Collaboration between WIC and Managed Care: A Resource Guide

Executive Summary

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Preface

Health care professionals and program staff who provide services to low-income pregnant women, infants, and children can help their clients better if they know how their services and programs relate to each other—in terms of eligibility, resources, and objectives. More than one in three pregnant women in the United States participate in the Special Supplemental Nutrition Program for Women, Infants and Children, known as WIC, and most of them are also eligible for Medicaid. Large numbers of infants and children also receive Medicaid benefits or health insurance provided by the State Children’s Health Insurance Program (SCHIP), and an increasing proportion of all Medicaid and SCHIP beneficiaries are also required to enroll in managed care plans. Mothers and children who receive WIC and publicly funded health care through a managed care plan may benefit more and find services more convenient when communications and services are coordinated. Such coordination, and ultimately, collaboration, can be facilitated by the state agencies responsible for administering WIC, Medicaid, and SCHIP.

This guide is intended to help state and local WIC program staff and managed care organizations (MCOs) plan collaborative activities that will improve health and nutrition outcomes for pregnant women, infants, and children. The guide describes approaches for coordinating WIC and managed health care services at the state and local levels. Local collaboration initiatives between WIC and managed care organizations (MCOs) are presented, together with specific strategies that can make collaboration easier.

The content of this guide relies on studies conducted and data collected at the Women’s and Children’s Center, Rollins School of Public Health, at Emory University in Atlanta. Between 1999 and 2000, we visited WIC programs that reported collaborations with managed care; we surveyed state and local WIC directors; and we analyzed data collected from co-located WIC and managed care providers.

This guide is intended primarily for decision-makers in managed care organizations and Medicaid agencies who work on quality improvement; for state and local health and WIC agencies, and for health care providers serving mothers, infants, and children enrolled in publicly funded managed care plans.

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Executive Summary—Resource Guide

In many communities, managed care now affects the way three national government programs help low-income women and children meet their health and nutritional needs. These large programs are: (1) Medicaid, which pays for more than one-third of all U.S. births and insures 22 million children under age 21; (2) the State Children’s Health Insurance Program (SCHIP), which extends health insurance coverage for poor children; and (3) the U.S. Department of Agriculture's Supplemental Nutrition Program for Women, Infants, and Children (WIC), which provides food supplements and nutrition education.

Since 1995, states have increasingly required that most women and children who are Medicaid or SCHIP beneficiaries must also enroll in managed care organizations (MCOs). At the same time, states have expanded publicly funded insurance for these groups. These changes have altered patterns of funding and communication between local government agencies, health care providers, and patients. They have produced new relationships and created more opportunities for collaboration. WIC programs, health care providers, and MCOs that contract with Medicaid must now take steps to coordinate services, to reach and serve more people, and to improve the quality of care.

The purpose of this resource guide is to show how WIC and managed care organizations can collaborate to promote health for the low-income women and children who participate in both programs.

The guide:

1. Reviews the health goals of WIC and managed care and how they interrelate.

2. Describes examples of collaboration and improved communication taking place between WIC and MCOs in locales across the United States.
3. Shows how joint or shared program activities can be coordinated in local settings.

4. Shares ideas about how to improve collaboration—gathered from a survey of WIC directors and managed care organizations and from program site visits conducted in 1999 and 2000.

5. Presents forms and sample documents from specific sites to illustrate how administrators coordinate WIC and managed care services to serve their similar client populations.

**Rationale for collaboration**

Collaboration or coordination between WIC programs and managed care organizations contracted with Medicaid and/or SCHIP is desirable for several reasons.

**Client similarities.** All pregnant women, infants, and children 4 years of age and younger with family incomes less than 185% of the federal poverty level are income-eligible for WIC, and most of them are also eligible for Medicaid or SCHIP. (See Table 1.) Conversely, all Medicaid beneficiaries in the age groups covered by WIC are income-eligible for WIC, by federal law. In local communities, most WIC participants are also enrolled in Medicaid.

