



CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT

**International Board Certified Lactation Consultants:
Allied Health Care Providers Contribute to the Solution**

Affordable Health Care Begins with Breastfeeding



The training of International Board Certified Lactation Consultants (IBCLCs) focuses exclusively on the care and support of lactation, resulting in allied health professionals uniquely qualified to address the health care needs of the breastfeeding family.

**Reimbursement
of the IBCLC yields a
significant return on
investment. Why pay
more for disease
when prevention
costs less?**

United States Lactation Consultant Association

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
info@uslca.org
www.uslca.org



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International Board Certified Lactation Consultants: Allied Health Care Providers Contribute to the Solution

Judith L. Gutowski, BA, IBCLC, RLC
Chair, Licensure and Reimbursement Committee
United States Lactation Consultant Association

Marsha Walker, RN, IBCLC, RLC
Director, Public Policy, Licensure and Reimbursement
United States Lactation Consultant Association
Board of Directors

Ellen Chetwynd, RN, BSN, MPH, IBCLC, RLC
Licensure and Reimbursement Committee
United States Lactation Consultant Association
Carolina Global Breastfeeding Institute
UNC Gillings School of Global Public Health



USLCA

United States Lactation Consultant Association

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
info@uslc.org
www.uslca.org

Recommended Citation:

Gutowski JL, Walker M, Chetwynd E.: "Containing Health Care Costs Help in Plain Sight. International Board Certified Lactation Consultants: Allied Healthcare Providers Contribute to the Solution. 2nd Edition" Morrisville, NC. United States Lactation Consultant Association, July 2012.

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EXECUTIVE SUMMARY

Skyrocketing medical costs have resulted in a greater emphasis on disease prevention by healthcare professionals, government agencies, and health insurers. By providing immune protection and proper nutrition, breastfeeding remains a cost-effective intervention for disease prevention with an accompanying reduction in health care spending. Informed women are initiating breastfeeding at an increasing rate, from 26% in 1970 to 75% in 2008. However, many women struggle to maintain breastfeeding for as long as it is recommended and fail to achieve the intensity and duration of breastfeeding that they planned. This is often due to poor access to effective breastfeeding support within the medical system, false and misleading infant formula marketing, and societal barriers including: lack of paid maternity leave, unsupportive places of employment, and cultural discomfort with breastfeeding. Consequently, health care dollars are spent on treating diseases and conditions that could have been effectively prevented by breastfeeding. In order to appropriately address this preventative health care gap and the excess costs that result, consumers, health care providers, insurers and employers need to be able to identify and access competent lactation consultants to provide services and protect quality of care.

The United States Lactation Consultant Association recommends:

- Recognition of the International Board Certified Lactation Consultant (IBCLC) certification as the preferred provider of lactation care and services
- Delineation of IBCLC-provided lactation services as distinct from other health care services in the medical system
- Credentialing of IBCLCs by third party insurers in order to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight
- Third party reimbursement of skilled breastfeeding support provided by the IBCLC

The training of IBCLCs focuses exclusively on the care and support of lactation, resulting in allied health professionals uniquely qualified to address the health care needs of the breastfeeding family.

**Reimbursement of the IBCLC yields a significant return on investment.
Why pay more for disease when prevention costs less?**



Photo Courtesy of Pennsylvania Department of Health

HEALTH CARE COSTS ARE RISING

Rapidly rising health care costs have placed a significant strain on the systems used to finance them, including both public and private insurance programs. Burgeoning health care costs in the United States surpassed \$2.6 trillion in 2010, accounting for 17.9% of the gross domestic product (GDP) in the country (Figure 1).¹ Politicians, government agencies, insurers, employers and health care consumers are all struggling to find ways to curb this growth. Chronic diseases including heart disease, stroke, cancer, diabetes, and obesity are reduced for breastfed infants and / or women who breastfed.^{2,3} Chronic diseases are expensive to treat, consume 75% of national health expenditures and are among the leading causes of death and disability.⁴ Today, two-thirds of U.S. adults and nearly one in three children are overweight or obese.⁵ Recent estimates show that obesity related medical costs make up almost 10 percent of all medical spending and may amount to \$147 billion per year.⁶

