Advancing Maternal and Infant Health: Expanding Coverage for In-Home Lactation Services in Nevada

White paper

September 2026

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Office of Minority Health and Equity

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Executive Summary

Breastfeeding provides major health benefits for mothers and infants, yet many families — especially those in marginalized or low-income communities — face barriers to sustaining it. Although private insurers must cover lactation support under the Affordable Care Act (ACA), Nevada Medicaid's coverage is conditional, creating significant gaps in access.

Problem statement

Nevada Medicaid does not have a standalone, dedicated provider type exclusively for lactation consultants; instead, lactation services must be billed under existing medical provider types — such as Physicians (PT 20), APRNs/PAs (PT 24/77), or Nurse Midwives (PT 74) — when working under or alongside an enrolled provider. International Board-Certified Lactation Consultants (IBCLC) and other trained providers counselors or specialists who hold IBCLC certification cannot bill Medicaid directly because they cannot enroll as independent Medicaid providers, as can certified nurse midwives. This results in fragmented coverage despite Medicaid financing nearly half of Nevada births. Nevada has successfully created direct reimbursement pathways for similar providers, such as doulas, demonstrating a feasible model for lactation care. Home based and telehealth lactation services could further expand access, but they remain limited in Nevada. This proposal recommends establishing a dedicated Medicaid lactation benefit that enables direct reimbursement, covers care from prenatal through six months postpartum, and includes in home and telehealth services. The benefit should prioritize communities with the lowest breastfeeding rates and families facing added structural or medical barriers

Introduction

Breastfeeding is associated with significant health benefits for both mother and child, including increased bonding; reduced risk of infectious and chronic diseases for infants; and reduced long-term risks of type 2 diabetes, hypertension and breast and ovarian cancers for mothers (Meek & Noble, 2022). Public health entities, such as the World Health Organization and the American Academy of Pediatrics, recommend breastfeeding exclusively with human milk for approximately the first six months of life (Meek & Noble, 2022). However, many new mothers stop breastfeeding prior to six months, instead supplementing with or substituting formula in lieu of exclusive breastfeeding. Comprehensive lactation support services administered by health care providers can help promote beneficial breastfeeding practices, though marginalized and low-income communities struggle to access such services (Biviji et al., 2025). An IBCLC is a lactation-specific credential that the U.S. Surgeon General has described as the only health professional certified in lactation care (U.S. Department of Health and Human Services, 2011; Wouk et al., 2017). It is the most advanced of several lactation credentials, which range from peer counselors to certified counselors and educators with differences in training length, clinical hours, and the health concerns each provider is prepared to handle.

The Affordable Care Act (ACA) requires private insurers to cover lactation support and counseling nationwide, but federal Medicaid laws leave coverage options up to each state (Biviji et al., 2025). Given that Medicaid financed 47.4% of Nevada births in 2018, which was well above the national average of 43%, the necessity for updated Medicaid mandates surrounding lactation support services is imperative (Medicaid and CHIP Payment and Access Commission, 2020). In Nevada, the gap between its existing mandate and the services Medicaid users actually receive is a reimbursement problem. The existing statute directs Medicaid to cover lactation consultation and support only "to the extent that money and federal financial participation are available," making the benefit contingent rather than guaranteed (NRS 422.27179).

The American Rescue Plan Act of 2021 gave states the option to extend Medicaid coverage to 12 months postpartum, and the Consolidated Appropriations Act of 2023 made that option permanent (American Rescue Plan Act, 2021; Consolidated Appropriations Act, 2023). However, after expansion in Nevada, several barriers remain:

- There is no standalone lactation provider type in Nevada Medicaid. International Board-Certified Lactation Consultant (IBCLC) services can currently be billed only under certain provider types (Nevada Medicaid, 2025).
- Medicaid generally reimburses licensed health professionals, but lactation credentials are certifications rather than state licenses. As a result, no lactation provider can bill Nevada Medicaid directly — including IBCLCs, certified lactation counselors, and certified breastfeeding specialists — leaving coverage fragmented and inconsistent (Medicaid and CHIP Payment and Access Commission, 2020).

Nevada has already built a direct reimbursement pathway for a similar birth support provider. It created a direct Medicaid doula benefit that pays a non-physician provider without routing the claim through a physician (Nevada Division of Health Care Financing and Policy, 2024). Common barriers for Medicaid families attempting to access maternal health support include reduced access to quality providers; lack of transportation to appointments; necessity to return to work without workplace support for pumping; and caring for other family members (Jones et al., 2026). Lactation services offered by telehealth (often called telelactation) may help close these crucial health care gaps for lower-income families and for those living in rural areas (Jones et al., 2026; Uscher-Pines, Kapinos, et al., 2025). However, access to in-home or telehealth lactation support services remain limited in Nevada (Kapinos, et al., 2025).

Objective

The objective of this proposal is to recommend that Nevada Medicaid cover home-based and telehealth lactation support services delivered by IBCLCs and other qualified lactation support providers, thereby improving maternal and infant health outcomes. This proposal endorses the following objectives:

- Identify the statutory and billing changes needed for lactation providers to enroll in and be reimbursed directly by Nevada Medicaid, following the framework the state established for doulas (Nevada Division of Health Care Financing and Policy, 2024; Nevada Medicaid, 2025).
- Assess the feasibility of adding a dedicated lactation benefit through a State Plan Amendment (SPA) under the preventive services category, similar to Nevada's existing doula benefit for maternal care (Biviji et al., 2025; Nevada Division of Health Care Financing and Policy, 2024).
- Include services that cover care in the home and by telehealth, from the prenatal period through at least six months postpartum (D'Hollander et al., 2025; Uscher-Pines, Kapinos, et al., 2025).
- Prioritize the mothers and infants with Nevada's lowest breastfeeding rates. These include Black, Native Hawaiian and Pacific Islander, multiracial families, families in rural counties, mothers covered by Medicaid rather than private insurance, young mothers and mothers with less formal education (Chiang et al., 2021; Diaz et al., 2023; Gurley-Calvez et al., 2018; Wood et al., 2023).
- Account for families that face added barriers to lactation support, including lactating parents with disabilities or chronic illness, families living below the poverty line, and parents whose jobs or housing make travel to a clinic difficult.

Data Analysis

Nevada's outcomes compared to other US states

Nevada performs below the national average on several Centers for Disease Control and Prevention (CDC) breastfeeding indicators, including initiation of breastfeeding after birth, 12-month duration, and six-month exclusivity, as shown in Table 1 (CDC, 2025). As Figures 4 and 5 show, Nevada's breastfeeding initiation rates, as well as exclusive breastfeeding rates at six months, have decreased since 2016 despite increased rates nationwide (Nevada Division of Public and Behavioral Health, 2026). Figure 1 shows a similar decline in postpartum care, with the share of Nevada women attending a checkup within 12 weeks postpartum falling to 84.6% in 2023, while the national rate rose to 90.3%. In addition, Nevada does not have a paid family leave program and the state's hospital maternity practice score was 76 compared with a national average of 82 (CDC, 2025).