**Legal requirements.** In 1989 federal legislation required all Medicaid programs to refer beneficiaries to WIC, and in 1995 official policy memoranda issued by the Health Care Financing Administration and USDA extended this provision to managed care organizations contracted with Medicaid. This requirement is specified in Public Law 103-448. Consequently, health care providers participating in a managed care arrangement financed by Medicaid must refer potentially eligible patients to WIC and supply medical information to WIC staff.

**Complementary strengths.** Managed care organizations, which formerly served mainly middle-income families, now enroll families who are harder to serve, who speak different languages, and who potentially have more medical and social problems. Community-based WIC programs, on the other hand, are experienced in serving culturally diverse groups and know how to respond to the needs of low-income pregnant women and young children. Conversely, managed care organizations can enhance WIC services by offering expertise in provider relations, information technology, and financial accountability. They can also refer clients for nutrition counseling and education.

**Overlapping goals.** WIC and managed care organizations share the same purpose: to improve health and nutritional outcomes for pregnant women, infants, and young children. Both WIC and managed care organizations use public funds to assure access to needed health, nutrition, and supportive services for the most vulnerable groups of
pregnant women, infants, and children in a range of community settings. Both programs seek to maximize program benefits, expand enrollment, improve quality of services, increase customer satisfaction, help families obtain supportive services, and promote health-enhancing behaviors. Both have patients who need special attention for medical care and nutritional education and supplements.

Current Situation

Although the merits of collaboration between WIC and managed care programs seem obvious, and the potential benefits to clients desirable, achieving it in practice at the local level is much more difficult. Administration of the two programs is governed by rules and regulations issued by two federal departments, and funding is commonly directed through different state agencies. Moreover, the entitlement Medicaid program funding involves state and federal matches, while the annual funding for WIC in each state comes almost entirely from a USDA grant. Managed care organizations operate specific programs for the Medicaid population, sometimes in more than one state, and staff may not be available in all local sites.

Three kinds of relationships generally characterize collaboration between WIC and managed care organizations:

- Relationships between WIC programs and Medicaid/SCHIP agencies.
- Relationships between local WIC programs and primary health care providers that belong to managed care networks.
- Relationships between state and local WIC programs and the clinical and/or administrative directors of MCOs that have contracts with state Medicaid agencies.

In preparation for writing this resource guide, the author and colleagues conducted national surveys of state and local WIC directors. Findings show that as of the year 2000, WIC and Medicaid agency representatives meet at least twice a year in 53% of responding states; and that specific arrangements for coordination between WIC and managed care organizations have been developed in 26%. In about one third (32%), WIC has a designated liaison person to coordinate services with managed care organizations.

State agencies, in particular, can play key roles in promoting local collaborations between WIC services and Medicaid-contracted MCOs and their providers. State health departments, WIC program directors, and Medicaid agencies can facilitate collaborations by dedicating special resources and initiating planning activities. For example, the state Medicaid agency can include provisions about coordination with WIC in managed care contracts or regulatory processes, or it can monitor compliance with requirements and evaluate outcomes.
Examples of collaboration

Based on the national surveys and interviews during site visits, this guide describes how collaboration projects and administrative protocols have been put into place in California, Wisconsin, Virginia, Michigan, and other states. The following two program examples, cited in the guide, illustrate the potential of WIC–managed care collaboration.

**The Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP)** recently began an initiative to promote collaborations between WCLPPP, WIC, and local managed care organizations. The Wisconsin Public Health Division prepared a document titled “Partnerships for Healthy Kids” to aid this process and to promote screening for lead for all children enrolled in WIC and managed care organizations. The Wisconsin WIC program director has made numerous presentations to Wisconsin managed care organizations to explain the benefits of collaborating with WIC on lead screening and immunization. Issues that must be analyzed and worked through include, among others, billing and information-sharing practices between public health departments, providers, and managed care organizations; and reimbursement mechanisms for lead screening services.