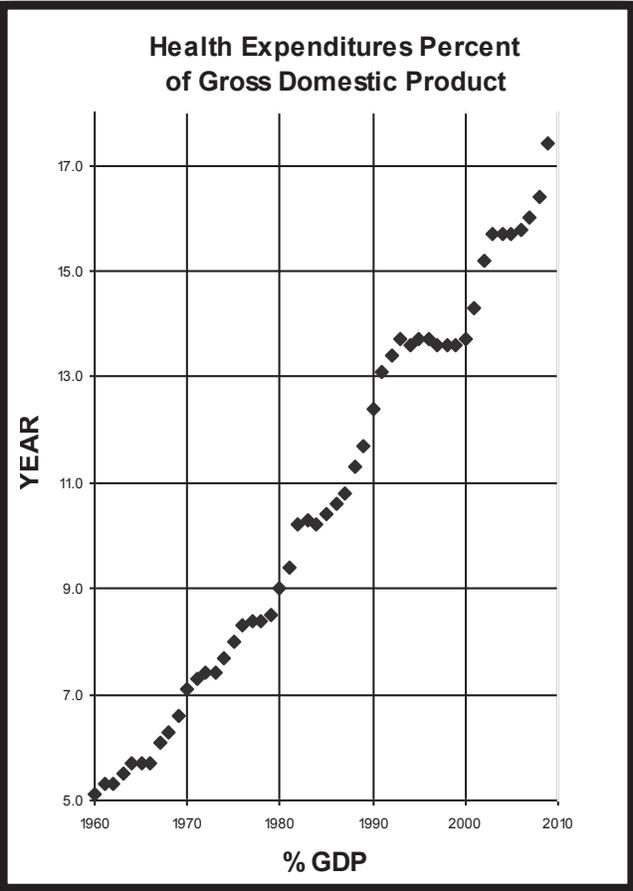


FIGURE 1



Photo Courtesy of Pennsylvania Department of Health

Organization for Economic Co-Operation and Development: Directorate for Employment, Labor and Social Affairs. OECD Health Data 2011 - Frequently Requested Data, 2011. Available at http://www.oecd.org/document/16/0,3343,en_2649_33929_2085200_1_1_1_1,00.html. Accessed May 21, 2012.

CAN WE DECREASE THE COST OF DISEASE TREATMENT?

Health promotion and disease prevention are effective tools to reduce the incidence of costly acute and chronic illnesses and conditions. Health care agencies have made recommendations to stop smoking, to increase exercise, and to improve nutrition as the basis of health messages. In addition, they have recognized that infant and child nutrition has a strong influence on lifelong health. Major health organizations and government health agencies acknowledge the need to promote exclusive breastfeeding for the first six months of life and for the first year or more as a part of a healthy diet and as an optimal start for both overall health and nutrition. (Table 1) Breastfeeding confers reduced health risks across the lifetime for children and their mothers and can improve the quality of life for the entire community.

Agency or Organization*	Duration	Exclusivity
National Business Group on Health ^I	At least a year	6 months
American Academy of Pediatrics ^{II}	At least 1 year and beyond as long as mutually desired by mother & child	6 months
American College of Obstetricians and Gynecologists ^{III}	Longer than 6 months and as long as possible	6 months
American Association of Family Physicians ^{IV}	Continue breastfeeding with appropriate complimentary foods for at least one year	6 months
American College of Nurse-Midwives ^V	Ideally continue throughout the first year of life	6 months
American Dietetic Association ^{VI}	With complementary foods from 6 months until at least 12 months.	6 months
International Lactation Consultant Association ^{VII}	2 years or more is normal. Women should breastfeed as long as they wish	6 months
American Public Health Association ^{VIII}	At least 1-2 years and beyond	6 months

* For a complete list of government agencies and organizations that support breastfeeding, see members of the United States Breastfeeding Committee: <http://www.usbreastfeeding.org/AboutUs/Membership/tabid/64/Default.aspx>

HOW CAN BREASTFEEDING HELP IN HEALTH PROMOTION AND DISEASE PREVENTION?

Human milk is an important building block in human development. It provides perfect nutrition, and is imperative for the development of a healthy immune system and gastrointestinal tract.⁷ Babies who are not breastfed, or who are breastfed for a brief time, are exposed to higher disease risks as infants, children, and adults. Because breastfeeding reduces the incidence and severity of acute and chronic diseases⁸ it can also be a cost saving intervention for insurers and self-insured employers. The Agency for Healthcare Research and Quality funded a review that found evidence for the significant reduction of multiple illnesses when a history of breastfeeding was present (Table 2).

Table 2: Excess Health Risks Associated with Not Breastfeeding *Adapted from the SGCTA Appendix 2.^{ix}	
Health Risk	Excess Risk (%)
Acute Otitis Media	100%
Atopic Dermatitis	47%
Gastrointestinal Infection	178%
Lower Respiratory Infection, Hospitalization Rate	257%
Asthma, with family history	67%
Asthma, no family history	35%
Childhood Obesity	32%
Type II Diabetes	64%
Acute Lymphocytic Leukemia	13%
Acute Myelogenous Leukemia	18%
Sudden Infant Death Syndrome	56%
Necrotizing Enterocolitis in Pre-term Infants	138%



Photo Courtesy of Pennsylvania Department of Health

It is not only breastfed children who benefit from breastfeeding. A mother who breastfeeds improves her health profile with increased total length of breastfeeding over her lifetime. This protection is likely to be related to the hormonal influences on the body during lactation.⁹ Women who do not breastfeed after pregnancy demonstrate an increased risk for developing ovarian and breast cancers, diabetes, metabolic disease, and heart disease (Table 3).