Noted disparities

Nevada law directs Medicaid to cover lactation consultation and support, but the state's breastfeeding rates, particularly among rural families and Black families, remain below national rates (CDC, 2025; Chiang et al., 2021; NRS 422.27179).

In Nevada, 64.1% of Black infants begin breastfeeding compared with 84.2% of White infants, a gap mapped by state in Figure 6 (Chiang et al., 2021). Black infants have Nevada's lowest initiation rate, followed by Native Hawaiian and Pacific Islander infants at 72.2% and multiracial infants at 77.4%, against a statewide rate of 80.0% (Chiang et al., 2021). Because Medicaid disproportionately covers births to Black and low-income mothers, the mothers most affected by the coverage gap are the same mothers with the lowest breastfeeding rates (Chiang et al., 2021; Nevada Department of Health and Human Services, Office of Analytics, 2022). Mothers with private insurance breastfeed about two months longer on average than mothers with Medicaid, as shown in Figure 7 (Gurley-Calvez et al., 2018). In a Clark County study, mothers with depression symptoms were less likely to breastfeed exclusively, and mothers with anxiety symptoms were less likely to continue breastfeeding (Neupane et al., 2025).

Current Nevada Medicaid policy and gaps

Coverage remains fragmented and optional. Nevada created a direct Medicaid doula benefit that reimburses non-physician birth-support providers directly, with rate-setting and rural incentives (Nevada Division of Health Care Financing and Policy, 2024). The doula and lactation benefits also work together in practice. Doula-facilitated breastfeeding education improved breastfeeding intentions and knowledge among low-income mothers (Louis-Jacques et al., 2021). Many breastfeeding problems appear 4 to 7 days after birth, so requirements such as prior authorization or a physician order can delay care past the point where it helps (Meek & Noble, 2022).

Delivering care in the home and by telehealth

Nevada has fewer lactation consultants than the U.S. Surgeon General’s recommendation, and every county in the state is a designated health care professional shortage area, mapped in Figures 2 and 3 (Nevada Health Authority, 2025; U.S. Department of Health and Human Services, 2011). As a result, most of the state is considered medically underserved, as shown in Figure 8 (Health Resources and Services Administration, 2026b; Nevada Health Authority, 2025). Rural mothers across White, Black, and Hispanic groups have significantly lower breastfeeding rates than urban mothers (Wood et al., 2023). A benefit that pays only for facility-based care requires members to travel to a facility. Literature recommends paying lactation providers separately using the Current Procedural Terminology (CPT) codes that already exist for office and home visits to make in-home care billable (Biviji et al., 2025).

Telehealth reaches members where local providers are scarce (Jones et al., 2026). A national trial conducted in states with the same shortage of lactation consultants as Nevada recommends making telelactation part of routine care, alongside broadband access and digital navigators (Uscher-Pines, Kapinos, et al., 2025). Telelactation modestly increased breastfeeding satisfaction and the share of mothers who said they were very likely to breastfeed a future child, with no evidence that these effects differed by race or ethnicity (DeYoreo et al., 2025). Results tended to favor in-person and combined care over fully remote care and the authors point to in-person support as a promising part of care (D’Hollander et al., 2025). Some conditions, such as mastitis, need an in-person exam, so the two forms of care work together rather than as substitutes (Mitchell et al., 2022).

Lactation Coverage in Other State Medicaid Programs

Since 2012, 14 states have added lactation support coverage to their Medicaid plans through 19 approved State Plan Amendments, or SPAs (Biviji et al., 2025). Eight states name IBCLCs as billable providers and seven extend billing to other lactation support providers, most often Certified Lactation Counselors (Biviji et al., 2025). Table 2 shows breastfeeding outcomes in select states with lactation support services compared to the national average. Illinois is a recent example, with an SPA approved in February 2024 that covers IBCLCs and other lactation support providers (Biviji et al., 2025).

Coverage design varies across these states. Several states condition provider eligibility on licensure, requiring either a licensed professional who also holds IBCLC certification or separate state-board licensure (Biviji et al., 2025). The IBCLC

credential does not require a state license, so each of these requirements shuts out providers who are certified but not licensed (Biviji et al., 2025). A systematic review conducted for the U.S. Preventive Services Task Force found that breastfeeding support helped whether professionals, trained peer counselors or remote services delivered it (Patnode et al., 2025). Some states limit coverage to a fixed number of sessions or to a postpartum-only period (Biviji et al., 2025).

Recommendations

Nevada should file an SPA adding in-home lactation support as a distinct Medicaid benefit under the preventive-services category, following the pathway established for the state's doula benefit (Biviji et al., 2025; Nevada Division of Health Care Financing and Policy, 2024). The recommendations below describe who may enroll and bill, where care may be delivered, how it is reimbursed and what the benefit covers.

1. Establish a standalone lactation provider type with two enrollment levels, both billing directly with the Current Procedural Terminology (CPT) codes that already exist for office and home visits rather than billing under a nurse midwife (Biviji et al., 2025).
    a. The first level covers IBCLCs and licensed health professionals who hold IBCLC certification. The second covers Certified Lactation Counselors and Certified Breastfeeding Specialists, who refer complex problems to an IBCLC (Biviji et al., 2025).
    b. Eligibility should not require a separate state license, which would exclude providers who are certified but not licensed (Biviji et al., 2025).
2. Cover lactation support services administered in the home and by telehealth (Uscher-Pines, Kapinos, et al., 2025).
3. Reimburse telelactation at the same rate as in-person care and state explicitly that telelactation is eligible for reimbursement (Uscher-Pines, Demirci, et al., 2025).
4. Require Medicaid managed care organizations to include the new provider type in their networks, so the benefit reaches the members enrolled in managed care and not only fee-for-service (42 C.F.R. § 438.68).
5. Cover a minimum of six visits from the prenatal period through at least six months postpartum, with additional visits up to a total of eight when clinically needed (D'Hollander et al., 2025). The proposed minimum is a policy choice within that range and is in line with Nevada's doula benefit, which covers four prenatal or postpartum visits plus one visit at labor and delivery (Nevada Division of Health Care Financing and Policy, 2024).
6. Do not require prior authorization for covered lactation visits within the benefit limit. Federal rules require preventive services to be recommended by a licensed practitioner, so the state should allow one recommendation to cover the full series rather than requiring approval visit by visit (42 C.F.R. § 440.130(c)).

