactation Supporters should be paid for the care and services that are provided for families. Families should not be responsible for the burden of cost. So how can be compensated for this care?

BILLING CODES

PRIVATE INSURANCE

MEDICAID/MEDICARE

SCRIPT WHEN CALLING INSURANCE PLANS

Feed the Babes
Birth & Breastfeeding

Suggestions for Billing Codes for IBCLCs

There are several classifications of CPT or HCPCS Codes which IBCLCs can theoretically use to bill for their services. There are advantages and disadvantages to each of these codes. None of the codes are really suited ideally for the work that IBCLCs do, but we are required to use the available existing codes which are meant for other kinds of health care professionals so we must adapt.

It is necessary to realize, that each insurance company may have different and predetermined policies delineating which codes are approved for payment to various provider types. If you are an IBCLC or other type of health care provider, contracted with specific insurers, then you should refer to their policies on coverage. For example, some insurers do not cover any education codes at all so a class may not be reimbursable. Some insurers will only cover preventive 994xx counseling codes for IBCLCs and will not cover any of the evaluation and management codes.

The following is a table of CPT / HCPCS codes <u>can</u> be used for **out-patient** billing in various settings. If you are not a credentialed or contracted provider with particular insurers, then you will have to try to best select a code that describes your work and will offer adequate payment for the time and expertise you are providing. Factors to consider in the billing code decision:

- **Place of Service** - Choosing the best code depends on the setting where you provide care, client home, home office, physician office, hospital out-patient facility.
- **Patient Status -** New or established (follow-up), consultation
- **Patient cost-sharing –** preventive codes for plans subject to the Affordable Care Act will not require any co-pay or meeting a deductible. See other articles on IBCLCs and health insurance in the USLCA E-News for more information, September 2012
- **Level of Coding** – Higher level evaluation and management codes pay more, but can you meet the billing criteria?

Place of Service	***CPT / HCPCS Codes*** Current Procedural Terminology (CPT®) copyright 2013 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association.	***Patient Contribution***
Education		
Any Location Prenatal/postpartum breastfeeding class	S9443 Lactation Classes, Non-Physician Provider, Per Session	No co-pay
Lactation Consultation	**Evaluation and Management Codes**	
Home visit only Evaluation and management <u>new</u> patient	99341 Requires these 3 key components: problem focused history; problem focused examination, straightforward medical decision making. Counseling/coordination of care with other physicians, qualified health care professionals, or agencies are	Subject to Co-pay, deductible

	provided consistent with the nature of the problem(s) and the patient's/ family's needs. Usually, the presenting problem(s) are of low severity. 20 minutes face-to-face with the patient 99342 Home visit for the evaluation and management of a new patient, which requires these 3 key components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. Counseling/ coordination of care with other physicians, qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's / family's needs. Usually, the presenting problem(s) are of moderate severity. 30 minutes face-to-face with the patient 99343 Requires these 3 key components: detailed history; detailed examination; medical decision making of moderate complexity. Counseling/ coordination of care with other physicians, qualified health care professionals, agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 45 minutes face-to-face with the patient *99344 Requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. 60 minutes face-to-face with the patient.	
Home visit only Evaluation and management <u>established</u> patient	93347 self-limited or minor problem, 15 min. see description 99341 99348 low to moderate problem, 25 min., see description 99342	Subject to Co-pay, deductible

	99349 moderate to high problem, 40 min, see description 99343 99350 moderate to high complexity problem, 60 min, see description 99344	
Physician office/clinic Office visit <u>new</u> patient	99201 Requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling/ coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's/ family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes face-to-face with the patient 99202 Requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes face-to-face with the patient 99203 Requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling/coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's/ family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes face-to-face with the patient *99204 Requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the	Subject to Co-pay, deductible

	patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes face-to-face with the patient	
Physician office/clinic Office visit <u>established</u> patient	99212 Requires At Least 2 Of These 3 Key Components: A Problem Focused History; A Problem Focused Examination; Straightforward Medical Decision Making. Counseling/Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Family's Needs. Usually, The Presenting Problem(s) Are Self Limited Or Minor. Physicians Typically Spend 10 Minutes Face-To-Face With The Patient 99213 Requires At Least 2 Of These 3 Key Components: An Expanded Problem Focused History; An Expanded Problem Focused Examination; Medical Decision Making Of Low Complexity. Counseling And Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients /Family's Needs. Usually, The Presenting Problem(s) Are Of Low To Moderate Severity. Physicians Typically Spend 15 Minutes Face-To-Face With The Patient *99214 Requires At Least 2 Of These 3 Key Components: A Detailed History; A Detailed Examination; Medical Decision Making Of Moderate Complexity. Counseling/Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients/ Family's Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 25 Minutes Face-To-Face With The Patient	Subject to Co-pay, deductible
Physician office/clinic Consultation , <u>new</u> patient MUST MEET 3R rules: • **Referral** (you must have it in	99243 Requires These 3 Key Components: A Detailed History; A Detailed Examination; And Medical Decision Making Of Low Complexity. Counseling / Coordination Of Care With Other Providers Or Agencies Are	Subject to Co-pay, deductible

hand before the visit from the PCP provider) • **Render** care • **Report** back to the referring provider. • The consultation codes generally have higher reimbursement than the 992xx codes.	Provided Consistent With The Nature Of The Problem(s) And The Patients / Family's Needs. Usually, The Presenting Problem(s) Are Of Moderate Severity. Physicians Typically Spend 40 Minutes Face-To-Face With The Patient *99244 Requires These 3 Key Components: A Comprehensive History; A Comprehensive Examination; And Medical Decision Making Of Moderate Complexity. Counseling/ Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients/ Family's Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 60 Minutes Face-To-Face With The Patient *99245 Requires These 3 Key Components: A Comprehensive History; A Comprehensive Examination; And Medical Decision Making Of High Complexity. Counseling / Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients / Family's Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 80 Minutes Face-To-Face With The Patient	
Out-Patient Hospital **Home** **Physician office/clinic** Preventive medicine individual counseling Theoretically, Suzanne Madden of the National Breastfeeding Center says we can legitimately bill a combination of these for a longer visit (such as 60 min plus 30 min for a 90 min visit), but only one code may be paid.	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 99401 - 15 minutes 99402 - 30 minutes 99403 - 45 minutes 99404 - 60 minutes	No co-pay

*Evaluation and management codes ending in 4 or 5, such as 99xx4 or 99xx5 are red flags for audit. It may be hard to argue in an audit that <u>any</u> IBCLC visit meets the criteria for these codes given the time, complexity and review of systems that the codes ending in "4" and "5" require. Extensive medical decision making > or = 4 diagnoses or treatments involve high risk, and have

an extensive amount of data reviewed with a complete history. I think we could justify these, but these higher codes also require a complete examination (8+ body areas or systems) and high level of medical decision making with additional workup and diagnostics planned. We typically are not doing this even with complex lactation visits.

If you work in a physician practice having share visits, with "incident-to" billing and the physician completes additional necessary components, and also advises or other follow-up evaluation then the higher codes could be used.

You may be able to document on *time alone* for lengthy and complex visits, and add time with additional codes, 99354 or 99359, if the following CMS criteria are met:

- Counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (direct face-to-face **only** time)
- Documentation is required in the medical record about the duration and content of the *medically necessary* evaluation and management *service and prolonged services* billed.
- The start and end times of the visit shall be documented in the medical record along with the date of service.
- The time approximation must meet or exceed the typical/average time of a specific CPT code billed and shall not be "rounded" to the next higher level.
- For E/M services, counseling may include a discussion of test results, diagnostic or treatment recommendations, prognosis, risks and benefits of management options, instructions, education, compliance or risk-factor reduction.

The CMS manual explains this in CR 5972 here: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1490CP.pdf

Nurses are sometimes billing the nurse code 99211. This is likely to yield insufficient reimbursement, usually less than $20, as the description of this code says, it is for a 5 minute visit.

> Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes performing or supervising these services.

Since the Affordable Care Act requires lactation counseling as a women's preventive service what we do at least fits this description appropriately. The preventive counseling codes based on time, however, only go up to 60 minutes. For office visits this may be adequate payment for services.

The only code that might account for the time and expense of travel is the home visit code. Healthcare reimbursement is for health services and is not meant to pay providers to travel to give care, except for with disabled persons which are generally when the home visit codes are used. It is meant to pay for health care services only. The cost of travel to obtain services may be deductible for the patient on their taxes and for the IBCLC as a business expense. One should consult with a tax accountant to determine if this can be done.

For additional guidance on documentation of services see the **1997 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/referenceii.pdf

NATIONAL WOMEN'S LAW CENTER

EXPANDING THE POSSIBILITIES

toolkit

New Benefits for Breastfeeding Moms: Facts and Tools to Understand Your Coverage under the Health Care Law

ABOUT THE CENTER

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's equality and opportunity. The Center focuses on major policy areas of importance to women and their families, including economic security, education, employment and health, with special attention given to the concerns of low-income women.

For more information about the Center or to make a tax-deductible contribution to support the Center's work, please visit: www.nwlc.org or call the Development office at 202-588-5180.

AUTHORS

This Toolkit was a collaborative endeavor that relied upon the work of many individuals. The primary authors—Anna Benyo and Stephanie Glover—were greatly assisted by Marcia Greenberger, Judy Waxman, and Karen Davenport. Beth Stover designed the Toolkit with layout/design assistance provided by Nancy Magill.

DISCLAIMER

While text and citations are, to the best of the authors' knowledge, current as this report was prepared, there may well be subsequent developments, including new administrative guidance, that could alter the information provided herein. This report does not constitute legal advice; individuals and organizations considering legal action should consult with their own legal counsel before deciding on a course of action. In addition, this report does not constitute medical advice. Individuals with health problems should consult an appropriate health care provider.

Introduction

The health care law requires new health plans to cover certain preventive services without any cost-sharing. This means that, as Americans enroll in new coverage options made possible by the Affordable Care Act (ACA), and an increasing number of existing health plans come under the law's reach, more and more people will have access to a wide range of preventive services without co-payments, deductibles, or co-insurance. This is especially important to women, who are more likely than men to avoid needed health care, including preventive care, because of cost.

As part of women's preventive services, new plans are required to cover breastfeeding support, supplies, and counseling. This is a significant step forward in making breastfeeding more accessible and affordable for millions of Americans.

This toolkit is designed for women, advocates, community-based organizations and health care providers to provide information on the coverage of breastfeeding support, supplies, and counseling in the health care law and offer tools to women who encounter problems with this coverage. We have also provided detailed instructions on how to call insurance companies and how to file an appeal if the plan denies coverage. The toolkit includes draft appeal letters tailored to commonly encountered scenarios.

If you have any questions or need further guidance, contact the National Women's Law Center at 1-866-745-5487 or prevention@nwlc.org. We are interested in hearing from you. Please let us know if you use this toolkit to obtain coverage successfully.

Factsheet:
New Benefits for Breastfeeding Moms

The Affordable Care Act (ACA) makes breastfeeding more accessible and affordable for millions of American women. The law requires that all new health plans must provide certain preventive services without any cost-sharing, including coverage for breastfeeding support and supplies. Breastfeeding benefits the mother and the child, but too often there is a gap between women's desire to breastfeed their babies and the support they need to successfully breastfeed. Although a majority of women plan to breastfeed, a much lower proportion actually do when they are discharged from the hospital after delivery.[1] In order to support women's efforts to breastfeed, and reduce cost as a barrier, the health care law requires new plans to cover breastfeeding supplies, and support and counseling without co-payments, deductibles, or co-insurance.

HEALTH INSURANCE PLANS MUST COVER WOMEN'S PREVENTIVE SERVICES

The health care law requires most insurance plans to offer a range of preventive services and took special steps to ensure coverage of new preventive services that are important to women. These services were developed by the Institute of Medicine and endorsed by the Health Resources Services Administration (HRSA). They include: (1) Breastfeeding support, supplies, and counseling; (2) Screening and counseling for interpersonal and domestic violence; (3) Screening for gestational diabetes; (4) DNA testing for high-risk strains of HPV; (5) Counseling regarding sexually transmitted infections, including HIV; (6) Screening for HIV; (7) Contraceptive methods and counseling; and (8) Well woman visits.

BREASTFEEDING EQUIPMENT AND SUPPLIES

All new health plans must cover breastfeeding equipment and supplies "for the duration of breastfeeding" without cost-sharing, which means plans may not apply any co-payment, co-insurance, or deductible to these benefits. Breastfeeding equipment and supplies most commonly refers to a breast pump, which is a device that extracts milk from a lactating woman, and related accessories. The FDA, which regulates breast pumps, states that they can be "used to maintain or increase a woman's milk supply, relieve engorged breasts and plugged milk ducts, or pull out flat or inverted nipples so a nursing baby can latch-on to its mother's breast more easily."[2] Many women use breast pumps to express and store their milk after they have returned to work, are traveling, or have to be away from their breastfeeding child. (Also, employers are required to provide a clean, private place for women to pump while on the job.)

While a health insurer must cover breastfeeding equipment and supplies, it can impose some requirements on this coverage, such as requiring a purchase, rather than rental, of a breast pump.

COMPREHENSIVE LACTATION SUPPORT AND COUNSELING

The health care law requires all new health plans to cover "comprehensive prenatal and postnatal lactation support [and] counseling." This means that breastfeeding mothers have health insurance coverage for lactation counseling without cost-sharing for as long as they are breastfeeding. Lactation consultants are trained specialists who work with women to help them begin and continue to breastfeed. Health insurers must cover such consultations without cost-sharing, but can require consumers to see only the providers on their list, called "in-network providers," or impose other requirements on coverage.

1 Institute of Medicine, "Clinical Preventive Services for Women: Closing the Gaps," (2011), the National Academies Press.

2 U.S. Food and Drug Administration, "Breast Pumps," available at http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BreastPumps/default.htm.

DIFFERENCES IN COVERAGE

The requirement to cover breastfeeding support and supplies applies to all new plans. Because some health plans existed before the health care law was passed, some differences in coverage still remain (also see the flow chart entitled "Does my insurance plan have to cover breastfeeding supplies and support without cost sharing?").

Medicaid and Medicaid Expansion

The requirement to provide breastfeeding support and supplies will vary by state and by type of Medicaid coverage. Traditional Medicaid programs already cover a wide range of preventive services for Medicaid enrollees with nominal or no co-payments. They are not, however, required to provide this new benefit under the ACA. This means that traditional Medicaid programs, including pregnancy-related coverage, are not required to provide breastfeeding support and supplies but many states choose to provide these benefits. Based on a 2012 survey with 44 states responding, 25 states covered breastfeeding education services, 15 states covered individual lactation consultations, and 31 states covered equipment rentals.[3]

The ACA allows states to expand eligibility for Medicaid to cover more low income people up to 138 percent of the federal poverty level (approximately $16,000 for an individual or $33,000 for a family of four). However, each state decides whether or not to expand eligibility. About half the states have expanded coverage through Medicaid. States that have expanded coverage are required to provide coverage of breastfeeding support and supplies for individuals newly eligible for Medicaid under this expansion.

In short, depending on where they live, traditional Medicaid enrollees may not have coverage for breastfeeding support and supplies. However, Medicaid enrollees who are newly eligible and covered as part of the "Medicaid expansion" will have coverage for these services.

Employer Sponsored Coverage

Most employees and their dependents who have health insurance through an employer are enrolled in plans that must provide coverage for breastfeeding support and supplies. Plans that existed before March 23, 2010, and have not made significant changes, are considered "grandfathered," and do not need to cover preventive services, including breastfeeding benefits. If the plan makes significant changes (like increasing employee costs or cutting benefits), it will become "ungrandfathered." All un-grandfathered private health plans have to follow the preventive health services coverage and offer breastfeeding support and supplies at no cost-sharing.

In 2013, only 36 percent of workers with employer sponsored coverage were in grandfathered plans, and more plans will become ungrandfathered in 2014.[4] Eventually all plans will lose their grandfathered status and distinctions between the two types of plans will disappear. At that point, all plans will cover these important preventive services without cost-sharing.

