



Texas Lactation Consultant Landscape Analysis

PROVIDED BY:

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING



“When Medicaid starts covering lactation care in Texas, it has the potential to truly improve outcomes for families who have historically had the least access to support.”

-Texas IBCLC® Participant



ABOUT THE STUDY

The Texas Lactation Consultant Landscape Analysis examines the availability and distribution of lactation consultant services across the state. Families in Texas often struggle to find skilled lactation support. These challenges lead to differences in health outcomes. This project documents where services exist, where gaps remain, and how community and health system leaders can work to improve access.

Funded by Episcopal Health Foundation

The Episcopal Health Foundation (EHF) funded this study as part of its commitment to improving health in Texas. EHF focuses on the root causes of poor health, including social and community factors that shape maternal and child outcomes. The foundation invests in projects that help families live healthier lives, strengthen local systems, and reduce disparities in access to care.

Conducted by MCH Impact Partners, LLC

MCH Impact Partners, LLC (MCHIP) is a maternal and child health consulting firm that provides research, evaluation, and policy support. The organization works with community leaders, hospitals, and health agencies. Together, they create solutions that create solutions to improve care and strengthen services across communities. With expertise in both research and practice, MCHIP brings a practical, action-focused approach to this work.

Approach

The project team combined survey data, interviews with providers, and a review of state policy. This mixed approach helps ensure that the report reflects both numbers and lived experiences. The study finds gaps in the current system. It also shows chances for improvement, like expanding the workforce and clarifying Medicaid reimbursement pathways. The report uses plain language to support all stakeholders.

What You Will Find

This analysis provides:

- Maps of lactation consultant distribution across Texas counties
- Insights into barriers faced by families, providers, and health systems
- Examples of innovative approaches in Texas and other states
- Recommendations for state agencies, health plans, and local organizations

Researchers intend the findings to inform decision makers and community leaders as they develop strategies to strengthen lactation support for all Texas families.

Authors

Shannon Scott, MPH, IBCLC, RLC
Hadeer Altawwar, MPH
Lindsey Cochran, MPA

Acknowledgments

During the preparation of this work, the author used Chat GPT5 and Hemingway Editor to improve linguistic readability. After using this tool, the authors reviewed and edited the content as needed and took full responsibility for the publication's content.



EXECUTIVE SUMMARY

Breastfeeding improves health for both infants and mothers. Experts agree that exclusive breast milk feeding is optimal nutrition for the first six months of life. It reduces medical costs, yet Texas continues to face persistent disparities in breastfeeding rates and access to care. CDC's 2022 National Immunization Survey–Child (NIS-Child) data show 85.7% ever breastfed. This drops to 62.1% of infants at six months. In 2022, US data shows that 47.6% of infants are exclusively breastfed for three months. However, only 27.9% are exclusively breastfed for six months. In Texas, 83.4% ever breastfed. This drops to 57.9% of infants at six months (CDC, 2025). Exclusive breastfeeding rates in Texas are also lower than national rates. Only 43.0% of infants are exclusively breastfed for three months and 26.4% for six months (CDC, 2025).

In 2024, survey data shows that Texas hospital maternity practices fall behind national benchmarks (CDC, 2025). Families often face challenges like inconsistent or absent health coverage, limited paid leave, and fewer lactation providers. Until 2025, families on Medicaid mainly turned to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program for clinical lactation support. House Bill 136 passed in the 89th Texas Legislature. Now, the Health and Human Services Commission must set up Medicaid reimbursement for lactation consultants. This change could help more people access evidence-based lactation care. The success of this policy relies on clear reimbursement pathways, provider readiness, and addressing the disparities that continue to limit breastfeeding outcomes in Texas.

The Texas Lactation Consultant Landscape Analysis gives a statewide look at lactation consultant access and availability. It also explores barriers to accessing care. The results provide a clear picture of the lactation care landscape in Texas, including:

- Highlighting where and how lactation consultants serve families across different settings.
- Pinpoint the main challenges and opportunities that affect Medicaid reimbursement for lactation consultant services.
- Amplify provider input to shape state policy.
- Improve communication with managed care organizations.
- Ensure systems are ready for successful implementation.

Funded by the Episcopal Health Foundation (EHF). This study aligns with their mission to address community health and strengthen maternal health outcomes in Texas. MCH Impact Partners, LLC conducted the study from July 21, 2025, to September 30, 2025. The study uses mixed methods, including surveys, interviews, and policy reviews, to document current challenges and opportunities. The findings will help health systems, policymakers, and community leaders improve maternal and child health care delivery in the state.

Findings from surveys, interviews, and policy reviews show that Texas faces critical shortages in both access and reimbursement systems for lactation services. These challenges fall hardest on rural communities and families with limited resources.

Key Findings

- **Provider Landscape:** Texas has an uneven distribution of International Board Certified Lactation Consultants (IBCLCs), with many counties lacking access altogether. Hospital-based consultants dominate the field, while fewer are in community or outpatient settings.
- **Barriers to Participation:** Surveyed IBCLCs cited unclear Medicaid enrollment pathways, inconsistent billing codes, and lack of credentialing as reasons for not pursuing reimbursement. Interviewees raised concerns about low pay, unclear guidance from Managed Care Organizations (MCOs), and administrative burdens.
- **System Gaps:** Families often rely on WIC clinics or hospital discharges for care, but few pathways exist for follow-up or continuity. Without coordination between Medicaid, WIC, and private providers, families face delays, fragmented care, or no care at all.
- **Clinical Urgency:** Delayed access to care harms breastfeeding outcomes. Medicaid infants in Texas—nearly 190,000 per year—may miss the early intervention window without timely outpatient lactation support.

Recommendations for Implementation of HB 136

To ensure the success of HB 136, Texas should take short-term actions that reduce barriers and encourage IBCLC participation in Medicaid:

- **Create clear billing pathways:** Provide public-facing resources that outline Medicaid enrollment, billing, and documentation for IBCLCs. MCOs should align on codes and modifier use.
- **Support dyad-based care:** Design policies that cover both mother and infant during lactation visits. Reimbursement should reflect the clinical intensity of care, including longer initial visits and hybrid or telehealth formats.
- **Address the workforce gap:** Texas should invest in IBCLC training pathways, support preceptorships, and encourage bilingual and bicultural recruitment. Encourage MCOs to support provider training and mentorships.
- **Track impact:** Require MCOs to monitor access by region, language, and payer. Use data to adjust caps, prior authorization rules, and visit settings.

Recommendations for Future Research, Policy, and Programs

Looking ahead, additional efforts are needed to evaluate HB 136 implementation and sustain improvements:

- **Expand data collection:** A second phase of this project should collect data from more IBCLCs across rural and urban regions. Focus groups with providers and families could explore how barriers vary by geography and population.
- **Build a licensure case:** To clarify clinical roles and reduce liability concerns, stakeholders should consider licensure for IBCLCs. A formal sunrise review could evaluate regulatory needs and model legislation.
- **Enhance system coordination:** Policy makers should explore ways to strengthen coordination between Medicaid, WIC, and community providers. Future analysis should include longitudinal outcomes such as exclusive breastfeeding at 3 months and postpartum care quality.

CONTENTS

About the Study	1
Executive Summary	2
Tables of Contents	4
Background	5
Methods	7
• Key Informant Interviews	8
• State-wide Survey	9
• Policy and Document Scan	10
Findings	11
• Key Informant Interviews	
◦ System and Access Barriers	12
◦ Workforce Capacity and Development	13
◦ Reimbursement and Administrative Challenges	14
◦ Facilitators and Opportunities	15
◦ Policy Implementation and Advocacy	16
• State-wide Survey	
◦ Results	16
◦ Research Questions	21
◦ SWOT Analysis	25
• Policy and Document Analysis	28
Discussion	30
Conclusion	42
• Recommendations for Implementation of HB 136	43
• Recommendations for Future Research, Policy, and Programs	44
References	45
Appendix	51

BACKGROUND

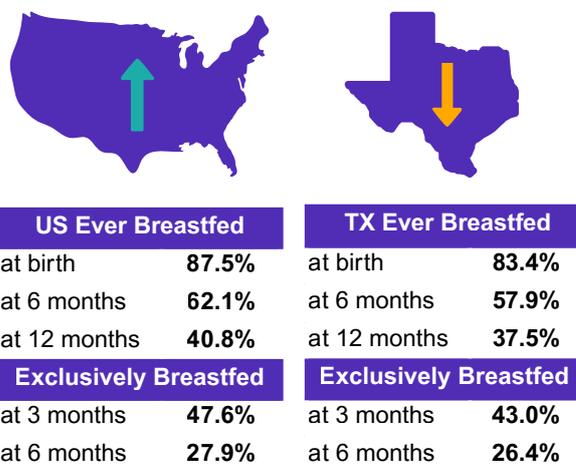
The Impacts and Benefits of Feeding Human Milk to Human Babies

Breastfeeding and human milk feeding offer clear health benefits. They help infants, mothers, and society as a whole. Breastfed infants have lower risks of ear, gastrointestinal, and respiratory infections, as well as sudden unexpected infant death (SUID), asthma, obesity, type 1 and type 2 diabetes, and some childhood cancers. Mothers who breastfeed reduce their risk of postpartum hemorrhage, breast and ovarian cancers, hypertension, cardiovascular disease, and type 2 diabetes (National Academies of Sciences, Engineering, and Medicine [NASEM], 2025).

From a broader perspective, breastfeeding reduces medical costs and improves workforce productivity. The CDC (2025) estimates that low breastfeeding rates cost over \$3 billion in medical expenses for mothers and infants each year. More recent modeling underscores the larger economic impact. Jeiger et al (2024) found that low breastfeeding rates in the U.S. lead to preventable costs each year. These costs range from \$17 billion to over \$100 billion. Estimates might not even show the full burden. Indirect costs, such as caregiver time and transportation, are not fully accounted for (Jeiger et al, 2024). Breastfeeding rates vary widely among different racial, ethnic, and socioeconomic groups. This means that some families and communities bear more financial and health challenges related to access to lactation care (NASEM, 2025).

Breastfeeding and in Texas

To put Texas outcomes into context, CDC's 2022 National Immunization Survey–Child (NIS-Child) data show breastfeeding data among U.S. and Texas infants born in 2022, Texas data show lower rates in all measures. The difference continues in available data from the CDC about hospital maternity practices. The Maternity Practices in Infant Nutrition and Care (mPINC) survey regional report includes 75% of hospitals in Texas reporting practices in 2024.



The Texas total score is lower than the national benchmark of 82 out of 100. Texas was below the national scores in 4 out of 6 practice area domains. Structural barriers span healthcare from hospital to community. The barriers include uneven access to lactation support and inconsistent insurance coverage and reimbursement. Texas families struggle with limited paid leave, and face barriers to care, especially in underserved, rural, and vulnerable communities. These factors make many parents stop breastfeeding earlier than they wish. To close the gap, Texas must tackle these linked challenges. This will help align the state with national breastfeeding progress and improve health.

Recent Policy

In May 2025, the Texas Legislature approved House Bill 136 (HB 136). This bill requires the Health and Human Services Commission (HHSC) to set up a new provider type for lactation consultants. This will allow lactation consultants to enroll as providers and receive reimbursement through Medicaid (Texas Legislature, 2025). Testimony during the legislative process named the International Board Certified Lactation Consultant® (IBCLC) as the main provider of specialized lactation care. The International Board of Lactation Consultant Examiners® (IBLCE) certifies IBCLCs through rigorous clinical training and examination, ensuring they have the expertise to manage complex lactation challenges (International Board of Lactation Consultant Examiners [IBLCE], n.d.). This study will use the terms lactation consultant and IBCLC interchangeably. Many authorities define lactation consultants as allied health professionals who hold an IBCLC certificate (Appendix D).

Before HB 136, the WIC program was the main source of lactation support for Medicaid families. Medicaid covers about half of all births in Texas and Medicaid qualifies women and child for WIC services. This means WIC is the main support for many families needing lactation care (Keranews, 2023; Kaiser Family Foundation, 2025). Texas operates more than 300 full-time WIC offices and over 200 satellite sites (Texas Health and Human Services, n.d.), at which WIC peer counselors offer basic breastfeeding help. They refer more complex cases to IBCLCs or other healthcare professionals. Many WIC agencies in Texas employ IBCLCs directly, while others access registered nurses and IBCLCs through phone, email, or telehealth consultation with WIC Lactation Support Centers. Because WIC clinics are not medical facilities, families needing care beyond routine lactation support are referred to health care providers (Texas WIC, n.d.).

The passage of HB 136 is an important step toward expanding access to high-quality, evidence-based lactation care for Medicaid-eligible families in Texas.



The passage of HB 136 is an important step toward expanding access to high-quality, evidence-based lactation care for Medicaid-eligible families in Texas. Yet, the success of this policy will depend on the effectiveness of its implementation. Key factors include Medicaid's ability to set clear billing and reimbursement paths. Addressing the role of lactation consultants and understanding that most licensed healthcare professionals receive minimal clinical lactation training. Roles and referral processes pose a risk to accessing high quality care.

Also important is whether lactation consultants are ready to enroll as providers. Finally, it's crucial to see if these changes tackle ongoing disparities in breastfeeding outcomes. Across the nation, many states are reimbursing lactation services through Medicaid. Texas is now part of this expanding effort. This landscape analysis explores the Texas context to highlight opportunities and obstacles for maximizing the potential of HB 136.

METHODS

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING



STUDY DESIGN

This study used a mixed-methods approach to evaluate the Texas lactation consultant workforce. The study took place from July 21, 2025, to September 30, 2025. It looked at their readiness for Medicaid reimbursement under HB 136. We used three data sources:

1. Semi-structured key informant interviews
2. A statewide survey of lactation consultants (IBCLCs)
3. A focused review of policies and documents.

This approach helped us see wide-ranging trends. It also connected these trends to real experiences and the settings that influence clinical lactation practice in Texas.

Mixed-methods research is now often recommended in public health and it blends statistical precision with valuable context. These designs work well for exploring health system issues. They focus on where workforce capacity meets reimbursement challenges (Houghton et al., 2023). Recent scholarship underscores that combining methods provides “whole-system” perspectives that single approaches cannot achieve (Efstathiou et al., 2025).

Key Informant Interviews

We interviewed 10 key informants. This helped us understand barriers, facilitators, and workforce readiness for Medicaid reimbursement. Participants included lactation consultants from hospitals and communities, Texas Managed Care Organizations (MCOs), and national lactation policy experts.

The research team tested the interview protocol with two informants, then made changes to improve clarity and flow. Trained researchers conducted the interviews, which lasted 45–60 minutes, in secure virtual rooms. The team recorded and transcribed the sessions with participant consent. We used Gemini software and performed a manual review of the transcripts to ensure their accuracy. Field notes captured contextual details that may not appear in transcripts.



Statewide Survey

We created a web survey to gather both quantitative (numbers) and qualitative (open-ended questions) reflecting the demographics and opinions from lactation consultants in Texas. The instrument captured details about:

- Practice settings
- Experience and Credentials
- Populations Served
- Reimbursement experiences
- Medicaid Awareness

We adapted items from workforce surveys, tailoring them to fit Texas's policy needs. We included optional open-ended questions to gain further understanding. These questions help identify strengths, weaknesses, opportunities, and threats to implementation. The research team performed a SWOT analysis with this data.

The team distributed the survey through social media and email. The IBLCE keeps a registry of 1,496 IBCLCs in Texas. The study team asked IBCLE to share the survey. However, there is a long review process to gain approval. A decision from IBCLE is pending at the time of this report. To prevent delays, the research team and funders decided to close the survey on September 17, 2025, following an extended recruitment period.

We received 152 valid responses. Of these, 139 respondents ($\approx 9.3\%$ of the IBCLCs in Texas) held an active IBCLC credential. An extra 13 respondents held other professional credentials. The distribution shows the survey's open recruitment strategy, by including both IBCLCs and other lactation care providers who chose to take part.



Data Analysis

Survey data were analyzed using Microsoft Excel and SAS OnDemand for Academics (SAS Institute Inc.). Researchers used Excel to compute descriptive statistics, including frequencies and percentages. This summarized the demographics of participants and their survey responses. The team utilized SAS to run statistical tests. They included chi-square tests and Fisher's Exact Tests to analyze the relationships between categorical variables. Three researchers analyzed the interview transcripts in Delve. They used an inductive thematic analysis approach. Intercoder reliability exceeded 0.8 (Krippendorff's alpha).

Policy and Document Review

We analyzed Medicaid efforts in other states to provide context for our survey and interview data. We also gathered public information on lactation care and Medicaid services in Texas. This included:

- State agency reimbursement policies and guidance.
- Reports from public health and community organizations.
- Legislative updates and information about states' implementation.
- Documents shared by key informants.

Triangulation

Combining these elements helped connect provider views, survey results, and the policy landscape. This integration helped us spot consistencies and gaps in workforce experiences and policies. It strengthened our findings and made them more relevant for decision-makers.



FINDINGS

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING



KEY INFORMANT INTERVIEWS

System and Access Barriers for Texas Families

Families in Texas face big challenges when looking for lactation support. These challenges hit hardest for those on Medicaid. Interviewees mentioned several structural issues. These include unpaid leave, lack of transportation, and family pressures. All these factors make it hard to continue breastfeeding. An MCO representative explained, **“There are no state taxes, so there’s no short-term disability. Moms don’t stay home for six weeks in Texas because they’re not getting paid. You can’t sit around and not get paid and still try and have a family. It just is not feasible.”** Another provider added a personal perspective, recalling that as a Medicaid patient, **“the lactation consultant said, ‘Your latch looks fine. Your nipples just need to toughen.’ But my nipples were cracked and bleeding. That was not normal. When I went to WIC, I just didn’t get the help that I needed.”**



Education scheduling and providing transportation for this population is a big thing to get these things met which then you know helps our metrics and the things that we’re required by the state to meet.

-MCO Representative #9



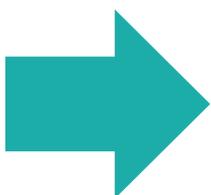
For nurses who are IBCLC’s here there is a lot of discontent [because] that they don’t get to work as an IBCLC. They want to work as an IBCLC. They pursued it for a reason. They find a lot of push back in hospital systems where they don’t get to do that full-time.

-State/Community Leader #2



The stories reveal how systemic barriers interact with gaps in communication and inconsistent support. Hospital environments also shape access. In some hospitals, lactation consultant positions are part of a separate service or department that supports the entire facility. While in others hospitals the bedside nursing staff may be IBCLCs or another type of lactation educator/counselor. IBCLCs help families receive consistent specialized care. Hospitals with rigid hierarchies or restrictive protocols prevent lactation consultants from practicing to their full potential. These dynamics have a direct impact on families' ability to begin and sustain breastfeeding.