Other Considerations

While they do not address the problem statement directly, these other considerations arose during discussion:

1. Nevada could set a standard screening and referral process for postpartum depression and anxiety during lactation visits, covering which tool providers use, where they refer and what they document (Neupane et al., 2025).
2. Consider building a handoff from inpatient lactation staff to an enrolled community provider before a family leaves the hospital. Problems most often appear after the family has gone home and before the first pediatric visit. The referral step could be added to existing discharge planning rather than built as a new process.
3. The state should plan for language access and for providers who reflect the communities they serve. Nevada families already have limited access to lactation counseling in their own language and culture (Neupane et al., 2025). Interpretation should be available for telelactation visits.
4. The state should confirm how lactation services would work in Indian Health Service and Tribal facilities, where services furnished to Medicaid-eligible American Indian and Alaska Native members draw a full federal match (Centers for Medicare & Medicaid Services, 2016).

5. Families with late preterm or NICU infants deserve particular attention as the benefit rolls out. Late preterm and preterm infants receive breast milk at lower rates than term infants, and their mothers will likely need extra help to establish and maintain a milk supply (Chiang et al., 2019).

Expected Outcomes

Expanding benefits for lactation support services in Nevada is expected to increase breastfeeding initiation, duration and exclusivity among Medicaid members. In a meta-analysis of 40 randomized trials, lactation consultant support reduced the risk of stopping breastfeeding of any kind and breastfeeding without formula. In the eight trials that measured breastfeeding duration while receiving lactation support, study participants breastfed an average of 3.63 weeks longer, with effects strongest in the early postpartum period (D'Hollander et al., 2025). The effect increased with the number of visits and leveled off at approximately eight visits (D'Hollander et al., 2025). In an Arkansas program that provided four telelactation visits to Medicaid mothers, 79% of mothers interviewed were still breastfeeding at two months and most reported increased confidence (Jones et al., 2026).

Across the five states analyzed (as shown in Table 3), rates of infants ever-breastfed and breastfeeding exclusively for six months rose in each state. Twelve-month rates increased in three of the states, with New York's 12-month rate increasing from 28.4% to 38.3% (Biviji et al., 2025).

Available cost estimates indicate the benefit is cost-effective. Nationally, suboptimal breastfeeding is estimated to cost between $17.2 billion and more than $100 billion each year (Bartick et al., 2017; National Academies of Sciences, Engineering, and Medicine, 2025). A North Carolina model estimated about $4.77 million in annual program cost against about $7.1 million in annual savings from three infant illnesses — a net savings of about $2.33 million (Wouk et al., 2017). The estimate excludes maternal disease and other costs, so the full savings are likely larger.

Tracking Indicators

Progress should be measured from baselines set at implementation, with each indicator mapped to a recommendation and evaluated on the specific gaps it targets rather than the statewide average.

- Breastfeeding initiation, duration and exclusivity should be tracked by payer (Medicaid versus private) and by race and ethnicity, measuring the size of the gap rather than the overall rate (Chiang et al., 2021).
- Enrolled lactation providers and IBCLC density per 1,000 Medicaid live births should be tracked from the current baseline of 2.4 per 1,000 toward the Surgeon General's recommended 8.6 per 1,000 (Neupane et al., 2025; U.S. Department of Health and Human Services, 2011).
- Provider counts should also be reported by credential level and by county to monitor where providers are practicing (Wouk et al., 2017).
- Lactation claims volume should be reported by place of service (home, telehealth and office) to confirm that reimbursement is reaching members in their homes.
- Telelactation use should be reported by county and by race and ethnicity to show whether the telehealth option is reaching rural members and the groups with the widest breastfeeding gaps (Uscher-Pines, Kapinos, et al., 2025).

Authorization denials and payment delays should be tracked from the start. If claims are denied or delayed because of paperwork or ordering requirements, the benefit is repeating the problem seen with the doula benefit's additional visits (Nevada Division of Health Care Financing and Policy, 2024).

Limitations

The supporting evidence has several constraints. Much of the cross-state coverage data shows patterns but cannot prove cause and effect. The authors describe the breastfeeding improvements observed in SPA states as exploratory (Biviji et al., 2025). The national telelactation trial's overall effect was not statistically significant, and while results were significant within the Black subgroup, the trial found no evidence that effects differed by race or ethnicity (Uscher-Pines, Kapinos, et

al., 2025). Use of the telelactation service was limited, with fewer than half of the treatment group using it (Uscher-Pines, Kapinos, et al., 2025). This is consistent with findings that coverage without active outreach produces limited change in use (Apanga et al., 2022; Gross et al., 2023). Breastfeeding initiation on birth certificates has not been validated across racial and ethnic groups, so misclassification may vary by group (Chiang et al., 2021).

Several factors limit how far the evidence transfers to rural Nevada. About 5% of telelactation trial participants described their community as rural, and no rural subgroup was analyzed (Uscher-Pines, Kapinos, et al., 2025). Reduced broadband access limits telehealth reach in rural areas (Jones et al., 2026; Uscher-Pines, Kapinos, et al., 2025). Evidence on fully remote delivery is limited, with 7 of 40 trials in the lactation consultant meta-analysis conducted entirely remotely (D'Hollander et al., 2025). A portion of the supporting literature reflects families in WIC rather than families with Medicaid (Apanga et al., 2022; Chatterji & Brooks-Gunn, 2004; Gross et al., 2023). In North Carolina, breastfeeding rates were higher mainly in counties that had any IBCLC at all rather than in counties with more of them, and the link was concentrated in urban counties (Wouk et al., 2017).

Workforce supply may also limit the benefit's reach, since approximately 20,570 IBCLCs were practicing in the United States and territories as of March 25, 2025 (International Board of Lactation Consultant Examiners, 2025). Becoming an IBCLC requires health science coursework, 95 hours of lactation-specific education and 300 to 1,000 supervised clinical hours depending on the pathway, at a total cost that commonly runs several thousand dollars (California WIC Association, 2023; International Board of Lactation Consultant Examiners, n.d.). Coverage alone does not create providers, so the benefit's reach would depend on whether an enrolled lactation provider practices in or serves a given county. The Nevada Lactation Hub Scholarship Program, funded by the Nevada Department of Human Services, is a collaborative effort between the University of Nevada, Las Vegas (UNLV), the Southern Nevada Breastfeeding Coalition (SNBC) and the Northern Nevada Breastfeeding Coalition (NNBC). This program is designed to empower aspiring lactation consultants by providing financial assistance, fostering professional growth and promoting the health and well-being of families across Nevada.

Nevada's current billing structure recognizes only two kinds of lactation providers: IBCLCs, who must bill under other provider types; and licensed clinicians who already hold a provider type (Nevada Medicaid, 2025). The federal preventive services guidelines take a broader view, calling for comprehensive lactation support services that include consultation, counseling, education by clinicians, and peer support services across the antenatal, perinatal and postpartum periods (Health Resources and Services Administration, 2025). Breastfeeding support improves outcomes whether professionals or trained peer counselors deliver it (Patnode et al., 2025). A Medicaid provider type that enrolls these providers directly would close that gap (Biviji et al., 2025). This white paper does not explore the financial aspects of lactation consultations and Medicaid finance.