Individual Coverage

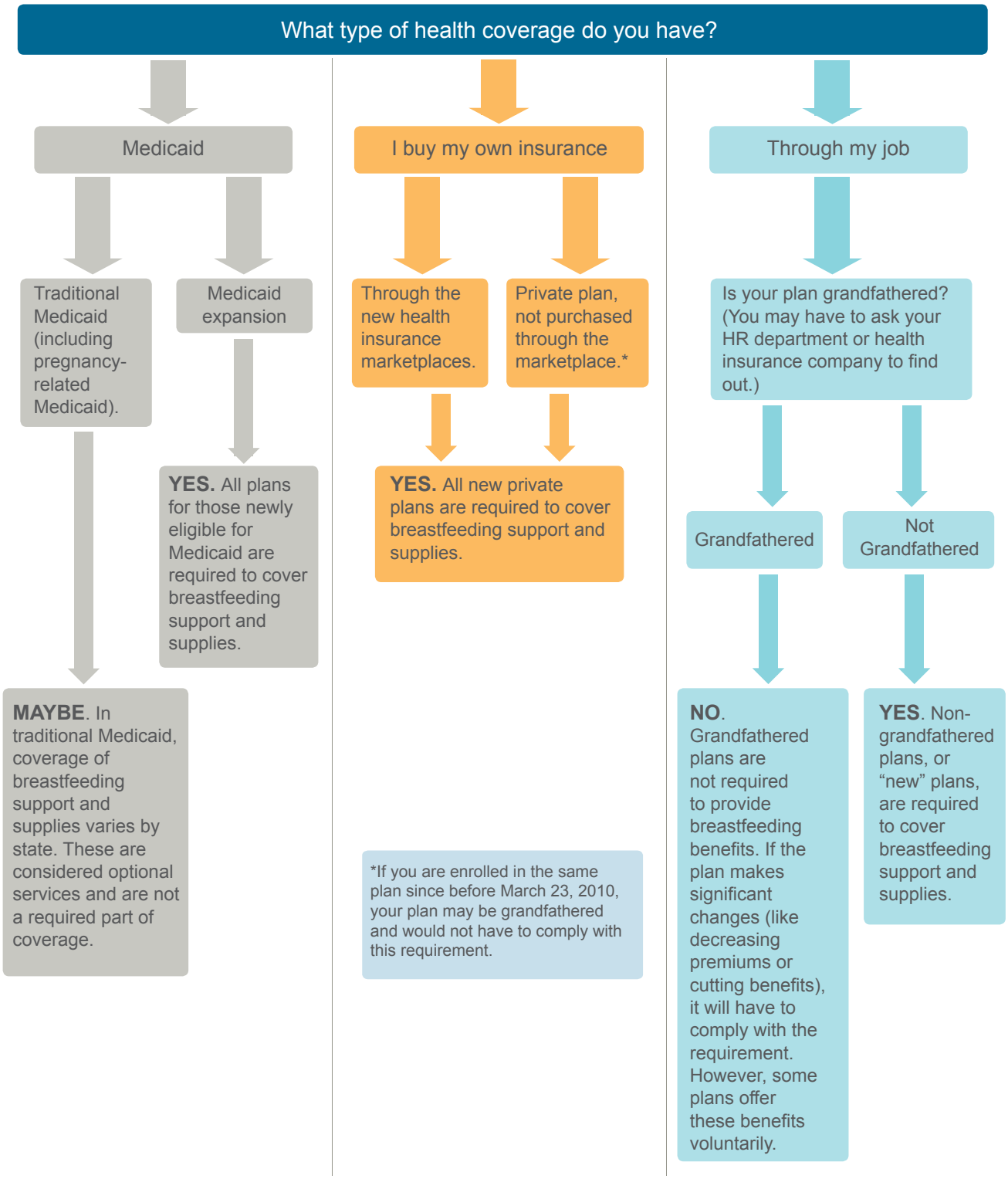
All plans purchased on the Health Insurance Marketplaces are considered "new" plans and are required to cover breastfeeding support and supplies.

Individual plans purchased outside of the Marketplace generally have to provide coverage of breastfeeding benefits as well. However, there is a small portion of individually purchased private plans that are not required to provide this coverage. If an individual has been enrolled in the same plan since before March 23, 2010, then the plan is considered "grandfathered," meaning that it doesn't have to comply with the health care law.

3 Centers for Medicare and Medicare Services, "Medicaid Coverage of Lactation Services," (January 10, 2012) available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf.

4 Kaiser Family Foundation, "Employer Health Benefits, 2013 Survey," (August 2013) available at http://kff.org/private-insurance/report/2013-employer-health-benefits/.

Does my health insurance have to cover breastfeeding supplies and support without cost-sharing?



Questions & Answers:
Breastfeeding Support and Supplies

Q: How does coverage of breastfeeding support and supplies fit into the health care law?

A: Under the new health care law, all new health insurance plans must cover certain preventive health services and screenings without cost-sharing. Breastfeeding support and supplies are one of the preventive services that plans must cover without any cost-sharing.

Q: Does this mean I won't have to pay anything for my breastfeeding pump or lactation consultant?

A: The law requires insurance companies to cover breastfeeding supports and supplies without a copayment or other cost-sharing. While some plans previously covered these services, many only paid a portion of the cost, while the woman would have to pay a co-payment or co-insurance. Now, breastfeeding support and supplies will be fully covered by insurance plans and you will not need to make a separate payment to your healthcare provider or pharmacy. However, we know that in practice, many women face obstacles in getting their pump or lactation counseling covered at all, or covered without cost-sharing. If you're having problems, there are additional resources in this toolkit to help you.

Q: How do I know if my plan is new and if these requirements apply to my plan?

A: Health plans that existed before the health care law are considered "grandfathered" into the new system. Grandfathered plans don't have to follow the preventive services coverage rules, including providing breastfeeding support and supplies without cost-sharing. This means that the plan can continue to operate just as it has until it makes significant changes. These changes include: cutting benefits significantly; increasing co-insurance, co-payments, or deductibles or out-of-pocket limits by certain amounts; decreasing employer premium contributions by more than 5 percent; or, adding or lowering annual limits.

Un-grandfathered plans are group health plans created after March 23, 2010, group health plans that have implemented significant changes, or individual plans purchased after that date, which is when the health care law was signed by the President. All un-grandfathered private health plans have to follow the new preventive health services coverage and cost-sharing rules. When you hear that "all new health plans" have to cover these services, it means that all "un-grandfathered" plans must cover them.

Q: What does "in-network" and "out-of-network" mean?

A: Insurance companies contract with certain providers and facilities that are then considered "in-network" for your health plan. "Out-of-network" providers are typically not fully covered by your health plan so when you visit an out-of-network provider you are often responsible for much greater cost sharing or even the whole cost of the visit. It is important to call your insurance company to verify that the provider you want to see is "in-network." In general, in order to obtain your breast pump and counseling at no cost-sharing, you have to go to an in-network provider or company.

Q: What if my insurance company doesn't have any lactation consultants or breast pump supplier in-network?

A: If your insurance company doesn't have any lactation consultants or breast pump providers in-network, the insurance company must cover services from an out-of-network provider without cost-sharing. Federal guidance makes clear that "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service."[1] If your insurance company does not have providers in its network to provide breastfeeding equipment or lactation counseling, you must be able to go out-of-network, the item or service must be covered; and covered at no cost-sharing.

Q: Can my insurance company place any limits on my breast pump or lactation counseling?

A: It depends. Federal regulations make clear that coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. An insurance company cannot impose an unallowable waiting period or limit, such as requiring you to obtain the pump within six months of delivery or limiting the benefit to one pump per year. Your insurance company is also not allowed to refuse to provide lactation counseling or limit this benefit to a hospital setting. However, an insurer can use some limits such as requiring you to rent a pump instead of purchasing one, or requiring you to see an in-network lactation consultant.

1 Centers for Medicare and Medicaid Services, "Affordable Care Act Implementation FAQs - Set 12," available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.

Calling Your Health Plan: How to Find Out What Your Health Plan Covers

If you have private insurance, either through a plan you bought on your own or through your employer, you must first determine if your plan is grandfathered or un-grandfathered. (If you have coverage through Medicaid, skip to the last question.) The best way to find out if your plan is not grandfathered and if you are entitled to this coverage is to call your insurance company.

WHO SHOULD I CALL?

We recommend you call the phone number on your insurance card. That number should connect you to customer service for your insurance company or plan and should have the most up to date information about your health plan. If you get your insurance through your job, and have an employer-sponsored plan, you may have a benefits administrator you can also ask.

Remember, the person answering the phone is not the person making the decisions. If the person with whom you are speaking is unable to answer a question you have, you might want to ask to speak with a supervisor. If you do not believe you are being told correct information and you have insurance through your employer, you may also want to let your benefits administrator know of the issues.

WHAT SHOULD I SAY?

The phone script provided on the next page includes suggested questions you can ask to find out if your plan is providing breastfeeding support and supplies, and follow up questions about the details of the coverage. You do not have to follow the script perfectly. You can use it as a guide.

WHAT IF I HAVE MEDICAID?

Medicaid coverage of breastfeeding support and supplies varies by state. You will probably have to call your state Medicaid office to find out about coverage. If your annual income is less than 185 percent of the federal poverty level (about $29,000 for a family of two or $44,000 for a family of four), you can also contact your local Women, Infant, and Children (WIC) office. WIC provides a range of breastfeeding services, including breast pumps, lactation counseling, and educational materials.

Sample Script:
Calling Your Health Plan

Hi, I understand that under the health care law, all plans are required to cover breastfeeding support and supplies without cost-sharing. I'm calling to confirm that my plan is covering these services. Can you tell me if it is?

YES, as a new plan, breastfeeding supplies and support are covered without any cost-sharing.

GREAT! Can you provide me a list of in-network lactation consultants?

YES, our list can be found here…

THANKS. And, what is the process for getting my breast pump?

YES, let me walk you through that process…

CONGRATULATIONS!
Thanks to the Affordable Care Act, your plan is covering your breastfeeding supplies and support.

NO, we don't have a list of providers. You can get breastfeeding counseling through your pediatrician or OB/GYN.

[Most pediatricians or OB/GYNs will not have a list of providers.] I don't think my pediatrician or OB/GYN will have a list, if you can't provide a list then I would like to speak to your supervisor about this policy.

NO, we don't cover breast pumps or lactation consultants.

Is my plan grandfathered?

YES, you're enrolled in a plan that began before March 23, 2010 so it doesn't have to comply with this requirement.

Unfortunately, you won't be able to get coverage for your breastfeeding support or supplies from your current plan. The plan will have to comply when it makes changes such as decreasing premiums or cutting benefits.

NO, your plan is not grandfathered, but we don't provide this benefit.

The healthcare law requires that you provide this benefit. Can I speak with a supervisor to make sure this is the correct information about this policy?

Repeat these questions to the supervisor.

If you are still not getting the correct answer, you have several options:

1. File an internal appeal (see letters at the end of the toolkit).
2. Contact us at Prevention@nwlc.org
3. If you purchase your plan on your own or through the marketplace, contact your state insurance commissioner.

Sending an Appeal Letter: Breastfeeding Support and Supplies

PREPARING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/faqs/faq-aca12.html
- Make a copy of the letter and keep it in your files.
- You can also find word versions of sample appeal letters here: www.nwlc.org/breastfeeding

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your breast pump or related services.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-745-5487 or prevention@nwlc.org.

Sample Letter:
No Coverage Policy for Breast Pump

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently tried to purchase a breast pump through my health insurance. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost-sharing. However, when I contacted [INSURANCE COMPANY NAME] about the coverage, I was told I could not get coverage of [BREAST PUMP REQUESTED].

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services for women with no cost-sharing. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment [] for the duration of breastfeeding" (see attachment).

My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

[INCLUDE THIS PARAGRAPH IF YOUR PLAN DOES NOT HAVE A CLEAR PROCESS TO GET A PUMP]
My health care provider has prescribed that I use [BREAST PUMP REQUESTED]. The insurance plan has not established a process for me to obtain a pump, such as through a durable medical equipment supplier, and thus it remains an over-the-counter product for the purposes of my plan. As the FAQs on the preventive services (dated February 20, 2013) state, "OTC recommended items and services must be covered without cost-sharing…when prescribed by a health care provider." Accordingly, [INSURANCE COMPANY] must cover [BREAST PUMP REQUESTED] as required under the Affordable Care Act.

LAST PARAGRAPH OPTIONS:
(1) I have spent [TOTAL AMOUNT] out-of-pocket on [NAME OF BREAST PUMP], despite the fact that it should have been covered. I have attached copies of receipts which document these out-of-pocket expenses. [COMPANY NAME] must rectify this situation by reimbursing me for the out-of-pocket costs I have incurred during the period it was not covered without cost-sharing. Furthermore, [COMPANY NAME] must ensure breastfeeding support and supplies, including lactation counseling are covered without cost-sharing in the future by changing any corporate policies that do not comply with the Affordable Care Act.

(2) I am prepared to order [BREAST PUMP REQUESTED] when [COMPANY NAME] assures that I have coverage without cost-sharing. I expect that [COMPANY NAME] will rectify this situation and notify me within 30 days of receipt of this letter that [BREAST PUMP REQUESTED] will be covered without cost-sharing.

Sincerely,

[YOUR SIGNATURE]

Encl:
Frequently Asked Questions about the Affordable Care Act (Part XII), available online at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out-of-Pocket Costs

Sample Letter:
Coverage for Lactation Consultant

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently tried to access lactation counseling that should be covered by my health insurance. The Patient Protection and Affordable Care Act requires insurance coverage of breastfeeding support and supplies with no cost-sharing. However, when I contacted [INSURANCE COMPANY NAME] about the coverage by [SPECIFY METHOD, PHONE] on [DATE], I was told I could not get coverage of [LACTATION COUNSELING] because [SPECIFY REASON, SUCH AS NO IN-NETWORK PROVIDERS].

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services for women with no cost-sharing. The list of women's preventive services that must be covered in plan years starting after Aug. 1, 2012 includes "comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment [] for the duration of breastfeeding" (see attachment).

My health insurance plan is non-grandfathered and the plan year started on [PLAN YEAR DATE]. Thus, the plan must comply with the women's preventive services provision.

The insurance plan has not established a process for me to obtain in-network lactation counseling, as required by federal law. Federal guidance on the preventive services clarify that, "… if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service."

Since [PLAN YEAR DATE], I have spent [TOTAL AMOUNT] out-of-pocket on [LACTATION COUNSELING], despite the fact that it should have been covered during that time. I have attached copies of receipts which document these out-of-pocket expenses. [COMPANY NAME] must rectify this situation by reimbursing me for the out-of-pocket costs I have incurred during the period it was not covered without cost-sharing. Furthermore, [COMPANY NAME] must ensure breastfeeding support and supplies, including lactation counseling are covered without cost-sharing in the future by changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:
Frequently Asked Questions about the Affordable Care Act (Part XII), available online at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out-of-Pocket Costs

11 Dupont Circle, Suite 800
Washington, DC 20036
202.588.5180 | fax 202.588.5185
www.nwlc.org

Phone

Insured DOB

Address (if different)

Relationship to PT

RELEASE: I authorize the undersigned healthcare provider to release any information acquired in the course of my examination or treatment.

SIGNED: (Insured or Authorized Person) _____ Date:_____

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to the undersigned healthcare provider. I am financially responsible for non-covered services.