Table 3: Maternal Risk Reduction from Breastfeeding	
Disease	Risk Reduction
Diabetes ^x	12%
Metabolic Syndrome ^{xi}	8.4%
Ovarian Cancer ^{xii}	21%
Breast Cancer ^{xiii}	4.3%
Coronary Artery Disease ^{xiv}	23%
Aortic Calcifications ^{xv}	22%
Coronary Calcifications ^{xvi}	15%

Promoting, protecting and supporting breastfeeding medically and culturally have the potential to make a profound impact on health care spending and on the health status of the United States population.

WHAT IS THE ECONOMIC COST OF NOT BREASTFEEDING?

The cost of formula feeding to society is substantial. Direct costs include the purchasing breast milk substitutes and families spend additional dollars on bottles, fuel and many other things.

- Unpublished proprietary data that the Nielsen Company prepared for ERS [Economic Research Service] indicate that total infant formula sales in 2005 totaled 3.5 billion dollars.¹⁰
- In the federal budget, the Women, Infants and Children’s (WIC) program spent approximately \$850 million on infant formula in fiscal year 2009.¹¹
- Between 57 and 68 percent of all infant formula sold in the United States in 2004-06 was purchased through WIC.¹²



Photo Courtesy of Pennsylvania Department of Health

Indirect costs of formula feeding include the cost of health care for preventable illnesses and diseases. Decreased risk of pediatric diseases identified by the Agency for Healthcare Research and Quality have been quantified by Bartick and Reinhold who found that if 90% of US families complied with the medical recommendations to breastfeed exclusively for 6 months \$13 billion could be saved and approximately 900 infant deaths could be prevented annually.¹³ Additional health related cost burdens for suboptimal breastfeeding rates include the following:

- The \$270 billion annual cost of overweight and obesity to the U.S. economy (2009)¹⁴
- The \$43.6 billion cost in treatment of heart disease in women (2008) which is among the top 10 most expensive conditions for women including cancer, hypertension, diabetes and hyperlipidemia, all of which are known to be reduced in women who breastfeed for more than 12 months (Table 3).^{15,16}

HOW IS THE UNITED STATES SUPPORTING BREASTFEEDING?

Breastfeeding duration rates in the United States are low (Figure 2).¹⁷ The Surgeon General's Call to Action to Support Breastfeeding stated that, "Many mothers in the United States want to breastfeed, and most try. And yet within only three months after giving birth, more than two-thirds of breastfeeding mothers have already begun using formula. By six months postpartum, more than half of mothers have given up on breastfeeding, and mothers who breastfeed one-year olds or toddlers are a rarity in our society."¹⁸ Perrine et al, explored women's breastfeeding goals and found that "Two-thirds of mothers who intend to exclusively breastfeed are not meeting their intended duration."¹⁹

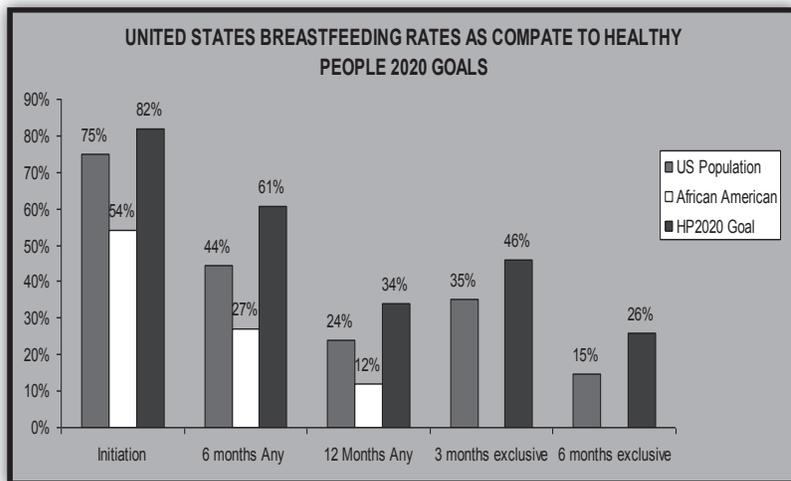


FIGURE 2

Furthermore, unacceptable racial / ethnic and socioeconomic disparities in breastfeeding persist."²⁰

Many health care and government agencies are creating programs and policies to support breastfeeding. These policies will improve health and bring down the costs of preventable disease and include:

PUBLIC HEALTH POLICIES:

- The Surgeon General issued a Call to Action to Support Breastfeeding stating, "The time has come to set forth the important roles and responsibilities of clinicians, employers, communities, researchers, and government leaders and to urge us all to take on a commitment to enable mothers to meet their personal goals for breastfeeding." The Call to Action details how each of these individuals and groups can provide breastfeeding support.²¹
- The Institute of Medicine's Consensus Report Clinical Preventive Services for Women: Closing the Gaps recommended third party coverage of, "Comprehensive lactation support and counseling and costs of renting breastfeeding equipment."²²
- The White House Task Force on Childhood Obesity Report to the President recommended that hospitals, health care providers and insurance companies should educate new mothers about breastfeeding and provide support for breastfeeding.²³
- US Department of Health & Human Services National Prevention Strategy recommends support policies and programs in order to increase the initiation and duration of breastfeeding including workplace breastfeeding support and access to lactation services.²⁴
- The Centers for Disease Control and Prevention publishes the Breastfeeding Report Card to provide state-by-state data so that health professionals, legislators, employers, business owners, community advocates and family members can identify states' needs, develop solutions, and work together within their community to better protect, promote, and support breastfeeding. This report includes data from the Maternity Practices in Infant Nutrition and Care Survey which assesses lactation support services in maternal / child care facilities.²⁵

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- The US Department of Agriculture WIC food packages were adjusted in 2009 to provide greater incentives for continued breastfeeding.²⁶
 - The United States Preventive Services Task Force Section 2713 Coverage of Preventive Health Services recommendations for breastfeeding include: pre and postnatal breastfeeding education, formal breastfeeding evaluations undertaken by trained caregivers in the hospital and out-patient care settings, followed by interventions to correct problems as needed.²⁷
 - The Internal Revenue Service ruled that breast pumps and other nursing supplies could qualify for tax breaks.²⁸

WORKPLACE POLICIES:

- The US Department of Health and Human Services, Health Resources and Services Administration, created the Business Case for Breastfeeding, a program whose goal is to provide the materials needed to create workplaces which are breastfeeding friendly.²⁹
- Section 4207 of the Patient Protection and Affordable Care Act included: “Reasonable Break Time for Mothers” stating, “Employers are required to provide unpaid, reasonable break time for an employee to express breast milk for her nursing child and provide a private place, other than a bathroom, which may be used by an employee to express breast milk.”³⁰

HEALTHCARE POLICIES:

- The Joint Commission has added “Exclusive breast milk feeding during the newborn’s entire hospitalization” to the Perinatal Core Measures Set. Exclusive breastfeeding was identified as most relevant to patient safety and quality of care.³¹
- The National Initiative for Children’s Healthcare Quality is leading a nationwide effort to help hospitals improve maternity practices necessary to be considered “Baby Friendly” meaning that they put in place comprehensive measures to support breastfeeding.³²
- United States Preventive Services Task Force recommendations have been adopted by Bright Futures, an initiative of the Maternal and Child Health Bureau of the Health Resources and Services Administration. Bright Futures recommendations are supported and coordinated by the American Academy of Pediatrics.^{33,34}
- The Patient Protection and Affordable Care Act requires health plans to cover preventive services and eliminate cost sharing for such services. This includes the Women’s Preventive Health Services as defined by the Institute of Medicine thus including, “Comprehensive lactation support and counseling, by a trained provider during the pregnancy and/or in the postpartum period... in conjunction with each birth.” Beginning August 1, 2012.³⁵

Despite mandates given to increase breastfeeding incidence and duration, the healthcare system has lagged behind in the provision of breastfeeding support services. The “Kaiser Family Foundation State Medicaid Coverage of Prenatal Services: Summary of State Survey Findings” notes that, despite the recognition of the importance of breastfeeding in improving health, coverage of breastfeeding support services for low-income women is far from universal.³⁶ Their report from November 2009 stated that Medicaid covered breastfeeding education services in only 25 states; and even fewer, 15 states, covered individual lactation consultations.³⁷

BREASTFEEDING HAS A “B” RATING WITHIN THE USPTF RECOMMENDATIONS MAKING THIS COVERAGE MANDATORY FOR PRIVATE INSURERS WITH NO COST SHARING REQUIREMENTS.

WHO SHOULD PROVIDE BREASTFEEDING SUPPORT?

Research shows that the role of the health care provider is critical to breastfeeding success.^{38,39,40,41,42,43} Despite the US Breastfeeding Committee’s Core Competencies in Breastfeeding Care for All Health Professionals,⁴⁴ many health care providers have difficulty imparting effective and appropriate lactation care and services. Training is often absent or minimal in academic medical programs and may not be available or pursued through continuing education.^{45,46} Deficiencies in breastfeeding management are seen in pediatricians,⁴⁷ obstetricians,⁴⁸ family practitioners,⁴⁹ clinic nurses and public health nurses,⁵⁰ pediatric nurse practitioners,⁵¹ hospital staff nurses,⁵² neonatal intensive care nurses,⁵³ and WIC personnel.⁵⁴ Furthermore, effective lactation support is time intensive with an average consultation lasting one hour.⁵⁵ These extended visits are often difficult for providers to accommodate as their time is already at a premium.^{56,57} Most providers specialize in the care of the mother OR the infant, rather than caring for them as a pair as a lactation consultant does.