Conclusion

Nevada performs below the national average for the CDC's breastfeeding indicators and has fewer lactation consultants than recommended throughout the state, with every county designated a health professional shortage area (CDC, 2025; Nevada Health Authority, 2025; U.S. Department of Health and Human Services, 2011). Medicaid finances close to half of Nevada births and disproportionately covers the families least likely to breastfeed, who breastfeed for less time on average than privately insured families (Chiang et al., 2021; Gurley-Calvez et al., 2018; Medicaid and CHIP Payment and Access Commission, 2020).

This paper recommends dedicated Medicaid coverage for lactation support that reimburses IBCLCs and other qualified lactation support providers directly; covers care delivered in the home and by telehealth; requires no prior authorization within the visit limit; and covers at least six visits from pregnancy through six months postpartum, filed through an SPA under the preventive-services category. Nevada's doula benefit demonstrates that the state can reimburse a non-physician provider directly under this same pathway. Establishing such coverage would give Medicaid members improved access to lactation support.

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Glossary of Terms

- Billable provider: A provider who is allowed to submit claims and get paid directly, instead of having their services billed under someone else's provider number.
- Breastfeeding duration: How long breastfeeding continues (for example, still breastfeeding at 12 months).
- Breastfeeding initiation: Whether an infant received any breast milk.
- Breastfeeding peer counselor: A parent who has breastfed and is trained to support other parents in her own community. Peer counselors answer everyday feeding questions, offer encouragement and connect families to clinical providers when a problem needs more help. Most work through WIC.
- Certified Breastfeeding Specialist (CBS): A trained provider who teaches parents what to expect from breastfeeding and supports them through routine feeding questions in the early weeks. Certified through a training course and an exam.
- Certified Lactation Counselor (CLC): A trained counselor who helps parents with common breastfeeding problems such as latch, positioning, pain, and milk supply, and who refers more complicated problems to an IBCLC. Certified by the Academy of Lactation Policy and Practice.
- Certified Lactation Specialist (CLS): A lactation support provider who offers breastfeeding education and routine support, similar to a Certified Lactation Counselor.
- Current Procedural Terminology (CPT) codes: Standard billing codes that identify a specific medical service. Separate codes exist for office visits and home visits, which is what makes in-home care billable.
- Digital navigator: A trained person who helps others get online and use internet services, such as video visits.
- Doula: A trained, non-medical professional who provides education and emotional and physical support during pregnancy, labor, birth and the postpartum period.
- Exclusive breastfeeding: Feeding an infant only human milk, with no formula, other liquids or solids. Usually measured through the first six months.
- Federal financial participation (FFP)/nonfederal share: How Medicaid costs are split. The federal government pays part (FFP) and the state pays the rest (the nonfederal share).
- Fee-for-service: A payment setup in which Medicaid pays providers directly for each service. The alternative is managed care, where Medicaid pays a health plan to deliver services.
- IBCLC (International Board-Certified Lactation Consultant): The health professional certified in lactation care, as recognized by the U.S. Surgeon General. Certified by an international board after clinical training and an exam.
- In-network provider: A provider under contract with a health plan. Members can see in-network providers at the plan's standard coverage level.
- Lactation: Making and providing breast milk to feed an infant. "Lactation support" is the clinical help a parent may need to do this successfully, such as help with positioning, latch, milk supply, pain, or feeding problems.
- Lactation period: The span of time a parent is breastfeeding or producing milk. Needs are highest in the first days and weeks after birth, when latch and supply problems are most common, and continue through the months of feeding. This is why coverage is proposed from the prenatal period through at least six months postpartum.
- Managed care organization (MCO): A health plan that Nevada Medicaid contracts with to deliver covered benefits to most members (NRS 422.047). For a benefit to reach these members, MCO networks must include the providers who deliver it.

- Mastitis: Inflammation or infection of breast tissue during breastfeeding. An example of a condition that generally requires in-person evaluation rather than telehealth.
- Medicaid Management Information System (MMIS): The computer system a state Medicaid program uses to enroll providers and process claims. A provider needs an MMIS number to enroll and contract with payers.
- Nurse midwife: A Registered Nurse with advanced training who provides care during pregnancy, birth and afterward. In Nevada Medicaid, nurse midwives are Provider Type 74.
- Payment parity: Paying the same rate for a telehealth service as for the equivalent in-person service. Without parity, providers are discouraged from offering telehealth.
- Perinatal: The period around birth, covering late pregnancy through the weeks after delivery.
- Place of service: Where care is delivered (such as home, office or telehealth). Claims record it, which is how the state can confirm a benefit is actually reaching members.
- Prenatal/postpartum: Before birth (prenatal) and after birth (postpartum).
- Preventive services: A Medicaid benefit category for services that prevent illness. Nevada's doula benefit was added under this category, and the proposed lactation benefit also would be a preventative service.
- Prior authorization: A requirement that the insurer approve a service before it is provided.
- Provider type: A category in a state Medicaid system that defines who may enroll and bill for a service (for example, Nevada's Provider Type 74, Nurse Midwife). There is currently no lactation provider type in Nevada Medicaid.
- State Plan Amendment (SPA): The formal document a state files with the federal government to change its State Plan. This is the proposed pathway for adding the lactation benefit, and the same one Nevada used for its doula benefit.
- Telehealth/telelactation: Care delivered remotely by video or phone. Telelactation is lactation support delivered this way.
- WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children. A federal nutrition program that also provides breastfeeding support. Some of the research supporting this paper comes from WIC rather than Medicaid populations.

Appendix
Supporting Tables and Figures

Table 1: Children Born in 2022

Children born in 2022	Nevada	National	Ideal
Ever breastfed	83%	86%	Higher
Breastfed through 12 months	37%	41%	Higher
Exclusive breastfeeding through 6 months	24%	28%	Higher
Breastfed infants fed formula before 2 days	29%	23%	Lower

Note: From Early Childhood Nutrition Report 2025: State Report — Nevada, by Centers for Disease Control and Prevention, 2025. Data source: National Immunization Survey-Child, 2022 births. In the public domain.