Why It Matters



Unless we address systems-level obstacles, disparities in access to skilled lactation care will persist, limiting HB 136’s potential impact.

Workforce Capacity and Role Clarity

Texas lacks enough lactation consultants to meet demand, especially in rural areas. Families in big cities often have many providers to choose from, but many rural areas may have none. As one health system lactation consultant observed, **“I think it’s hit or miss based on whether you’re urban or rural. The urban areas, the desirable cities, have more access to lactation support, and rural areas sometimes have none.”** Another MCO representative emphasized the broader shortage, stating that **“we just need more lactation consultants to meet the needs.”**

Confusion about the lactation consultant role compounds these workforce shortages. Families, clinicians, and payers often don’t understand what lactation consultants do. This misunderstanding can limit referrals and reimbursement. Advocacy leaders said that lactation consultants (IBCLCs) do clinical assessments, create care plans, and work with medical providers. Yet, people sometimes confuse them with peer counselors or educators.

“

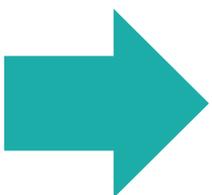
Lactation consultants are taking medical histories, individualized histories on the mother and baby, doing focused assessments, and making clinical decisions. That is very clinical and with risk. They need a license to do that work.

-Advocacy Leader #1

”

Limited opportunities exist for entering the workforce, including IBCLC mentorship and clinical training. This limits efforts to increase the number of lactation consultants in Texas. The workforce will stay short of meeting demand unless we strengthen pathways through universities, community colleges, hospitals, and supervised practice sites.

Why It Matters



Texas must expand its lactation consultant workforce and ensure that healthcare teams understand, respect, and integrate their scope for Medicaid reimbursement to succeed.

Reimbursement and Administrative Hurdles

Administrative barriers emerge as some of the most pressing challenges facing lactation consultants in Texas. Providers often face issues with billing codes. Payment delays are lengthy, and enrolling as commercial insurance or Medicaid providers is complex. A regional practice owner summarized the frustration: **“It takes 90 days, honestly. We’ve been trying to get Medicaid to reimburse us for our services for five years now.”** Another community IBCLC echoed the challenges of communication and credentialing, noting, **“First and foremost, communication, because I’ve heard nothing. I mean absolutely nothing since I heard it was supposed to go into effect. Zero.”**

Underlying these frustrations is the absence of state licensure for lactation consultants (IBCLCs). Without a license, lactation consultants find it hard to gain recognition as healthcare providers. Insurers often see them as “educators.” This means even if they submit for reimbursement they get paid less. Many felt a lack of understanding led to unfair practices and payments that don’t reflect IBCLC’s clinical support. Advocacy leaders warned that this gap reduces the role of lactation consultants. It also discourages doctors from making referrals. Administrative burdens including paperwork, multiple provider platforms, and inconsistent policies across care organizations compound these challenges.

“

“It takes 90 days, honestly. We’ve been trying to get Medicaid to reimburse us for our services for five years now.”

-Regional Practice IBCLC #7

”

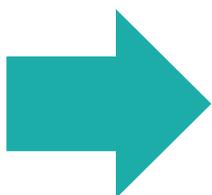
“

First and foremost, communication, because I’ve heard nothing. I mean absolutely nothing since I heard HB 136 was supposed to go into effect. Zero.

-Community IBCLC #8

”

Why It Matters



If we don’t fix the administrative issues, few providers will join Medicaid. This means families who need public coverage will still miss out on clinical lactation services.

KEY INFORMANT INTERVIEWS

Facilitators and Opportunities

Participants pointed out various barriers to reimbursement for lactation consultants. They also suggested practical strategies to enhance access to lactation care and support the rollout of HB 136. Workforce expansion was a consistent theme. An advocacy leader suggested leveraging existing peer counselor networks. **“This is a great career for people already working in WIC as peer counselors if they want to continue their education and become an IBCLC. It would be a good career path.”** A private practice owner described the need for regional expansion, **“We would love to support training IBCLCs in those areas that currently do not have any available.”**

Participants noted the opportunity innovative service delivery models, especially telehealth. This approach can improve access in rural areas and after-hours like evenings and weekends. One MCO representative noted, **“Your more rural areas would benefit from virtual. To be honest, when people need help it is at two in the morning when they’re falling apart. A 24/7 virtual option would be ideal.”** The description highlighted university and community college partnerships as another opportunity to build training pipelines and clinical placements. Better coordination of care involves adding lactation consultants to medical teams and standardizing referral pathways. This was expressed as a key factor for success.

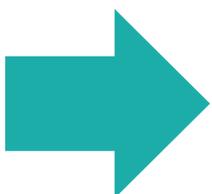
Finally, participants emphasized the importance of clear state and MCO guidance. Representative coding with modifiers, onboarding sessions, and technical assistance could help providers navigate Medicaid participation. Other states served as models that Texas could adapt.



What you need to do is pick out five or six across the state spread out and get programs started in those community colleges to increase your numbers. You could do all of your prerequisite health science courses if you go full-time, in two to three semesters. Community colleges already have the pre-health science courses that they would need. The colleges will need to bring in people qualified to teach the lactation specific portion. If you partner with community colleges that already have nursing programs, they have contracts with hospitals, physician offices, and other clinics. They can place students for clinical training hours that is so important in this line of work. The only barrier is colleges have to know, upfront. They need to show their graduates will be able to obtain jobs, Most hospitals will not hire someone for this level of independent clinical patient care without a license.

-Advocacy Leader #1

Why It Matters



Success relies on more than just reimbursement. It also needs workforce development, innovation, and solid support from state agencies and MCOs.

Policy Awareness and Advocacy

The last theme centers on communication and clarity in policy design. Providers showed strong support for HB 136. Still, they raised questions about definitions, billing structures, and documentation standards. A private practice IBCLC explained, **“I haven’t heard whether they have actual details. Do we have to be licensed with the state? Do they have a plan for that, or are there fees? I just don’t know.”** A policy leader echoed concerns about credentialing, stating, **“The bill says ‘national or international lactation consultant,’ but there are many certifications out there that don’t meet the same education standards. That language is unclear.”**

Stakeholders also debated reimbursement models. Some suggested time-based billing to better match the length and complexity of lactation visits. One health system IBCLC stated, **“Time-based coding makes more sense because new visits are 80 to 90 minutes long. That is a better way to capture the work that’s actually being done.”** Others proposed tiered rates for higher-acuity cases or flat-rate structures for simplicity. Providers highlighted the need for fair rates and straightforward billing. Healthcare providers should receive reimbursement for parents and infants as different patients when it's clinically necessary.

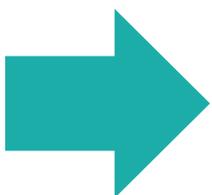


We document on both mom and baby and we bill on both. They are separate patients requiring a separate assessment planning. Blue Cross Blue Shield is currently trying to say you can only bill one of them because they're a dyad, I think is very unfair. Not just on a financial perspective but from clinical care and even a medical records perspective like if a baby is part of a visit, something should be documented on the baby. This is my opinion like it would be absolutely bizarre if I had two patients come to me with like let's say two siblings come to me with strep throat and insurance tried to tell me oh well they're in the same family they have the same illness. And they say 'you can only bill for one of them.' Like what? That makes zero sense.

-Health System IBCLC #3



Why It Matters



If we lack clear communication, timelines, and realistic reimbursement models, Medicaid provider participation will stay low. This means access gaps will keep growing.

CONCLUSION

Across ten key informant interview transcripts over 1,500 codes were placed. The three person coding team refined a code book that included 41 sub-codes and 23 main codes. Through collaborative meetings the team identified the five themes explained in this report.

Together, the themes reveal a clear picture of the current Texas lactation landscape. Texas families often lack access to skilled lactation care. This disparity is due to everyday challenges, hospital policies, and an uneven distribution of lactation consultants. Licensure and administrative gaps keep all lactation consultants from fully engaging with the healthcare systems. This limits families' access to important support. Stakeholders suggested several actionable solutions: **growing the workforce, utilizing telehealth, care coordination, and clear guidance from the state and MCOs.**

The implications for HB 136 are clear. To achieve its goals, the policy must **establish reimbursement pathways**. It also needs to **tackle workforce shortages, simplify administrative tasks, and assist providers**. Clear communication and practical implementation tools will be essential. This approach will help Texas ensure that all families, particularly those on Medicaid, have quick access to skilled lactation care through HB 136.

- 
Growing the Workforce
- 
Utilizing Telehealth
- 
Care Coordination
- 
Clear Guidance for Enrollment

SURVEY DATA ANALYSIS

The total number of IBCLCs in Texas IBCLE reports is 1,496 as of March 2025. We aimed to recruit 306 IBCLCs. This would give us a margin of error of about $\pm 5\%$ at a 95% confidence level. The survey wasn't distributed by the International Board of Lactation Consultant Examiners (IBLCE) as we intended. This affected our ability to meet the planned sample size. Instead, we relied on a market research source that provided 295 contacts, who were then reached via email or phone.

We received responses from 153 individuals in the survey. This gives us a **response rate of roughly 52%** from the accurate contact list. This rate aligns with typical response rates for healthcare professional surveys (Meyer et al., 2022). Of these, 152 responses were usable after excluding one respondent who resided outside Texas, resulting in a margin of error of $\pm 7.5\%$ at the 95% confidence level. This represents a clear improvement over the initial 72 responses $\pm 11.3\%$ collected before implementing secondary outreach strategies. The margin of error is larger than expected, but this survey is still the most complete dataset on Texas lactation consultants to date.

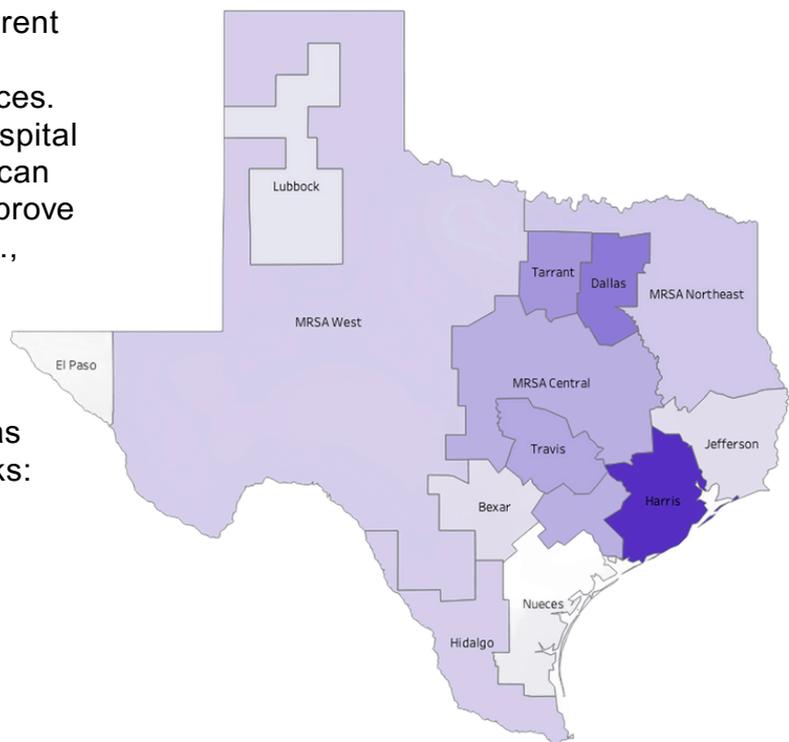
Location

The location of our survey participants demonstrates how monitoring health profession trends can aid in policy and program development. Expanding the availability of IBCLCs across different regions can help reduce gaps in maternal and infant health resources. Unlike programs limited to one hospital or clinic, wider access to IBCLCs can address systemic barriers and improve support for families (Dockins et al., 2025).

The following maps illustrate the distribution of IBCLC lactation providers across the state of Texas using three geographic frameworks:

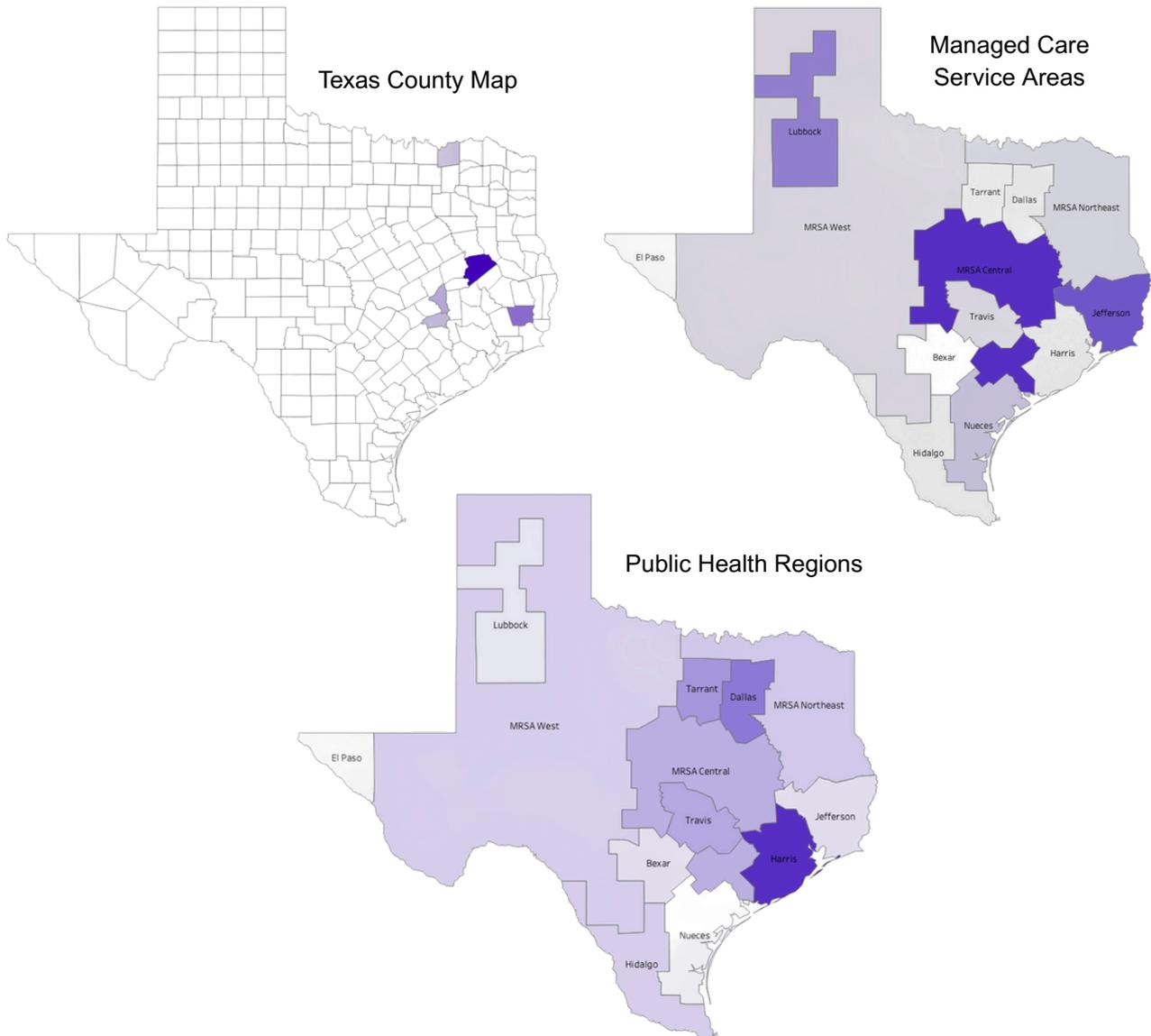
- County
- Managed Care Service Area
- Public Health Region.

Count of Lactation Providers by Manage Care Service Area



Provider information was collected through the state-wide survey conducted by MCHIP, while population and regional data were drawn from the Texas Health Data system (HHSC, 2025.)

Lactation Providers Per Capita (100,000)



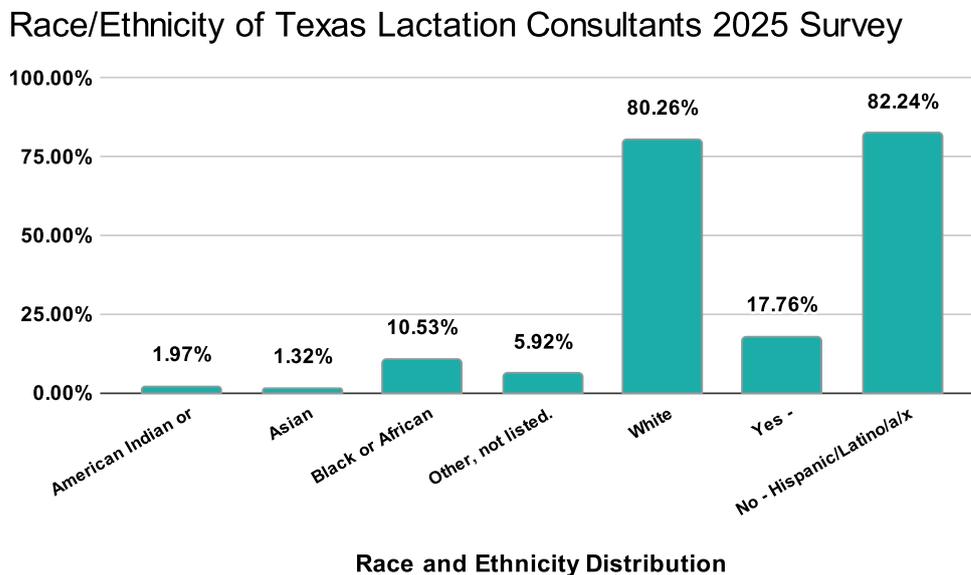
Key Findings

- Provider availability is uneven across the state, with higher concentrations in urban counties and limited presence in many rural areas.
- When adjusted for population, several regions with a fair number of providers still show low per-capita coverage, such as Harris County, signaling access challenges for families.
- Managed care service areas and public health regions highlight structural differences in coverage that may influence how families connect with lactation support.

Demographics

The majority of respondents were White (80.26%) (n= 122), followed by 10.53% Black/African American (n=16). 82.24% were of non-Hispanic origin (n=125) (Chart 1 and Appendix A, Table 1).