SIGNED: (Insured or Authorized Person) _____ Date:_____

NEW	ESTAB	TYPE	FEE
○ 99203 15min	○ 99213 15min	Office	
○ 99204 45min	○ 99214 25min	Office	
○ 99205 60min	○ 99215 40min	Office	$
○ 99342 30min	○ 99347 25min	Home	
○ 99343 45min	○ 99348 40min	Home	
○ 99344 60min	○ 99349 60min	Home	
○ 99345 75min	○ 99350 75min	Home	$
○ 99401 15min		Prev Medicine	
○ 99402 30min		Prev Medicine	
○ 99403 45min		Prev Medicine	
○ 99404 60min		Prev Medicine	$
○ S9443		Class	$

Mother Codes

☐	B37.9	Candidiasis/thrush
☐	O91.03	Infection of nipple associated with lactation
☐	O91.13	Abscess of breast associated with lactation
☐	O91.23	mastitis associated with lactation
☐	O92.03	Retracted nipple associated with lactation
☐	O92.13	Cracked nipple associated with lactation
☐	Q83.8	Other congenital malformations of breast (tubular/
☐	Q83.3	asymmetry) Accessory nipple
☐	O92.2	Breast Lump
☐	O92.3	Agalactia
☐	O92.4	Hypogalactia
☐	O92.5	Suppressed lactation
☐	Z39.1	Encounter for care and examination of lactating mother
☐	Q83.2	Absent nipple
☐	_____	_____

Child Codes

☐	P92.3	Underfeeding of newborn
☐	P92.5	Neonatal difficulty in feeding at breast
☐	P92.9	Feeding problem of newborn, unspecified
☐	P37.5	Neonatal candidiasis
☐	P92.6	Failure to thrive in newborn
☐	R63.3	Feeding difficulties
☐	Q38.1	Ankyloglossia
☐	Q38.5	Congenital malformations of palate, not elsewhere classified
☐	Q18.9	Congenital malformation of face and neck, unspecified
☐	M26.9	Dentofacial anomaly, unspecified
☐	R68.12	Fussy infant (baby)
☐	Q35.3	Cleft soft palate sub-muc
☐	Q35.9	Cleft palate- hard palate
☐	Q36.0	Cleft Lip
☐	_____	_____

BREAST PUMP/SUPPLY CODES		FEE
☐ E0602	Manual Pump	$_____
☐ E0603	Double Electric Pump	$_____
☐ E0604	Hospital Grade Pump	$_____
☐ A4281-A4286	Parts for Kit Milk Storage	$_____
☐ A9900	Bags	$_____
☐ 99070	SNS	$_____
☐ 99070	Nipple Shield	$_____
☐ 99070	Breast Shells	$_____
☐ A6242	Hydro Gel	$_____
☐ 99071	Pads Books/Pamphlets	$_____
☐ _____	_____	$_____

Place of Service Code

○ 11 Office ○ 12 Home ○ other_____

Medicaid for infant Referred by Physician (1unit = 15 mins)

☐ 96150 units ____ 6 units max/day 36 for life

☐ 96151 units ____

☐ 96152 units ____

Referring Provider

NOTES:

ALL SERVICES AND SUPPLIES ARE NON-REFUNDABLE
NO RETURNS OR EXCHANGES

REC'D BY:

☐ CHARGE
☐ CASH
☐ CHECK

TODAY'S FEE $_____

TOTAL DUE $_____

AMT REC'D $_____

PROVIDER SIGNATURE : _____ **DATE :** _____

THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

April 2017

Medicaid Coverage of Pregnancy and Perinatal Benefits:

RESULTS FROM A STATE SURVEY

Prepared by:

Kathy Gifford and Jenna Walls
Health Management Associates

and

Usha Ranji, Alina Salganicoff, and Ivette Gomez
Kaiser Family Foundation

Table of Contents

Executive Summary

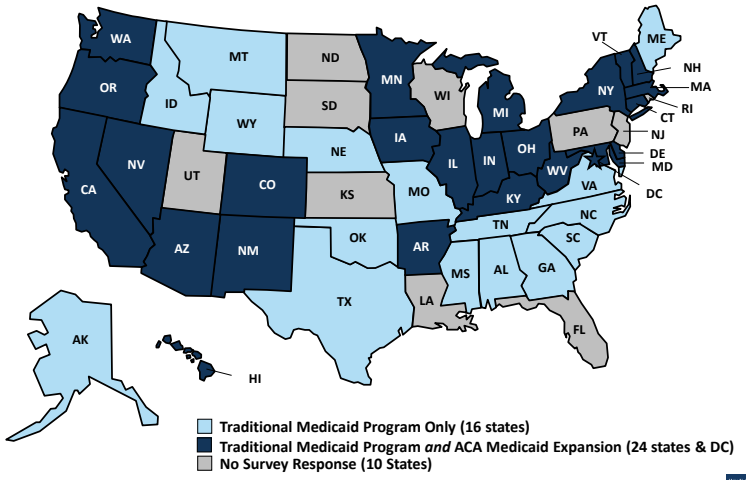
Overview

Maternity care has emerged as a key issue in the current policy debates about the future of the Affordable Care Act (ACA) and Medicaid restructuring. While the inclusion of maternity care as an essential health benefit has been important to many women who gained private coverage because of the ACA coverage expansion, Medicaid has been the primary funding source for perinatal and maternal services for low-income women in the US for several decades. In 2010, Medicaid financed nearly 45% of all births in the United States.[1] By federal law, all states provide Medicaid coverage for pregnancy-related services to pregnant women with incomes up to 133% of the federal poverty level (FPL) and cover them up to 60 days postpartum. All states must provide some level of maternity care free of cost-sharing to eligible pregnant women, although there are state level variations in the scope and type of services that states offer. In addition, many states extend eligibility to pregnant women with incomes considerably higher than this threshold. The ACA broadened Medicaid eligibility by allowing states to extend continuous Medicaid eligibility in 2014 to individuals with family income at or below 138% FPL and 31 states and the District of Columbia (DC) have adopted Medicaid expansion programs which extended coverage for new mothers beyond the postpartum period, where historically many women lost coverage. [2]

Figure 1

State Medicaid Eligibility Pathways for Women, as of July 1, 2015

Based on responses from 40 States & DC



SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits

Because there is no formal federal definition of what services states must cover for pregnant women beyond inpatient and outpatient hospital care, states have considerable discretion to determine the specific scope of maternity care benefits. While the ACA also does not define maternity benefits, states that have expanded Medicaid eligibility under the ACA must cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF) for beneficiaries that qualify as a result of the ACA expansion. These now include many pregnancy-related services, such as prenatal screenings, folic acid supplements, and breastfeeding supports for those who qualify for Medicaid as a result of the expansion. This coverage requirement, however, does not apply to any of the Medicaid eligibility pathways that were available prior to the ACA (i.e., for parents or pregnant women). As a result, there is leeway for states to vary coverage standards for different Medicaid eligibility pathways (e.g. traditional Medicaid available prior to the ACA, ACA Medicaid expansion, or pregnancy-related eligibility).

To understand how states were covering services under Medicaid in the wake of the ACA expansions, the Kaiser Family Foundation and Health Management Associates conducted a survey of states about the status of Medicaid benefit policies for perinatal and family planning services across the nation. With 31 states and DC adopting Medicaid expansions, the extent to which states had decided to make their programs consistent across the different eligibility categories was unknown. This report, a companion to the Family Planning

Report, asked states about benefits in place as of July 1, 2015 for women enrolled in fee-for-service Medicaid through different eligibility pathways, including traditional pre-ACA Medicaid pathways, expansion, and pregnancy-related eligibility for the following services: basic prenatal care, counseling and support services, delivery and postpartum care, and breastfeeding supports. This report presents survey findings for the 40 states and DC that provided responses to the survey. Throughout the report, DC is counted as a state, totaling 41 respondents. As illustrated in **Figure 1**, of the 41 respondents, 24 states and DC had adopted the ACA Medicaid expansion *as of July 1, 2015*. This report is the only one we know of that has examined Medicaid benefits for maternity care since the ACA's passage.

Key Findings

While the benefits requirements vary between eligibility pathways, one overarching finding from the survey is that most states provide the same benefits to beneficiaries who qualify through Medicaid's pregnancy eligibility pathway and adult pathway. Some states reported that in fact, they do not distinguish between the traditional full-scope Medicaid and pregnancy eligibility pathways in terms of the covered benefits. The survey questions covered four broad topics: prenatal services, counseling and support services, delivery and postpartum care, and breastfeeding services. Key findings on these topics are:

Prenatal Services

> *Prenatal care services monitor the progress of a pregnancy and identify and address potential problems before they become serious for either the mother or baby. Routine prenatal care encompasses a variety of services, including provider counseling, assessment of fetal development, genetic screening and testing, prenatal vitamins that contain folic acid and other nutrients, and ultrasounds, which provide important information about the progress of the pregnancy.*

- All survey states reported that they cover **prenatal vitamins** and **ultrasounds** for pregnant women. However, some states impose quantity limits or require a prescription for vitamins.
- Nearly all responding states (38/41) reported covering **amniocentesis** and **chorionic villus sampling** (CVS) tests across all eligibility pathways available in the state, but fewer states (33/41) reported covering **genetic counseling**, some of which limit the service to women with higher risk or that have a positive result in genetic screens.

Counseling and Support Services

> *There are a variety of support services that can aid pregnant and postpartum women with pregnancy, delivery, and child rearing and improve birth outcomes. These include educational classes on childbirth and infant care, transportation to appointments, and home visits during or after pregnancy to assist with basic medical care, counseling on healthy behaviors, and in-person infant care assistance.*

- Less than half of the responding states report that they provide **education services** to support childbirth, infant care or parenting in any of the Medicaid eligibility pathways. However, in some states services may be available through other public programs.
- Nearly all responding states provide **substance or alcohol abuse treatment** services for pregnant or postpartum women in most of the Medicaid eligibility pathways.

- Approximately three-fourths of the responding states cover prenatal and postpartum **home visits,** which give the opportunity for nurses and other clinicians to assist pregnant women and new parents in their homes with pregnancy management and child rearing skills.

Delivery and Postpartum Care

While all states are required to cover inpatient hospital care for Medicaid enrollees, there is more variation in coverage for delivery at birth centers or home births. Coverage for deliveries at birth centers is required in all states that license such facilities. In addition, coverage for doula assistance, which pays for a trained non-clinician to assist a woman before, during and/or after childbirth, by providing physical assistance, labor coaching, emotional support, and postpartum care is rare.

- A majority of responding states cover deliveries in **birth centers**, while half of the states cover **home deliveries**.
- Of all the services covered in the survey, coverage was lowest for **doula** care. Only four states reported that they cover doula assistance for women.

Breastfeeding Services

- There is a range of supports that have been found to help women initiate and maintain breastfeeding. These include breast pumps, lactation counseling by certified consultants both inpatient and outpatient after delivery, and educational programs, which can begin during pregnancy and continue after the birth of a child. States are required to cover breast pumps and consultation services for Medicaid expansion beneficiaries under the ACA's preventive services requirement. A majority of responding states cover both electric and manual **breast pumps**, but some report using various utilization controls such as prior authorization and quantity limits.
- While most responding states report that **breastfeeding education** and hospital-based **lactation consultations** are covered under traditional Medicaid, far fewer states continue coverage once the woman goes home.

Conclusion

The analysis of state responses to this survey found that overall most states cover a broad range of perinatal services in their full scope traditional Medicaid program, under full scope ACA Medicaid expansion, and pregnancy-related eligibility pathways. Most, but not all, of the 41 surveyed states report that they cover basic prenatal services such as ultrasounds and vitamins, prenatal genetic testing, home visits, delivery in birth centers, postpartum visits, and breast pumps for nursing mothers. Many states recognize that these services are critical to improving birth outcomes. Coverage for services that help women and their families care for their children after delivery, such as childbirth and parenting classes, breastfeeding education and lactation consultation is less common (**Table 1**). Only half of reporting states cover home births, and very few states cover doula supports despite research suggesting that this assistance results in better health outcomes.[3] While coverage requirements differ between eligibility pathways, in general, there is strong alignment within states across the various pathways.

The Medicaid program has a long history and excellent record of providing coverage for low-income pregnant women, with nearly half of all births nationwide provided through the program. Regardless of the outcome of current debates over the future of Medicaid or the ACA, the millions of low-income pregnant women that are

served by Medicaid will continue to need to have access to coverage that includes the broad range of pregnancy-related services that help assure healthy maternal and infant outcomes.

Table 1: Summary Results on Coverage of Selected Perinatal Services	
	States Reporting Coverage Under Traditional Medicaid:
Prenatal Services	
Genetic Counseling (33/41 states)	AR, CA, CO, CT, DC, DE, GA, HI, IA, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, NH, NV, NY, OH, OK, OR, SC, TN, TX, VA, VT, WA
Chronic Villus Sampling and Amniocentesis (38/41 states)	AK, AR, AZ, CA, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, NH, NM, NV, NY, OH, OK, OR, SC, TN, TX, VA, VT, WA, WV
Counseling and Support Services	
Case Management (35/41 states)	AK, AL, AR, AZ, CA, CO, DC, DE, GA, IA, ID, IL, IN, KY, MA, ME, MN, MO, MS, MT, NC, NE, NM, NV, NY, OH, OK, OR, TN, TX, VA, VT, WA, WV, WY
Substance Alcohol Abuse Treatment (40/41 states)	AK, AL, AR, AZ, CA, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NM, NV, NY, OH, OK, OR, SC, TN, TX, VA, VT, WA, WV, WY
Prenatal and Postpartum Home Visits (30/41 states)	AK, AR, CA, CT, DC, DE, GA, IA, ID, IL, IN, MA, MI, MN, MO, MS, MT, NC, NE, NH, NM, NY, OH, OK, OR, SC, VA, VT, WA, WV
Childbirth Education Classes (14/41states)	AR, CA, DC, DE, GA, HI, MI, MN, MS, NC, OH, OR, VA, WA
Infant Care/ Parenting Education (17/41 states)	AL, AR, CA, DC, DE, GA, HI, KY, MI, MN, MS, NM, NV, OH, OR, VA, WA
Deliveries and Postpartum care	
Birth Center Deliveries (32/41 states)	AK, AL, AZ, CA, CO, CT, DC, DE, GA, IA, IL, IN, KY, MA, MD, MN, MO, MT, NC, NE, NH, NM, NV, NY, OH, OK, OR, SC, TN, TX, WA, WV
Home Births (21/ 41 states)	AK, AZ, CA, CO, CT, IA, ID, IL, MD, MO, NH, NM, NY, OH, OR, SC, TX, VA, VT, WA, WV
Doula Services (4/41 states)	KY, MN, MS, OR
Postpartum Visit (41/41 states)	AK, AL, AR, AZ, CA, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, NY, OH, OK, OR, SC, TN, TX, VA, VT, WA, WV, WY
Breastfeeding Services	
Breastfeeding Education (27/41 states)	AK, AL, AR, AZ, CA, CO, CT, DC, DE, GA, HI, ID, IN, MA, MI, MN, MO, MS, NC, NV, NY, OH, OK, OR, SC, TN, VA
Electric Breast Pumps in Traditional Medicaid Program (35/41 states)	AK, AZ, CA, CO, CT, DC, DE, GA, HI, ID, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, NE, NH, NM, NY, OH, OK, OR, TN, TX, VA, VT, WA, WV, WY
Lactation Consultation in Hospital (26/41 states)	AK, AR, AZ, CA, CO, CT, DC, DE, HI, ID, IN, KY, MI, MN, MO, MS, NC, NE, NY, OH, OK, OR, SC, TN, VA, WA
Lactation Consultation in clinic and/or at home (16/41 states)	AR, CA, CO*, CT, DC, DE, HI, MN, MS, NC*, NY, OH, OK*, OR, VA*, WA*
NOTES: *CO, NC, OK, VA, & WA cover lactation consultation in clinic, but not in a home visit.	

***

Introduction

Overview

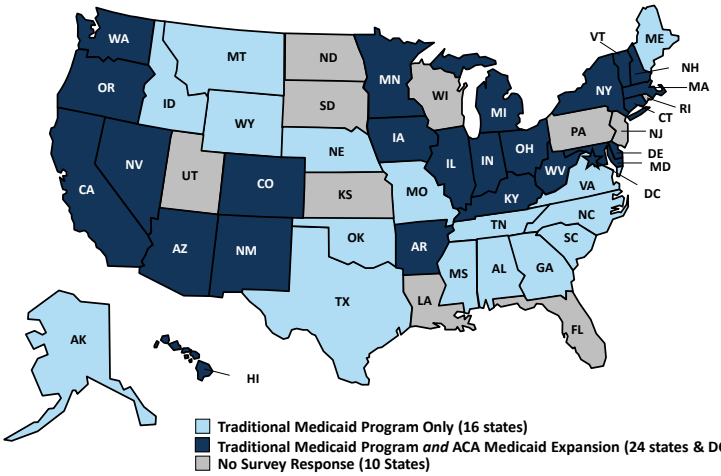
Medicaid is the leading source of financing for births in the U.S., covering nearly half in 2010.[4] While the federal and state governments jointly finance the program, states operate their programs and establish benefits, eligibility and coverage policies subject to broad federal guidelines. While states must provide eligible pregnant women with coverage of inpatient and outpatient medical care, they can make different choices regarding the broad range of pregnancy-related support services and other non-hospital care offered to pregnant women. To understand variations in the scope of coverage for perinatal and family planning services and related state Medicaid policies across the nation, the staff of the Kaiser Family Foundation and Health Management Associates surveyed states about perinatal and family planning services benefit policies that were in place as of July 1, 2015.