Table 2: Breastfeeding Outcomes in Select States Two Years Pre- and Post-SPA Implementation

State	SPA Implementation	Ever BF (pre to post) (%)	Exclusive 6m (pre to post) (%)	12 m (pre to post) (%)
Delaware	2017	77.4 to 83.6	23.6 to 25.0	33.4 to 34.9
Nebraska	2017	82.2 to 86.1	25.4 to 26.0	40.2 to 37.7
New York	2012	82.6 to 85.1	16.5 to 21.4	28.4 to 38.3
Oregon	2020	87.2 to 91.4	34.2 to 35.9	44.0 to 43.1
Vermont	2018	89.3 to 92.9	38.0 to 38.1	51.3 to 56.5

Note: From Biviji et al. (2025). Data source: Centers for Disease Control and Prevention. Because state-level tables are not published for every birth cohort, the authors used 2015 data as a proxy for 2014 and 2019 data as a proxy for 2018.

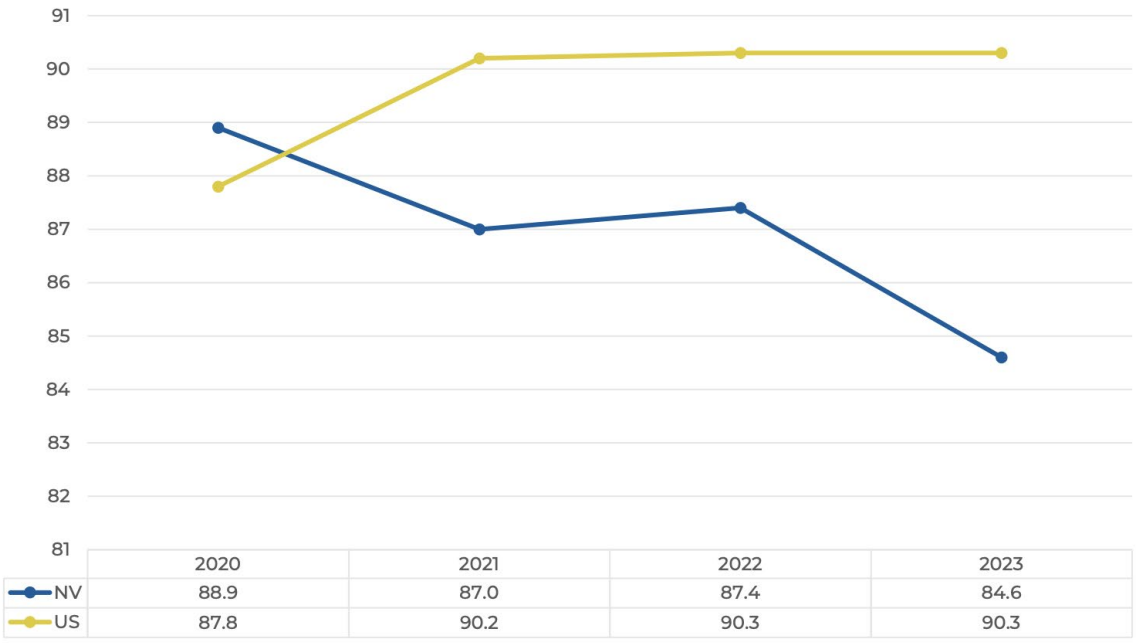
Table 3: Breastfeeding Outcomes in Select States Versus U.S. National Average (2022)

State	Ever breastfed (%)	Exclusive through 6 months (%)	Breastfed at 12 months (%)

Delaware	80.2	24	35.7
Nebraska	91.2	36.7	53.2
New York	88.4	26.4	44.3
Oregon	91.4	35.9	43.1
Vermont	95.4	35.7	55
5 State Average	89.3	31.7	46.3
National Average	85.7	27.9	40.8

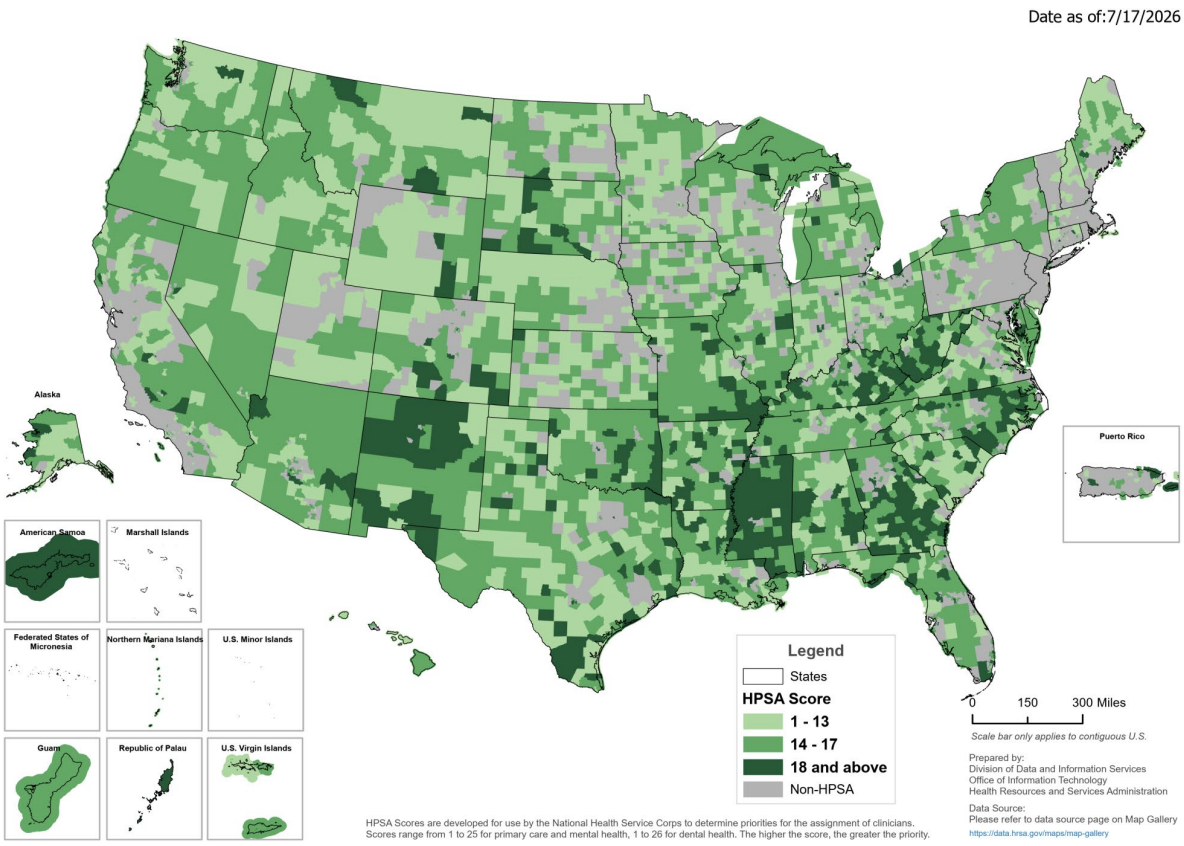
Source: Centers for Disease Control and Prevention

Figure 1: Percentage of Women Who Attended a Postpartum Checkup Within 12 Weeks After Giving Birth