Chart 1



More than half of respondents (55.26%, n=84) reported holding a bachelor's degree, followed by 26.32% (n=40) with a master's degree. The majority (91.5%, n=139) reported holding a valid IBCLC certification. Among these, 36.84% received certification within the past five years, while 42.1% held certification for 5–10 years or 10–15 years. Only a small proportion had been certified for 20–25 years (3.95%) or for more than 25 years (4.61%). Participants reporting other credentials including registered nurses or licensed speech pathologists (n=91) totaling 59.87% of respondents (Appendix A, Table 1).

The majority of respondents practice in community based settings (56.58% n= 86). This includes Outpatient Clinic or Office (not connected with a hospital), Outpatient Home Visiting Private Practice Setting, WIC Office, Telehealth services, and Public health clinics (Appendix A, Table 1).

For those who work in hospital settings the survey asked participants to select the answer that best describes IBCLC/lactation support at their hospital. A notable proportion (42.4%) indicated their hospital has a dedicated lactation services staffed daily with IBCLCs, and 21.2% reported dedicated staffing but less than 7 days per week. A smaller share (4.5%) noted coverage extends into the night. However, gaps are evident with 10.5% describing IBCLC staffing as generally consistent but not universal. Additionally, 8.6% reported variable in the quality of care depending on staff or shift, and 3.0% indicated IBCLCs are often pulled to staff patient units. Minimal staffing was reported by a small minority, with only 3.0% stating their hospital lacks IBCLCs entirely. Overall, while many hospitals appear to offer structured IBCLC services, responses reveal variability in consistency and coverage, as well as substantial uncertainty among providers about staffing (Appendix A, Table 2).

Demographics (Cont.)

About one-third of respondents (32.67%) reported a weekly caseload of 1–5 patients, while smaller proportions reported fewer than one (8.91%), 6–10 (15.84%), 10–20 (15.84%), 20–30 (9.90%), or more than 30 patients (5.94%). Roughly 11% indicated the question was not applicable (Appendix A, Table 4).

Regarding visit duration, nearly half (48.00%) reported an average of 90 minutes per patient, followed by 18.00% at 120 minutes, 12.00% at 60 minutes, and smaller proportions reporting 30 minutes (8.00%) or less (2.00%).

Overall, the majority of respondents who provided an answer reported accepting self-pay in some form. Specifically, 28.95% accepted both private insurance and self-pay, 10.53% accepted self-pay only, and 5.92% accepted self-pay along with private insurance and Medicaid/CHIP. Acceptance of insurance without self-pay was much less common, with 1.32% accepting private insurance only and 1.32% accepting Medicaid or CHIP only.

Most respondents reported little familiarity with billing and coding, with 29% indicating no knowledge and 37% reporting limited knowledge. Fewer reported moderate (18%) or good knowledge (7%), and only 1% identified as having expert-level knowledge. About 7% indicated the question was not applicable.

The majority of respondents (51.32%) reported having no billing experience, while only a small proportion (6%) agreed that the medical coding used by insurance for reimbursement accurately reflects the services they provide. Among those who had billing experience, (71% n=39), believe that the process to bill insurance and receive payment is not easy or accessible (Appendix A, Table 4). When asked about the preferred billing model, 35% favored a time-based approach (e.g., per 15- or 30-minute unit), 25% preferred a flat rate per visit and 24% were unsure. Regarding which patient account should a provider use when seeking reimbursement, 59% responded that it should be for both mother and infant (Appendix A, Table 4).

Fifty-nine percent of respondents were aware of the bill, while 40% were not. Regarding the scope of lactation consultation services under HB 136, 46% had a basic understanding, 22% moderate, 8% good, 6% very strong, and 18% had no understanding (Appendix A, Table 5).

For billing intent, most respondents were neutral (41%), while 25% strongly agreed and 17% agreed. For billing interest, the majority expressed agreement, with 43% strongly agreeing and 28% agreeing (Appendix A, Table 5).

Most respondents indicated that lactation consultant supply (defined as 1,496 IBCLCs) in Texas is insufficient, with 39% strongly disagreeing and 39% disagreeing. Regarding training availability, 42% disagreed that opportunities were adequate. In contrast, support for an accredited university training program was strong, with 44% agreeing and 34% strongly agreeing. Most respondents supported creating a lactation consultant licensure in Texas, with 37% strongly agreeing and 28% agreeing (Appendix A, Table 5).

RESEARCH QUESTION 1

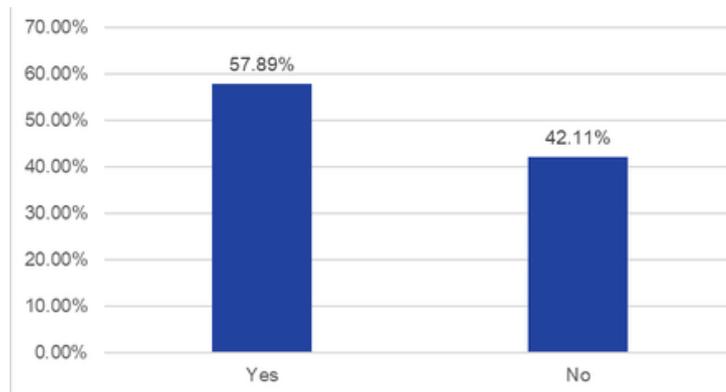
Survey Analysis Results

To investigate the patterns and barriers related to insurance reimbursement for lactation services in Texas we hypothesized this question: **Are providers who hold another credential in addition to an IBCLC more likely to report successful reimbursement for lactation services compared to those with only an IBCLC credential?**

A new binary variable was created to identify participants with dual credentials (Graph 1), defined as respondents who held both an IBCLC certificate and another state healthcare license, or those with another lactation certification/educator credential plus a state healthcare license. This variable (dual credential: yes/no) served as the independent variable. Billing ease measured by the item, **“The process to bill insurance and receive payment is easy and accessible for me”** on a 5-point Likert scale was the dependent variable (Graph 2). Of the 152 respondents, 91 were categorized as “dual credential” and 61 as “IBCLC only.” After excluding those who selected “N/A” or did not answer the billing ease item, 87 participants remained for analysis.

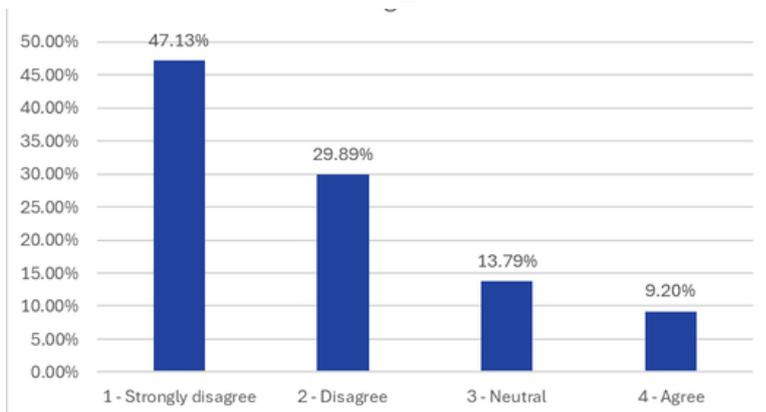
Results from a Mann–Whitney U test indicated that participants with dual credentials reported slightly higher billing ease (mean rank = 47.5) compared to those with only an IBCLC (mean rank = 39.5). However, the difference was not statistically significant ($U = 1500.0$, $Z = -1.58$, $p = .11$). These findings suggest that while dual-credentialed providers may perceive billing to be somewhat easier, the observed difference was not strong enough to conclude that credential status is associated with billing ease in our sample.

Dual Credentials



Graph 1: Dual credential

Billing Ease



Graph 2: Billing Ease

RESEARCH QUESTION 2

Survey Analysis Results (Cont.)

We examined whether IBCLCs and lactation care providers in Texas are ready to enroll and bill Medicaid under Texas HB 136. Two hypotheses were tested:

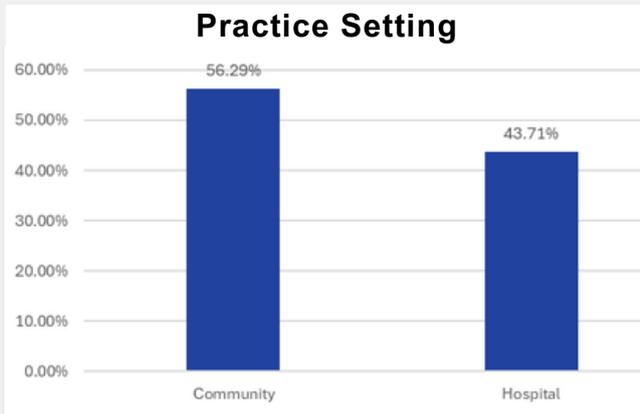
1. **IBCLCs working in hospital settings would be less likely than those in community settings to be aware of HB 136.**
2. **Providers with greater billing knowledge and prior experience submitting billing codes would be more likely to report intent to bill Medicaid for lactation services.**

For the first hypothesis, the independent variable was practice setting. The variable was categorized as hospital-based (inpatient hospital or outpatient hospital-attached clinic) or community-based (outpatient clinic or office not connected with a hospital, public health clinic/WIC office, maternal home visiting public health program, or private practice home visiting). The dependent variable was awareness of HB 136 (Graph 4), measured by the question: **“Did you know that the Texas Legislature passed House Bill 136? It offers reimbursement for lactation support services to Texas Medicaid patients.”**

Responses were coded as yes or no (Graph 4). After excluding one respondent who did not answer the awareness question, 151 participants remained for analysis. A chi-square test of independence showed no significant association between practice setting and HB 136 awareness ($\chi^2(1, N = 151) = 1.25, p = .26$). Fisher’s Exact Test confirmed this result ($p = .32$). Thus, awareness of HB 136 did not significantly differ between hospital- and community-based providers.

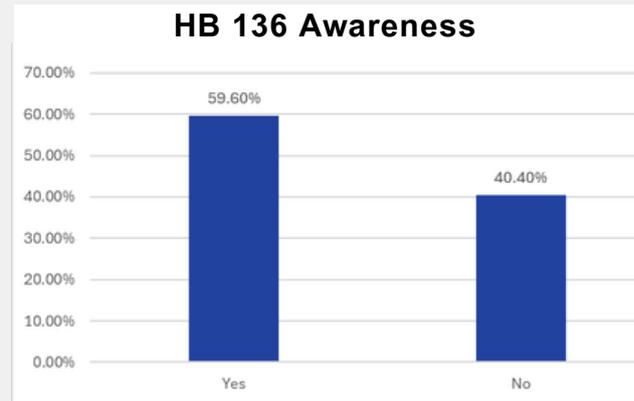
For the second hypothesis, billing experience, we measured the item **“Have you ever submitted or reviewed billing codes for lactation services?”** as the independent variable (yes/no) (Graph 4). The dependent variable was intent to bill Medicaid, measured by the item **“I will start asking Texas Medicaid for reimbursement for lactation support services given to patients,”** rated on a 5-point Likert scale (Graph 5). After excluding 19 respondents who did not answer or selected “N/A” to the billing experience question, 133 responses remained. A Wilcoxon rank-sum test indicated no significant difference in Medicaid billing intent between providers with billing experience ($n = 55$) and those without ($n = 78$), $Z = 0.35, p = .73$. A Kruskal–Wallis test confirmed these findings, $\chi^2(1) = 0.12, p = .72$.

Together, the results suggest that neither practice setting nor prior billing experience significantly influenced awareness of HB 136 or intent to bill Medicaid. Although we hypothesized that providers with billing experience would be more likely to express readiness to bill, the findings indicate that billing intent was comparable across groups. This suggests that factors beyond prior billing exposure like knowledge, lack systems support, recognition of the lactation consultant role, or administrative burden may play a larger role in shaping providers’ willingness to bill Medicaid.

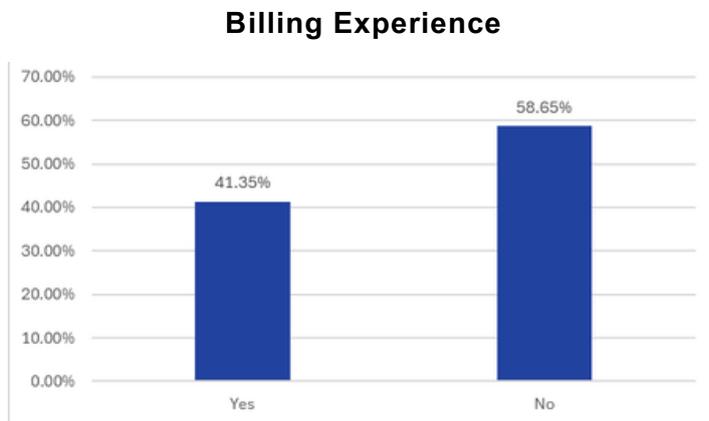


Graph 3

Hypothesis One

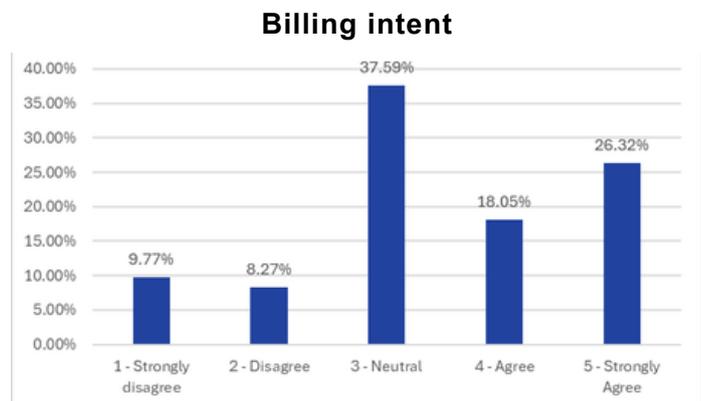


Graph 4



Graph 5

Hypothesis Two



Graph 6

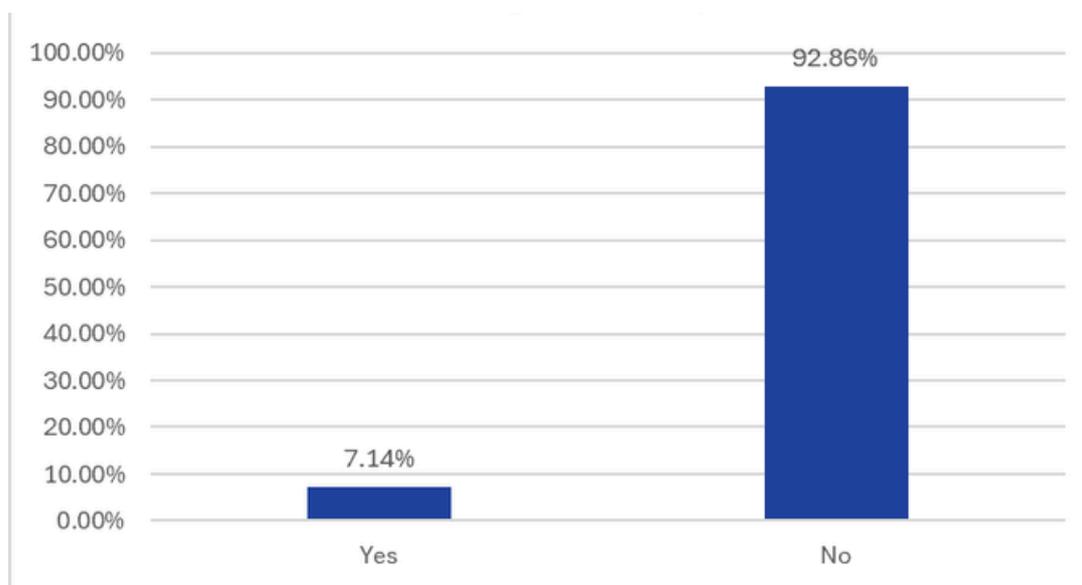
RESEARCH QUESTION 3

Survey Analysis Results (Cont.)

For our third research question, **What are the provider-perceived gaps in capacity to meet statewide lactation care needs?** We hypothesized that provider perspectives on the availability of training opportunities to support aspiring IBCLCs would differ by practice setting. The independent variable was practice setting, categorized as hospital-based and community-based. The dependent variable was training availability, measured by the item, **“There are enough training opportunities/clinical teaching sites to support aspiring IBCLCs in Texas.”** Responses on a 5-point Likert scale were re-coded into a binary outcome: yes (strongly agree/agree) or no (disagree/strongly disagree) (Graph 7). Neutral responses were excluded, leaving 126 participants for analysis.

A chi-square test of independence showed no significant association between practice setting and perceived training availability, $\chi^2(1, N = 126) = 1.94, p = .16$. Fisher’s Exact Test confirmed this result (two-sided $p = .18$). The effect size was small (Cramer’s $V = .12$), suggesting that perceptions of training availability did not meaningfully differ by practice setting. In other words, providers working in hospital and community settings reported similar views on the sufficiency of training opportunities.

Training Availability



Graph 7: Dual credential

SWOT ANALYSIS OF STATEWIDE SURVEY RESPONSES

The team carried out a SWOT analysis to support the project's goals. The SWOT method is a popular tool in healthcare planning. It helps identify internal and external factors that impact policy implementation (Helms & Nixon, 2010; Phadermrod et al., 2019). The structured approach categorizes provider perspectives. It highlights the benefits of Medicaid reimbursement, the barriers that may limit provider participation, the opportunities for system change, and the risks that could undermine policy goals.

Strengths

Medicaid reimbursement for lactation consultant services has key benefits that support public health goals. Coverage gives low-income families, at higher risk for breastfeeding issues, access to skilled lactation care. This is similar to what privately insured families receive, helping to reduce gaps.

Quality lactation support enhances breastfeeding initiation, exclusivity, and duration. This results in healthier outcomes for both mothers and infants. Breastfeeding reduces illness and the need for WIC formula. It also leads to fewer missed workdays and lowers long-term health risks, including diabetes and cancer. These benefits lessen Medicaid and taxpayer costs while strengthening community health.

“Covering lactation through Medicaid ensures that families who need the most support actually receive it. It helps parents reach their goals, improves infant and maternal health, and makes breastfeeding success possible regardless of income.”

Reimbursement boosts the sustainability of lactation consultants, especially in underserved areas. It also integrates lactation care into the wider healthcare system.

Weaknesses

Several weaknesses could blunt the impact of Medicaid reimbursement. Low and unpredictable rates may not reflect the time needed for clinical care. This can discourage providers from participating and may limit visits to rural or home-based locations.