**Michigan’s OmniCare Health Plan**, a federally qualified health maintenance organization and a subsidiary of United American Healthcare Corporation, delivers health care to 100,000 members in five Detroit-area Michigan counties. OmniCare has offered WIC services for over 23 years at participating health care provider offices through a subcontract with the City of Detroit Health Department, a local WIC agency. WIC services reach approximately 2,500 participants on a weekly schedule at 20 different offices, delivered by a staff of five, including a supervisor (registered dietitian), a clerk, and three nutrition technicians. Most pregnant members of OmniCare participate in the Plan’s WIC program, receiving WIC services at the 20 sites managed by OmniCare WIC staff. United American Healthcare Corporation employs the WIC staff members and covers a portion of expenses. OmniCare conducts outreach for WIC by informing employers, health care providers, and plan members of the availability of WIC services at provider sites, and displays WIC posters at all primary care offices.

This guide also illustrates how state and local WIC directors, managed care organizations, and health care providers can collaborate to achieve specific health objectives for their clients. Two of many types of proposed collaborative activities concern breastfeeding and early childhood nutrition. (See Table 3)
Breastfeeding promotion

To ensure healthier babies, many local WIC programs have greatly increased activities that support breastfeeding over the past decade. WIC staff actively promote breastfeeding by training peer counselors, organizing support groups, offering special classes, and presenting written and audiovisual educational materials. In many states, WIC staff have led the way by organizing coalitions to advocate policies that favor and promote breastfeeding and educate health care providers.

Partnerships to promote breastfeeding could work like this:

**WIC agencies could:**

- Offer pregnant women group and individual breastfeeding education.
- Sponsor breastfeeding hotlines.
- Offer lactation consultation and referrals.
- Provide breast pumps purchased with WIC food funds (new USDA policy).
- Participate in and sponsor breastfeeding coalitions.

**Medicaid managed care organizations** could:

- Issue policies on breastfeeding and educate providers.
- Participate in community breastfeeding coalitions.
- Make breast pumps and lactation consultants available.
- Provide prompt case management support, including home visits, to breastfeeding mothers with problems.

**Health care providers** could:

- Educate patients about breastfeeding education and refer to WIC for additional education and support.
- Refer patients to lactation consultants when needed.
- Prescribe breast pumps for lactating mothers.

Early childhood nutrition

Risks for poor nutrition remain greatest in low-income children in comparison to other children. In recent years, there has been an increase in the proportion of overweight children, especially among Hispanic and Native American populations. WIC screens infants and young children for nutritional risks and gives high priority to those with risk factors. Young children who consume WIC food packages have higher intakes of protein, calcium, iron, folic acid, and vitamin E than low-income children who do not receive WIC supplements. Also, WIC limits the fat, sugar, and sodium content in its food packages,
in accord with concerns about the contribution of these foods to health and nutrition problems.

WIC and managed care organizations could work in partnership to improve early childhood nutrition:

**WIC** could:

- Complete dietary histories for toddlers.
- Monitor height for weight at each infant’s visit.
- Offer individual counseling for high-risk individuals.
- Notify primary care providers about high-risk individuals.

**Managed care organizations** could:

- Inform providers of WIC’s role in child nutrition.
- Reimburse WIC for medical nutrition therapy when needed.

**Health care providers** could:

- Refer high risk children to WIC for an individual care plan.
- Prescribe medical nutrition therapy for children with very high risk conditions.

**Barriers/solutions for collaboration**

A growing number of local WIC agencies and managed care organizations have established excellent working relationships to improve care for jointly enrolled participants. They have achieved success despite obstacles that once appeared formidable. Most of these barriers to collaboration exist because of the differences in the two organizational/professional cultures and because of a lack of shared information about each other’s organizational purposes and activities.

Among the barriers the two groups must overcome are the following:
- State Medicaid agencies may not have initiated specific contractual requirements for managed care organizations or providers to make referrals or supply medical information to WIC.