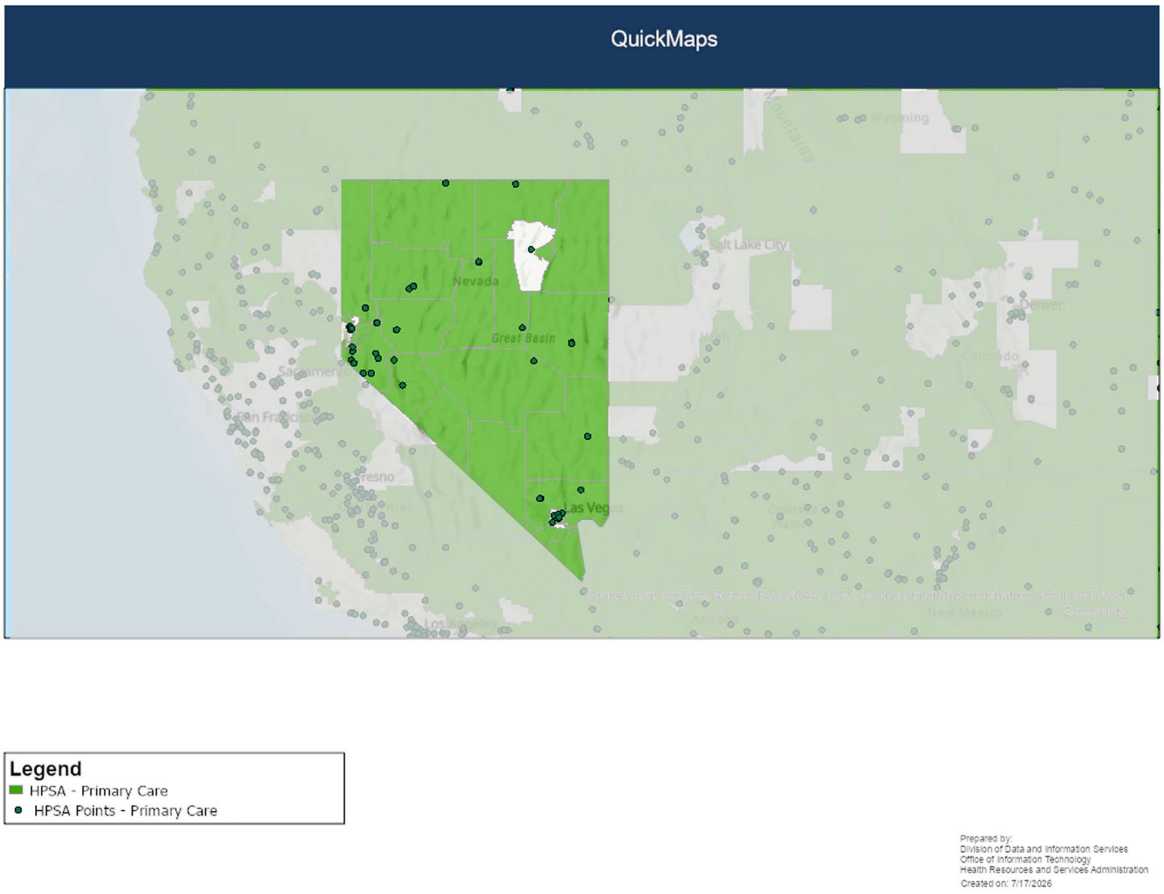
Note: From Nevada Division of Public and Behavioral Health (2026). Data source: Pregnancy Risk Assessment Monitoring System. Nevada PRAMS had a weighted response rate of 40.5% for 2023, so these data should be interpreted with caution.

Figure 2: Health Professional Shortage Areas (HPSA) Map



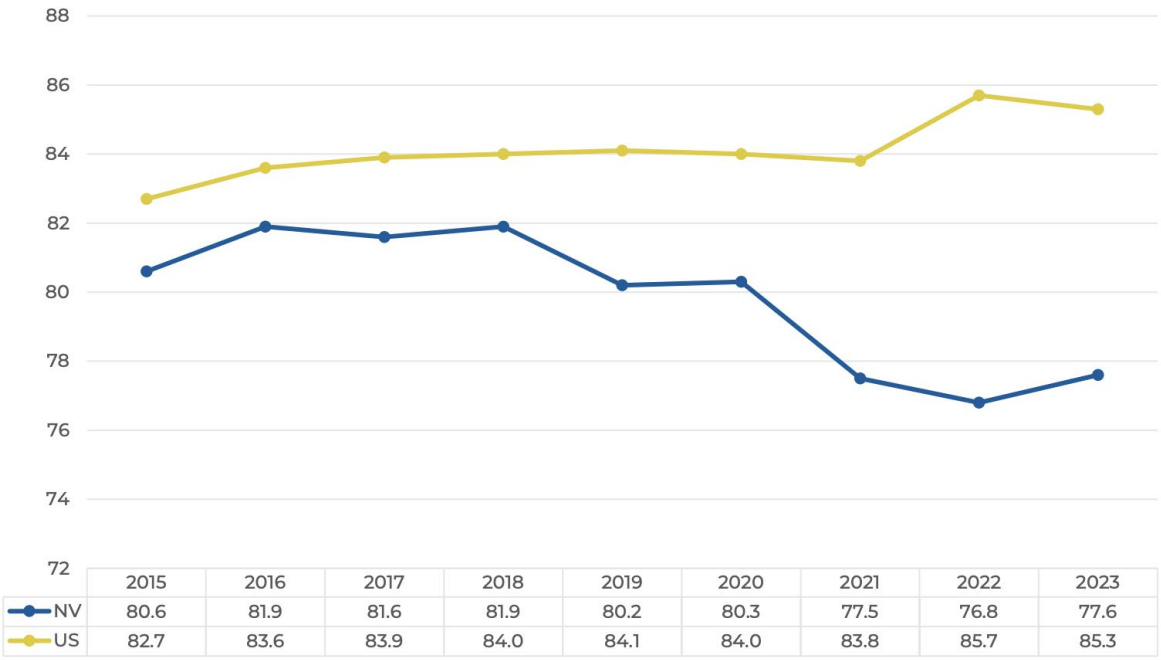
Note: From Health Resources and Services Administration, 2026, U.S. Department of Health and Human Services (https://data.hrsa.gov/ExportedMaps/MapGallery/HPSAPC.pdf). In the public domain.

Figure 3: Primary Care Health Professional Shortage Areas in Nevada



Adapted from Quick map of primary care health professional shortage areas (HPSA) [Map], by Health Resources and Services Administration, 2026, U.S. Department of Health and Human Services (https://data.hrsa.gov/topics/health-workforce/shortage-areas/quick-map-HPSAPC). In the public domain.