The survey was conducted between October 2015 and February 2016. Forty states and the District of Columbia (DC) responded to the survey. Non-responding states are: Florida, Kansas, Louisiana, New Jersey, North Dakota, Pennsylvania, Rhode Island, South Dakota, Utah and Wisconsin. The survey asked states to consider only state Medicaid policies under fee-for-service when responding to the questions. As illustrated in **Figure 2**, of the 41 respondents, *as of July 1, 2015,* 24 states and DC had adopted the ACA's Medicaid expansion and 16 states had not.[5]

Figure 2

State Medicaid Eligibility Pathways for Women, as of July 1, 2015

Based on responses from 40 States & DC



SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits

This report presents the survey findings on 41 states' Medicaid coverage of perinatal services under fee-for-service as of July 2015 (**DC** is referred to as a state throughout this report, for simplicity). Summary tables are presented throughout the report and more detailed, state-level tables are presented in **Appendix A**. A companion report summarizing state Medicaid coverage of family planning services is available on the Kaiser Family Foundation's website.

Background

For decades, Medicaid has been a critical safety net program for pregnant women. In response to increasing rates of infant mortality, Medicaid eligibility levels were increased incrementally throughout the late 1980s and early 1990s to promote access to early prenatal care and to improve birth outcomes. Prior to the ACA, federal law extended mandatory categorical Medicaid eligibility to pregnant women with family incomes up to 133% of the Federal Poverty Level (FPL), although states had the option of setting income thresholds above this level. Furthermore, pregnancy was considered a preexisting condition in the individual insurance market, and most individual policies required a waiting period or costly riders for maternity coverage. Therefore, Medicaid was virtually the only pathway to coverage for uninsured, low-income, pregnant women.

Coverage under the pre-ACA eligibility pathway for "pregnancy-related services" continued for up to 60 days postpartum. At that point, some women qualified for traditional Medicaid coverage as the parent of a dependent child, but many did not as the income threshold for parents was typically much lower than for pregnant women. This means that some women lost Medicaid coverage 60 days after the birth of a child, although their infant would remain eligible for one year.

The ACA allowed states to extend Medicaid coverage to nearly all individuals with incomes up to 138% FPL regardless of category, creating the structure for continuous coverage before, during, and after pregnancy for many more low-income women. In the 19 states that have not adopted the ACA's Medicaid expansion, pregnant women typically still lose coverage after the 60-day postpartum period because they are no longer eligible for coverage. Since the ACA's passage, there are now three major pathways to obtain Medicaid coverage for pregnant women (**Table 2**).

Table 2: Medicaid Eligibility Pathways for Pregnant Women
Pregnancy-only eligibility – Medicaid coverage available prior to the ACA for pregnant women through 60 days postpartum; all states required to cover pregnant women up to at least 133% FPL
Traditional Medicaid – Medicaid coverage available prior to the Affordable Care Act (ACA) based on an individual having income below a state's threshold as well as being in one of the program's eligibility categories: pregnant woman, parent of children 18 and younger, disabled, or over age 65
ACA Medicaid Expansion - The ACA allowed states to eliminate categorical requirements and extend Medicaid to most women and men with family income at or below 138% FPL. States that have adopted this expansion must cover all recommended preventive services without cost sharing for beneficiaries in this pathway.

In addition to increasing income eligibility levels, states have taken other steps to facilitate Medicaid coverage for pregnant women, such as presumptive eligibility, which allows providers to grant immediate, temporary Medicaid coverage to women who meet certain criteria while a formal eligibility determination is being made. For example, regular Medicaid coverage may overlay the presumptive eligibility period and provide a full range of services including prenatal vitamins, genetic counseling, case management services for high risk women, non-emergency medical transportation, and substance or alcohol abuse treatment. Pregnant beneficiaries also cannot be charged any cost-sharing under Medicaid.

Prior to the ACA, there were no federal requirements regarding the scope of services provided to pregnant women in traditional Medicaid or under the pregnancy-only pathway and no requirement to standardize coverage across the pathways. For the ACA Medicaid expansion population, however, the law defines a minimum "Alternative Benefit Plan" (ABP) that states must provide to beneficiaries under the Medicaid expansion option. The ACA specifies that the ABP must include 10 "essential health benefits," including maternity care and preventive care which must be provided at no cost to the patient.[6] The preventive care under this policy includes several services related to maternity care, such as prenatal visits, screening tests, folic acid supplements, and breastfeeding supports and equipment rental (**Table 3**). Benefit policies for traditional (pre-ACA) Medicaid programs and for pregnancy-only eligibility programs, are not bound by the ABP requirements, which means that the benefit packages can vary within states for different Medicaid populations based on their eligibility pathway.

Table 3: Preventive Services for Pregnant Women Required for Coverage under ACA Medicaid Expansion
Anemia screening on a routine basis for pregnant women
Bacteriuria urinary tract or other infection for pregnant women
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding **supplies including pumps**, for pregnant and nursing women
Depression Screening for all adults, including pregnant and postpartum women
Folic Acid supplements for women who may become pregnant
Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes
Hepatitis B screening for pregnant women at their first prenatal visit
HIV screening for all pregnant women, including those in labor who are untested or with unknown HIV Status
Rh Incompatibility screening for all pregnant women, and follow-testing for women at higher risk
Tobacco use screening and interventions for all women, and expanded for pregnant tobacco users
Syphilis screening for all pregnant women and other women at increased risk
SOURCE: HHS, Preventive Services Covered Under the Affordable Care Act, September 27, 2012

This survey asked states about the scope of coverage for pregnancy-related benefits under multiple eligibility pathways for Medicaid. Detailed findings from 40 states and DC on commonalities and differences between and within states are presented for routine prenatal services, counseling and support services, delivery and postpartum care, and breastfeeding supports. Coverage of postpartum contraception is discussed in a companion report on coverage of family planning services, available on the Kaiser Family Foundation's website.

Survey Results

Prenatal Services

Prenatal care services monitor the progress of a pregnancy and identify and address potential problems before they become serious for either the mother or baby. Increasing the share of pregnant women who begin care in the first trimester is one of the national objectives of the federal government's Healthy People 2020 initiative.[7] Routine prenatal care encompasses a variety of services, including provider counseling, assessment of fetal development, screening for genetic anomalies, prenatal vitamins that contain folic acid and other nutrients, and ultrasounds, which provide important information about the progress of the pregnancy.

Prenatal Vitamins and Ultrasound

All states that responded to the survey reported that they cover prenatal vitamins and ultrasounds for pregnant women regardless of eligibility pathway (**Table 4**). Some states impose limitations on this

Key Finding: Prenatal Vitamins and Ultrasound

All states cover prenatal vitamins and ultrasounds for pregnant women. Some states impose quantity limits or require a prescription for vitamins.

coverage however, such as requiring a prescription for prenatal vitamins or limits on the number of ultrasounds allowed during the course of a pregnancy.

Table 4: Coverage and Utilization Controls for Prenatal Vitamins and Ultrasounds			
	Traditional Medicaid (n=41)	Medicaid ACA Expansion (n=25)	Pregnancy Only Medicaid (n=41)
Prenatal Vitamins	41	25	41
Ultrasound	41	25	41
Limitations and Utilization Controls			
	Prenatal Vitamins	Ultrasound	
Prescription or other documentation (4)	AK, CO, CT, NY		
Price/quantity controls (6)	AR	AL, CO, MO, SC, TX	
Prior Authorization to exceed state quantity limits (3)		AL, SC, TX	
Age limitations (1)	MS – limited to ages 8-50		
Preferred Drug List (PDL) (1)	MS		
Pregnancy status (e.g. high-risk) (2)		TX, WV	

Appendix Table A1 provides state detail for states' prenatal service coverage policies.

Genetic Screening Services

Routine prenatal care typically includes ultrasound and blood marker analysis to determine the risk of certain birth defects such as sickle cell, down syndrome, or other birth abnormalities. While these tests are effective screening tools to determine risk, they are not diagnostic. If the results of screening tests are abnormal, genetic counseling is recommended and additional testing such as chorionic villus sampling (CVS) or amniocentesis may be needed.

Key Finding: Genetic Screening Services

Nearly all responding states reported covering CVS and amniocentesis across all eligibility pathways available in the state, but fewer states reported covering genetic counseling service, which is generally limited to women with higher risk or for those that have a positive result in genetic screens.

Table 5: State Coverage for Genetic Lab and Counseling Services				
	Traditional Medicaid (n=41)	ACA Medicaid Expansion (n=25)	Pregnancy Only (n=41)	Not Covered in Any Pathway (n=41)
Genetic Counseling	33	21	33	8
Chronic Villus Sampling	38	24	38	3
Amniocentesis	39	24	39	2

States were questioned about their policies with respect to genetic counseling, CVS, and amniocentesis testing for pregnant women. Of the 41 responding states, 33 reported covering all three services across all eligibility pathways (**Table 5**). Genetic counseling is covered in fewer states than either of the screening tests. The eight states that do not provide genetic counseling services through any Medicaid pathway are **Alabama, Alaska, Arizona, Idaho, Nebraska, New Mexico, West Virginia,** and **Wyoming.** Only one state, **Nebraska**, does not cover any of the three services under any of its eligibility pathways, but the state noted that genetic testing is covered for the mother and baby with prior authorization after delivery. Few states reported utilization controls or limitations. Medical necessity and an indication of risk for genetic anomalies were the

most frequently noted restrictions. **Appendix Table A2** provides detail on state Medicaid policies for genetic testing and counseling.

Counseling and Support Services

There are a variety of support services that can aid pregnant and postpartum women with pregnancy, delivery, and child rearing. These include educational classes on childbirth and infant care, transportation to appointments, and home visits during or after pregnancy to assist with basic medical care, counseling on healthy behaviors, and in person infant care assistance.

Childbirth and Parenting Education

Key Finding: Childbirth & Parenting Education

Less than half of the responding states report that they provide education services to support childbirth, infant care or parenting in any of the Medicaid eligibility pathways.

Less than half of responding states reported that they cover childbirth and parenting education for pregnant women (**Table 6**). The 13 states that cover both services are: **Arkansas**, **California, District of Columbia, Delaware, Georgia, Hawaii, Michigan, Minnesota, Mississippi, Ohio, Oregon, Virginia and Washington.** Conversely, two-thirds of states indicated they do not cover childbirth education in any of their programs (27 of 41 states) and over half indicated they do not cover formal or standalone infant care or parenting education (24 of 41 states). Among the states that reported that they do not cover educational services, some stated that such services are available through other public programs and some reported they provide education as part of prenatal visits. See **Appendix Table A3** for details on states' coverage of childbirth and parenting education.

Table 6: State Coverage for Childbirth and Parenting Education Services

	Traditional Medicaid (n=41)	Medicaid ACA Expansion (n=25)	Pregnancy Only Medicaid (n=41)	Not Covered in Any Medicaid Program
Childbirth Education	14	9	14	27
Infant care/Parenting education	17	12	17	24

Case Management and Substance Abuse Treatment

Key Finding: Case Management and Substance Abuse Services

Over three quarters of responding states indicated that they cover case management services for pregnant women across all Medicaid eligibility pathways. Nearly all states surveyed reported that they cover substance/alcohol abuse treatment for pregnant women

Case management can help pregnant women obtain and coordinate services that may be available from multiple providers. Six states do not provide case management in any Medicaid pathway: **Connecticut, Hawaii, Maryland, Michigan, New Hampshire,** and **South Carolina**. While the service is not separately billable, **Connecticut** notes that case management would be covered as part of a hospital admission or through a clinic or office visit. Most of the remaining 35 states provide case management through all eligibility pathways, with exceptions noted in **Appendix Table A4**.

Case management is often limited to women at higher health risk, or with medical conditions. For instance, **Missouri** noted that participants must qualify for case management services; **Nebraska** does not provide the benefit universally, rather it is based on the need of the individual; **West Virginia** provides the service

through its targeted case management program based on medical need. Four states also noted that the case management benefit is provided through managed care or utilization management contracts.

Misuse of alcohol and other substances during pregnancy is correlated with a wide range of negative infant outcomes, including premature birth, fetal alcohol syndrome, and infant drug withdrawal. The ACA requires states to cover counseling services for alcohol misuse for beneficiaries enrolled under the ACA's Medicaid expansion option.

All states surveyed reported that they cover substance/alcohol abuse treatment for pregnant women in at least one Medicaid eligibility pathway and most states align coverage across pathways (**Table 7**). **New Hampshire** is the only state that reported it does not cover substance abuse treatment in its traditional Medicaid pathway. **Appendix Table A4** provides detail around state coverage of case management services and substance and alcohol use treatment for pregnant women.

Table 7: Number of States Covering Counseling and Support Services

	Traditional Medicaid (n=41)	ACA Medicaid Expansion (n=25)	Pregnancy Only (n=41)	Not Covered in Any Program (n=41)	Utilization Controls
Case Management	35	19	32	6	• High risk or other medical criteria (AZ, MO, MT, NE, WV) • Components of contracted services (DC, GA, MS, WY) • Not separately billable (CT)
Substance/ Alcohol Abuse Treatment	40	Required	38		

Home Visiting Services

Key Finding: Home Visiting Services

Most of the responding states indicated they cover prenatal and postpartum home visits.

Home visits both during and after pregnancy can help pregnant and postpartum women care for themselves as well as their newborns. Typically conducted by nurses and social workers, they may use the time at home visits to counsel new and expectant parents on a wide range of subjects related to healthy pregnancies and raising healthy children, such as diet and nutrition, basic infant care, breastfeeding, and positive child development. These visits are meant to provide the time for deeper, one-on-one contact and counseling that pregnant women and new parents may not have during routine prenatal and well-baby appointments. Research has found that home visits are associated with a variety of positive outcomes, including lower severity of postpartum depression and improved mother-child interactions.[8] Home visits may also cover management of substance abuse, depression, and other chronic conditions. As shown in **Table 8**, over a quarter of responding states do not provide prenatal home visit supports in any Medicaid program (11 of 41 states). Nearly one fifth (8 of 41 states) do not provide postpartum home visit supports. Of the 30 states that cover both prenatal and postpartum home visits, nearly all provide the service across all eligibility pathways.

Three states provide postpartum home visits but do not provide prenatal home visits through any pathway: **Alabama, Maryland** and **Tennessee**. Some states cover prenatal or postpartum home visits under limited

circumstances. For example, **Michigan** notes that the state allows three postpartum home visits only when a physician has determined the mother or newborn to be at risk. **Appendix Table A5** details state coverage policies on home visiting services.

Table 8: Number of States Covering Prenatal and Postpartum Home Visits

	Traditional Medicaid (n=41)	ACA Medicaid Expansion (n=25)	Pregnancy Only (n=41)	Not Covered in Any Program (n=41)	Utilization Controls
Home Visit–Prenatal	30	17	29	11	• High risk or other medical criteria (CT, MI, MT) • A component of contracted services (GA) • Quantity controls or requirements (MI)
Home Visit–Postpartum	33	19	31	8	• High risk or other medical criteria (CT, MI) • A component of contracted services (GA) • Quantity controls or requirements (MI, NY, WV) • Not separately billable (AL)

Delivery and Postpartum Care

The survey questioned states about the provision of specific delivery services including deliveries at birth centers, home births, doula assistance, and postpartum visits. A doula is a trained non-clinician who assists a woman before, during and/or after childbirth, by providing physical assistance, labor coaching, emotional support, and postpartum care.