Administrative tasks, like dealing with various managed care organizations (MCOs), lead to too much paperwork for community-based practices. Each MCO has different portals, rules, and payment timelines, adding to the burden. Few lactation consultants are currently credentialed, and recognition as independent billers remains inconsistent.

Providers highlight a shortage of guidance on enrollment steps, billing codes, and documentation standards. Additionally, misalignment in coding could lead to underpayment risks. In addition, limited awareness of the lactation consultant (IBCLC) role and scope contributes to confusion and reduced reimbursement for clinical care.

“The paperwork and time that Medicaid requires for services takes valuable time away from patient care. We don’t have the staffing to do that at this time.”

SWOT ANALYSIS OF STATEWIDE SURVEY RESPONSES

Opportunities

The new benefit opens doors to better access, improved outcomes, and a stronger healthcare system. Families in rural and underserved regions can now gain access to services that were previously unavailable. Coverage has the potential to fund a full continuum of care, from prenatal through postpartum. Care delivery can vary, delivered in-person, via tele-health, and in group settings.

Evidence shows that skilled clinical care from lactation consultants improves breastfeeding outcomes. This means healthier families and generating cost savings for Medicaid and the broader healthcare system. Reimbursement also opens opportunities for lactation consultants to integrate into the health care system, creating stronger referral networks and consistent standards of care. Fair payment could encourage more professionals to join the field and expand Texas's capacity.

“Now that Medicaid will reimburse for lactation consultant services under HB 136, there’s tremendous potential to expand access and improve care for families across Texas—especially in underserved regions like the Rio Grande Valley.”

Threats

Despite authorization, several external risks may limit the reach and quality of this benefit. Low reimbursement rates and caps on visit time could drive providers away or shorten services. Codes that do not match the clinical nature of lactation care increase the risk of denials and underpayment.

Complex MCO processes, like prior authorization and slow payments, may challenge small practices. Families and clinicians may also lack awareness of the benefit, reducing uptake. Larger institutions could capture most reimbursements, leaving rural communities underserved. Structural issues, such as language access and transportation barriers, can still affect who benefits. Postpartum time constraints may also play a role.

“This still won’t be easily accessible to small practices in small towns... most of the money will end up going to hospitals and clinics in big cities.”

Strengths and Weaknesses Questions from the State-wide Survey:

- What are the benefits or advantages of Medicaid providing reimbursement for lactation consultant services?
- What are the limitations or challenges of Medicaid providing reimbursement for lactation consultant services?

SWOT ANALYSIS RESPONSES

Opportunities and Threats Questions from the Statewide Survey:

- Where do you see potential to expand access or improve care now that Medicaid will reimburse for lactation consultant services?
- Do you have any specific worries or barriers related to Medicaid providing reimbursement for lactation consultant services?

S STRENGTHS

"Accessibility and equity for Medicaid populations to receive skilled lactation services and further overall long term health benefits for Texas citizens."

"I would like to see Medicaid sit down and talk with lactation consultants who are providing services, to understand the full scope of providing services, the depth of work done to help clients meet their goals, and to clarify the costs of our services are not like medications or other services that have been inflated to create a large revenue stream for mega-corporations."

"In our practice, 90 percent of our clients are still breastfeeding at 6 months, and 74 percent continue to at least one year. Even more importantly, 84 percent say they met their breastfeeding goals. That doesn't happen by chance. It takes high-quality, individualized, ongoing support from trained lactation professionals."

"Allow in home visits and pay the IBCLC an amount worth her time and skill to travel to rural areas where skilled providers are unavailable. Pay a travel fee."

"Adding lactation consultants to other areas of practice such as pediatrician offices and by having IBCLCs work exclusively in this field in hospitals where they currently wear multiple hats and face several barriers when trying to be accessible to breastfeeding mothers and infants."

"Many more clients. All WIC offices could refer out for IBCLC services. There is a huge population of WIC clients that could be better served and the moms deserve the same level of care!"

O OPPORTUNITIES

W WEAKNESSES

"The paperwork and time that Medicaid requires for services takes valuable time away from patient care. We don't have the staffing to do that at this time."

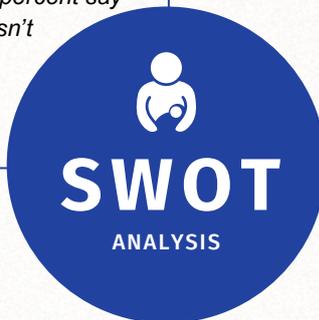
"I don't want to spend unpaid time fighting for a meager reimbursement... families can't afford to wait days for an appointment when their baby is unable to latch or mom is in severe pain."

"Likely anticipate it will be a low amount not sustainable for the provider to have too many scheduled each day. Wondering how easy it will be for reimbursement."

"I'm curious what they will actually pay. We can charge \$120, they may reimburse \$30. That's the reality. Mcd reimburses <\$100 for a doctor perform a circumcision."

"Low reimbursement rates, Medicaid does not accept the Z39.1 diagnosis code, but they should. IBCLCs should not have to be required to work under a doctor, NP, CNM to provide true lactation services and receive reimbursement. I am concerned that Medicaid will do what (XXXX TX insurance) is doing: only reimbursing the IBCLC for 30 minutes of lactation education and only allowing the IBCLC to use billing codes S9443 and 98960. They deny all claims if any other billing codes are used by an IBCLC unless the IBCLC is billing under a Doctor, NP, or CNM. That is not lactation care. It's breastfeeding education only. Families need skilled Lactation Care! If Medicaid takes the route that (insurance) company is taking for what they consider 'lactation care', IBCLCs won't sign up or credential to become Medicaid providers because it will not be worth our time or effort. I for one, will not!"

T THREATS



Medicaid Reimbursement for Lactation Services

As Texas prepares to implement HB 136 beginning September 1, 2025, understanding how other states have structured Medicaid reimbursement for lactation services is essential. Looking at national models and guidance shows ways to increase provider participation. It helps guarantee equal access and supports the lasting sustainability of services.

National Landscape of Medicaid Reimbursement

At least 16 states currently reimburse lactation services through Medicaid, most often using HCPCS code S9443. Payment structures vary considerably: some states use fee-for-service (e.g., per 15-minute unit), others pay per session, and a few fold lactation care into bundled maternity payments. States like Colorado and New Mexico are stepping up. They offer telehealth options and have added modifiers to separate individual care from group care. Also, they require Managed Care Organizations (MCOs) to pay at least the same rates as Medicaid fee-for-service (CDHCPF, 2025; NMHSD, 2024).

Eligibility standards also differ across states. Medicaid typically recognizes licensed clinicians, such as nurses, nurse practitioners, and doctors. It also requires lactation consultants to have special certification. Some states accept lactation consultants regardless of licensure. However, in areas where they aren't licensed as healthcare providers, barriers may persist.

National surveys indicate momentum toward broader coverage. A Kellogg Foundation report found that most states provide some mix of breastfeeding education, inpatient help, or outpatient support through Medicaid (2021). Several states have since expanded these benefits. This shows a trend toward adding lactation support to maternal and child health systems.

Best Practices

Colorado offers one of the clearest and most provider-friendly reimbursement models. Its Medicaid program offers public manuals that include billing codes, modifiers, and clear eligibility criteria. Illinois and Kansas use flat rates or modifiers to simplify payments based on provider type. New Mexico ensures that lactation providers receive fair pay by requiring MCOs to match fee-for-service rates. Centralized guidance and clear information help providers in these states. This reduces confusion and makes it easier to navigate the system. (See Appendix D for additional information and sources for Medicaid reimbursement in other states.)

Implementation Challenges

Despite progress, several challenges remain. Providers in several states report confusion and the need for clarity about billing procedures (Rosenzweig et al., 2025). This is common when visits include both the mother and baby. Some states restrict reimbursement through global maternity fees that bundle prenatal and postpartum care, limiting the ability to bill separately for lactation services. Eligibility rules create unfairness. When only licensed clinicians qualify, community-based lactation consultants aren't eligible for reimbursement. Inconsistent implementation by MCOs adds further complexity, leaving families with uneven access to covered services (Rosenzweig et al., 2025).

Fiscal Context and Caseload Analysis

According to reports HHSC projects that 137,000 women will benefit from 12-month postpartum Medicaid coverage in FY 2025 (Texas Tribune, 2023). The March of Dimes Peristats dashboard shows nearly 388,000 live births in 2023 and 48.8% of those were covered by Medicaid. Based on this rate, approximately 189,000 newborns were covered by Medicaid that year (CDC, 2023; National Center for Health Statistics, 2025). The Baker Institute reports Texas' 2024 Medicaid extension from 60 days to 12 months has the potential to improve health for 137,000 women (Sampson & Kennedy, 2024).

According to the fiscal note for HB 136, the state expects about 54,861 Medicaid users to access lactation services by fiscal year 2027 increasing to 56,916 by 2030 (Texas Legislative Budget Board, 2025). This represents an estimated utilization rate of 40.04% of mothers or 29.02% of Medicaid covered births. Factoring in available data from the Texas Department of State Health Services (DSHS) 87.5% of infants serviced by Medicaid ever breastfed (DSHS, PRAMS, 2019). This is higher than the 83.4% of infants ever breastfed from Texas total population data in 2022 (CDC, 2025).

Looking at the Texas WIC's Infant Feeding Practices Survey provides perspective about the population serviced by HB136. The report shares that over 55% of respondents said they did not breastfeed as long as they wanted to (HHSC, 2023). In the WIC program, about 60% of eligible postpartum people who are breastfeeding get support. But according to the fiscal note attached to HB136 the number of people expected to use Medicaid-covered lactation consultant services is low at 29-40%. This means more families in Texas might use these services than the state expects. Based on other programs across the country, it would be reasonable to plan for 40% to 60% of postpartum people on Medicaid to use lactation support. Prior to implementation case load estimates may need to be refined. HHSC will need to outline how the vital breastfeeding programs within WIC align with HB136 to avoid duplication of effort.

Texas can learn from the experiences of other states when creating its Medicaid reimbursement policy for lactation consultants. Clear billing guidance, fair provider eligibility, and easy enrollment can help cut down barriers for providers and families. At the same time, we must address challenges like licensure recognition, global or bundled maternity fees, and inconsistent implementation. Using evidence and lessons from other states will be key for Texas' policy on HB 136. This approach will help improve access, sustainability, and equity in lactation support.

DISCUSSION

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING



Access and Sustainable Solutions in Lactation Care

Why access matters now

Texas families need timely, skilled lactation support to start and sustain human milk feeding. Breastfeeding success should not fall only on mothers. It requires support from families, communities, health systems, and policies. Research shows that breastfeeding improves when communities work together. Using effective strategies across various settings helps at all social levels (Pérez-Escamilla et al., 2023). The combined data show uneven access across Texas. Medicaid-enrolled families face the biggest barriers. This aligns with the WIC survey showing over **55% of respondents said they did not breastfeed as long as they wanted to** (HHSC, 2023).

Postpartum Medicaid patients may struggle with transportation and other challenges related to non-medical drivers of health. The challenges become worse where large lactation care deserts exist. Lack of access to skilled providers has a direct impact on feeding outcomes. Dockins, Pahl, and Lingerfelt (2025) **found that states with more IBCLCs per woman of childbearing age have higher breastfeeding rates**. This is especially true for exclusive breastfeeding at 3 months. Dockins et al. report that families need more access to professional lactation support. It's a key part of wider public health efforts to boost breastfeeding rates (2025).

Low reimbursements across payers make this issue worse. Payment rates often don't cover the full scope of lactation consultant services. This problem becomes more severe when the provider's role remains unclear and undefined.

Our findings agree with national evidence that **inconsistent coverage, bundled maternity payments, and payer differences make it harder to access standard lactation care and supplies**. This challenge is especially significant for people with low incomes (NASEM 2025; WPSI 2025; CMS, 2023). The mixed methods data suggest that HB 136 implementation can address these issues.



What our data adds

Texas is known for doing things big, and that includes making sure that lactation care providers' voices are heard. Their insights match what other reports have found. Providers highlighted common barriers, gaps in the delivery of services, and their ideas for improving care. They shared what works well and made recommendations to support HB136 and breastfeeding families in the state.

- ✚ **Workforce distribution and setting.** Most respondents responded that they primarily practice the hospital setting (43.42%) with less identifying the community setting (27.63%) and many identified “other” (28.95%). This pattern limits reach for families who need help after discharge or who live far from maternity hospitals.
- ✚ **Workforce sufficiency.** Respondents largely disagreed that 1,496 IBCLCs statewide can meet needs (mean 1.88/5). They also reported too few training sites and preceptorships and strongly supported developing accredited programs in Texas.
- ✚ **Awareness and navigation.** Four in ten had not heard of HB 136. Among those aware, understanding of “who is covered” and “what’s covered” was basic to moderate for most.
- ✚ **Reimbursement and billing literacy.** Knowledge of billing/coding was low (mean 2.08/5). More than half reported no experience with billing codes. Most said the current codes don't accurately reflect clinical lactation care.
- ✚ **Preferred coverage design.** Participants and data sources match. They indicate that time-based billing and coverage for both mother and infant reflect clinical lactation care. This includes the time needed for assessment, support, and care planning for two individuals.

Interview insights deepen the picture. Providers highlighted the struggles faced by Texas families:

- Short or unpaid leave
- Transportation issues
- Limited options during evenings or weekends
- Difficulty locating in-network lactation consultants who are available.



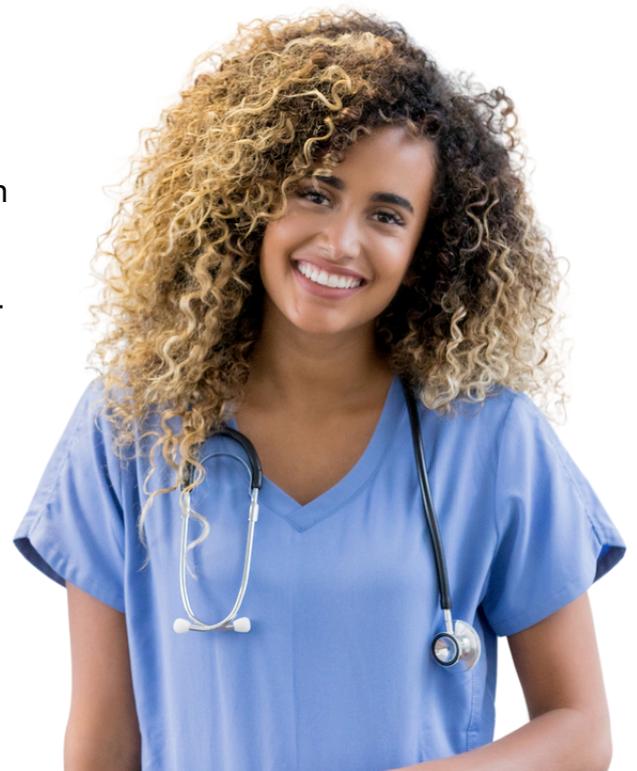
DISCUSSION

Many mentioned that hospital policies, staffing issues, or hierarchy can restrict lactation consultant care in hospital settings. Defining how and when HB 136 applies to hospitals needs explicitly addressing global fees and provider's fees for service. This is essential if HB 136 implementation includes limitations. HHSC must balance the fiscal impact of inpatient lactation reimbursement with the service needs of patients after discharge.

Hospital practices and optimal staffing must connect to inpatient reimbursement. Dedicated lactation care and improving maternity practice help families get breastfeeding off to the right start. Participants pointed out the value of telehealth and hybrid care. They also highlighted early prenatal education and partnerships with WIC and pediatric practices. Prenatal strategies aim to engage families earlier and reduce missed care.

How the evidence base intersects with Texas

- **Coverage consistency matters.** National analyses show a “patchwork” of coverage. This makes it hard for facilities to offer lactation services and puts a strain on families. Bundling can also hide or leave out lactation services from payment (NASEM, 2025).
- **Texas is on the right track.** Extending postpartum Medicaid to 12 months and covering lactation care boosts initiation and duration. This is especially true for low-income groups (NASEM, 2025; CMS, 2023).
- **Cost savings are real.** Boosting breastfeeding rates, even a little, could save state Medicaid programs millions annually. Researchers estimate that each breastfed baby cuts health care costs by nearly \$500 in the first six months (Oliveira, Prell, & Cheng, 2019).
- **Behavioral counseling is effective.** The United States Preventative Services Task Force (USPSTF) recommends counseling during pregnancy and after birth. The United States Health Resource Service Administration (HRSA) guidelines require comprehensive prenatal and postnatal lactation support, counseling, and equipment rental without cost-sharing (Patnode et al., 2025; CMS, 2024).
- **Administrative design shapes access.** Rosenzweig et al.'s landscape analysis explores the barriers faced in other states. This includes restrictive benefit designs, unclear billing, workforce shortages, and poor coordination (2025). The data within this study found similar concerns raised by Texas lactation consultants.



Building and Sustaining the Workforce

The findings show challenges in creating and keeping a strong lactation consultant workforce in Texas. **Almost 80% of respondents felt there aren't enough lactation consultants to meet the state's needs.** This matches ongoing national worries. Geographic distribution, cultural and language representation, and institutional support are uneven. Texas, with its large and diverse population, illustrates this problem acutely. More than 1,400 IBCLCs are board certified across the state. Dockins, Pahl, and Lingerfelt (2025) report the **population density of IBCLCs per 100,000 females of childbearing age is 19.4.** Texas lactation consultants are not easy to identify through public records. This may impact awareness and provider enrollment. Rural regions, areas with many Medicaid recipients, and communities of color may struggle with access.

Fragmented postpartum care in the U.S. adds stress for patients and systems. This care often involves different providers for mothers and infants. They have separate medical records, which leads to a lack of coordination. This may result in issues affecting breastfeeding families (NASEM, 2025). The study's participants perspectives echo this.



I hear a lot about families that can't find help they are either back to their pediatrician, back to their OB, or they'd be told to go to one of the WIC sites that has a lactation consultant, which could be really far away because there's not very many of them.

- IBCLC Policy Expert #4



Lactation is a complex process tied to the health of both mother and infant. Problems often happen after hospital discharge. The problems reflect barriers within the health care system. Texas hospital practices and lack of medical provider training contribute to the challenges. The NASEM report shows that this leads families to get bad advice, like using supplements or starting weaning too soon (2025). **Coordinated care from doctors, advanced practice providers, and lactation consultants is key.**

Texas lactation consultants have the knowledge and skills to fill the gaps in our health care system. Participants provided examples of how they support both moms and babies. Examples of clinical lactation support included addressing physical and social-emotional needs to help families achieve their health and feeding goals.