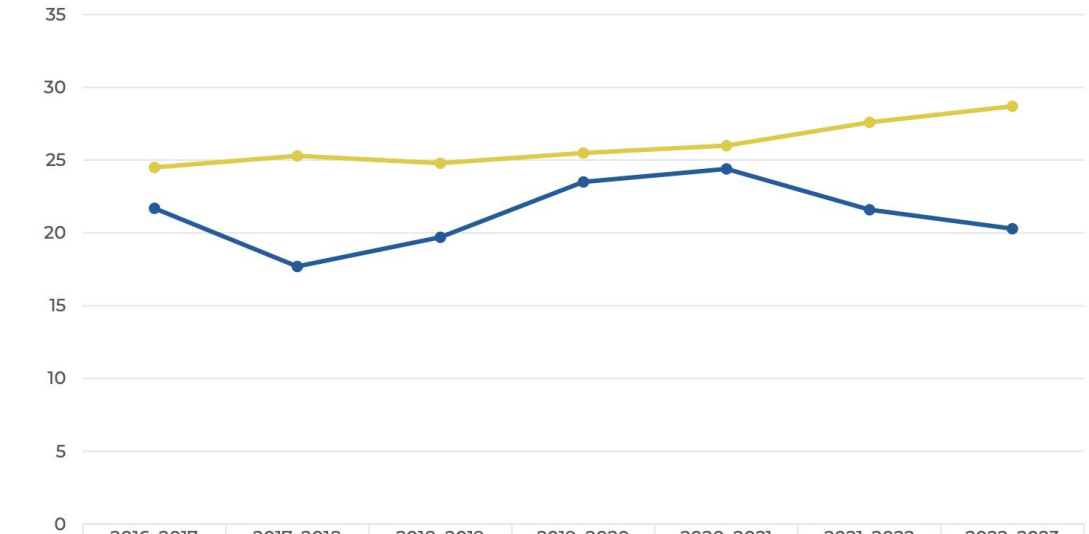
Figure 4: Percentage of Infants Who Are Ever Breastfed



	2015	2016	2017	2018	2019	2020	2021	2022	2023
NV	80.6	81.9	81.6	81.9	80.2	80.3	77.5	76.8	77.6
US	82.7	83.6	83.9	84.0	84.1	84.0	83.8	85.7	85.3

Note. From "Title V Maternal and Child Health (MCH) Block Grant: 5-year needs assessment," by Nevada Division of Public and Behavioral Health, 2026 (https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2026/3.%20%20%20PPC%20MCH%20TVBG%20NA%20Overview_2.27.26.pdf). In the public domain. Data source: National Survey of Children's Health.

Figure 5: Percentage of Children Ages 6 Months through 2 Years Who Were Breastfed Exclusively for the First 6 Months

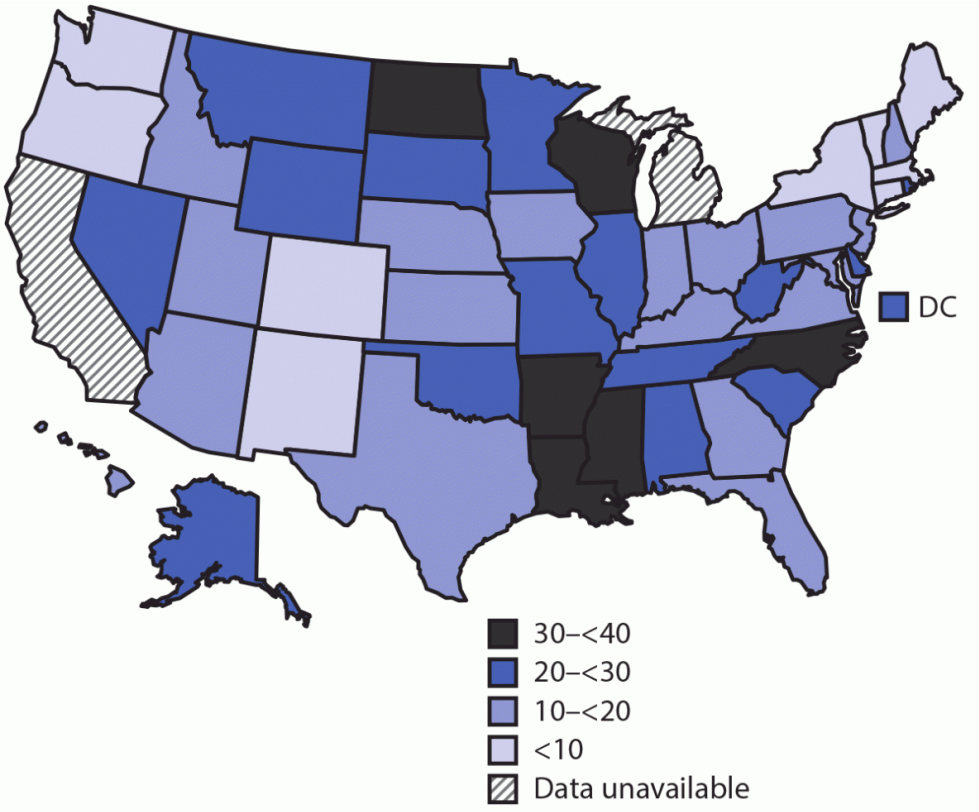


	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023
NV	21.7	17.7	19.7	23.5	24.4	21.6	20.3
US	24.5	25.3	24.8	25.5	26.0	27.6	28.7

Note. From "Title V Maternal and Child Health (MCH) Block Grant: 5-year needs assessment," by Nevada Division of Public and Behavioral Health, 2026

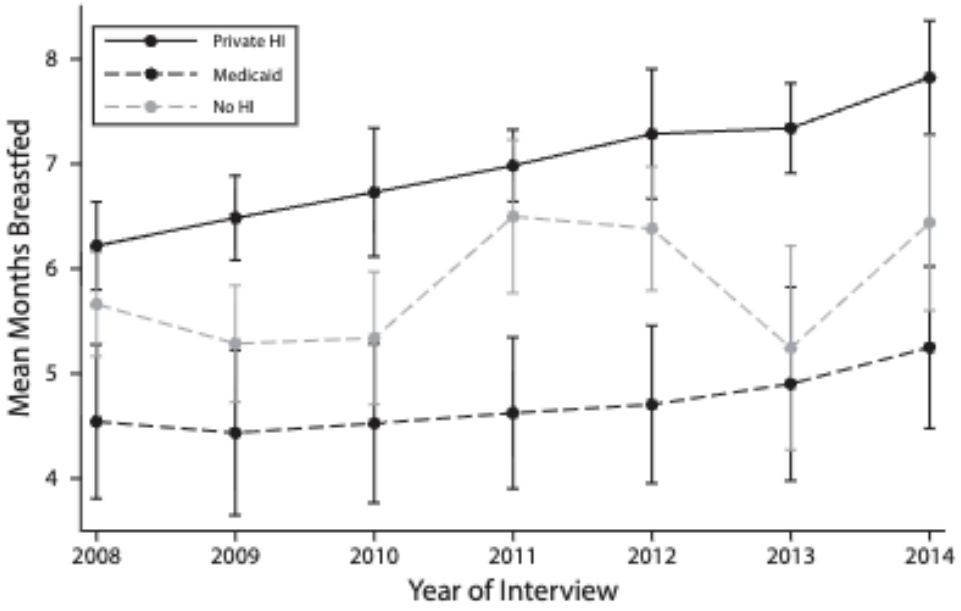
(https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2026/3.%20%20%20PPC%20MCH%20TVBG%20NA%20Overview_2.27.26.pdf). In the public domain. Data source: National Survey of Children's Health.