Lactation evaluation and management by a qualified lactation consultant, involves an office visit of 60-120 minutes to include at least the following (Figure 3):

Facets of a Lactation Consultation

- Maternal, infant, birth and feeding comprehensive history
- Physical examination that includes:
 - ❖ Maternal nipple and breast
 - ❖ Infant oral and facial anatomy
 - ❖ Infant suck assessment
- Feeding observation
- Problem assessment
- Management plan and patient education

It has been identified that “the vast majority of first-time mothers have early breastfeeding problems coupled with low confidence” and they do not receive adequate assistance in the primary care setting resulting in early formula use and reducing breastfeeding duration and exclusivity.⁵⁸

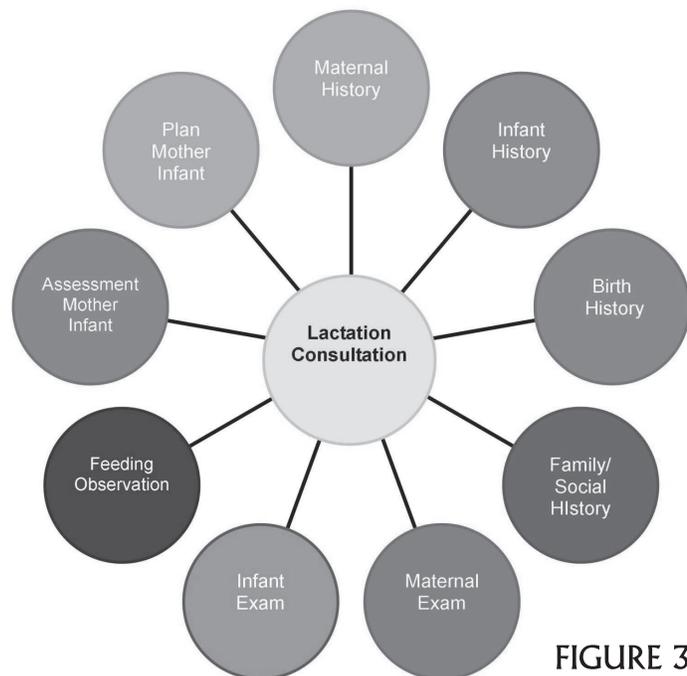


FIGURE 3

Utilization of IBCLCs for breastfeeding support is a cost effective solution. They provide safe and effective care with ensuing improvements in breastfeeding initiation, duration, and exclusivity—all of which result in reduced health care claims. Research has shown that IBCLCs have a positive effect on breastfeeding success (Table 4). Their clinical competencies encompass a broad range of lactation care and services.⁵⁹

Table 4: Effectiveness of IBCLCs	
Setting	Effect on breastfeeding when IBCLCs were utilized on-staff
WIC	More mothers initiate breastfeeding ^{xvii}
Primary Care	Promote a longer duration of breastfeeding ^{xviii}
NICU	Breastfeeding rates 50% compared to 36% without an IBCLC ^{xix}
Hospitals	2.28 times increase in the odds of breastfeeding at discharge ^{xx}
Medicaid mothers with IBCLC contact in hospitals	4.13 times increase in the odds of breastfeeding at discharge ^{xxi}

“For primary care, breastfeeding support constitutes the quintessential health maintenance and disease prevention intervention....Traditionally, medical practitioners may have eschewed breastfeeding support interventions because they tend to be labor intensive, which as a general rule are poorly reimbursed. If breastfeeding-related metrics can be included in performance standards upon which Medicare bonuses are based, there could quite conceivably be a very substantial financial incentive for physicians to become far more actively involved in breastfeeding support in their respective practices....The nature of primary care could be radically altered in a short period of time, and in a very favorable manner. Our task now is to keep the importance of breastfeeding support front and center in the thinking of our policy makers....We need to educate the leaders of our professional health societies and the Centers for Medicare and Medicaid Services (CMS) that breastfeeding must not be overlooked if we truly wish to reduce the cost of medical care and safeguard the health of American citizens in the years ahead.”

Jerry Calnen, MD, is a pediatrician and is the Immediate Past President of the Academy of Breastfeeding Medicine.

WHAT IS AN INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANT?

Lactation Consultants (IBCLCs) have been working in the health care field for 27 years in the United States and around the world.⁶⁰ The certification can be added to an existing health care profession, or function as a stand-alone certification.⁶¹

The IBCLC works in hospital maternity and pediatric care units to provide clinical lactation services and lactation education to staff. In the outpatient setting, lactation consultants work independently, or in medical practices or public health settings. Lactation consultants can be employed by corporations to provide workplace lactation services or work for government or other health care agencies. Their expertise is used to develop and implement policies to support, protect, and promote breastfeeding. Some IBCLCs carry out breastfeeding-related research.