I use a postpartum depression screening checklist. I can connect with the mom's physician and refer her to a counselor. I spend time with patients in conversation. While we talk I'm observing her body language and what she's saying to me. I document how she like at the end of the visit. Is she feeling really good about herself, or still kind of really doubting herself.

-Community IBCLC #8



Workforce Training and Education Pathways

Our data show strong support for creating accredited university-based lactation education programs. Participants feel that there aren't enough training opportunities and clinical mentors. **More than 75% of respondents said that creating academic programs would boost the number of qualified lactation consultant providers.** This reflects recent national guidance. It recommends investing in training that represents different cultures. It also stresses adding lactation education to maternal and infant health provider curriculum. IBCLC certification through Pathway 2 includes completing a comprehensive academic program. The program focuses on human lactation and breastfeeding. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits academic programs.

Several states have academic programs to train lactation consultants. North Carolina Agricultural and Technical State University (NCAT) created an accredited two-semester postgraduate program in 2020 to train IBCLC students. This program has graduated 41 students. As a result, NCAT is the nation's largest producer of Black lactation consultants in recent years. It boasts an 83% pass rate on the certification exam. The program aims to close gaps in breastfeeding support. It trains providers from underrepresented communities to be culturally responsive. Also, the program started a free lactation clinic in North Carolina. This was made possible with help from funding through an MCO. **Targeted investment can help Texas grow its IBCLC workforce.** By funding education, clinical training, and culturally relevant service models, the state can tackle current care disparities (Cooper, 2024).



You've got to get into these community colleges. What you need to do is pick out five or six across the state spread out and get programs started in those community colleges to increase your numbers. They could do it so you could do all of your prerequisite health science courses if you go full-time. You could do that in two to three semesters our community colleges already do the pre-health science courses that they would need.

-Advocacy Leader #1



Licensure and Professional Recognition

Interviews and survey responses provide insight into the struggles lactation consultants experience. **IBCLCs are a vital link supporting families from hospital to home.** They must be knowledgeable and trained to provide clinical care and support to mothers and infants. Further they bridge the gap within medical care. IBCLCs often collaborate with a mom's medical provider and the infant's provider. However, the data shows system barriers that contribute to what many participants felt was a lack of respect and understanding.

Misrepresentation of the IBCLC certification is often seen as an add-on for licensed professionals contributes to stagnant growth of the workforce and the development of what some participants describe as the lactation “alphabet soup”. (See Appendix D for definitions and sources related to the role of lactation consultants.)

Most survey participants strongly supported lactation IBCLC licensure in Texas. About two-thirds were in favor. (See Appendix A Table 5) Respondents mentioned that licensure could protect families by ensuring quality standards. It could also simplify reimbursement processes and recognize lactation consultants as important members of the healthcare team. A knowledge brief published by National Lactation Consultants Alliance (NLCA) stresses the need to ensure safe and effective breastfeeding care. They urge policy makers to clearly define the qualifications of lactation care providers in legislation (Strong, G., Gober, M., & Walker, M., 2024). This is illustrated by our survey data. **Survey participants were provided the bill text for HB 136. Results show that only 54% of participants report a good or very strong understanding of the bill’s broad language.**

The IBCLC has received specialized training to provide clinical lactation care. The NLCA brief confirms what many participants in interviews and surveys report about confusion within the lactation care roles. **The IBCLC role is different from the education and support provided by other lactation staff. Clinical care involves key components summarized here:**

- Taking a health history.
- Performing breastfeeding assessments.
- Using critical thinking to create a care plan.
- Teaching and recommending breastfeeding tools.
- Communicating with health care teams.

Each element of clinical lactation care is vital for effective support.

Without a license, IBCLCs will likely only be able to get paid as “educators” with education codes. That does not capture what they do, it will not diminish the risk of liability for physicians who make referrals to them, and it will not engender growth of the IBCLC profession because it will keep IBCLCs excluded as members of the healthcare team. IBCLCs will not be respected for their knowledge and the value that they are able to offer.

-Advocacy Leader #1

Providers and advocates worry when states don't differentiate between these roles in Medicaid policy or licensure law. This confusion can raise the risk of harm and restrict access to quality care. **Licensure of IBCLCs provides a pathway forward build academic training opportunities and grow the profession in Texas.** Participants describe why licensure is needed to an increase in training programs and partnerships with academic institutions. Most survey respondents, **65% strongly agreeing** (Appendix A, Table 5) support creating a state licensure pathway for IBCLCs. Licensure will help ensure Texas families receive care from properly trained professionals who are qualified to deliver clinical services, especially when reimbursed by Medicaid (Strong, Gober, & Walker, 2024).

Workforce Sustainability

The sustainability of the workforce hinges on reimbursement rates and job security. Many lactation consultants work in hospitals. Participants shared that providing care as a lactation consultant isn't their full-time position (FTE). Many hospitals offer lactation as an ancillary service or report IBCLC FTEs of nurses covering dual responsibilities. Lactation consultants also work in public health or private practice. Some rely on patients out-of-pocket payments due to the commercial insurance barriers including low reimbursement. Effective Medicaid reimbursement could stabilize careers by ensuring steady payment for services. Low reimbursement and strict enrollment rules may discourage providers from joining, which weakens the workforce even more. As one participant emphasized, **"If rates don't cover the cost of clinical lactation care, private practice IBCLCs won't be able to participate sustainably."**



No one's going to seek out credentials as an IBCLC as difficult as it is to become one and then go and make \$15 an hour.

-State/Community Leader #2



Improving Processes and Reimbursement Models

The shift from lawmakers' goals to real Medicaid payments for lactation services depends on clear rules and effective reimbursement models. **The landscape analysis shows that billing and administrative barriers are a major threat to the successful uptake of Texas HB 136.** HB 1575 recently created two provider types for non-medical providers, like doulas. Doulas and community health workers (CHWs) provide case management for pregnant women with Medicaid.

HB 1575 outlines the Texas Targeted Case Management for Pregnant Women (TTF) program. It will serve 56,610 pregnant women in fiscal year 2023, led by HHSC (2024). The same clarity is not addressed in bill text to support the implementation of HB 136. HHSC should provide a public summary of the structures tied to HB 136 implementation. The summary should outline funding, programs, and define providers eligible reimbursement under HB 136. **To optimize implementation HHSC can review lessons learned from HB 1575. Then gather stakeholders and develop implementation structures that focus on long-term success.**

Complexity of Billing and Coding

Texas lactation consultants are in agreement. Current commercial structures and billing codes do not match the clinical care they provide. **Evidence points to clear solutions like:**

- **Consistent coverage**
- **Dyadic and time-based payments**
- **Telehealth access**
- **Coordinated outreach efforts**

If Texas implements HB 136 with these elements, the state can expand timely, accessible clinical lactation care. This will increase capacity and position lactation consultants to deliver the preventive care that families need most.

Participants expressed substantial dissatisfaction with the current billing processes in both commercial and Medicaid systems. **This is clear in the survey data where more than 75% indicated that existing codes (HCPCS S9443, CPT 98960) do not accurately reflect the scope of lactation consultant services.** The difficulty is not unique to Texas (Rosenzweig et al., 2025).

National analyses show that lactation services are often included in obstetric or pediatric global payments. This bundling discourages hospitals and clinicians from investing in lactation support (NASEM, 2025). The 2025 WPSI Coding Guide is the key resource for best practices with available HCPCS and CPT codes. Expanding understanding of the issues, the role and landscape of clinical lactation is important. It may help bridge the gap between lactation care and personalized support. This could improve available reimbursement structures.



I mean I think time-based coding makes more sense because if you look at like E&M coding, there are two ways to do it. One is time-based and one is medical decision-making-based. the medical decision-making criteria is hard to meet in the context of lactation because generally even if there's a weight issue or low supply both the patients are not having extreme acute health issues so I feel like time is probably a better way to capture the work that's actually being done generally for us a new patient visit's like 80 to 90 minutes long and then a follow up.

--Health System IBCLC #3



Example billing and coding details from a sampling of states is available for reference in Appendix E of this report. Neither the October 2025 HCPCS Code Update from CMS nor the 2026 American Medical Association 2026 CPT Code Set does not include new codes specific to lactation clinical care..

Preferred Reimbursement Structures and Fair Rates

Providers in the Texas survey showed a preference for time-based billing models, followed by flat rates per visit. This aligns with best practices identified in other states. Colorado uses time-modifier billing units. These allow visits of up to two hours. This flexibility helps meet different clinical needs (Health First Colorado, 2025; Rosenzweig et al., 2025). Kansas' new \$40 flat rate for lactation counseling may not be fair for a session that takes up to 120 minutes. Flat rates are easy to code, but they often overlook extra provider costs. These costs include software, administrative time, and travel for community providers and small businesses.

The biggest issue right now is that (XXXX health insurance company) is not reimbursing providers at a sustainable rate to allow us to keep our offices if we have them open. They're also not reimbursing families at a reasonable rate either.

-Private Practice IBCLC#6

The complete data set of this study highlights that reimbursement rates must not only exist but also reflect the true costs of care. **Most Texas lactation consultants (59%) suggest that payers should reimburse for both mother and infant when suitable.** This reflects the clinical lactation care, which often addresses the health of two patients. If claims processing lacks flexibility, care for mothers and infants could become fragmented. This would separate billing streams and miss the combined value of lactation services. Other states' policies illustrate potential pathways. (Refer to Appendix E Table 1.) Colorado's reimbursement rate table is well designed with time-based modifiers. Colorado and other states guide how to include non-clinical lactation counselors and educators. They work under the supervision of a lactation consultant (Colorado Department of Health Care Policy and Financing [CDHPF], 2025).

Beyond other states' Medicaid reimbursement rate tables, HHSC can review rate tables related to HB 1575. Comparing payments for a bill focusing on non-medical providers and case management. Case management services for pregnant women often align with the knowledge, training, and skills of IBCLCs. However, the evidence shows that IBCLCs provide clinical lactation care where CHWs and doulas do not unless they also hold certification as IBCLCs.

We bill Medicaid for some patients as an NP. And I will tell you, I have zero hope of this working out because their reimbursement for me as an NP with a master's degree is so bad that we lose money on Medicaid patients.

-Health System IBCLC #3



It goes back to what are they going to pay because Medicaid is known for not payinmg well. I have to tell my providers when I walk in and try and educate them I understand that this I'm representing Medicaid and I understand that we're the lowest paid and and I'm not your top priority.

-MCO Representative #9

Streamlining Enrollment and Credentialing

The success of HB136 depends on how many providers enroll in Medicaid. The results show a lack of provider understanding of the Medicaid process. Many lactation consultants don't fully understand the complexities of Medicaid reimbursement. This is true of lactation consultants working in hospitals and in the community. **The data shows a lot of uncertainty about how lactation consultants can get credentialed with Medicaid managed care organizations (MCOs).** Recent reports highlight this issue. They point to restrictive benefit designs, inconsistent payer directories, and a lack of standardized taxonomy codes. These barriers discourage participation (Rosenzweig et al., 2025; USBC, 2022). The U.S. Breastfeeding Committee suggests payer solutions to lower barriers and improve access (2022). (See Appendix B)

Increasing Access and Flexibility

The pandemic showed the benefits and challenges of using telehealth for lactation support.

Providers faced challenges with:

- Observing infant latch
- Conducting physical assessments
- Weighing babies using remote tools

Many noted that, despite the issues, telehealth improved access for families in rural or underserved areas (Johnson et al., 2022). Medicaid can improve access to care by covering telehealth for lactation services. Success hinges on tackling key challenges like safety, coding requirements, documentation rules, service location limits, and payment rates. One survey participant warned that poorly regulated national telehealth companies may create more harm than good.

This concern highlights the need for state guidance and oversight. Implementation will need clear quality standards and reporting systems. This ensures telehealth tools are safe and effective for new parents. Uscher-Pines, L et al.'s random controlled trial results suggest that offering telelactation could be a component of a comprehensive strategy to reduce racial and ethnic disparities in breastfeeding rates (2025).



“I have concerns that national telehealth tech start-ups will swoop in and try to offer solutions that seem innovative but may cause harm to patients unless guardrails are in place... I ended up seeing the patient pro bono due to the harms I felt the company and her insurance caused...”

-Survey Participant

Bottom line

Our findings show a need for clear guidance. Collaboration between the agency MCOs and lactation consultants is critical. **Widespread messaging should clarify:**

- **The role of WIC within the context of reimbursement.**
- **The role of lactation consultant and how to find one.**
- **How MCO's support providers and patients across Texas.**
- **Guidance for tele health lactation care.**

In the current year Medicaid funding is often in the news cycle. Identifying duplication and focusing funds may support sustainability. The data highlights a worry about how Medicaid, WIC, managed care organizations, and community providers work together. Texas must build a more connected system so families are not left without care. Our data echos what other reports note, gaps in coordination of care. They called for better alignment across funding streams (Rosenzweig et al., 2025; Mudumala et al., 2024).

HHSC is well positioned to engage providers. **Our results found most lactation consultants were interested in enrollment.** A successful implementation requires collaboration and addressing known barriers. HHSC can lean on lessons learned from other states. But it must meet the mission HB 136 improving care for breastfeeding families with Texas lactation consultants.



Like currently if a clinic has an IBCLC, WIC gives them money to pay for that IBCLC... But then what if WIC decides, well, now Medicaid's covering this, we're going to not fund this. I mean, this could make the problem worse.

-Health System IBCLC #3



CONCLUSIONS

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING



CONCLUSION: RECOMMENDATIONS FOR HB136 IMPLEMENTATION

House Bill 136 presents an important opportunity to expand access to clinical lactation care for Texas families. However, successful implementation depends on a clear, coordinated approach that addresses administrative burden, enrollment pathways, and appropriate reimbursement. The following short-term steps can help ensure lactation consultants are able to serve Medicaid populations effectively:

Clarify and Align Medicaid Policy and Payment Structures

- **Define benefits** to reflect the mother–infant dyad. Ensure both are covered when clinically appropriate.
- **Enable time-based billing** (such as per 15–30 minutes, up to two hours) to match visit complexity, especially during the initial consultation.
- **Avoid restrictive visit caps.** If needed, provide clear medical guidance on allowable limits based on setting, modality, and timing.
- **Create a public-facing enrollment guide** for lactation consultants and a client-facing guide for finding Medicaid-covered care.
- **Standardize billing codes, modifiers, and documentation rules** across all Medicaid Managed Care Organizations (MCOs).

Build Infrastructure and Workforce Capacity

- **Ensure Medicaid reimbursement supports community-based outpatient lactation consultants**, not just hospital-employed staff.
- **Fund bilingual and interpreter-supported visits.** Focus outreach in historically underserved neighborhoods where disparities are most severe.
- **Support technical assistance and training** to help lactation consultants navigate Medicaid enrollment and billing systems.
- **Encourage MCOs to partner with lactation consultants** to develop regional quality-improvement collaboratives and extend telehealth access while setting safe clinical guardrails.

“

Unless reimbursement processes are clear, efficient, and adequately compensated, participation in Medicaid will remain limited.

- Community IBCLC #8

”

CONCLUSION: RECOMMENDATIONS FOR FUTURE RESEARCH, POLICY, AND PROGRAMS

Bottom line

Addressing long-standing barriers to Medicaid reimbursement will require investment in research, evaluation, and systems-level coordination. The following recommendations support the sustained rollout and refinement of HB 136 and help mitigate existing disparities in access:

Data Collection and Monitoring

- **Track utilization and outcomes** by payer type, demographics, and region.
- **Create benchmarks** such as timely lactation visits within 10 days of birth, exclusive breastfeeding at early well-child visits, and gaps in follow-up care.
- **Act on findings** to adjust Medicaid policies over time, including prior authorization rules and approved visit sites.

Expand Research and Feedback Loops

- **Conduct follow-up surveys** to reassess provider awareness, willingness to bill, and perceived barriers to participating in Medicaid.
- **Disaggregate findings** by credential type, geography, and experience level to identify targeted solutions.
- **Integrate focus groups** with Medicaid-enrolled families and lactation consultants, especially in rural and low-access counties.

“We need to hear from families and lactation consultants in these communities. If the infrastructure isn’t there, the policy won’t work.”
-MCO Representative #3

Support Long-Term Workforce Development

- **Launch a second phase** of this landscape analysis with larger samples and geographic mapping of provider distribution and caseload demand.
- **Support clinical pathways**, preceptorships, and university-based training programs with Medicaid partnerships.
- **Encourage cross-sector alignment** with the Texas Women, Infants, and Children (WIC) program, MCOs, hospitals, and communities.

Policy and Advocacy Actions

- **Protect families by clarifying professional scopes.** Texas should consider initiating a “sunrise review” for licensure of International Board Certified Lactation Consultants (IBCLCs). Licensure would reduce confusion, liability risk, and reinforce standards of care.
- **Support state coalitions** and advocacy for advancing lactation policy in the next legislative session. Advocates can build bipartisan awareness of the role lactation consultants play in improving maternal and infant outcomes and reducing disparities in access to care.