Figure 6: Racial and Ethnic Disparities in Breastfeeding Initiation — United States, 2019



Note: From "Racial and Ethnic Disparities in Breastfeeding Initiation — United States, 2019," by K. V. Chiang, R. Li, E. H. Anstey, and C. G. Perrine, 2021, MMWR Morbidity and Mortality Weekly Report, 70(21), p. 773 (https://doi.org/10.15585/mmwr.mm7021a1). In the public domain. Data source: National Vital Statistics System, 2019 birth certificates.

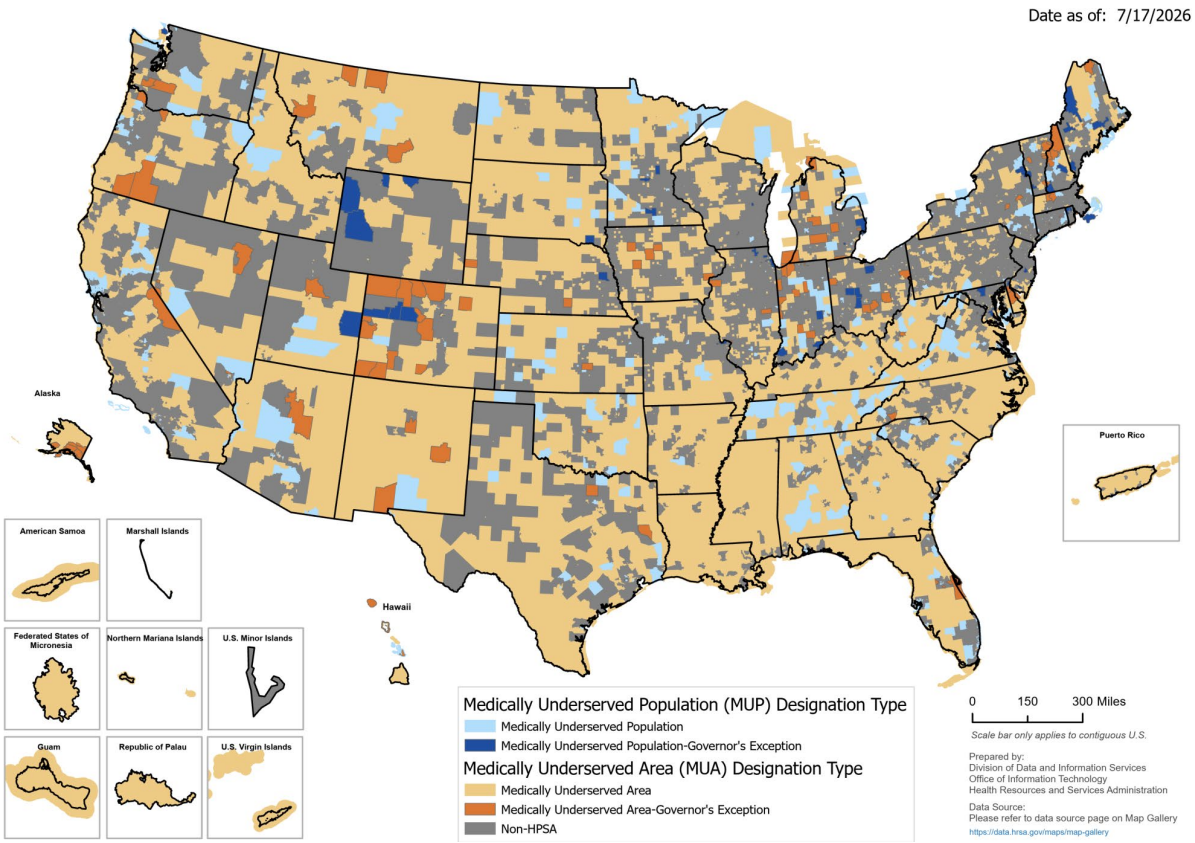
Figure 7: Mean Breastfeeding Duration in Months, by Insurance Status: National Immunization Survey, United States, 2008–2014



Note. HI = health insurance. The whiskers indicate 95% confidence intervals.

Note: From Gurley-Calvez et al. (2018).

Figure 8: Medically Underserved Areas/Populations Map



Note: From Medically Underserved Areas/Populations map [Map], by Health Resources and Services Administration, 2026, U.S. Department of Health and Human Services (https://data.hrsa.gov/ExportedMaps/MapGallery/MUA.pdf). In the public domain.

Acknowledgements

This white paper was prepared by University of Nevada, Las Vegas, graduate students Jay Barilla and Kim Chua, who worked on this paper while serving as interns for the Nevada Office of Minority Health and Equity (NOMHE). The authors thank Tiara Flynn, Jshauntae Marshall and Jollina Walker for sharing their invaluable insights regarding maternal health barriers, particularly for lactation supportive services, in Nevada. The authors also thank Dr. Siddharth Raich of NOMHE for his guidance and feedback throughout the writing process. This paper references publicly available data from the Centers for Disease Control and Prevention, including the Behavioral Risk Factor Surveillance System (BRFSS); the Pregnancy Risk Assessment Monitoring System (PRAMS); the National Immunization Survey-Child; the National Vital Statistics System; the Health Resources and Services Administration; and the Nevada Health Authority's Office of Analytics.

The white paper was also reviewed by Nevada Medicaid to ensure no contradiction of policy context was present in the paper.

All analytical conclusions, interpretations and recommendations contained in this report were developed by the authors Certain elements in this report, including diagrams, conceptual models, and illustrative graphics, were generated with the assistance of artificial intelligence (AI) tools. Figure 3 was enhanced to show Nevada using AI, and colors for graphs and regions were enhanced using AI in Figures 4, 5, and 6. The use of AI tools does not replace professional judgment, subject matter expertise or statutory and regulatory requirements. Readers should rely on verified data sources, official policies and engineering or public health standards when making decisions or forming conclusions.

The findings and conclusions are those of the authors and do not represent the official position of these agencies.