Testimony in Support of Medicaid Reimbursement for IBCLC Clinical Care

Dear Members of the Committee,

My name is Paula Norcott, and I am an International Board Certified Lactation Consultant (IBCLC), CLC, in private practice. I am here today to express my strong support for the bill mandating Medicaid reimbursement for IBCLC clinical care.

I was a CLC for 15 years, working with WIC families to provide non-clinical counseling support. I knew I wanted a deeper clinical understanding of acute lactation difficulties, so I pursued a rigorous didactic program through UCSD Extension, followed by 1,000 directly supervised, in-hospital, unpaid clinical hours. I then sat for the rigorous board examination to achieve the high standard of an International Board Certified Lactation Consultant.

As an IBCLC, I have the privilege of supporting families through their feeding journeys, both in hospital and in the community, often stepping in when parents feel like they have run out of options. I am currently credentialed with Aetna, United, Cigna, Community Health Options, and work with a third party for Anthem. However, MaineCare and a few other payers still refuse to credential our provider type. This lack of Medicaid coverage creates a significant barrier, particularly for families who cannot afford out-of-pocket care but desperately need specialized clinical lactation services.

A Story of Impact: Sarah and Her Baby

Let me share the story of one such family.

A Maine mother, Sarah, gave birth to a full-term baby who, for an undetermined reason, was unable to take in appropriate volumes by breast or bottle. At two weeks old, her baby was readmitted to the hospital for failure to thrive. An NG feeding tube was placed, and Sarah was told the next step would likely be a G-tube—a surgical placement of a permanent feeding tube. She was also told by a team of well-meaning doctors—most of whom had little to no clinical lactation training—that breastfeeding was unlikely to happen. The hope she had for nursing her baby was slipping away, and the emotional toll on her was profound.

But Sarah reached out for IBCLC support, and together, we built a plan. I led an **interdisciplinary team** that included physical therapy, speech therapy, occupational therapy, and Sarah's medical providers to address her baby's feeding challenges holistically. Through weeks of consistent support, responsive feeding techniques, and strategies tailored to her baby's unique needs, we helped her baby transition from tube feeding to direct breastfeeding.

The day Sarah's baby latched and nursed—**fully, without a tube, without supplementation—was a moment of triumph.** She had been told it was impossible, but it wasn't. It simply required the right care team, with IBCLC-led clinical expertise at the center.

The Need for IBCLC Care in Maine

Unfortunately, too many families like Sarah's never get this opportunity. **Without Medicaid reimbursement, families who rely on public insurance are often left without access to the IBCLC care that could mean the difference between success and early weaning, between a feeding tube and an independent feeder, between a confident parent and one struggling with anxiety and depression.**

I also serve as the **Breastfeeding Educator for the Perinatal Outreach and Education Program,** a state-run initiative in conjunction with MaineHealth. In this role, I provide essential training to professionals working with lactating families, including public health nurses, Maine Families home visitors, WIC staff, pediatricians, obstetricians, and midwives.

One of my favorite opportunities is educating **medical students and residency programs,** as many of them receive **little to no breastfeeding education in school or during their residencies.** At UNE, I am invited twice a year—on the students' own time, during their club meetings—because they recognize the significant gaps in their knowledge. They **want** to learn but are simply not receiving lactation education in their formal training.

I frequently hear from physicians: **"I received ZERO breastfeeding education in school or during my residency."** When they do receive training, it is taught **by an IBCLC.**

This is a fundamental issue. An interdisciplinary team includes **PTs, OTs, SLPs, ENTs,** and more. **We don't expect pediatricians to have expertise in physical therapy. Why would we expect them to have expertise in lactation?** IBCLCs **are** the infant feeding specialists, yet Medicaid does not recognize our role.

In our busy practice in **Brunswick, Farmington, and Portland, Maine,** the **majority** of our referrals come from these very physicians and providers—many of whom have **shadowed me in practice** to learn more. One even spent **her sabbatical** with me to gain hands-on experience in lactation care. Some of them have even **been our patients themselves.**

The Gaps in Lactation Care for Medicaid Families

I have also worked directly with bedside nurses, hospital staff, and in-hospital IBCLCs. **They are overwhelmed with inpatient work and simply cannot support lactation needs beyond discharge.** Anyone working in this field knows that **most feeding problems don't emerge until after the first three days of life—after families have already left the hospital.**

Without community access to IBCLC clinical lactation services, there is NO ONE to help them.

The Dyadic Nature of Lactation Care

I also want to address a critical issue: the **baby versus parent billing debate.**

IBCLCs treat **dyads**—both the feeding parent and the baby. Our visits are **often 60 minutes long** because we are treating two patients.

Not all feeding problems are with the baby. Not all are with the parent. **Many involve both.**

If I am treating a parent for:

- Severe nipple damage
- Supply concerns
- Mastitis
- Bacterial infections of the nipple
- Abscesses

How would we bill under the baby? This approach demonstrates a **deep lack of knowledge and understanding** of lactation care. We must be able to bill appropriately for all patients involved.

If a **family practice doctor** sees both parent and baby, **they bill accordingly.** IBCLCs should be treated the same.

In cases of multiples, we may be treating three or four patients in a single visit. The current Medicaid policies fail to recognize the complex, specialized, **clinical** nature of our work.

A Public Health Imperative

Breastfeeding is a **public health issue.** It reduces the risk of:

Infant infections
Chronic diseases
Maternal health complications
Several types of cancer

It also **lowers healthcare costs.** Studies show that increasing breastfeeding rates could save **millions** in Medicaid spending on preventable illnesses such as:

- Ear infections
- Respiratory infections
- Gastrointestinal disorders

By passing this bill, you ensure that **all families—regardless of income—have access to expert clinical lactation care.**

You ensure that parents like Sarah **aren't left to navigate feeding challenges alone.**

You ensure that when a family **wants** to breastfeed, they have the **support they need** to make that a reality.

Healthy Moms and Babies equals healthy communities. This benefits our entire state in both health outcomes and bottom lines.

I urge you to support this bill and remove the financial barriers to IBCLC care.

Thank you for your time.

Sincerely,
Paula Norcott, IBCLC, CLC