REFERENCES

American College of Obstetricians and Gynecologists. (2025). Women's Preventive Services Initiative (WPSI) 2025 coding guide. Women's Preventive Services Initiative. Retrieved September 15, 2025 from <https://www.womenspreventivehealth.org/wp-content/uploads/Womens-Preventive-Services-Initiative-WPSI-2025-Coding-Guide.pdf>

Berwick, M., & Louis-Jacques, A. F. (2023). Prenatal counseling and preparation for breastfeeding. *Obstetrics and Gynecology Clinics of North America*, 50(3), 549–565. <https://doi.org/10.1016/j.ogc.2023.03.007>

Centers for Disease Control and Prevention. (2025). Breastfeeding data: National immunization survey. Retrieved September 15, 2025 from <https://www.cdc.gov/breastfeeding-data/about/index.html>

Centers for Disease Control and Prevention. (2025). Breastfeeding rates by state. Retrieved September 15, 2025 from <https://www.cdc.gov/breastfeeding-data/about/rates-by-state.html>

Centers for Disease Control and Prevention. (2025). mPINC Regional Report. Retrieved September 15, 2025 from <https://www.cdc.gov/breastfeeding-data/mpinc/regional-report.html>

Centers for Disease Control and Prevention. (2023). Provisional birth data. National Center for Health Statistics. Retrieved September 15, 2025 from <https://www.cdc.gov/nchs/nvss/vsrr/provisional-tables.htm>

Centers for Medicare & Medicaid Services. (2024, September 10). Affordable Care Act implementation FAQs — Set 12. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12

Centers for Medicare & Medicaid Services. (2022, March 25). Improving maternal health during the postpartum period: Postpartum coverage extension webinar. U.S. Department of Health & Human Services. Retrieved September 15, 2025 from <https://www.medicare.gov/medicaid/quality-of-care/downloads/ppc-ext-webinar.pdf>

Centers for Medicare & Medicaid Services. (2023, August). Increasing access, quality, and equity in postpartum care in Medicaid and CHIP: A toolkit for state Medicaid and CHIP agencies (CMS). Retrieved September 15, 2025 from <https://www.medicare.gov/medicaid/quality-of-care/downloads/ppc-for-state-and-medicare-toolkit.pdf>

Chetwynd, E. (2024). Ethical use of artificial intelligence for scientific writing: Current trends. *Journal of Human Lactation*, 40(2), 211–215. <https://doi.org/10.1177/08903344241235160>

Colorado Department of Health Care Policy & Financing. (2025). Lactation services billing manual. Health First Colorado. Retrieved September 26, 2025 from <https://hcpf.colorado.gov/lactserv-manual>

Cooper, J. (2024, September 27). Supporting mothers, helping infants, transforming lives. College of Agriculture and Environmental Sciences Research, North Carolina Agricultural and Technical State University. <https://caesresearch.news/supporting-mothers-helping-infants-transforming-lives>

District of Columbia Department of Health Care Finance. (2019). Transmittal No. 19-20: Enrollment code and rate for lactation consultation services. <https://dhcf.dc.gov/publication/transmittal-19-20-enrollment-code-and-rate-lactation-consultation-services>

Dockins, J. F., Pahl, H. D., & Lingerfelt, D. J. (2025, July 17). *Lactation consultant access and breastfeeding outcomes in the United States: Cross-sectional analysis. Interactive Journal of Medical Research, 14*, e70098. <https://doi.org/10.2196/70098> i-jmr.org+1

Efstathiou, N., Dyson, J., Faulkner, A., & Yates, J. (2025). Advancing mixed-methods research in health care: Bridging quantitative outcomes with lived experiences. *Journal of Mixed Methods Health Research, 3*(1), 45–59. <https://doi.org/10.1016/j.jmmhr.2025.100022>

Hamilton, B. E., Martin, J. A., & Osterman, M. J. K. (2025, April). Births: Provisional data for 2024 (Vital Statistics Rapid Release No. 38). National Center for Health Statistics. <https://www.cdc.gov/nchs/data/vsrr/vsrr038.pdf> CDC
Helms, M. M., & Nixon, J. (2010). Exploring SWOT analysis – where are we now? *Journal of Strategy and Management, 3*(3), 215–251. <https://doi.org/10.1108/17554251011064837>

Houghton, L. C., Aiello, A. E., Westreich, D. J., & Herd, P. (2023). Why and how epidemiologists should use mixed methods. *Epidemiology, 34*(2), 175–185. <https://doi.org/10.1097/EDE.0000000000001565>

Howard, C. R. (2007). Breastmilk & breastfeeding jaundice. In L. C. Garfunkel, J. M. Kaczorowski, & C. Christy (Eds.), *Pediatric clinical advisor* (2nd ed., pp. 82–84). Mosby. <https://doi.org/10.1016/B978-032303506-4.10047-1>

Illinois Department of Healthcare and Family Services. (2024). *Provider notice PRN241219C*. <https://hfs.illinois.gov/medicalproviders/notices/notice.prn241219c.html>

International Board of Lactation Consultant Examiners. (2025). *About IBLCE*. Retrieved September 26, 2025 from <https://iblce.org/about-iblce/>

International Board of Lactation Consultant Examiners. (2025, March 24). *IBCLCs in the U.S. and territories*. Retrieved September 26, 2025 from https://iblce.org/wp-content/uploads/2025/03/2025_March-24_IBCLC®_US_and_Territories_FINAL.pdf

Jeiger, B. J., Engstrom, J. L., Meier, P. P., Patel, A. L., & Loera, F. (2024). Economic costs of suboptimal breastfeeding in the United States. In National Academies of Sciences, Engineering, and Medicine, *Breastfeeding in the United States: Strategies to support families and achieve national goals* (pp. 2-31–2-33). The National Academies Press. . <https://doi.org/10.17226/29118>

Johnson, D. H., Henebury, M. J. E., Arentsen, C. M., Sriram, U., & Metallinos-Katsaras, E. (2022). Facilitators, barriers, and best practices for in-person and telehealth lactation support during the COVID-19 pandemic. *Nursing for Women's Health*, 26(6), 420–428. <https://doi.org/10.1016/j.nwh.2022.09.003>

Kaiser Family Foundation & Health Management Associates. (2022, May). *Medicaid coverage of pregnancy-related services: Findings from a 2021 state survey*. Retrieved September 26, 2025 from <https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf>

Kaiser Family Foundation. (2025). *Births financed by Medicaid by metropolitan status*. Retrieved September 26, 2025 from <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/>

Keranews. (2023, February 14). *Medicaid covers half of all births in Texas*. Retrieved September 26, 2025 from <https://www.keranews.org/health-wellness/2023-02-14/texas-maternal-health-pregnancy-medicaid-coverage>

Kansas Department of Health and Environment. (2023). *KMAP-23208: Lactation consultation services update*. Retrieved September 26, 2025 from <https://www.sunflowerhealthplan.com/newsroom/kmap-23208.html>

Lawrence, R. A. (2022). Breastfeeding support groups and community resources. In R. A. Lawrence & R. M. Lawrence (Eds.), *Breastfeeding* (9th ed., pp. 710–718). Elsevier. <https://doi.org/10.1016/B978-0-323-68013-4.00025-0>

Lober, A., Harmon, D., & Thomas-Jackson, S. (2021). Position paper—Professional lactation support staffing in the hospital setting. *Clinical Lactation*, 12(4), 157–158. <https://doi.org/10.1891/CL-2021-0011>

Mercado, K., Vittner, D., & McGrath, J. (2019). What is the impact of NICU-dedicated lactation consultants? An evidence-based practice brief. *Advances in Neonatal Care*, 19(5), 383–393. <https://doi.org/10.1097/ANC.0000000000000673>

Meyer, V. M., Benjamins, S., Moumni, M. E., Lange, J. F. M., & Pol, R. A. (2022). Global overview of response rates in patient and health care professional surveys in surgery: A systematic review. *Annals of Surgery*, 275(1), e75–e81. <https://doi.org/10.1097/SLA.0000000000004078>

Mudumala, A., Gifford, K., Ranji, U., & Hinton, E. (2024, May 3). Challenges and strategies in expanding non-traditional pregnancy-related services: Findings from a survey of state Medicaid programs. KFF. Retrieved September 26, 2025 from <https://www.kff.org/medicaid/challenges-and-strategies-in-expanding-non-traditional-pregnancy-related-services-findings-from-a-survey-of-state-medicaid-programs/> KFF

National Academies of Sciences, Engineering, and Medicine. (2025). Breastfeeding in the United States: Strategies to support families and achieve national goals. The National Academies Press. Retrieved September 26, 2025 <https://doi.org/10.17226/29118>

National Center for Health Statistics. (2025). *Final natality data*. Retrieved September 25, 2025, from <https://www.marchofdimes.org/peristats>

National Lactation Consultant Alliance. (2024, November). *Knowledge brief: By the numbers*. Retrieved September 26, 2025 from <https://nlca.us/wp-content/uploads/2024/11/Knowledge-Brief-By-the-Numbers.pdf>

National Women's Law Center (NWLC). (2015). State of breastfeeding coverage: Health plan violations of the Affordable Care Act. Retrieved September 26, 2025 from <https://nwlc.org/wp-content/uploads/2015/04/State-of-Breastfeeding-Coverage-Health-Plan-Violations-of-the-Affordable-Care-Act.pdf>

New Mexico Human Services Department. (2024). State Plan Amendment 24-0004: Doula and lactation services. Retrieved September 26, 2025 from https://www.hca.nm.gov/wp-content/uploads/SPA-24-0004-Doula-and-Lactation-spa-pages_-1.pdf

Ohio Department of Medicaid. (2021). Medical Transmittal Letter (MTL) 3336-21-13: Lactation consultant services. Retrieved September 26, 2025 from <https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/About%20Us/PoliciesGuidelines/MTL/MTL-3336-21-13.pdf>

Patnode, C. D., Senger, C. A., Coppola, E. L., Perdue, L. A., Rushkin, M. C., & Lin, J. S. (2025, April). *Interventions to support breastfeeding: Updated evidence report and systematic review for the U.S. Preventive Services Task Force*(Evidence Synthesis No. 242). Agency for Healthcare Research and Quality. <https://www.ncbi.nlm.nih.gov/books/NBK615503/>

Phadermrod, B., Crowder, R. M., & Wills, G. B. (2019). Importance–performance analysis based SWOT analysis. *International Journal of Information Management*, 44, 194–203. <https://doi.org/10.1016/j.ijinfomgt.2016.03.009>

Ratcliffe, S. D., Baxley, E. G., Cline, M. K., & Sakornbut, E. L. (2008). Postpartum biomedical concerns: Breastfeeding. In S. D. Ratcliffe, E. G. Baxley, M. K. Cline, & E. L. Sakornbut (Eds.), *Family Medicine Obstetrics* (3rd ed., pp. 618–643). Mosby. <https://doi.org/10.1016/B978-032304306-9.50025-2>

Rosenzweig, C., Forster, J., Silow-Carroll, S., Savage, H., Rodin, D., & Rabinovitz, J. (2025, August). *Medicaid Coverage of Breastfeeding Support and Supplies: Landscape Analysis* (Draft). Health Management Associates. Retrieved September 28, 2025 from https://www.healthmanagement.com/wp-content/uploads/Meals4Families-Report-DRAFT_8.28.25_FINAL.pdf

Sarsby, A. (2016). SWOT analysis or SWOT matrix tool as a strategic planning and management technique in the healthcare industry and its advantages. *International Journal of Health Planning and Management*, 31(4), 518–529. <https://doi.org/10.1002/hpm.1032>

Sampson, M., & Kennedy, P. P. (2024, February 28). How Texas' Medicaid and CHIP extension addresses birth equity [Policy brief]. Rice University's Baker Institute. Retrieved September 26, 2025 from <https://www.bakerinstitute.org/research/how-texas-medicaid-and-chip-extension-addresses-birth-equity>.

Strong, G., Gober, M., & Walker, M. (2024). Orientation to Lactation Personnel (Knowledge Brief). National Lactation Consultant Alliance. Retrieved September 26, 2025 from <https://nlca.us/wp-content/uploads/2024/07/NLCA-Knowledge-Brief.pdf>

Texas Department of State Health Services. (n.d.). *Pregnancy Risk Assessment Monitoring System (PRAMS)*. Texas Health Data. Retrieved September 30, 2025, from <https://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/pregnancy-risk-assessment-monitoring-system>

Texas Department of State Health Services. (n.d.). *Health profession supply (Health Professions Resource Center)*. Texas Health Data. Retrieved September 30, 2025, from <https://healthdata.dshs.texas.gov/dashboard/health-care-workforce/hprc/health-profession-supply>.

Texas Health and Human Services. (n.d.). *WIC general information*. Retrieved September 26, 2025 from <https://www.hhs.texas.gov/providers/wic-providers/wic-general-information>

Texas Health and Human Services Commission. (2024, December 9). *Non-medical health-related needs of certain pregnant women: Report 2024*. Retrieved September 26, 2025 from <https://www.hhs.texas.gov/sites/default/files/documents/non-medical-health-related-needs-certain-pregnant-women-2024.pdf> Texas Health and Human Services+2Texas Health and Human Services+2

Texas Health and Human Services. (2023). 2023 Texas WIC feeding practices survey: Statewide results. Retrieved September 26, 2025 from <https://www.hhs.texas.gov/sites/default/files/documents/wic-2023-feeding-practices-survey.pdf>

Texas Legislature. (2025). House Bill 136, 89th Legislature, Regular Session. Retrieved September 26, 2025 from <https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=89R&Bill=HB136>

Texas Legislative Budget Board. (2025). *Fiscal note for HB 136, 89th Legislature (2025)*. LegiScan. Retrieved September 26, 2025 from <https://legiscan.com/TX/supplement/HB136/id/587032>

Texas Medicaid & Healthcare Partnership. (2024, October 11). *Updates to CPW program services benefit criteria effective December 1, 2024*. <https://www.tmhp.com/news/2024-10-11-updates-cpw-program-services-benefit-criteria-effective-december-1-2024>

Texas Tribune. (2023, May 16). *Texas lawmakers vote to extend postpartum Medicaid coverage to a year*. Retrieved August 26, 2025 from <https://www.texastribune.org/2023/05/16/texas-postpartum-medicaid-extension-legislature/>

Texas WIC. (2025). *Texas WIC breastfeeding services*. Updated: September 25, 2025. Retrieved September 26, 2025 from <https://texaswic.org/health-partners/breastfeeding-services>

U.S. Breastfeeding Committee. (2022). *Payer policy guidance: Innovative approaches to coverage of breastfeeding support, equipment, and supplies*. U.S. Breastfeeding Committee. Retrieved August 26, 2025 from <https://web.usbreastfeeding.org/External/WCPages/WCWebContent/webcontentpage.aspx?ContentID=2409>

U.S. Department of Agriculture, Food and Nutrition Service. (2024). *National- and state-level estimates of WIC eligibility and WIC program reach in 2022 (WIC EER 2022 summary)*. Retrieved August 26, 2025 from <https://fns-prod.azureedge.us/sites/default/files/resource-files/wic-eer-2022-summary.pdf> Food and Nutrition Service

United States Department of Agriculture, Food and Nutrition Service. (2021). *WIC eligibility and program reach estimates 2020*. Retrieved September 26, 2025 from <https://www.fns.usda.gov/research/wic/eligibility-program-reach-estimates-2020>

Uscher-Pines L, Kapinos K, Waymouth M, et al. *Telelactation Services and Breastfeeding by Race and Ethnicity: A Randomized Clinical Trial*. *JAMA Netw Open*. 2025;8(2):e2461958. doi:10.1001/jamanetworkopen.2024.61958

Williams, J.M. (2025, March 6). *Re:Search. Supporting mothers, helping infants, transforming lives*. North Carolina A&T State University Family and Consumer Sciences. Retrieved September 26, 2025 from <https://caesresearch.news/supporting-mothers-helping-infants-transforming-lives/>

Wouk, K., Chetwynd, E., Vitaglione, T., & Sullivan, C. (2017). *Improving access to medical lactation support and counseling: Building the case for Medicaid reimbursement*. *Maternal and Child Health Journal*, 21(4), 836–844. Retrieved August 26, 2025 <https://doi.org/10.1007/s10995-016-2175-x>

APPENDIX A: TABLE 1 SURVEY DEMOGRAPHICS

Respondents Characteristics

Which racial designations best describes you?

Category	Percentage
American Indian or Alaska Native	1.97%
Asian	1.32%
Black or African American	10.53%
Native Hawaiian or Other Pacific Islander	0.00%
Other, not listed	5.92%
White	80.26%

Are you of Hispanic, Latino/a/x, or Spanish origin?

Category	Percentage
No	82.24%
Yes	17.76%

What is your highest level of education?

Category	Percentage
High School Diploma	1.32%
Some College	2.63%
Associates Degree	11.84%
Bachelor's Degree	55.26%
Master's Degree	26.32%
Doctorate Degree	2.63%

IBCLC Experience and Setting

Do you hold a valid IBCLC certificate?

Category	Percentage
No	8.55%
Yes	91.45%

Do you hold any other clinical License?

Category	Percentage
No	40.13%
Yes	59.87%

Where do you primarily provide lactation services to Texas families?

Category	Percentage
Community Setting	56.58%
Hospital Setting	43.42%

APPENDIX A: TABLE 2 HOSPITAL-BASED LACTATION CONSULTANTS

Hospital Based Lactation Consultants			
How do you rate the quality of lactation support for families in your hospital?		Select the statements that best describe the lactation support/IBCLC staffing at your hospital.	
Category	Percentage	Category	Percentage
1 – No support offered	0%	I don't know what staffing is like at the hospital.	0.00%
2 – Minimal or inconsistent support	3.00%	There are no IBCLCs at our hospital.	3.03%
3 – Some support provided, varies by staff or shift	8.55%	The IBCLCs at the hospital regularly get pulled to staff patient units.	3.03%
4 – Generally consistent support, but not universal	10.53%	The hospital has a dedicated lactation services program staffed with IBCLCs.	21.21%
5 – All patients receive high-quality, consistent support from well-trained staff	17.76%	The hospital has a dedicated lactation services program staffed with IBCLCs, including at night.	4.54%
Blank	56.58%	The hospital has a dedicated lactation services program staffed everyday with IBCLCs.	42.42%
		The hospital has a dedicated lactation services program staffed everyday with IBCLCs, including at night.	4.54

Hospital Based Lactation Consultants			
Does the lactation support/IBCLC staff represent the diverse backgrounds of the hospital's patient population?		Does the community hospital have enough lactation support/IBCLCs to serve the patients population?	
Category	Percentage	Category	Percentage
No, our lactation support staffing is not representative of our patient population.	40.90%	Yes	31.80%
Yes, our lactation support staffing is representative of our patient population.	42.42%	No	53.00%
I'm not really sure.	12.12%	Unsure	16.70%
I don't want to answer.	4.54%	Not applicable	1.50%

APPENDIX A: TABLE 2 HOSPITAL-BASED LACTATION CONSULTANTS

Hospital Based Lactation Consultants

Select the answer that shows how easily your patients can get clinical lactation support from an IBCLC in the community after leaving your hospital.

Please select the type of community breastfeeding support available to families after they leave the hospital. (select all that apply)

Category	Percentage	Category	Percentage
There are between one (1) and five (5) IBCLCs providing services within 30 miles of my community.	50.00%	Hospital Outpatient IBCLCs	14.50%
There are between six (6) and ten (10) IBCLCs providing services within 30 miles of my community.	18.18%	Community based IBCLC who takes insurance.	14.80%
There are more than fifteen (15) IBCLCs providing services within 30 miles of my community.	24.24%	Community based IBCLC who does NOT take insurance.	11.48%
There are more than ten (10) IBCLCs providing services within 30 miles of my community.	6.06%	Free community breastfeeding support group.	11.48%
There are no IBCLCs available in my community.	1.52%	Physician's office staffed with IBCLCs	6.64%
		Tele-health IBCLCs	9.06%
		Texas Breastfeeding Hotline	13.29%
		WIC Office staffed with peer counselors and/or IBCLC.	18.13%
		Other	0.62%

APPENDIX A: TABLE 3 COMMUNITY BASED LACTATION CONSULTANTS

Lactation Consultant (IBCLC) Workforce in Texas

Please rate your agreement with this statement:
"The current number of IBCLCs in Texas, (1,496 as of March 2025) is enough
to meet the clinical lactation needs of Texas."