- WIC staff do not understand the managed care system, and managed care organizations do not understand what WIC does.

- Coordination and communication with managed care organizations is difficult when MCO ownership changes, when Medicaid contracts are terminated, or when the MCO headquarters are located in a state different from the WIC agency.

Information provided by state and local WIC directors suggests that WIC agencies and managed care organizations can seek and find ways to resolve issues that impede coordination. Managed care organizations that contract with Medicaid have much to learn about each state’s system of public health services, including WIC, which low-income clients rely on. Similarly, WIC agencies (accustomed to coordinating with health care providers directly) now must learn to communicate effectively with managed care organization administrators in order to coordinate services. State and local examples of coordination and collaboration cited in the guide suggest that, in many cases, public health programs like WIC can help managed care organizations meet quality services and customer satisfaction goals, as well as address long-term health promotion goals.

The resource guide’s final chapter provides many descriptions of state and local coordination, citing contacts for each. The [internet links] display samples of forms and memoranda to show how collaboration can be organized and documented. An itemized suggestion checklist (See Table 4) completes the document.

**Specific Actions Needed**

Collaboration between WIC and Medicaid managed care has the potential to improve health outcomes for vulnerable populations enrolled in both programs, by increasing access to healthy food and preventive services and by promoting healthy behaviors. However, collaboration between WIC and Medicaid managed care organizations will not succeed without the involvement of state and local public health and medical assistance agencies.

WIC staff can refer uninsured participants to Medicaid or SCHIP, assist high-risk participants to obtain health care or social services, and counsel them about nutritional problems in coordination with managed care providers. Managed care organizations can assist health care providers to supply medical information to WIC, refer patients to WIC for nutritional counseling, and work with WIC to implement health promotion initiatives.
Specific recommendations to facilitate and promote collaborative efforts between WIC and MCOs are listed separately for state Medicaid agencies and health departments, state WIC programs, and managed care organizations.

1. **State Medicaid agencies and health departments** should consider:
   - Adding or revising contract requirements with MCOs to require coordination with WIC.
   - Assigning staff to be responsible for overseeing coordination between WIC and MCOs.
   - Establishing administrative guidelines for coordination and overcoming obstacles to collaboration between WIC and MCOs.
   - Facilitating joint health promotion and breastfeeding initiatives.

2. **State WIC programs** should provide more support and information to help local WIC directors coordinate with managed care organizations. Particular needs include:
   - Establishing contractual relationships between local WIC agencies and MCOs.
   - Collaborating on joint health promotion and nutrition activities with MCOs.
   - Setting up outreach and referral relationships with MCOs.

3. **Managed care organizations** contracted with Medicaid should help their providers coordinate with WIC through:
   - Appointing liaison staff to meet regularly with local WIC program directors.
   - Educating their staff on a regular basis about WIC.
   - Issuing directives about referral and supply of medical information to WIC.
   - Supporting joint health promotion initiatives.
   - Encouraging co-location of WIC and health care services.

While surveys indicate that, to date, collaboration has been uneven across the country, some states are moving ahead by offering guidance, incentives, and directives. An essential component is the strong involvement of state and local public health officials and medical assistance agency administrators. Likewise, sustained attention and support from WIC program leaders is also necessary—and ways to reimburse WIC staff for additional responsibilities may be needed. USDA funds alone will not accomplish collaboration goals because of budget restraints and procedural guidelines.
Coordination planning between WIC and managed care organizations should involve discussions with front-line workers at the outset—to identify obstacles and develop strategies for removing them. The collaborations that emerge will then have the potential to improve the health of communities and establish models for managed care systems.


2 Ibid. Suggested medical information includes “nutrition related metabolic disease; diabetes; low birth weight; failure to thrive; infants of alcoholic, mentally retarded or drug addicted mothers; AIDS; allergy or intolerance that affects nutritional status; and anemia.”