Photo Courtesy of Pennsylvania Department of Health



Photo Courtesy of Pennsylvania Department of Health

Depending on their educational and professional background, IBCLCs receive:

- 300-1000 hours of supervised lactation specific clinical experience and
- 90 hours of didactic education in human lactation and breastfeeding
- Training in another health care field or 14 general education classes in health sciences

Following this education and training, they must pass an independent criterion referenced exam which provides a standard for IBCLC certification. The exam is repeated every 10 years, and in the interval, the IBCLC recertifies at 5 years with 75 hours of lactation specific continuing education.

The IBCLC is the only certification. Though, other education programs and certificate courses providing knowledge of basic lactation support for the normal course of breastfeeding exist they offer only a certificate of completion.⁶² Generally these are 15 to 45 hour courses with no prerequisites and limited continuing education requirements.

The Surgeon General's Call to Action to Support Breastfeeding states, "International Board Certified Lactation Consultants (IBCLCs) are the only health care professionals certified in lactation care."

Additionally, the Surgeon General’s Call to Action, statements in Action Step 11 specify the need to make IBCLC services available by policy changes.⁶³ The Surgeon General has published implementation strategies for doctors, nurses and health care leaders. These documents summarize Action Step 11 as follows:

- “Guarantee equitable access to services provided by International Board Certified Lactation Consultants.
- Include support for lactation as an essential medical service for pregnant women, breastfeeding mothers, and children.
- Ensure that reimbursement of IBCLCs is not dependent on their having other professional certification or licensure.”⁶⁴

WHY IS HEALTHCARE SUPPORT OF BREASTFEEDING IMPORTANT?

Breastfeeding has been called the great equalizer, providing the best start in life regardless of the social or economic background of the family. It is also a healthcare equalizer, reducing the need for later health care services. Human milk is free and nutritionally adapted to the needs of infants and children, regardless of the quality of a mother’s diet or her socioeconomic status. A woman does not need to be wealthy to provide her baby with her own milk but in doing so she provides superb nutritional, immunologic, developmental, psychological, social, economic, and environmental advantages.

A study from the Centers for Disease Control found that, “Most mothers who want to exclusively breastfeed intend to do so for 3 months, but the majority are not meeting their intended duration.”⁶⁵ Additionally, the study found that more than half of the mothers in their analysis had stopped exclusively breastfeeding by 2 months” even when their infants were delivered in “Baby Friendly” Hospitals.⁶⁶ Women are significantly more likely to achieve their breastfeeding goals if they are supported prenatally, in the maternity care facility, and after discharge.



Photo Courtesy of Pennsylvania Department of Health

According to the Surgeon General’s Call to Action, “Despite overall improvements in breastfeeding rates, unacceptable disparities in breastfeeding have persisted by race/ethnicity, socioeconomic characteristics, and geography.”⁶⁷ Often, mothers must pay out of pocket for breastfeeding support services. This creates disparity in care, placing vulnerable populations at the greatest risk for breastfeeding failure. This also contributes to low breastfeeding rates among mothers of lower socioeconomic status and African American mothers, leaving these populations with increased health care needs from infancy through the lifespan.⁶⁸

A new mother can be hormonally labile, recovering from surgery and / or birth, suffering from fatigue, and learning how to fit a baby into her life. If breastfeeding problems exist, women confront them every two or

three hours around the clock. Difficult breastfeeding is grueling, and if support is not initiated immediately, the breastfeeding relationship can be lost within a matter of days or even hours affecting the mother, child, and family for the rest of their lives. The support she needs is typically limited to a few visits, with rare cases requiring prolonged assistance.

The most common problems treated by IBCLCs are suppressed lactation, latching difficulties, pain, slow weight gain, oversupply, and jaundice.⁶⁹ Li et al identified 35 different self-reported reasons that mothers wean in the first year.⁷⁰ IBCLC support could moderate or eliminate all of these reasons to wean with evidence-based clinical interventions and proper follow-up.

Women who want to breastfeed and are unsuccessful in achieving their goals may be reminded of their loss each time they give their baby formula, their baby experiences an illness, or they see other women breastfeed. A family with breastfeeding issues needs simple, swift and convenient access to lactation support. A small investment in lactation care and services for an infant can reap a long term gain in quality of life.

IS REIMBURSEMENT FOR LACTATION CONSULTANTS COST EFFECTIVE?