Use a scale from 1 to 5, where 1 means you completely disagree and 5 means you completely agree.

Category	Percentage
1 - Strongly disagree	19.00%
2 - Disagree	20.00%
3 - Neutral	15.00%
4 - Agree	3.00%
5 - Strongly agree	3.00%
Not applicable	40.00%

Please rate your agreement with this
statement: "There are enough training
opportunities/clinical teaching sites to
support aspiring IBCLCs in Texas."

Use a scale from 1 to 5, where 1 means you
completely disagree and 5 means you
completely agree.

Please rate your agreement with this statement:
"Aspiring IBCLCs in Texas would benefit from an
accredited university training program."

Use a scale from 1 to 5, where 1 means
you completely disagree and 5 means
you completely agree.

Category	Percentage	Category	Percentage
1 - Strongly disagree	35.00%	1 - Strongly disagree	4.00%
2 - Disagree	42.00%	2 - Disagree	3.00%
3 - Neutral	17.00%	3 - Neutral	15.00%
4 - Agree	5.00%	4 - Agree	44.00%
5 - Strongly Agree	1.00%	5 - Strongly Agree	34.00%

Please rate your agreement with this statement:
"The state of Texas should create a license for IBCLCs."

Use a scale from 1 to 5, where 1 means you completely disagree and 5 means you completely agree.

Category	Percentage
1 - Strongly disagree	7.00%
2 - Disagree	9.00%
3 - Neutral	19.00%
4 - Agree	28.00%
5 - Strongly Agree	37.00%

APPENDIX A: TABLE 4

HOUSE BILL 136 AWARENESS

House Bill 136

Did you know that the Texas Legislature passed House Bill 136?
It offers reimbursement for lactation support services to Texas Medicaid patients.

Category	Percentage
Yes	59.00%
No	40.00%
Blank	0.66%

What is your level of understanding for the scope of services for "lactation consultation services" under HB 136 included based on the bill language below? (Bill Text Provided)

Category	Percentage
Basic understanding	46.00%
Good understanding	8.00%
Moderate understanding	22.00%
No understanding	18.00%
Very strong understanding	6.00%

Please rate your agreement with this statement: "I will start asking Texas Medicaid for reimbursement for lactation support services given to patients." Use 1 for completely disagree and 5 to completely agree.

Category	Percentage
1 - Strongly disagree	9.00%
2 - Disagree	8.00%
3 - Neutral	41.00%
4- Good Knowledge	17.00%
5 - Strongly agree	25.00%

Please rate your agreement with this statement: "I want to learn how to become an enrolled Texas Medicaid provider for lactation consultation services." Use a scale from 1 to 5, where 1 means you completely disagree and 5 means you completely agree.

Category	Percentage
1 - Strongly disagree	5.00%
2 - Disagree	7.00%
3 - Neutral	17.00%
4- Good Knowledge	28.00%
5 - Strongly agree	43.00%

APPENDIX A: TABLE 5 LACTATION WORKFORCE DEVELOPMENT

Lactation Consultant (IBCLC) Workforce in Texas

Please rate your agreement with this statement:
"The current number of IBCLCs in Texas, (1,496 as of March 2025) is enough
to meet the clinical lactation needs of Texas."

Use a scale from 1 to 5, where 1 means you completely disagree and 5 means you completely agree.

Category	Percentage
1 - Strongly disagree	19.00%
2 - Disagree	20.00%
3 - Neutral	15.00%
4 - Agree	3.00%
5 - Strongly agree	3.00%
Not applicable	40.00%

Please rate your agreement with this
statement: "There are enough training
opportunities/clinical teaching sites to
support aspiring IBCLCs in Texas."

Use a scale from 1 to 5, where 1 means you
completely disagree and 5 means you
completely agree.

Category	Percentage
1 - Strongly disagree	35.00%
2 - Disagree	42.00%
3 - Neutral	17.00%
4 - Agree	5.00%
5 - Strongly Agree	1.00%

Please rate your agreement with this statement:
"Aspiring IBCLCs in Texas would benefit from an
accredited university training program."

Use a scale from 1 to 5, where 1 means
you completely disagree and 5 means
you completely agree.

Category	Percentage
1 - Strongly disagree	4.00%
2 - Disagree	3.00%
3 - Neutral	15.00%
4 - Agree	44.00%
5 - Strongly Agree	34.00%

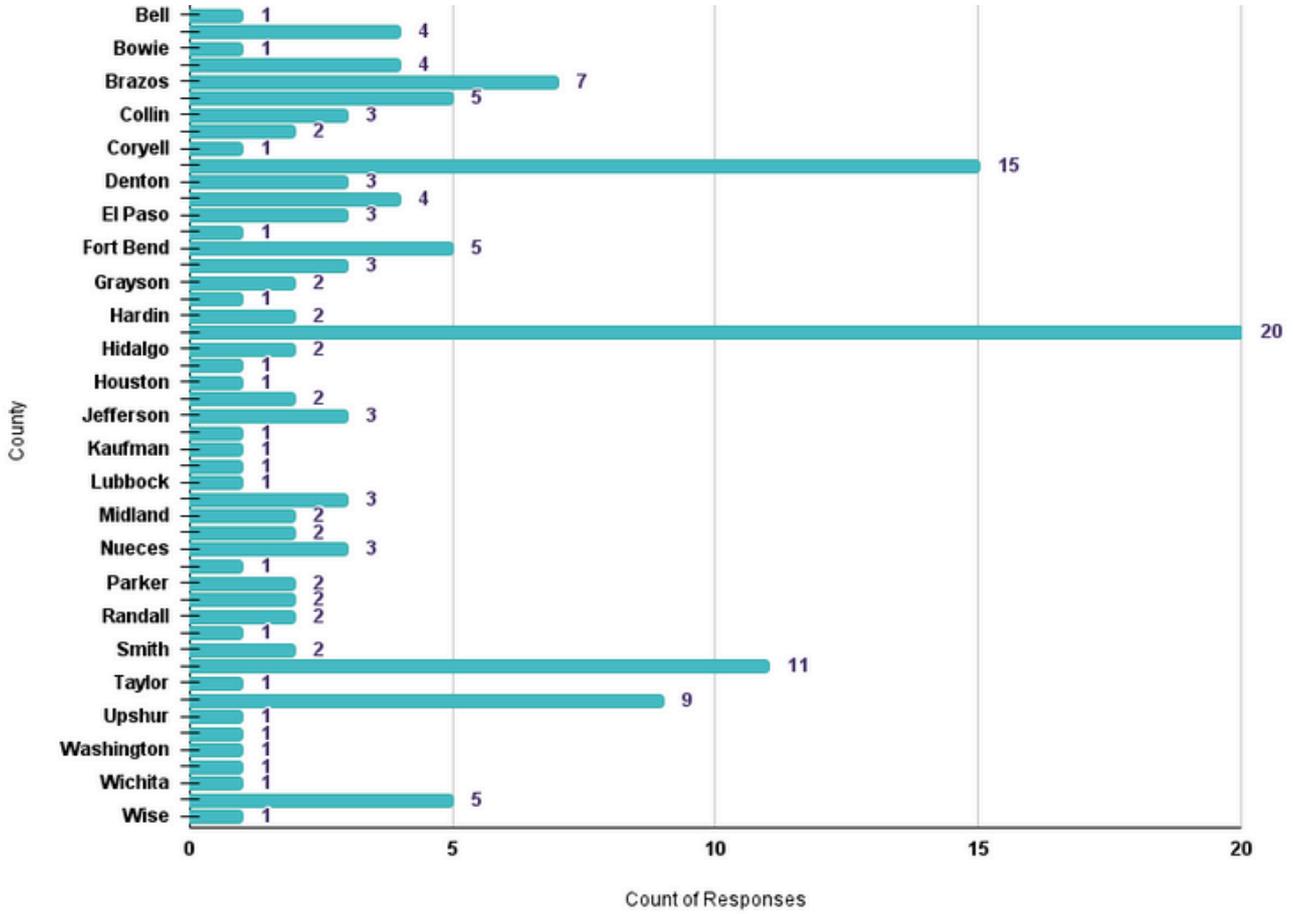
Please rate your agreement with this statement:
"The state of Texas should create a license for IBCLCs."

Use a scale from 1 to 5, where 1 means you completely disagree and 5 means you completely agree.

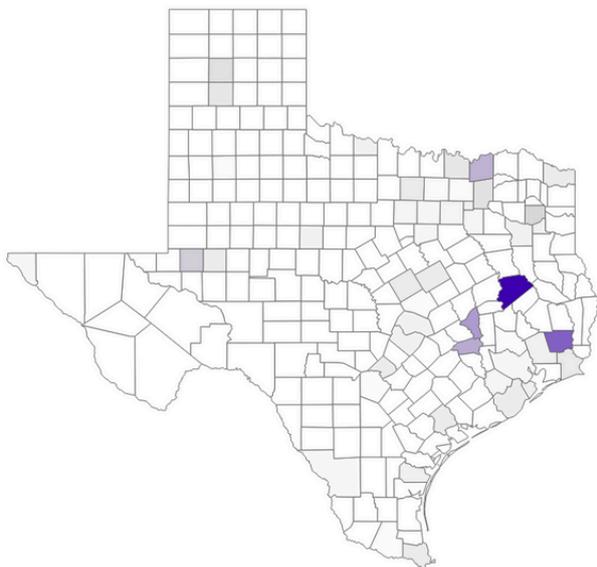
Category	Percentage
1 - Strongly disagree	7.00%
2 - Disagree	9.00%
3 - Neutral	19.00%
4 - Agree	28.00%
5 - Strongly Agree	37.00%

APPENDIX B: SURVEY COUNTY LEVEL DATA

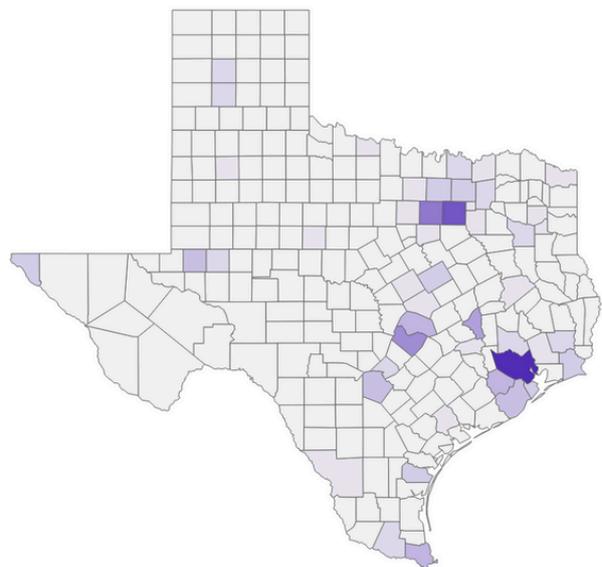
State-wide Survey Lactation Providers By County



Lactation Providers Per Capita (100,000)



Count of Lactation Providers



APPENDIX B: (CONTINUED) SURVEY COUNTY LEVEL DATA

Texas Lactation Landscape Analysis

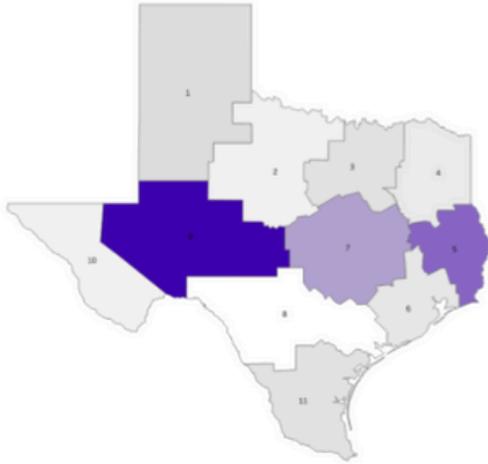
Cumulative total of lactation care providers per 100,000 residents

View data by: 

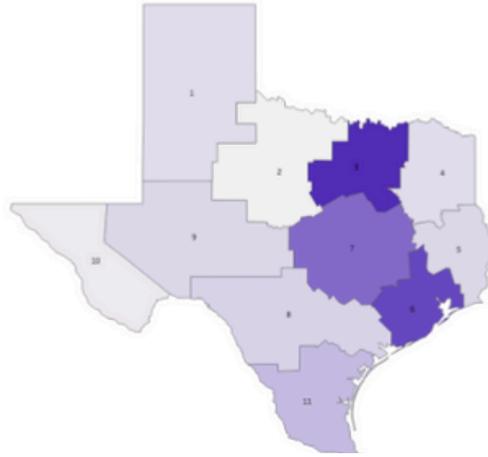
Coverage Maps | Public Health Region Views

.png format

Lactation Providers Per Capita (100,000)



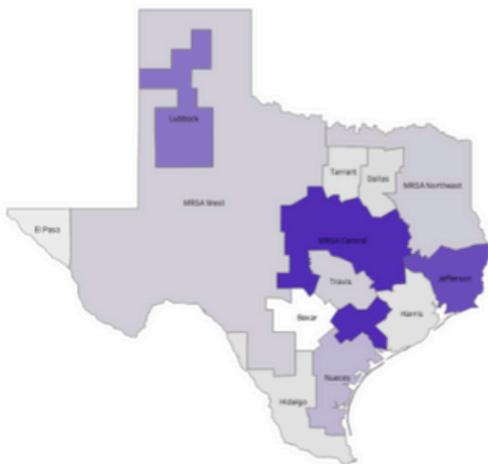
Count of Lactation Providers



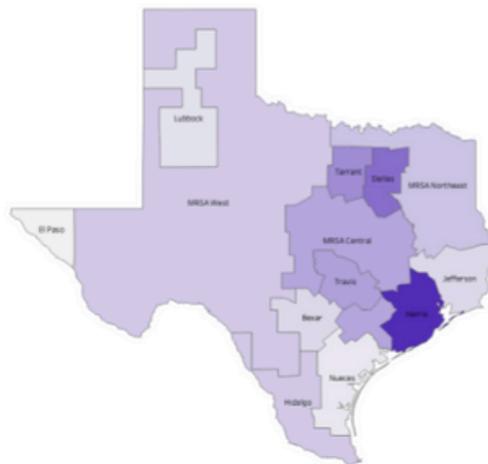
Coverage Maps | Managed Care Service Area Views

.png format

Lactation Providers Per Capita (100,000)



Count of Lactation Providers



Explore the interactive maps:

<https://public.tableau.com/views/IBCLC/TexasIBCLCCoverageMap>

APPENDIX C: TABLE 1 LACTATION CONSULTANT DEFINITIONS

Appendix C Table 1

Organization, type	Text of definition and use	Source
American Pregnancy Association , national health organization	“Board Certified Lactation Consultant (IBCLC) – The lactation consultant who is board certified has gone through comprehensive training and board testing to qualify as someone who can offer extensive support in the most complicated breastfeeding problems.”	American Pregnancy Association. (n.d.). <i>Lactation consultant</i> . https://americanpregnancy.org/healthy-pregnancy/breastfeeding/lactation-consultant/
Breastfeeding: A Guide for the Medical Profession (Ninth Edition) Chapter 25 - Breastfeeding Support Groups and Community Resources	Lactation Consultant: A lactation consultant is defined as a health care professional who provides education and management to prevent and address breastfeeding issues, while promoting a supportive environment for the breastfeeding mother-infant dyad.	Lawrence, R. A. (2022). Breastfeeding support groups and community resources. In R. A. Lawrence & R. M. Lawrence (Eds.), <i>Breastfeeding</i> (9th ed., pp. 710–718). Elsevier. https://doi.org/10.1016/B978-0-323-68013-4.00025-0
Family Medicine Obstetrics (3rd edition) Chapter 20: Postpartum biomedical concerns: Breastfeeding	“Lactation consultants (LCs) are health professionals, often International Board Certified Lactation Consultants (IBCLCs), who provide clinical management and support for breastfeeding, having met specific academic and clinical requirements and passed a rigorous examination. They typically work in collaboration with primary care providers and may come from various academic backgrounds, predominantly nursing.”	Ratcliffe, S. D., Baxley, E. G., Cline, M. K., & Sakornbut, E. L. (2008). Postpartum biomedical concerns: Breastfeeding. In S. D. Ratcliffe, E. G. Baxley, M. K. Cline, & E. L. Sakornbut (Eds.), <i>Family Medicine Obstetrics</i> (3rd ed., pp. 618–643). Mosby. https://doi.org/10.1016/B978-032304306-9.50025-2
International Lactation Consultant Association (ILCA) , national/international professional association	“An IBCLC is a healthcare professional specializing in the clinical management of breastfeeding and lactation.”	International Lactation Consultant Association. (n.d.). *Find a lactation consultant (Why IBCLC?)* https://ilca.org/why-ibclc-falcl
National Lactation Consultant Alliance (NLCA) , advocacy organization for IBCLCs	“The National Lactation Consultant Alliance (NLCA) describes the International Board Certified Lactation Consultant (IBCLC®) as providing clinical lactation care, especially in high-risk or complex cases.”	National Lactation Consultant Alliance. (2024). <i>Knowledge Brief: Orientation to Lactation Personnel</i> https://nlca.us/wp-content/uploads/2024/07/NLCA-Knowledge-Brief.pdf

APPENDIX C: TABLE 1 (CONTINUED) LACTATION CONSULTANT DEFINITIONS

Organization, type	Text of definition and use	Source
United States Breastfeeding Committee (USBC) , national coalition; CDC-supported resource	Category: “Lactation Consultants.” “Referral to these health professionals is appropriate for the full range of breastfeeding care, particularly involving high acuity breastfeeding situations... Often work clinically as part of the healthcare team... International Board Certified Lactation Consultant® (IBCLC®).”	U.S. Breastfeeding Committee. (2021, August). Lactation Support Provider (LSP) descriptors. [Fact sheet]. https://www.usbreastfeeding.org/uploads/1/3/9/7/139788899/2021-08_lsp_descriptor_chart_final.pdf
United States Lactation Consultant Association (USLCA) , national professional association for IBCLCs	“The International Board Certified Lactation Consultant (IBCLC) is qualified to provide clinical lactation care... Only IBCLCs are educated and trained to clinically assess and manage lactation and breastfeeding...”	U.S. Lactation Consultant Association. (2020, August). Who’s Who [PDF]. https://uslca.org/wp-content/uploads/2019/07/Whos-Who-August-2020.pdf
U.S. Department of Health and Human Services, Office on Women’s Health , federal agency	“International Board Certified Lactation Consultant (IBCLC). IBCLCs are certified breastfeeding professionals...”	Office on Women’s Health. (n.d.). Your guide to breastfeeding. [Brochure]. U.S. Department of Health and Human Services. https://www.womenshealth.gov/resources-assets/breastfeeding-guide/
U.S. Department of Health and Human Services, Office on Women’s Health , federal agency	“An international board-certified lactation consultant (IBCLC) is a trained health care professional who is considered the gold standard in breastfeeding experts..”	Office on Women’s Health. (n.d.). *It takes a village: Building your breastfeeding support network. [Website]. U.S. Department of Health and Human Services. https://womenshealth.gov/its-only-natural/finding-support/it-takes-village-building-your-breastfeeding-support-network
Women’s Preventive Services Initiative (WPSI), clinical recommendations supported by HRSA/HHS ; federal agency-funded	“Clinical lactation professionals providing clinical care include, but are not limited to, licensed lactation consultants, the IBCLC®...”	Women’s Preventive Services Initiative. (2022). Clinical summary: Breastfeeding services and supplies. (HRSA-supported). https://www.womenspreventivehealth.org/wp-content/uploads/WPSI-ClinicianSummary-Breastfeeding-051322-1.pdf

APPENDIX D: TABLE 1

SAMPLING OF CODING AND QUOTES

Table 1: This table provides examples and summarizes themes, codes, and sub-codes from the thematic analysis of key informant interviews. Each row includes a concise definition and a short exemplar quote. The full code book and quotations are retained in the analytic files.