Key Finding: Delivery & Postpartum Care

A majority of responding states reported that they cover deliveries in birth centers but only half cover home deliveries. Very few states noted utilization controls for delivery options, and usually restrictions are related to provider requirements. Four states reported covering doula assistance.

Birth center delivery is more likely to be a covered benefit than is home birthing (**Table 9**). Over three-quarters of responding states (32 of 41) cover deliveries in birth centers compared with about half (21 of 41) covering home births. All states that cover the options within their traditional Medicaid program also provide coverage across all eligibility pathways available within the state. Per the ACA, coverage for deliveries at birth centers is required in all states that license such facilities. There is no comparable requirement for coverage of home births, but in states that have chosen to cover home births, some such as **Colorado** and **Virginia** reported that the births must be performed by Certified Nurse Midwives.

All states covered postpartum visits in all eligibility pathways except **Oklahoma** which does not cover the benefit in its program for pregnant women. **Illinois** and **Texas** allow reimbursement for one postpartum procedure per pregnancy. In **Texas,** the reimbursement covers all postpartum care regardless of the number of visits provided.

Conversely, the *only* states that cover doula services are **Kentucky, Minnesota, Mississippi** and **Oregon**, and they cover the service in all available eligibility pathways.[9] **Appendix Table A6** presents state coverage of delivery options and postpartum care.

Table 9: States Covering Delivery Services				
	Traditional Medicaid (n=41)	ACA Medicaid Expansion (n=25)	Pregnancy Only Medicaid (n=41)	Not Covered in Any Program
Birth Centers	32	21	32	9
Home Births	21	15	21	20
Doula Services	4	3	4	37
Postpartum Visit	41	25	40	0

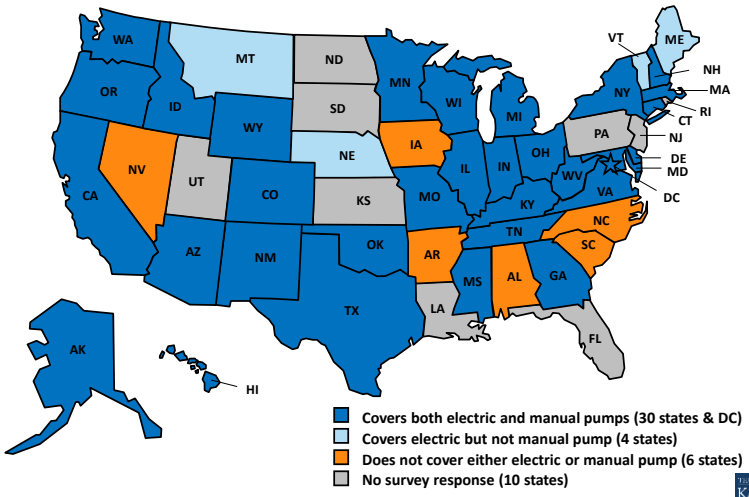
Breastfeeding Services

Raising breastfeeding rates is one of the country's national Healthy People 2020 goals.[10] There is a range of supports that have been found to help women initiate and maintain breastfeeding, including breast pumps, lactation counseling by certified consultants both inpatient and outpatient after delivery, and educational programs, which can begin during pregnancy and continue after the birth of a child. States are required to cover breast pumps and consultation services for Medicaid expansion beneficiaries under the ACA's preventive services requirement.

Figure 3

Traditional Medicaid Coverage of Breastfeeding Pumps

Based on 40 states & DC



SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits

Breast Pumps

Key Finding: Breast Pump Coverage

A majority of responding states cover both electric and manual breast pumps, but some report using various utilization controls such as prior authorization or quantity limits.

Most responding states report that they cover electric breast pumps (35 of 41 states) and manual pumps (31 of 41 states) in their traditional Medicaid program (**Table 10**).[11] All states that cover pumps in their traditional Medicaid program also cover the benefit in all eligibility pathways except **Illinois** and **Oklahoma,** which do not provide the benefit in their program for pregnant women. Six states do not provide either electric or manual pumps under either their traditional Medicaid program or their pregnancy-only eligibility pathway: **Alabama, Arkansas, Iowa, North Carolina, Nevada,** and **South Carolina** (**Figure 3**).[12]

Table 10: Breastfeeding Supplies			
	Traditional Medicaid (n=41)	Pregnancy Only Medicaid (n=41)	Not Covered in Any Pathway (n=41)
Electric Breast Pump	35	33	6
Manual Breast Pump	31	29	10

*While coverage of breast pumps is required for all ACA Medicaid expansion enrollees, coverage detail regarding the type of pump covered was not reported by Arkansas, Iowa or Nevada.

Breast Pump Utilization Controls

Several states reported utilization controls for breast pumps. As shown in **Table 11**, prior authorization is the most frequently employed utilization control, followed by quantity/time limits. Some states noted multiple utilization policies. For instance, **Colorado** requires prior authorization for electric pumps. The state allows rental or purchase of a breast pump based on the situation of the infant or mother. The state covers rental of an electric pump when the infant is expected to be hospitalized for less than 54 days, but allows breast pump purchase for hospital stays expected to last longer than this.

For quantity/time limits, **Massachusetts** limits the purchase of either an electric pump or manual to one per member every five years. **Ohio** limits electric pumps to one every five years, and a manual pump to one every 24 months but did not specify rental or purchase requirements. **Texas** limits the purchase of an electric or manual breast pump to one every three years, but does not time-limit the rental of a hospital grade pump. **Appendix Table A7** provides policy detail around state Medicaid coverage for breast pumps.

Table 11: Utilization Controls Applied to Breast Pump Benefit

Utilization Control	States with Utilization Policy
Prior Authorization (7)	CO, MA*, MI*, MO, MT, OH*, WA
Limited to mothers with critical care/NICU infants (3)	CO, MI, TN
Quantity/time limits (4)	MA, MI, OH, TX,
Conditions determine rental or purchase (3)	CO, MI, TX*
Limited to rental (2)	Rental: MT, WA

*MI: Prior authorization is not required when standards of care are met. It is required for rental beyond 3 months.
MA and OH: Prior authorization required to exceed quantity limit.
TX: Purchase of a breast pump is limited to one per three years. Rental is not time-limited.

Breastfeeding Education and Lactation Consultation

Key Finding: Breastfeeding Education and Lactation Consultation

Most responding states reported that breastfeeding education and hospital-based lactation consulting services are covered under traditional Medicaid, but most states do not provide lactation consultation in settings other than a hospital.

The survey asked about coverage for breastfeeding education such as classes and about coverage for lactation consultation in the hospital, clinic/outpatient, and home settings. There is more variation across the states in the coverage of breastfeeding education and consultation than for breast pumps. As shown in **Table 12**, 27 of 41 responding states cover breastfeeding education under traditional Medicaid. Individual lactation consultant services are most likely to be covered in the hospital setting. Nearly two-thirds of states responding to the survey stated they cover services in the hospital compared with a little over one-third of responding states providing the service in an outpatient/clinic setting, and less than a quarter of states providing the benefit for postpartum women in their homes.

States did not report utilization controls for breastfeeding support services but a few states noted provider requirements. For example, **Connecticut** allows the services in hospital and clinic settings if provided by any of these licensed provider types: Physician, DO, Physician Assistant, Advanced Practice Registered Nurse (APRN), or Certified Nurse Midwife (CNM), and is a component of the hospital or clinic reimbursed services. In **New York**, qualified practitioners for Medicaid reimbursable lactation counseling must be state licensed, registered, or certified health care professionals who are International Board Certified Lactation Consultants (IBCLCs) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) and one of the following: Physician, Nurse Practitioner, Midwife, Physician Assistant, Registered Nurse.

Table 12: State Coverage for Breastfeeding Support Services				
	Traditional Medicaid (n=41)	ACA Medicaid Expansion (n=25)	Pregnancy-Only Medicaid (n=41)	Not Covered in Any Program (n=41)
Breastfeeding Education	27	15	26	14
Individual Lactation Consultation				
• **Hospital Based**	26	16	25	15
• **Outpatient Clinic**	16	12	15	25
• **Home Visit**	11	10	11	30

Alignment Across Eligibility Pathways and Reimbursement Mechanisms

In the 27 states that cover breastfeeding education in their traditional Medicaid program, coverage is aligned across the three Medicaid eligibility pathways, except in **Nevada**, which provides the service under traditional Medicaid, but not through the ACA Medicaid expansion or through the state's program for pregnant women.

However, there is more variation between eligibility pathways for coverage of lactation consultation. Of the 26 states that cover individual lactation services, only 11 cover hospital-based, outpatient, and home consultations services in all of the eligibility pathways available in the state: **Arkansas, California, Connecticut, District of Columbia, Delaware, Hawaii, Minnesota, Mississippi, New York, Ohio,** and **Oregon**. All of the 26 states cover inpatient consultation in all of their pathways, with the exception of Oklahoma in the pregnancy only pathway.

Many states reported that reimbursement for lactation consultation is not a separately reimbursable service but is included as a component of other services provided (**Table 13**), most frequently as a component of hospital reimbursement (11 states). For example, **Connecticut** noted that the service is not a separately billable service but it is covered as part of a clinic/office visit or hospital stay.

Table 13: Reimbursement Methodologies for Lactation Consultant Services		
Included in Hospital DRG or Global Fee (10)	Included in Outpatient Clinic Visit (3)	Included in Home Visit (2)
• Arkansas • Arizona • Colorado* • Connecticut • Kentucky • Michigan • Missouri • Oklahoma • Virginia • Washington	• Arkansas • Colorado* • Connecticut	• Arkansas • Connecticut
* Colorado provides the service as a part of problem specific care, or a special program service such as the Nurse Home Visitor Program but not separately reimbursable.		

Appendix Table A8 reports coverage policies for breastfeeding education services across the states. **Appendix Table A9** presents information on states' coverage of lactation consultation and **Appendix Table A10** compares coverage within states between eligibility pathways.

Conclusion

The survey of state responses found that in 2015, most states cover a broad range of perinatal services in their full scope traditional Medicaid program, under full scope ACA Medicaid expansion, and pregnancy-related eligibility pathways. Most of the 41 surveyed states report that they cover basic prenatal services such as ultrasounds and vitamins, prenatal genetic testing, home visits, delivery in birth centers, postpartum visits, and breast pumps for nursing mothers. Coverage for services that help women and their families care for their children after delivery, such as childbirth and parenting classes, breastfeeding education and lactation consultation is less common. In particular, very few states cover doula supports despite research suggesting that this assistance results in better health outcomes.[13] While coverage requirements differ between eligibility pathways in some cases, for the most part, there is strong alignment within states for the various pathways.

Maternity care is typically reimbursed with a global fee that covers all care for pregnant women through the postpartum period. Some states reported that support services, such as childbirth and breastfeeding education are included in the global fee and are not reimbursed separately. In these cases, the structure of the benefit is not clear, particularly who would provide these services and the scope of services available to beneficiaries.

Medicaid enrollment across the country has risen significantly since the ACA's passage but in states that have not expanded eligibility under the ACA, many women lose coverage after 60 days postpartum and become uninsured. Furthermore, it is important to recognize the ACA's role in establishing a floor of benefits for pregnant women enrolled in the program in expansion states. The ACA's requirement that newly eligible beneficiaries are covered for federally recommended preventive services means that pregnant women on the program in expansion states are guaranteed coverage for folic acid supplements, breast pumps, and several screening tests. Many states have structured their programs so all pregnant women on Medicaid are covered for their services regardless of the eligibility pathway that qualifies them for coverage.

The Medicaid program has a long history and excellent record of providing coverage for low-income pregnant women, with almost half of the nation's birth covered under the program. Regardless of the outcome of current debates over the future of Medicaid or the ACA, the millions of low-income pregnant women that are served by Medicaid will continue to need to have access to coverage that includes the broad range of pregnancy-related services that help assure healthy maternal and infant outcomes.

Acknowledgements

The authors express appreciation for the assistance of several individuals who assisted with the preparation, testing, and refinement of the survey instrument, including Yali Bair of Ursa Consulting, Amy Moy from the California Family Health Council, Tasmeen Weik of the federal Office of Population Affairs, Melanie Reece of Colorado's Department of Health Care Policy and Financing, and Lisa DiLernia of Michigan's Department of Health and Human Services.

We thank the following colleagues from Health Management Associates: Joan Henneberry for guidance and subject matter expertise; Dennis Roberts for database development and management; and Nicole McMahon for assistance with compiling the state data tables.

We also thank the Medicaid directors and staff in the 40 states and the District of Columbia who completed the survey on which this brief is based.

Appendix A: State-Level Survey Results

Table A1: Medicaid Coverage Policies for Routine Prenatal Services			
States	Prenatal Vitamins (n=41) Yes = 41	Ultrasound (n=41) Yes = 41	Limitations/ Utilization Controls
Alabama	✓	✓	Requires prior authorization for 3 or more ultrasounds
Alaska	✓	✓	Require prescription for prenatal vitamins
Arizona	✓	✓	
Arkansas	✓	✓	
California	✓	✓	
Colorado	✓	✓	Require prescription for prenatal vitamins. Covered during pregnancy and postpartum with prescription. Two ultrasounds covered for low-risk-uncomplicated pregnancies; more allowed if medically necessary.
Connecticut	✓	✓	Require prescription for prenatal vitamins. Vitamins available to individuals under age 21 over-the-counter.
Delaware	✓	✓	
District of Columbia	✓	✓	
Georgia	✓	✓	
Hawaii	✓	✓	
Idaho	✓	✓	
Illinois	✓	✓	
Indiana	✓	✓	
Iowa	✓	✓	
Kentucky	✓	✓	
Maine	✓	✓	
Maryland	✓	✓	
Massachusetts	✓	✓	
Michigan	✓	✓	
Minnesota	✓	✓	
Mississippi	✓	✓	Prenatal vitamins included on state's Preferred Drug List; covered for females age 8-50.
Missouri	✓	✓	Allows 3 ultrasounds per rolling year
Montana	✓	✓	
Nebraska	✓	✓	
Nevada	✓	✓	
New Hampshire	✓	✓	
New Mexico	✓	✓	
New York	✓	✓	Requires fiscal order to obtain vitamins
North Carolina	✓	✓	
Ohio	✓	✓	
Oklahoma	✓	✓	
Oregon	✓	✓	
South Carolina	✓	✓	Requires prior authorization for more than 3 ultrasounds
Tennessee	✓	✓	
Texas	✓	✓	Requires prior authorization for more than 3 ultrasounds, but does not count those received in ER, under outpatient observation, or during a hospital stay. Ultrasounds are covered when medically indicated and may be indicated for suspected genetic defects, high risk pregnancies and fetal growth retardation.
Vermont	✓	✓	
Virginia	✓	✓	
Washington	✓	✓	

Table A1: Medicaid Coverage Policies for Routine Prenatal Services			
States	**Prenatal Vitamins (n=41) Yes = 41**	**Ultrasound (n=41) Yes = 41**	**Limitations/ Utilization Controls**
West Virginia	✓	✓	Allows ultrasounds when medically necessary and in accordance with criteria for high risk pregnancies established by American Congress of Obstetrics and Gynecology.
Wyoming	✓	✓	
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.			