One study done by the Commonwealth of Virginia analyzed the cost of standard provision of breastfeeding services and equipment to medical assistance clients and found that it was at least cost neutral. They determined that given the overwhelming scientific evidence regarding the benefits of breastfeeding, and the fact that the services provided are at least cost neutral and likely cost saving, the Medicaid State Plan should cover comprehensive breastfeeding services, including supplies and education for Medicaid recipients.⁷¹

The fees for outpatient lactation consultant's services range from \$50-\$110 (median cost \$80) per counseling session.⁷² The National Business Group on Health recommends insurance coverage of up to five postpartum lactation consultant visits per pregnancy delivered by an IBCLC.⁷³ In the unlikely event that every US mother received five lactation consultations at the cost of \$400, the total cost would be \$1,652,266,000 for the 4,130,665 infants born in the US in 2009.⁷⁴ If the cost of these five postpartum lactation consult visits was subtracted from the cost savings of \$13,000,000,000 (billion) per year, which is the amount of health care spending saved on diseases prevented by breastfeeding if all babies in the United States were breastfed exclusively for the first six months of life,⁷⁵ this would still present a cost savings of \$11,347,734,000 annually.



Photo Courtesy of Pennsylvania Department of Health

HOW ARE LACTATION CARE AND SERVICES CURRENTLY REIMBURSED?

Lack of licensure for IBCLCs is a significant barrier to reimbursement due in part to federal requirements regarding state licensure of Medicaid providers in section 1905 of the Social Security Act. The relevant federal regulations regarding the licensure requirement can be found at the Centers for Medicare and Medicaid Services website (42 C.F.R. 440.60 and 42 C.F.R. 440.90). Within these regulations, the provision regarding “other diagnostic, screening, preventive, and rehabilitative services” was added to section 1905 in 2010 by the Patient Protection and Affordable Care Act. Although IBCLC support could potentially be covered by this, there’s not yet language specific to lactation counseling in the regulation.⁷⁶

In 2011, a survey of IBCLCs in the United States found that lactation management by IBCLCs is infrequently and inconsistently reimbursed by third party payers. While a part of this appears to be due to IBCLCs not consistently submitting claims to insurance providers, there is also clearly a lack of recognition of the IBCLC certification. Of the lactation consults submitted to insurance providers, only 10% of IBCLCs reported that their care was recognized by insurance companies at least 4 out of 5 times.⁷⁷



Photo Courtesy of Pennsylvania Department of Health

Many facilities do not have a separate department code for lactation services. In these situations, there is no separate accounting for the service and no further reimbursement from third party payers for the increased care provided. This inappropriately spreads the cost of care to every patient in the hospital as a general operating expense. Additionally, when budgets are scrutinized, this cost can be seen as superfluous and lactation care is then at risk of being eliminated.

In the outpatient or community settings, if the IBCLC is also a nurse, the lactation services are sometimes communicated to third party payers as nurse visits. While these visits are more likely to be recognized, they do not accurately identify the provider as an IBCLC or the service as a lactation consultation because nursing visit costs are based on a typical brief nursing encounter rather than the time intensive lactation consult.

If the IBCLC possesses medical credentials such as physician, midwife, nurse practitioner, therapist or dietician, they can bill commensurate with these credentials and their services are covered by insurance at the usual professional rates, however, they are not seen as lactation services. IBCLCs can also provide a lactation consult jointly with a licensed provider and the cost of care is then communicated to insurance providers under the licensed provider, which is called “incident to” billing. When incident-to billing is utilized, lactation care is also invisible within the financial health care record. Although these “shared visits” provide

a successful “work around” for third party reimbursement of lactation services, the licensed provider must complete a face-to-face portion of the evaluation and management service⁷⁸ necessitating complicated office management strategies and sometimes limiting patient flow.



Photo Courtesy of Pennsylvania Department of Health

Lactation services are sometimes billed as nurse visits in hospital or clinical settings. These visits can be reimbursed, but do not accurately identify the provider as an IBCLC or the service rendered as a lactation consultation. This often results in departmental revenue losses because the low level of reimbursement for nursing visits is based on a typical brief nursing encounter rather than more time intensive lactation consults. Many lactation programs have been discontinued or poorly staffed due to negative financial outcomes.

Because of the difficulty in receiving appropriate recognition and compensation of lactation consult visits by insurance companies, lactation consulting services within established medical care systems have been discontinued or poorly staffed due to negative financial outcomes. In the IBCLC survey from 2011, 307 IBCLCs or about 14% of respondents reported losing a job due to lactation services being reduced or eliminated, most of those (56%) were in the hospital setting.⁷⁹

An independent IBCLC may bill using standard Healthcare Common Procedure Coding System numbers (HCPS) and Diagnosis Codes (ICD-9).⁸⁰ The clients typically pay at the time of the visit and seek insurance reimbursement on their own to recover the cost of the service. In order to make this process easier for the client, an IBCLC can obtain a National Provider Identifier (NPI) which is required for all health care financial transactions. Then, billing can be done under the Nursing Service Providers, Registered Nurse, Lactation Consultant (163WL0100X) or the Other Service Providers, Lactation Consultant Non-RN (174N00000X) NPI or under another NPI category that is not reflective of the IBCLC credential or service provided. Even with the lactation consultant NPI taxonomy code, it still appears to be difficult to obtain any or appropriate reimbursement for independent lactation consultations.