Code	Sub-code	Description	Quotes	Source
Theme 1: System and Access Barriers				
Access to care	Paid leave/ transportation/ scheduling	Life constraints (no paid leave, transport, caregiving) reduce ability to attend lactation visits.	"Education scheduling and transportation are big issues."	MCO Rep #9
Medicaid-Specific Barriers	Eligibility/ fewer in-network options	Administrative and financial hurdles for Medicaid families increase stress and delay care.	"I just didn't get the help that I needed."	Community IBCLC #8
Hospital Systems	Obstacles for IBCLCs	Policies/hierarchy limit IBCLC scope; expertise underused within hospital workflows.	"My IBCLC is not respected... beyond policy."	Health System IBCLC #3
Hospital Systems	Best practices/ lactation staff /quality care	Embedding IBCLCs on care teams improves continuity and outcomes.	"IBCLCs are a vital part of the medical team."	Policy Director #4
Missing Care	Provider shortages/ delays	Gaps where care is unavailable or delayed, especially in under-resourced areas.	"We don't have enough health care providers here."	State/ Community Leader #2
Theme 2: Workforce Capacity and Development				
Role of Lactation Consultants	Education and counseling	Teach latch/position; normalize vs. warning signs; provide emotional support.	"It's a learned behavior... person-to-person support matters."	Community IBCLC #8
Role of Lactation Consultants	Role awareness	Low awareness of IBCLC expertise reduces referrals and appropriate utilization.	"People don't know IBCLCs exist or what they do."	State/ Community Leader #2
Role of Lactation Consultants	Identity and integration	Licensure/scope debates affect team recognition and billing pathways.	"Teams won't recognize IBCLCs without a license."	Advocacy Leader #1
Roles of Other Providers	Non-IBCLC clinicians	Physicians/APNs provide related care; clear roles support collaboration and billing.	Scope overlaps require clarity for referrals and documentation.	Advocacy Leader #1
Roles of Other Providers	Dual credentials	RN/RD/other licenses alongside IBCLC; facility policies may restrict services.	"Some facilities restrict services to APN/PA/physicians."	Health System IBCLC #3
Roles of Other Providers	Educator/ counselor/ peer roles	Peer counselors/ breastfeeding educators/lactation counselors extend reach under but are not clinical	"I think a peer counselor is more of a cheerleader..."	State/ Community Leader #2

APPENDIX D: TABLE (CONTINUED) SAMPLING OF CODING AND QUOTES

Code	Sub-code	Description	Quotes	Source
Theme 2: Workforce Capacity and Development				
Training Gaps	none	Needed training, mentorship, placements, supervised hours, structured pipelines.	"You need 95 hours credit hours of lactation specific topics... anatomy and physiology and the pharmacology."	Policy Director #4
Theme 3: Reimbursement and Administrative Challenges				
Billing Systems	Codes / delays / errors	Confusion about CPT/ HCPCS; long payment lags and denials strain viability.	"Tried for years— 90+ day delays."	Regional Practice IBCLC #7
Medicaid Enrollment (HHSC)	Credentialing and communication	Complex onboarding; limited feedback; unclear requirements.	"Heard nothing since it's supposed to go-live."	Community IBCLC #8
Admin Burden	Paperwork / compliance	Time-consuming documentation and unclear steps reduce capacity for care.	"Not a lot of info on how to do [get reimbursed] correctly."	State/ Community Leader #2
Lack of Licensure	Recognition and parity	No state licensure undermines recognition and reimbursement parity.	"Without a license, IBCLCs get 'educator' codes only."	Advocacy Leader #1
Lack of Licensure	Recognition and parity	No state licensure undermines recognition and reimbursement parity.	"[Health system] will not allow us to credential IBCLCs because they're not licensed... even if the Medicaid accepts them, my system won't"	Health System IBCLC #3
Justification for Reimbursement	Rates vs. visit length	Low rates shorten visits; misaligned incentives reduce quality and sustainability.	"Reimbursement cuts shorten standard visits."	Health System IBCLC #3
MCO Onboarding	Low rates / delays / templates	Credentialing, low rates, and lack of standardized tools hinder participation.	"Medicaid is the lowest paid; not your top priority."	MCO Rep #9
Theme 4: Facilitators and Opportunities				
Capacity Building	Pipelines / mentorship	Grow workforce via pipelines, supervised practice, and rural targeting.	"Good path for WIC peers to advance to IBCLC."	Advocacy Leader #1
Coordination and Partnerships	Team-based care / referrals	Warm handoffs and prenatal education improve uptake and continuation.	IBCLCs as allied health within physician-led teams.	Advocacy Leader #1

APPENDIX D: TABLE (CONTINUED) SAMPLING OF CODING AND QUOTES

Code	Sub-code	Description	Quotes	Source
Theme 2: Workforce Capacity and Development				
Training Gaps	none	Needed trainging, mentorship, placements, supervised hours, structured pipelines.	"You need 95 hours credit hours of lactation specific topics... anatomy and physiology and the pharmacology."	Policy Director #4
Theme 3: Reimbursement and Administrative Challenges				
Billing Systems	Codes / delays / errors	Confusion about CPT/ HCPCS; long payment lags and denials strain viability.	"Tried for years—90+ day delays."	Regional Practice IBCLC #7
Medicaid Enrollment (HHSC)	Credentialing and communication	Complex onboarding; limited feedback; unclear requirements.	"Heard nothing since it's supposed to go-live."	Community IBCLC #8
Admin Burden	Paperwork / compliance	Time-consuming documentation and unclear steps reduce capacity for care.	"Not a lot of info on how to do [get reimbursed] correctly."	State/ Community Leader #2
Lack of Licensure	Recognition and parity	No state licensure undermines recognition and reimbursement parity.	"Without a license, IBCLCs get 'educator' codes only."	Advocacy Leader #1
Lack of Licensure	Recognition and parity	No state licensure undermines recognition and reimbursement parity.	"[Health system] will not allow us to credential IBCLCs because they're not licensed... even if the Medicaid accepts them, my system won't"	Health System IBCLC #3
Justification for Reimbursement	Rates vs. visit length	Low rates shorten visits; misaligned incentives reduce quality and sustainability.	"Reimbursement cuts shorten standard visits."	Health System IBCLC #3
MCO Onboarding	Low rates / delays / templates	Credentialing, low rates, and lack of standardized tools hinder participation.	"Medicaid is the lowest paid; not your top priority."	MCO Rep #9
Theme 4: Facilitators and Opportunities				
Capacity Building	Pipelines / mentorship	Grow workforce via pipelines, supervised practice, and rural targeting.	"Good path for WIC peers to advance to IBCLC."	Advocacy Leader #1
Coordination and Partnerships	Team-based care / referrals	Warm handoffs and prenatal education improve uptake and continuation.	IBCLCs as allied health within physician-led teams.	Advocacy Leader #1

APPENDIX D: TABLE (CONTINUED) SAMPLING OF CODING AND QUOTES

Code	Sub-code	Description	Quotes	Source
Theme 4: Facilitators and Opportunities				
State Agency Guidance	Clear HHSC guidance	Single hub with steps, codes, timelines, templates; TA and onboarding sessions.	"Dedicated website with steps, rates, timelines, online registration."	Community IBCLC #6
MCO Implementation	Onboarding sessions	MCO's providers engagement; communication, website, and other examples	"Like we did for douglas-host onboarding sessions."	MCO Rep #9
Lessons from Other States	Codes / TA / leadership	Use dedicated codes; pair reimbursement with TA; clarify credential distinctions.	"Differentiate IBCLCs from short-course credentials via hours/competencies."	Policy Expert #10
Innovation Models	Community College/ University	Launch programs at colleges with nursing/clinical partners and qualified faculty.	"if we had, you know a university here in Texas like UC Davis in California has done,"	Policy Expert #10
Innovation Models	Telehealth / hybrid	Virtual + in-person extend reach, off-hours access, and rural coverage.	"24/7 virtual option would be ideal."	MCO Rep #3
Theme 5: Policy Implementation and Advocacy				
Policy Awareness	HB 136 knowledge	General awareness of HB 136 and Medicaid reimbursement	"Do they have actual details? Do we have to be licensed with the state? Do we need to register?"	Community IBCLC #6
Policy Awareness	Bill language	Clarify 'national or international' language; define eligible credentials.	"CLC is not the same as IBCLC requirements."	Policy Expert #10
Reimbursement Structure Ideas	Time-based / flat fee/ acuity tiers	Rates reasoning; visit time and complexity; allow exceptions.	"Time-based coding reflects coordination and prevention work."	Regional Practice IBCLC #7
Reimbursement Structure Ideas	Dyad reimbursement	Separate patients, documentation, and billing when both are evaluated.	"We document evaluate, care for, and document on both mom and baby and we bill on both."	Health System IBCLC #3
Reimbursement Structure Ideas	Visit minimums / exceptions / limitations	Reasonable limits with a pathway for additional visits when justified.	"We need safeguards to balance access, quality, and cost."	MCO Rep #3
Reimbursement Structure Ideas	Fairness of Payment / Reimbursement Rates	Rates must support practice viability to expand access and reduce disparities.	"No one will pursue IBCLC to make \$15/hour."	State/Community Leader #2

APPENDIX E: TABLE 1 EXAMPLES OF MEDICAID COVERAGE BY STATE

Appendix E Table 1 compiles a sampling of available public information about U.S. state Medicaid programs and managed care organizations (MCOs) that cover lactation consultant services. The table includes updates to the national analysis conducted in 2021 by the Kellogg Foundation. It provides available codes/modifiers, any published rates, mother–infant billing rules, and whether an IBCLC needs a separate state license. It reflects research gathered so far and is not yet a complete 50-state survey. Where information is not publicly posted, the entry is marked as “TBD” or “Not publicly posted.” Prepared by MCHIP research team in September 2025.

Coverage Status / Setting	Codes / Modifiers	Published Rate	Dyad Billing Policy	Role of IBCLC / Providers / Licensing	Key State or MCO Resources
Colorado					
Covers outpatient/inpatient lactation support under Health First Colorado; standalone S9443 billing allowed.	S9443 + U1 (individual), U2 (group); U3–UA for timed increments; telehealth FQ/FR/93/95.	https://hcpf.colorado.gov/provider-rates-fee-schedule	Bill one member per service date (mother OR infant). Multiples may be billed with documented separate time or extended time.	No: International Board-Certified Lactation Consultants (IBCLCs) with current certification by the International Board of Lactation Consultant Examiners (IBLCE) may provide lactation support services without supervision Certified Lactation Counselors (CLCs) with current certification by the Academy of Lactation Policy and Practice, Inc. (ALPP) and Certified Lactation Educators (CLEs) with current certification by the Childbirth and Postpartum Professional Association (CAPP) may only provide lactation support services under the general supervision of enrolled	HCPF Lactation Billing Manual: https://hcpf.colorado.gov/lactserv-manual FAQ: https://hcpf.colorado.gov/sites/hcpf/files/Lactation%20FAQs.pdf ; Provider Bulletin: https://hcpf.colorado.gov/sites/hcpf/files/Bulletin%200625_B2500524_1.pdf
District of Columbia					
Covers lactation consultation via S9443 (per 15-minute units) for Medicaid beneficiaries.	S9443 (15-minute units); up to 4 units per visit.	\$15.63 per 15-minute unit; max 4 units per visit.	Not explicitly specified in transmittal; default is one member per service.	Provided by eligible licensed providers with lactation training/credentialing.	DHCF Transmittal 19-20: https://dhcf.dc.gov/publication/transmittal-19-20-enrollment-code-and-rate-lactation-consultation-services

APPENDIX E: TABLE 1 (CONTINUED) EXAMPLES OF MEDICAID COVERAGE BY STATE

Coverage Status / Setting	Codes / Modifiers	Published Rate	Dyad Billing Policy	Role of IBCLC / Providers / Licensing	Key State or MCO Resources
Kansas					
KanCare MCOs cover S9443 for lactation counseling sessions.	S9443 (per session).	<u>\$40.00 per session (effective 10/01/2023).</u>	Not specified; standard is one member per service.	No separate IBCLC state license; provider must meet MCO/state credentialing.	KMAP 23208 (Sunflower): https://www.sunflowerhealthplan.com/newsroom/kmap-23208.html
District of Columbia					
Covers lactation consultation via S9443 (per 15-minute units) for Medicaid beneficiaries	S9443 (15-minute units); up to 4 units per visit.	\$15.63 per 15-minute unit; max 4 units per visit.	Not explicitly specified in transmittal; default is one member per service.	Provided by eligible licensed providers with lactation training/credentialing.	DHCF Transmittal 19-20: https://dhcf.dc.gov/publication/transmittal-19-20-enrollment-code-and-rate-lactation-consultation-services
Illinois					
HFS covers lactation services; MCOs follow with appropriate modifiers for provider type/group size.	S9443 + HD (IBCLC individual), no modifier (CLC/CLS individual), HD HQ (IBCLC group), HQ (CLC/CLS group).	Not publicly posted; available in HFS/IMPACT fee schedule.	Not specified; standard is one member per service.	No separate IBCLC state license; credentialing as IBCLC and provider enrollment required.	HFS Notice (12/19/2024): https://hfs.illinois.gov/medicalproviders/notice/notice.prn241219c.html
Tennessee					
TennCare covers lactation consults via MCOs using S9443.	S9443 (no public modifiers).	Not publicly posted; MCO contracts govern.	Not specified; standard is one member per service.	No separate IBCLC state license; providers must meet MCO credentialing.	TennCare Lactation Providers: https://www.tn.gov/tenncare/providers/programs-and-facilities/maternal-health/lactation-providers.html

APPENDIX E: TABLE 1 (CONTINUED) EXAMPLES OF MEDICAID COVERAGE BY STATE

Coverage Status / Setting	Codes / Modifiers	Published Rate	Dyad Billing Policy	Role of IBCLC / Providers / Licensing	Key State or MCO Resources
Connecticut					
Lactation services bundled in maternity episodes (not separately itemized).	Bundled; S9443 not separately paid under the maternity bundle.	Bundled payment—no separate S9443 rate.	N/A within the bundle; follows maternity episode rules.	State IBCLC licensure program authorized; IBCLC must obtain state license when fully implemented.	CT DSS SPA 24-M Maternity Bundle Notice: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/SPAs/SPA-24-M---Maternity-Bundle--Website-Notice.pdf
Ohio					
Medicaid covers lactation services; MCOs (e.g., CareSource) pay per policy; outpatient S9443 grouped under EAPG 428.	S9443; TH for telehealth; TD for IBCLC RN in some payer guidance; FQHC/RHC use T1015 + U1.	See Appendix DD of OAC 5160-1-60 (FFS baseline); MCOs follow plan contracts.	Manuals do not explicitly allow dual billing; standard is one member per service.	No separate IBCLC state license; licensed clinician with IBCLC credential per payer policy.	ODM MTL reference: https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/About%20Us/PoliciesGuidelines/MTL/MTL-3336-21-13.pdf ; CareSource guidance: https://www.caresource.com/documents/oh-med-p-3514285-access-to-lactation-consulting-services-for-medicaid-beneficiaries.pdf
Virginia					
DMAS indicates coverage of lactation consultation (IBCLC) across FFS/MCO programs.	S9443; details in plan manuals.	Not publicly posted; MCO contracts govern.	Not specified; standard is one member per service.	No separate IBCLC state license; IBCLC credential and provider enrollment required.	DMAS Fact Sheet: https://www.dmas.virginia.gov/media/2159/breast-pumps-and-lactation-consultation-services-fact-sheet.pdf

APPENDIX E: TABLE 1 (CONTINUED) EXAMPLES OF MEDICAID COVERAGE BY STATE

Coverage Status / Setting	Codes / Modifiers	Published Rate	Dyad Billing Policy	Role of IBCLC / Providers / Licensing	Key State or MCO Resources
New Mexico					
Coverage added 07/01/2024; MCOs must pay at least Medicaid FFS rates.	S9443 (and S9445 for education); see HCA/HSD fee schedules.	At least fee-for-services (FFS) per state rule; see fee schedule portal.	Not specified; standard is one member per service.	State IBCLC licensure enacted; licensure applies to use of 'lactation consultant' title/practice.	SPA 24-0004: https://www.hca.nm.gov/wp-content/uploads/SPA-24-0004-Doula-and-Lactation-spa-pages_-1.pdf ; Fee Schedules: https://www.hca.nm.gov/providers/fee-schedules/
New Jersey					
NJ FamilyCare MCOs (e.g., Horizon NJ Health) cover lactation counseling.	S9443 (non-physician).	Not publicly posted; plan manuals govern.	Not specified; standard is one member per service.	No separate IBCLC state license; provider licensure per plan policy.	Horizon NJ Health policy: https://www.horizonnjhealth.com/providers/resources/policies/reimbursement-policies-guidelines/breast-pump-reimbursement

MCH **IMPACT**
PARTNERS
MATERNAL CHILD HEALTH CONSULTING