Table A2: Coverage Policies for Perinatal Genetic Screening Services				
States	Genetic Counseling (n=41) Yes = 33 No = 8	Chorionic Villus Sampling (n=41) Yes = 38 No = 3	Amniocentesis (n=41) Yes = 39 No = 2	Limitations/ Utilization Controls
Alabama	No	No	✓	
Alaska	No	✓	✓	
Arizona	No	✓	✓	
Arkansas*	✓	✓	✓	
California	✓	✓	✓	
Colorado	✓	✓	✓	Requires documentation of clinical indication for genetic testing procedures.
Connecticut	✓	✓	✓	
Delaware	✓	✓	✓	
District of Columbia	✓	✓	✓	
Georgia	✓	✓	✓	
Hawaii	✓	✓	✓	
Idaho	No	✓	✓	
Illinois	✓	✓	✓	
Indiana	✓	✓	✓	
Iowa*	✓	✓	✓	
Kentucky	✓	✓	✓	For genetic counseling, allows report and interpretation only
Maine	✓	✓	✓	
Maryland	✓	✓	✓	
Massachusetts	✓	✓	✓	Genetic counseling limited to antepartum counseling for high-risk women.
Michigan	✓	✓	✓	Prior authorization required for genetic testing when necessary to establish a molecular diagnosis and treatment of a genetic disease, and all conditions are met as outlined in Michigan Medicaid Provider Manual. If medically necessary and on a case-by-case basis, prior authorization may be requested to allow for exceptions to policy restrictions.
Minnesota	✓	✓	✓	
Mississippi	✓	✓	✓	Covers genetic testing when medically necessary to establish a diagnosis of an inheritable disease if: **a)** the beneficiary displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic), **b)** the result of the test will directly guide the treatment being delivered to the beneficiary, and **c)** after history, physical exam, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.
Missouri	✓	✓	✓	
Montana	✓	✓	✓	
Nebraska	No	No	No	
Nevada	✓	✓	✓	

Table A2: Coverage Policies for Perinatal Genetic Screening Services				
States	Genetic Counseling (n=41) Yes = 33 No = 8	Chorionic Villus Sampling (n=41) Yes = 38 No = 3	Amniocentesis (n=41) Yes = 39 No = 2	Limitations/ Utilization Controls
New Hampshire	✓	✓	✓	
New Mexico	No	✓	✓	
New York	✓	✓	✓	
North Carolina	✓	✓	✓	
Ohio	✓	✓	✓	
Oklahoma	✓	✓	✓	
Oregon	✓	✓	✓	Covers CVS for a positive aneuploidy screen, maternal age greater than 34, fetal structural anomalies, family history of inheritable chromosomal disorder, or elevated risk of neural tube defect.
South Carolina	✓	✓	✓	
Tennessee	✓	✓	✓	
Texas	✓	✓	✓	Restricts genetic counseling to one service per pregnancy.
Vermont	✓	✓	✓	
Virginia	✓	✓	✓	
Washington	✓	✓	✓	
West Virginia	No	✓	✓	
Wyoming	No	No	No	State reported that genetic counseling covered for BRCA only.

NOTES: * **AR** covers procedures and counseling through traditional Medicaid and pregnant women eligibility pathways, but not through ACA Medicaid expansion. **IA** covers counseling through traditional Medicaid and ACA Medicaid expansion, but does not offer the benefit to those eligible through the pregnancy pathway. **NE** does not cover "unborn genetic testing and counseling, per a provider bulletin: http://dhhs.ne.gov/medicaid/Documents/pb1547.pdf
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.

Table A3: Coverage Policies for Childbirth and Parenting Classes			
States	Childbirth Ed./ Classes (n=41) Yes = 14 No = 27	Infant Care/ Parenting Ed. Classes (n=41) Yes = 17 No = 24	Limitations/ Utilization Controls
Alabama	No	✓	Provides parenting and infant care education through its care coordination program and global payment methodology
Alaska	No	No	
Arizona	No	No	
Arkansas	✓	✓	Childbirth and parenting/infant care education included in risk management services for pregnant women under traditional Medicaid program and pregnancy eligibility pathway, but not covered under ACA Medicaid expansion eligibility pathway.
California	✓	✓	
Colorado	No	No	Considers childbirth and parenting education as part of the bundled labor and delivery reimbursement, but does not reimburse for separate education
Connecticut	No	No	Services could be part of an office or clinic visit
Delaware	✓	✓	State is working with opioid treatment programs to enhance prenatal care in high risk populations
District of Columbia	✓	✓	
Georgia	✓	✓	
Hawaii	✓	✓	
Idaho	No	No	
Illinois	No	No	
Indiana	No	No	
Iowa	No	No	
Kentucky	No	✓	Childbirth education services are available through other publicly funded program
Maine	No	No	
Maryland	No	No	
Massachusetts	No	No	
Michigan	✓	✓	
Minnesota	✓	✓	
Mississippi	✓	✓	
Missouri	No	No	
Montana	No	No	Services not covered at the time of survey, but as of 1/1/2016, added coverage for "Centering Pregnancy" classes offered by certified facilities.
Nebraska	No	No	Services are available through other publicly funded program
Nevada	No	✓	
New Hampshire	No	No	
New Mexico	No	✓	Some managed care entities provide both childbirth and parenting education services.
New York	No	No	Parenting and child care education may be provided as a component of nursing or other services, but is not separately reimbursable
North Carolina	✓	No	
Ohio	✓	✓	
Oklahoma	No	No	

Table A3: Coverage Policies for Childbirth and Parenting Classes			
States	Childbirth Ed./ Classes (n=41) Yes = 14 No = 27	Infant Care/ Parenting Ed. Classes (n=41) Yes = 17 No = 24	Limitations/ Utilization Controls
Oregon	✓	✓	Provides services to individuals through their nurse home visiting program, or through office visit. Does not reimburse for group classes.
South Carolina	No	No	
Tennessee	No	No	
Texas	No	No	
Vermont	No	No	
Virginia	✓	✓	
Washington	✓	✓	
West Virginia	No	No	Services are available through other publicly funded program
Wyoming	No	No	
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.			

Table A4: Coverage of and Utilization Controls for Case Management Services and Substance and Alcohol Abuse Treatment			
State	Case Management (n=41) Yes = 35 No = 6	Substance and Alcohol Abuse Treatment (n=41) Yes= 41	Limitations/ Utilization Controls
Alabama	✓	✓	State's Screening, Brief Intervention, Referral, and Treatment Program (SBIRT) services are not a covered benefit for smoking or tobacco abuse, individuals who have been diagnosed with a substance use disorder, or individuals who have had previous and/ or are now receiving treatment for a substance abuse disorder. Providers must be certified to provide such a service.
Alaska	✓	✓	
Arizona	✓	✓	If high risk, case management available
Arkansas*	✓	✓	
California*	✓	✓	
Colorado	✓	✓	Case management: General service & provided as part of some special programs (i.e. Prenatal Plus, Nurse Home Visitor's program, Special Connections) Substance Abuse Treatment: Primarily through Behavior Health Organization for also some FFS coverage
Connecticut	No	✓	Case management not a separately billable service, but would be covered as part of the overall hospital admission or office/ clinic visit
Delaware	✓	✓	
DC	✓	✓	Case management is required by contract for all pregnant beneficiaries enrolled in a MCO
Georgia	✓	✓	Case management is available only for women enrolled in managed care.
Hawaii	No	✓	
Idaho	✓	✓	
Illinois*	✓	✓	
Indiana	✓	✓	
Iowa*	✓	✓	Substance Abuse Treatment: Covered outside of the family planning benefit
Kentucky	✓	✓	
Maine	✓	✓	
Maryland	No	✓	
Massachusetts	✓	✓	
Michigan	No	✓	
Minnesota	✓	✓	
Mississippi*	✓	✓	Case management is a benefit for Managed Care members. Restricted to certain provider types.
Missouri	✓	✓	Participants must qualify for prenatal case management services
Montana	✓	✓	Covers targeted case management for high risk pregnant women. Providers must be approved by the Department.
Nebraska	✓	✓	Case management not covered for all, but depends on the individual
Nevada	✓	✓	
New Hampshire*	No	✓	
New Mexico	✓	✓	
New York	✓	✓	
North Carolina	✓	✓	

Table A4: Coverage of and Utilization Controls for Case Management Services and Substance and Alcohol Abuse Treatment			
State	**Case Management (n=41) Yes = 35 No = 6**	**Substance and Alcohol Abuse Treatment (n=41) Yes= 41**	**Limitations/ Utilization Controls**
Ohio	✓	✓	
Oklahoma	✓	✓	
Oregon	✓	✓	
South Carolina	No	✓	
Tennessee	✓	✓	Provided as medically necessary.
Texas	✓	✓	
Vermont	✓	✓	
Virginia	✓	✓	
Washington	✓	✓	
West Virginia	✓	✓	Through targeted case management. No hard caps for utilization, based upon medical necessity Substance Abuse Treatment: Based on medical necessity
Wyoming	✓	✓	Case management: Through a utilization management contract for non-waiver situations Substance Abuse Treatment: Outpatient only for adults.

NOTES: *__AR__ does not cover case management through ACA Medicaid Expansion. __CA__ & __MS__ do not cover case management through Pregnancy-Only Medicaid. __IL__ does not cover case management or substance abuse treatment through Pregnancy-Only Medicaid. __IA__ does not cover substance abuse treatment through Pregnancy-Only Medicaid. __NH__ does not cover substance abuse treatment through Traditional Medicaid or Pregnancy only Medicaid.
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits

Table A5: Coverage Policies of Prenatal and Postpartum Home Visits			
State	Home Visits – Prenatal (n=41) Yes = 30 No = 11	Home Visits – Postpartum (n=41) Yes = 33 No = 8	Limitations/ Utilization Controls
Alabama	No	✓	Postpartum home visits are included in the global payment methodology.
Alaska	✓	✓	
Arizona	No	No	
Arkansas*	✓	✓	
California	✓	✓	
Colorado	No	No	Provided as part of some special programs
Connecticut	✓	✓	Prenatal nursing care services provided to women at high risk of negative pregnancy outcome Pregnancy related preventive postpartum nursing care services only for high risk women and limited to services provided during the 60-day time period following childbirth.
Delaware	✓	✓	
DC	✓	✓	
Georgia	✓	✓	Home visits are available in association with case management through the managed care plans.
Hawaii	No	No	
Idaho	✓	✓	
Illinois*	✓	✓	
Indiana	✓	✓	
Iowa	✓	✓	
Kentucky	No	No	
Maine	No	No	
Maryland	No	✓	
Massachusetts	✓	✓	
Michigan	✓	✓	Medicaid covers prenatal home visits when there is a medical condition. Home visits provided for preventive health services would be covered by the MIHP, allowing for up to 9 visits. Home visits for assessment, evaluation, and teaching are covered for women and newborns following delivery when a physician has determined the mother or newborn may be at risk. Medicaid allows one initial postpartum visit, one initial newborn visit, and one subsequent visit to the mother and newborn for a total of 3 visits per pregnancy. Services may also be provided by an MIHP provider.
Minnesota	✓	✓	
Mississippi	✓	✓	
Missouri	✓	✓	
Montana	✓	✓	Home visits are allowed through targeted case management.
Nebraska	✓	✓	
Nevada	No	No	
New Hampshire	✓	✓	
New Mexico	✓	✓	
New York	✓	✓	Postpartum home visits: Limitation 1 visit
North Carolina	✓	✓	
Ohio	✓	✓	
Oklahoma*	✓	✓	
Oregon	✓	✓	

Table A5: Coverage Policies of Prenatal and Postpartum Home Visits			
State	Home Visits – Prenatal (n=41) Yes = 30 No = 11	Home Visits – Postpartum (n=41) Yes = 33 No = 8	Limitations/ Utilization Controls
South Carolina	✓	✓	
Tennessee	No	✓	Postpartum home visits provided as medically necessary.
Texas	No	No	
Vermont	✓	✓	Home nursing visits
Virginia	✓	✓	
Washington	✓	✓	
West Virginia*	✓	✓	"Right From the Start" program requires Designated Care Coordinators (DCCs) to make at least one visit within 60 days postpartum to help ensure the client has followed up with her postpartum doctor's visit. DCCs are allowed to provide necessary services within that 60-day postpartum period, so more than one visit is permitted and encouraged.
Wyoming	No	No	Public Health Nurse completes these visits. Postpartum home visit paid through state/ local funds (not Medicaid)

NOTES: *__AR__ does not cover prenatal or postpartum home visits through ACA Medicaid Expansion. __IL__ does not cover prenatal or postpartum home visits through Pregnancy-only Medicaid. __WV__ does not cover prenatal home visits through ACA Medicaid Expansion. __OK__ does not cover postpartum home visits through Pregnancy-Only Medicaid.
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits

Table A6: Coverage Policies for Delivery and Postpartum Care					
States	Birth Centers (n=41) Yes = 32 No = 9	Home Births (n=41) Yes = 21 No = 20	Doula Services (n=41) Yes = 4 No = 37	Postpartum Visit (n=41) Yes = 41	Limitations/ Utilization Controls
Alabama	✓	No	No	✓	
Alaska	✓	✓	No	✓	
Arizona	✓	✓	No	✓	
Arkansas	No	No	No	✓	
California	✓	✓	No	✓	
Colorado	✓	✓	No	✓	Requires birth centers to be licensed and enrolled as specialty providers. Requires home births to be performed by physicians or Certified Nurse Midwives (CNMs) carrying malpractice insurance covering home births.
Connecticut	✓	✓	No	✓	Postpartum visits are covered in the hospital, office, clinic and home settings
Delaware	✓	No	No	✓	
District of Columbia	✓	No	No	✓	
Georgia	✓	No	No	✓	
Hawaii	No	No	No	✓	
Idaho	No	✓	No	✓	Only covers hospital-based birth centers
Illinois	✓	✓	No	✓	One postpartum visit limit
Indiana	✓	No	No	✓	
Iowa	✓	✓	No	✓	
Kentucky	✓	No	✓	✓	
Maine	No	No	No	✓	
Maryland	✓	✓	No	✓	
Massachusetts	✓	No	No	✓	Limits the use of birth centers to women at low risk for delivery complications.
Michigan	No	No	No	✓	
Minnesota	✓	No	✓	✓	
Mississippi	No	No	✓	✓	
Missouri	✓	✓	No	✓	
Montana	✓	No	No	✓	Requires birth centers to be accredited by a national organization and licensed by the state
Nebraska	✓	No	No	✓	
Nevada	✓	No	No	✓	
New Hampshire	✓	✓	No	✓	
New Mexico	✓	✓	No	✓	
New York	✓	✓	No	✓	
North Carolina	✓	No	No	✓	
Ohio	✓	✓	No	✓	
Oklahoma	✓	No	No	✓	Does not cover postpartum visit for pregnancy-only pathway
Oregon	✓	✓	✓	✓	

Table A6: Coverage Policies for Delivery and Postpartum Care					
States	Birth Centers (n=41) Yes = 32 No = 9	Home Births (n=41) Yes = 21 No = 20	Doula Services (n=41) Yes = 4 No = 37	Postpartum Visit (n=41) Yes = 41	Limitations/ Utilization Controls
South Carolina	✓	✓	No	✓	
Tennessee	✓	No	No	✓	
Texas	✓	✓	No	✓	One postpartum care procedure code reimbursed per pregnancy covering all postpartum care regardless of the number of postpartum visits provided.
Vermont	No	✓	No	✓	
Virginia	No	✓	No	✓	Requires a Certified Professional Midwife to perform home births.
Washington	✓	✓	No	✓	
West Virginia	✓	✓	No	✓	
Wyoming	No	No	No	✓	
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.					