Beginning this year, due to the multiple health benefits associated with breastfeeding, “the Centers for Medicare and Medicaid Services encouraged States to go beyond the requirement of solely coordinating and referring enrollees to the Special Supplemental Food Program for Women, Infants, and Children (WIC) and include lactation services as separately reimbursed pregnancy-related services.” They published an issue brief offering billing strategies for lactation, unfortunately IBCLC services were not specifically mentioned in these strategies.⁸¹

DOES THE CURRENT SYSTEM PROVIDE SUFFICIENT LACTATION SERVICES?

Recommended inpatient IBCLC staffing ratios have been evolving as research on the work of inpatient IBCLCs has increased. Initially, Riordan recommended one full time IBCLC for every 1000 births based on an estimated fifty minutes of direct consulting time with each couplet, but no indirect work (charting, collaborating with other health care providers, etc) was included. In 2010, the United States Lactation Consultant Association issued the following staffing recommendations:

- 1.9 FTE per 1000 births for Level III hospitals
- 1.6 FTE per 1000 births for Level II hospitals
- 1.3 FTE per 1000 births for Level I hospitals⁸²

These recommendations were based on the work of Mannel and Mannel who used data collected from chart reviews and time studies to estimate actual time spent over a two year period from a large tertiary care teaching hospital.⁸³ Their estimates included the acuity of the hospital, as well as factoring in both direct and indirect clinical activities.

Utilizing patient satisfaction scores, reimbursement patterns, cost of care, and lactation failure admissions, Francis-Clegg and Francis evaluated and standardized lactation services in a twenty-three hospital system in order to optimize IBCLC care and provide staffing recommendations. They utilized two internal time studies at 10 hospitals to segment work into standard breastfeeding support tasks that could be deferred to non-clinical staff or bedside nurses. Using a matrix which ranked lactation support providers from IBCLCs (Level IV) to bedside nurses who had received a standardized three day training course (Level II), results of the time studies, billing records, and a review team of 10-12 IBCLCs, they found that 29% of inpatient breastfeeding support tasks could be deferred to well-trained non-IBCLCs hospital care providers.⁸⁴ Mannel has described an evidence based model for evaluating and responding to maternal-infant lactation acuity, rather than the wider hospital level acuity, which will allow further refinement in utilizing in-patient IBCLCs appropriately.^{85,86}

There are no calculations of acuity or staffing needs in the outpatient or community setting, nor is it standard to provide lactation support outside of the hospital setting, despite 92% of mothers reporting difficulties on day three after birth, and 83% still reporting difficulties on day seven after birth.⁸⁷ Integration of lactation consultants into community settings will further duration rates, as demonstrated by Witt's study which showed improved duration with the addition of standardized IBCLC support in a pediatric practice.⁸⁸

There are currently 12,970 IBCLCs in the United States.⁸⁹ There were 4,130,665 births in the most recent CDC statistics (2009),⁹⁰ making for approximately three IBCLCs for every 1000 live births. The Surgeon General's Call to Action uses Mannel & Mannel's work to estimate that 8.6 IBCLCs are needed for each 1000 live births in the United States in order to maintain inpatient staffing levels, without taking into account the care needed to provide support in the community settings. Many hospitals do not employ IBCLCs or enough IBCLCs to meet the recommended staffing guidelines. The rate of inpatient IBCLCs range from 1.01 IBCLCs per 1000 live births in Nevada to 11.13 IBCLCs per live birth in Vermont.⁹¹

In order to effectively increase breastfeeding duration in the United States, the services of IBCLCs will need to be utilized in all of the settings where pregnancy and postpartum-related services are obtained. Embracing coverage of lactation services as the ubiquitous standard-of-care is crucial in the US health care system model to ultimately improve the health of all insured individuals.

RECOMMENDATIONS

The United States Lactation Consultant Association recommends:

- Recognition of the International Board Certified Lactation Consultant (IBCLC) certification as the preferred provider of lactation care and services
- Delineation of IBCLC-provided lactation services as distinct from other health care services in the medical system
- Credentialing of IBCLCs by third party insurers in order to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight
- Third party reimbursement of skilled breastfeeding support provided by the IBCLC



For more information contact:

United States Lactation Consultant Association

WWW.USLCA.ORG

2501 Aerial Center Parkway, Suite 103

Morrisville, NC 27560 USA

Phone: 919-861-4543

Email: info@uslca.org

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**United States Lactation
Consultant Association**

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA

info@uslca.org
www.uslca.org

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