Table A7: Coverage of and Utilization Controls for Breast Pumps			
States	Electric (n=41) Yes = 35 No = 6	Manual (n=41) Yes = 31 No = 10	Utilization Controls
Alabama	No	No	Breast pumps are provided under the WIC Program through the Alabama Department of Public Health
Alaska	✓	✓	
Arizona	✓	✓	If medically necessary.
Arkansas	No	No	
California	✓	✓	
Colorado	✓	✓	Electric: Prior Authorization required. Rental for critical care infants with anticipated hospitalizations <54 days. Purchase allowed if hospitalization > 54 days. Manual: Covered for use with premature & critical care infants
Connecticut	✓	✓	
Delaware	✓	✓	
District of Columbia	✓	✓	
Georgia	✓	✓	
Hawaii	✓	✓	
Idaho	✓	✓	
Illinois*	✓	✓	Physician order required for Electric Pump
Indiana	✓	✓	
Iowa	No	No	
Kentucky	✓	✓	
Maine	✓	No	
Maryland	✓	✓	
Massachusetts	✓	✓	For electric or manual purchases, prior authorization required to exceed 1 pump per member every 5 years
Michigan	✓	✓	Electric: Rental of hospital grade pump covered for a beneficiary with a NICU infant up to 3 months of age with a condition or situation that is specified in policy. Prior authorization is not required when Standards of Coverage are met, but is required beyond 3 months. A double electric breast pump, purchase only, is covered once per 5 years for a beneficiary. A manual breast pump is covered once per birth.
Minnesota	✓	✓	
Mississippi	✓	✓	
Missouri	✓	✓	Electric breast pump must be prior authorized.
Montana	✓	No	Rental of electric pump through a durable medical equipment provider covered. Requires Prior Authorization.
Nebraska	✓	No	Electric pump is the only pump on our fee schedule
Nevada	No	No	
New Hampshire	✓	✓	
New Mexico	✓	✓	
New York	✓	✓	
North Carolina	No	No	
Ohio	✓	✓	Electric: Allow 1 every 5 years. Requires prior authorization to receive another within this time period. Manual: Allow 1 every 24 months
Oklahoma*	✓	✓	
Oregon	✓	✓	
South Carolina	No	No	Not covered by Medicaid however it is provided by the Health Department
Tennessee	✓	✓	Provided to postpartum mothers with premature infants receiving care in the neonatal intensive care unit.
Texas	✓	✓	In Medicaid fee-for-service, the purchase of a breast pump is limited to one every three years. Rental of a hospital-grade breast pump is not time-limited.
Vermont	✓	No	

Table A7: Coverage of and Utilization Controls for Breast Pumps			
States	Electric (n=41) Yes = 35 No = 6	Manual (n=41) Yes = 31 No = 10	Utilization Controls
Virginia	✓	✓	Covered as a benefit through Managed care. Fee-for-service coverage added effective 1/1/16.
Washington	✓	✓	Electric: Prior authorization required. E0604 is covered as rental only; if kit dispensed in hospital additional kit is not covered
West Virginia	✓	✓	
Wyoming	✓	✓	

NOTES: **IL** and **OK** do not cover breast pumps through Pregnancy-only Medicaid.
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.

Table A8: Coverage of and Utilization Controls for Breastfeeding Education Services		
States	Covered? (n=41) Yes = 27 No = 14	Utilization Controls
Alabama	✓	Breastfeeding education is provided through care coordination in the Maternity Program
Alaska	✓	
Arizona	✓	Provided by most delivering hospitals.
Arkansas	✓	Included in physician or midwife's visit or institutional global payment
California	✓	
Colorado	✓	Covered as part of normal bundled L&D & postpartum care services, for problem specific care & Preventive E/M visits. Breastfeeding/lactation classes NOT covered
Connecticut	✓	Not a separately billable services, but it is covered as part of the office/clinic visit or hospital stay.
Delaware	✓	
District of Columbia	✓	
Georgia	✓	
Hawaii	✓	
Idaho	✓	
Illinois	No	Covered under WIC program
Indiana	✓	
Iowa	No	
Kentucky	No	
Maine	No	
Maryland	No	
Massachusetts	✓	
Michigan	✓	Included in reimbursement rate for office visit
Minnesota	✓	
Mississippi	✓	
Missouri	✓	Covered if provided during a physician office visit.
Montana	No	Effective 1/1/16 breastfeeding education will be covered for Baby Friendly facilities only.
Nebraska	No	Medicaid does not cover after discharge from the hospital but DHHS has a department devoted to this that anyone can attend
Nevada	✓	Offered under traditional Medicaid but not covered under the ACA Medicaid Expansion or Pregnancy-only eligibility pathways
New Hampshire	No	
New Mexico	No	
New York	✓	
North Carolina	✓	Revision to policy in progress to allow coverage
Ohio	✓	
Oklahoma	✓	
Oregon	✓	
South Carolina	✓	
Tennessee	✓	Provided as medically necessary
Texas	No	
Vermont	No	
Virginia	✓	
Washington	No	WIC may provide breastfeeding education and lactation consultation.
West Virginia	No	Not a separate billable service. Included as part of the prenatal and postpartum visits. Also available through the WV Public Health program Right From the Start
Wyoming	No	
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.		

Table A9: Coverage Policies of and Utilization Controls for Lactation Consultation Services				
States	Hospital-Based (n=41) Yes = 26 No = 15	OP/ Clinic (n=41) Yes = 16 No = 25	Home Visit (n=41) Yes = 11 No = 30	Utilization Controls and Provider Requirements
Alabama	No	No	No	
Alaska	✓	No	No	
Arizona	✓	No	No	Provided by most delivering hospitals. Not reimbursed separately.
Arkansas	✓	✓	✓	Included in global hospital delivery payment, outpatient clinic visit payment and physician home visit payment
California	✓	✓	✓	
Colorado	✓	✓	No	Covered as part of normal hospital bundled labor and delivery payment, postpartum care services, and for problem specific care. Also home visit provided as part of some special programs (e.g., Nurse Home Visitor Program), but not separately reimbursed as a FFS item.
Connecticut	✓	✓	✓	State does not have an enrolled provider type for lactation consultant. Services provided as part of the overall hospital in-patient payment, outpatient office/clinic visit with an MD, DO, PA, APRN, or CNM, or home visit with a nurse from a home health agency.
Delaware	✓	✓	✓	
District of Columbia	✓	✓	✓	
Georgia	No	No	No	
Hawaii	✓	✓	✓	
Idaho	✓	No	No	
Illinois	No	No	No	Covered under WIC program
Indiana	✓	No	No	
Iowa	No	No	No	
Kentucky	✓	No	No	Provided as a part of the hospital DRG
Maine	No	No	No	
Maryland	No	No	No	
Massachusetts	No	No	No	
Michigan	✓	No	No	Included in global hospital fee/DRG
Minnesota	✓	✓	✓	
Mississippi	✓	✓	✓	
Missouri	✓	No	No	Included in the hospital per diem rate.
Montana	No	No	No	Effective 1/1/16 breastfeeding education and outpatient lactation classes and consultations will be covered for Baby Friendly facilities only
Nebraska	✓	No	No	Covered in hospital if infant is on Medicaid. Home visits are offered through the Maternal, Infant & Early Childhood Home Visiting Program. The state does not cover the service after discharge from the hospital but has a department devoted to breastfeeding education which anyone can attend.
Nevada	No	No	No	
New Hampshire	No	No	No	
New Mexico	No	No	No	
New York	✓	✓	✓	Qualified practitioners of Medicaid reimbursable lactation counseling services must be New York State licensed, registered, or certified health care professionals who are International Board Certified Lactation Consultants (IBCLCs) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) and one of the following: physician, nurse practitioner (NP), midwife (MW), physician assistant (PA), registered nurse (RN)

Table A9: Coverage Policies of and Utilization Controls for Lactation Consultation Services				
States	Hospital-Based (n=41) Yes = 26 No = 15	OP/ Clinic (n=41) Yes = 16 No = 25	Home Visit (n=41) Yes = 11 No = 30	Utilization Controls and Provider Requirements
North Carolina	✓	✓	No	Revision to policy in progress to allow
Ohio	✓	✓	✓	
Oklahoma	✓	✓	No	Not separately billable while inpatient.
Oregon	✓	✓	✓	
South Carolina	✓	No	No	
Tennessee	✓	No	No	Provided as medically necessary
Texas	No	No	No	
Vermont	No	No	No	
Virginia	✓	✓	No	Included in hospital DRG. Covered as an outpatient benefit through Managed care. Fee-for-service coverage added effective 1/1/16.
Washington	✓	✓	No	Breast feeding support is provided through Maternity Support Services and is part of the global fee for hospitals. Also covered if provided by an enrolled provider, i.e. MD, ARNP, PA. RN. State does not have an enrolled provider type for lactation consultant.
West Virginia	No	No	No	Not a separate billable service, but included as part of services provided post-delivery in the hospital if a lactation consultant is available at the hospital.
Wyoming	No	No	No	
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits				

Table A10: Variation in Individual Lactation Consultant Service Coverage Across Eligibility Pathways

	Traditional Medicaid (n=26)			ACA Medicaid Expansion (n=17)			Pregnancy Only Medicaid (n=26)		
	IP	OP/Clinic	Home	IP	OP/Clinic	Home	IP	OP/Clinic	Home
	Yes = 26	Yes = 16	Yes = 11	Yes =16	Yes = 12	Yes = 10	Yes = 25	Yes = 15	Yes = 11
Alaska	✓	No	No		N/A		✓	No	No
Arkansas	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona	✓	No	No	✓	No	No	✓	No	No
California	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	No	✓	✓	No	✓	✓	No
Connecticut	✓	✓	✓	✓	✓	✓	✓	✓	✓
District of Columbia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho	✓	No	No		N/A		✓	No	No
Indiana	✓	No	No	✓	No	No	✓	No	No
Kentucky	✓	No	No	✓	No	No	✓	No	No
Michigan	✓	No	No	✓	No	No	✓	No	No
Minnesota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Missouri	✓	No	No		N/A		✓	No	No
Mississippi	✓	✓	✓		N/A		✓	✓	✓
North Carolina	✓	✓	No		N/A		✓	✓	No
Nebraska	✓	No	No		N/A		✓	No	No
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ohio	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma	✓	✓	No		N/A		No	No	No
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Carolina	✓	No	No		N/A		✓	No	No
Tennessee	✓	No	No		N/A		✓	No	No
Virginia	✓	✓	No		N/A		✓	✓	No
Washington	✓	✓	No	✓	✓	No	✓	✓	No

NOTE: N/A indicates "not applicable."
SOURCE: Kaiser Family Foundation and Health Management Associates, Survey of States on Medicaid Coverage of Family Planning and Perinatal Benefits.

Appendix B: Methodology

The Kaiser Family Foundation and Health Management Associates developed a questionnaire (see Appendix C) to collect information from 50 states and the District of Columbia on their family planning policies. Forty states and the District of Columbia responded to the survey. Non-responding states are: Florida, Kansas, Louisiana, New Jersey, North Dakota, Pennsylvania, Rhode Island, South Dakota, Utah and Wisconsin.

The survey asked about policies in place as of July 2015, and Health Management Associates conducted the survey between October 2015 and February 2016. The questionnaires were sent to Medicaid Directors or identified Medicaid reproductive health policy staff. The survey asked states about coverage as of July 1, 2015 for family planning services and perinatal services across various Medicaid eligibility pathways ("traditional Medicaid," the program in place prior to the ACA; "ACA Medicaid expansion," for states that have opted to expand eligibility under the ACA; and "pregnancy-only Medicaid eligibility.") Multiple states reported that they provide the same scope of Medicaid benefits to women who are eligible for Medicaid through the eligibility pathway for pregnant women. Through the survey response, we found that many states tended not to recognize the "pregnancy-only Medicaid" eligibility pathway as a discrete program, but as fully integrated into their traditional Medicaid program, and thus did not respond to the questions for "pregnancy-only." HMA staff followed up with these states to verify that pregnant women receive the same perinatal benefits as women who are financially eligible for the traditional Medicaid program during pregnancy. For purposes of this report, the analyses apply the state's reported coverage policies in the traditional Medicaid program to the "pregnancy-only Medicaid" pathway as well.

The survey also asked states to respond based on state Medicaid policy only (rather than managed care policies). The survey also inquired about any limitations or utilization controls on coverage of specific benefits, such as prior authorization. In general, coverage of all Medicaid benefits is limited to "medical necessity." Therefore, this analysis does not include "medical necessity" within the count of states with utilization controls when this is indicated by a state since medical necessity is a requirement for federal reimbursement of Medicaid services. However, we have noted some instances when states included "medical necessity" in their response in the Appendix A tables. We note any deviation of this approach within the narrative of the report.

Appendix C: Perinatal Services Questionnaire

Kaiser Family Foundation Survey of Family Planning and Perinatal Services under Medicaid, Fiscal Year 2015:

MEDICAID AND PERINATAL SERVICES

This Section is intended to identify whether various perinatal services are normally covered under Medicaid State Plan or waiver programs in your state for adults 21 and older and also identify coverage variations between programs. Please indicate the Medicaid Perinatal benefits that are provided under the programs offered in your state as of July 1, 2015. **Please do NOT include services that are provided by managed care plans as value-added benefits (that is, are not a required state benefit).** ***Please check all that apply***. Describe utilization controls or conditions your state applies by entering text in the space provided. If your state does not cover the benefit under any circumstances, check the box for "Not covered in any Medicaid program."

Medicaid Program Coverage as of July 1, 2015					
Benefit/Service	**Not Covered in any Medicaid Program**	**Traditional Medicaid**	**Medicaid ACA Expansion**	**Pregnancy Only Medicaid**	**Describe limits or utilization controls**
B1. Prenatal Care					
1.a Prenatal vitamins	☐	☐	☐	☐	<Triple-click to enter text>
1.b Ultrasound	☐	☐	☐	☐	<Triple-click to enter text>
1.c Childbirth education/Classes (such as birth or Lamaze)	☐	☐	☐	☐	<Triple-click to enter text>
1.d Infant care/Parenting education or classes	☐	☐	☐	☐	<Triple-click to enter text>
1.**e Comments on Prenatal Care**: <Triple-click to enter text>					
B2. Genetic Lab and Counseling					
2.a Genetic counseling	☐	☐	☐	☐	<Triple-click to enter text>
2.b Chorionic Villus sampling	☐	☐	☐	☐	<Triple-click to enter text>
2.c Amniocentesis	☐	☐	☐	☐	<Triple-click to enter text>
2.d **Comments on Genetic Lab and Counseling**: <Triple-click to enter text>					
B3.Counseling and Support Services					
3.a Case management	☐	☐	☐	☐	<Triple-click to enter text>
3.b Non-emergency medical transportation	☐	☐	☐	☐	<Triple-click to enter text>
3.c Home visits - prenatal	☐	☐	☐	☐	<Triple-click to enter text>
3.d Home visits - postpartum	☐	☐	☐	☐	<Triple-click to enter text>
3.e Substance/alcohol abuse treatment	☐	☐	☐	☐	<Triple-click to enter text>
3.f **Comments on Counseling and Support Services**: <Triple-click to enter text>					
B4. Delivery and Postpartum Care					
4.a Birth Centers	☐	☐	☐	☐	<Triple-click to enter text>
4.b Home births	☐	☐	☐	☐	<Triple-click to enter text>
4.c Doula Services	☐	☐	☐	☐	<Triple-click to enter text>
4.d Postpartum visit	☐	☐	☐	☐	<Triple-click to enter text>

Medicaid Program Coverage as of July 1, 2015					
Benefit/Service	**Not Covered in any Medicaid Program**	**Traditional Medicaid**	**Medicaid ACA Expansion**	**Pregnancy Only Medicaid**	**Describe limits or utilization controls**
4.e. **Comments on Delivery and Postpartum Care**: <Click here to enter text>					
B5. Breastfeeding Support Services					
5.a Breastfeeding education	☐	☐	☐	☐	<Triple-click to enter text>
5.b Individual lactation consultant – hospital-based	☐	☐	☐	☐	<Triple-click to enter text>
5.c Individual lactation consultant – outpatient/clinic	☐	☐	☐	☐	<Triple-click to enter text>
5.d Individual lactation consultant – home visit	☐	☐	☐	☐	<Triple-click to enter text>
5.e Electric Pump	☐	☐	☐	☐	<Triple-click to enter text>
5.f Manual Pump	☐	☐	☐	☐	<Triple-click to enter text>
5.g **Comments on Breastfeeding Support Services**: <Triple-click to enter text>					

Endnotes

[1] Kaiser Family Foundation; Births Financed by Medicaid

[2] Kaiser Family Foundation; Status of State Action on the Medicaid Expansion Decision.

[3] The American Congress of Obstetricians and Gynecologists. Safe Prevention of the Primary Cesarean Delivery. March 2014.

[4] Markus AR, Andres E, West KD, Garro N, Pellegrini C. Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform. *Women's Health Issues*. Sept-Oct 2013

[5] Kaiser Family Foundation; *Status of State Action on the Medicaid Expansion Decision;* As of January 12, 2016; Since July 1, 2015 Alaska implemented a Medicaid expansion (9/1/2015) as did Montana (1/1/2016) and Louisiana (7/1/2016).

[6] Kaiser Family Foundation. Women's Health Insurance Coverage. October 2016.

[7] Healthy People 2020. Maternal, Infant, and Child Health. Office of Disease Prevention and Health Promotion.

[8] Horowitz JA, Murphy CA, Gregory K, Wojcik J, Pulcini J, & Solon L. (2013). Nurse Home Visits Improve Maternal-Infant Interaction and Decrease Severity of Postpartum Depression. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 42(3), pp 287-300.

[9] New Mexico reported that some managed care entities provide Doula services but it is not a Medicaid covered benefit. Ohio noted that there are no certified Doulas in the state currently.

[10] Healthy People 2020: Breastfeeding Objectives.

[11] Virginia reported that both electric and manual pumps are covered as a benefit through managed care. Fee-for-service coverage was added effective 1/1/2016.

[12] Alabama notes that breast pumps are provided through the WIC program and through the Alabama Department of Public Health. South Carolina also noted provision through its Health Department.

[13] The American Congress of Obstetricians and Gynecologists. Safe Prevention of the Primary Cesarean Delivery. March 2014.

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270

www.kff.org

This publication (#9019) is available on the Kaiser Family Foundation's website at www.kff.org.

Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Center for Medicaid and CHIP Services

Medicaid Coverage of Lactation Services

Issue

This issue brief sets forth current levels of State Medicaid coverage for lactation services and explores how CMS can encourage and assist States in increasing access to such services.

Background

Improving the health of the population and reducing preventable causes of poor health, such as obesity, is a priority of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS).[i] Current research shows that the practice of breastfeeding for the first 6 to 12 months of life is highly beneficial for both the mother and infant. On January 20, 2011, the United States Surgeon General released "The Surgeon General's Call to Action to Support Breastfeeding."[ii] This report indicates that there is a 32% higher risk of childhood obesity and a 64% higher risk of type 2 diabetes for children who are not breastfed. An extensive body of research supports these assertions and provides evidence of the positive effects of breastfeeding on both short and long term infant and maternal health.[iii] Professional organizations advocate for exclusive breastfeeding during the first 6 months of life, meaning that infants should not be given any other substance other than breast milk, including water.[iv] Breastfeeding also serves additional advantages for low birth weight infants. Human milk consumption is associated with a reduction in sepsis infections and gastrointestinal illnesses among very low birth weight newborns in the neonatal intensive care unit (NICU).[v]

The U.S. Preventive Services Task Force (USPSTF) specifically recommends coordinated interventions throughout pregnancy, birth, and infancy to increase breastfeeding initiation, duration, and exclusivity.[vi] Such recommended interventions include formal breastfeeding education for mothers and families, direct support of the mother during breastfeeding observations, and the training of health professional staff about breastfeeding and techniques for breastfeeding support.[vii] The opportunity to promote and provide support for breastfeeding occurs many times throughout the interactions that women have with various types of health care providers during and after pregnancy.

Categories of Coverage for Lactation Services

All States participating in the Medicaid program cover pregnancy-related services. 42 C.F.R. § 440.210 defines "pregnancy-related services" as those that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services. States must provide coverage of pregnancy-related services for an

extended postpartum period, defined as beginning on the last day of pregnancy and extending through the end of the month in which the 60-day period following termination of pregnancy ends. This definition of "pregnancy-related services" is broad enough to encompass lactation services.

Due to the multiple health benefits associated with breastfeeding, CMS encourages States to go beyond the requirement of solely coordinating and referring enrollees to the Special Supplemental Food Program for Women, Infants, and Children (WIC) (established in 42 C.F.R. § 431.635) and include lactation services as separately reimbursed pregnancy-related services.

States may use the following Medicaid coverage categories to reimburse lactation services:

- Inpatient hospital services (other than services in an institution for mental disease), per Social Security Act (SSA)§ 1905(a)(1);
- Outpatient hospital services, per SSA § 1905(a)(2)(A) and 42 C.F.R. § 440.10;
- Early and periodic screening, diagnostic, and treatment services for individuals who are eligible under the plan and are under the age of 21, per SSA § 1905(a)(4)(B);
- Physicians' services furnished by a physician under the physician's supervision, whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, per SSA § 1905(a)(5)(A);
- Services furnished by a nurse-midwife, which the nurse-midwife is legally authorized to perform under State law, per SSA § 1905(a)(17);
- Freestanding birth center services, per SSA § 1905(a)(28); and
- Services furnished by nurse practitioners per 42 C.F.R. § 440.166 and other licensed practitioners per 42 C.F.R. § 440.60.

Current State Practices

Because lactation services are not specifically mentioned in the Medicaid statute or Federal Medicaid regulations, not all States separately reimburse lactation services as pregnancy-related services.[viii] In fact, States vary widely in the amount and scope of coverage they provide for lactation services as a part of prenatal, postpartum, and infant care.

The Kaiser Family Foundation and the George Washington University Department of Health Policy conducted a survey in 2008 to assess each State's Medicaid coverage of perinatal services.[ix] This survey, to which 44 States provided a response, focused on three main categories of lactation services: 1) Breastfeeding Education, 2) Individual Lactation Consultation, and 3) Equipment Rentals (see attachment). The findings of the study showed that despite the establishment of breastfeeding as an important preventive health measure, Medicaid coverage of lactation services was far from comprehensive. While States do cover lactation related services as a part of the hospital/facility fee after delivery, not all States cover and separately reimburse for such services. Specifically, 25 of the responding States covered breastfeeding education services, 15 of the responding States covered individual lactation consultations, and 31 of the responding States covered equipment rentals.

Some States have taken additional or alternative steps to promote breastfeeding. For example, some provide Medicaid coverage for donor milk from a human milk bank for infants whose mothers are unable to breastfeed due to medical reasons or in cases where the infant cannot tolerate formula use.[x] New Hampshire Medicaid provides coverage of a Maternal Postpartum Assessment, which specifically includes an evaluation of whether the mother is properly breastfeeding and provides the accompanying postpartum education to ensure she continues to breastfeed.[xi] Florida operates a Medicaid waiver program that coordinates prenatal care through monthly outreach and case management. The program specifically stresses healthy nutrition and breastfeeding habits, but is limited to Medicaid enrollees identified as high-risk for poor birth outcomes or those referred to the program by their health care provider.[xii]

Aside from variation in the amount and scope of coverage provided for lactation services, States also differ in the ways that these services are billed and coded. For example, in Illinois, both breastfeeding education and individual lactation consultations are billed as part of an exam, not as a separate service.[xiii] Some States simply allow providers to bill individual lactation consultations as part of an "Evaluation and Management" visit. In many cases, lactation consultations may be provided as part of Childbirth Education Classes or covered (and coded) as part of a woman's inpatient hospital stay.[xiv] The home health nurse visit provided after discharge from the hospital also allows health care providers to engage in a one-on-one lactation evaluation and consultation for new mothers.

The following provides examples of different codes that States use for billing and receiving federal matching funds for coverage of lactation services:

- Lactation Consultation (face-to-face visit), HCPCS code S9443
- Postpartum Care and Examination of Lactating Mother, ICD-9 code V24.1
- Manual Breast Pump purchase, CPT Code E0602
- Hospital Grade Electric Breast Pump rental, CPT Code E0604
- Individual Electric Breast Pump purchase, CPT Code E0603

Example of a State Benefit Package

Rhode Island provides the following benefit package for breastfeeding mothers enrolled in Medicaid. None of the services are associated with co-payments.[xv]

	Benefit	Criteria
Education	Prenatal Breastfeeding Classes/ Childbirth Education Classes	Covered benefit – group and individual sessions No referral or authorization needed
	Breastfeeding Support Group	Not a covered benefit
Lactation Support	In-patient hospital	Covered as part of inpatient stay
	Outpatient hospital	Covered benefit – initial consult must occur within first two weeks of delivery. Benefit limited to 2 additional visits within first month after delivery

	Home	Covered benefit – prior approval required. Initial consult must occur within first two weeks of delivery. Benefit limited to 2 additional visits within first month after delivery
Equipment	Manual Breast Pump Purchase	Covered benefit for medical necessity or for mother returning to work or school (up to child's first birthday) Requires prescription
	Hospital Grade Electric Breast Pump Rental	Covered benefit for medical necessity or for mother returning to work or school (up to child's first birthday) Requires prescription
	Individual Electric Breast Pump Purchase	Covered benefit for medical necessity or for mother returning to work or school (up to child's first birthday) Requires prescription
	Pump Kits Purchase	Covered benefit – authorized with electric pump (1 maximum)

Options for Improving Access to Lactation Services

Aside from providing a benefit package, there are a number of strategies that States can undertake to improve access to lactation services for Medicaid beneficiaries.

- Encourage managed care entities/organizations and other providers to direct patients to Baby-Friendly Hospitals. The Baby-Friendly Hospital Initiative was established by the World Health Organization (WHO) and UNICEF in 1991 and gives special recognition to hospitals and birthing centers that follow the Ten Steps to Successful Breastfeeding for Hospitals.[xvi] As of November 17, 2011, there are 121 Baby-Friendly Hospitals and Birth Centers throughout the United States that provide new mothers with the information and skills needed to successfully initiate and continue breastfeeding.[xvii] Baby-Friendly Hospitals have experienced significant increases in the rates of successful and sustained breastfeeding among Medicaid and privately insured mothers, more so than in non-Baby-Friendly Hospitals.[xviii]
- Because primary care interventions to promote and support breastfeeding received a grade of B from the USPSTF, coverage of lactation services without cost-sharing will be eligible for a 1 percentage point increase in federal medical assistance percentage (FMAP) in 2013 per Section 4106 of the Affordable Care Act. CMS encourages States to begin formulating coverage policies for such services.

- Encourage managed care organizations to either collect data that establishes a baseline for breastfeeding rates and/or initiate a performance improvement project (PIP) or focused study that seeks to increase rates of breastfeeding within the population. For example, a health plan in New York State operates a performance improvement project that seeks to increase education among pregnant women, mothers, and providers while specifically stressing breastfeeding in the first years of life and provider encouragement of breastfeeding.[xix]
- Eliminate variation of coverage among Medicaid managed care plans and encourage managed care contractors to provide breastfeeding education, either by means of referrals to Special Supplemental Food Program for Women, Infants, and Children (WIC) or direct provision of the services through its provider network.[xx] WIC provides breastfeeding women with lactation support by means of counseling, the provision of breastfeeding educational materials, the option to receive an enhanced food package, follow-up support through peer counselors, and the provision of breast pumps or other equipment to help reinforce a healthy and successful breastfeeding routine. [xxi] .[xxii]
- Coordinate with the "*Let's Move!"* initiative, launched by the First Lady of the United States, Michelle Obama, in an effort to promote breastfeeding as one of the many strategies to prevent childhood obesity.[xxiii]
- Disseminate information to providers that discuss the benefits of lactation services, as well as information and other resources regarding the promotion of lactation services.

January 10, 2012

---

[i] Other agencies within HHS have undertaken the following initiatives related to breastfeeding: 1) The Centers for Disease Control and Prevention (CDC) publishes a CDC Guide to Breastfeeding Interventions (Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005) ; 2) The Health Resources and Services Administration (HRSA) operates the Business Case for Breastfeeding program, which is a comprehensive program designed to educate employers about the value of supporting breastfeeding employees in the workplace; 3) The Agency for Healthcare Research and Quality (AHRQ) provides information and research that assesses breastfeeding with maternal and infant health outcomes; 4) The Office on Women's Health published the 2000 HHS Blueprint for Action on Breastfeeding.

[ii] US Department of Health and Human Services, The Surgeon General's Call to Action to Support Breastfeeding, 2011, available at: http://www.surgeongeneral.gov/topics/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[iii] Ip S, et al. Breastfeeding and Maternal and Infant Outcomes in Developed Countries: Evidence Report/Technology Assessment Number 153, Agency for Health Care Research and Quality Publication No. 07-E007; April 2007, available at: http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf.

[iv] The American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Nurse Midwives, American Dietetic Association, and American Public Health Association all recommend that infants be breastfed for a minimum of 12 months.

[v] El-Mohandes A, Picard MB, Simmens SJ, et al. Use of human milk in the intensive care nursery decreases the incidence of nosocomial sepsis Journal of Perinatology 1997; 2:130-134; Taylor G, Minich N, Hack, M. The Effect of Maternal Milk on Neonatal Morbidity of Very Low-Birth-Weight Infants. Arch Pediatric and Adolescent Medicine. 2003;157:66-71; Meinzen-Derr J, Poindexter B, Wrage, L, Morrow A, Stoll B, DonovanE. Role of human milk in extremely low birth weight infants' risk of necrotizing enterocolitis or death, Journal of Perinatology. 2009 Jan; 29(1):57-62.

[vi] USPSTF, Primary Care Interventions to Promote Breastfeeding: Recommendation Statement, October 2008, available at: http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfeedrs.htm.

[vii] Ibid.

[viii] See 42 C.F.R. 440.210 Required Services for the Categorically Needy and 42 C.F.R. 440.220 Required Services for the Medically Needy.

[ix] Stewart A, Cox M, Doamekpor L, Ranji U, Salgancioff A*, State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings*. The Henry J. Kaiser Family Foundation, November 2009, available at: http://www.kff.org/womenshealth/upload/8014.pdf.
[x] Texas Medicaid and Health Partnership, Texas Health Steps Medicaid Manual: Donor Human Milk, available at: http://www.tmhp.com/HTMLmanuals/TMPPM/2008/2008%20TMPPM-46-108.html.
[xi] N.H. ADMIN. RULES [HE-W] 547.04 (2011).
[xii] AHCA, Florida Medicaid Summary of Services for Fiscal Year 2010-2011 at 105, available at http://ahca.myflorida.com/Medicaid/pdffiles/SS_10_100501_SOS_ver2-4_1164_1011_FINAL2.pdf. .
[xiii] Stewart A, Cox M, Doamekpor L, Ranji U, Salgancioff *A, State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings*. The Henry J. Kaiser Family Foundation, November 2009, available at: http://www.kff.org/womenshealth/upload/8014.pdf.
[xiv] Rhode Island Department of Health, *Breastfeeding Insurance Benefits Guidelines*, available at: www.health.ri.gov/family/breastfeeding/insurancebenefits.php.
[xv] Ibid.
[xvi] The Ten Steps to Successful Breastfeeding are: 1) Have a written breastfeeding policy that is routinely communicated to all health care staff; 2) Train all health care staff in skills necessary to implement this policy; 3) Inform all pregnant women about the benefits and management of breastfeeding; 4) Help mothers initiate breastfeeding within one hour of birth; 5) Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants; 6) Give newborn infants no food or drink other than breast milk, unless *medically* indicated; 7) Practice "rooming in" which is allowing the mother and infant to remain together 24 hours a day; 8) Encourage breastfeeding on demand; 9) Give no pacifiers or artificial nipples to breastfeeding infants; and 10) Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic. For more information, please see http://www.babyfriendlyusa.org/eng/index.html.
[xvii] To be recognized as a Baby-Friendly Hospital, facilities must register with Baby-Friendly USA and undergo an on-site assessment to demonstrate the facility has integrated the "Ten Steps to Successful Breastfeeding" into hospital policies and procedures for healthy newborns. More detailed information can be found in the Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation, 2010 edition, available at: http://babyfriendlyusa.org/eng/docs/2010_Guidelines_Criteria_4.19.11.pdf.
[xviii] Philipp B, Merewood A, Miller L, et al., Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US Hospital Setting. *Pediatrics.* 2001; 108(3): 677-681.
[xix] New York State Medicaid Managed Care Performance Improvement Projects, 2009-2010 Pediatric Obesity - Summary of Projects, available at: http://www.health.ny.gov/health_care/managed_care/reports/pediatric_obesity.htm.
[xx] Specifically, 42 C.F.R. 431.635 requires the coordination of Medicaid with WIC, which includes providing written notice of the availability of WIC benefits to all individuals in the State who are determined eligible for Medicaid and who are pregnant, postpartum, breastfeeding, or a child under the age of five. In addition, the State must at least annually provide written notice of the availability of WIC benefits (including the telephone number and address of the local WIC agency) to all Medicaid recipients who might be pregnant, postpartum, or breastfeeding.
[xxi] United States Department of Agriculture, Food & Nutrition Service, Women, Infants, and Children, available at: http://www.fns.usda.gov/wic/.
[xxii] All states that utilize managed care to deliver Medicaid services are required by 42 C.F.R. 438.358 to engage in three mandatory external quality review activities, including the validation of PIPs and performance measures.
[xxiii] For more information, please see www.letsmove.gov.