Collaboration between WIC and Managed Care: A Resource Guide
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By Karen N. Bell, MPH

Funded by the Center for Health Care Strategies, Inc.
under the Robert Wood Johnson Foundation’s
Medicaid Managed Care Program

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Executive Summary

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Acknowledgments

A grant from the Center for Health Care Strategies, Inc. under the Robert Wood Johnson Foundation’s Managed Care Program provided the support to develop this guide. The National Immunization Program at the Centers for Disease Control and Prevention funded some of the background research and the site visits to state and local WIC programs through a grant to the Women’s and Children’s Center under a cooperative agreement with the Association of Schools of Public Health. The National Association of WIC Directors collaborated with and supported the three national surveys of state and local WIC directors.

I am grateful to the following individuals who contributed ideas and encouragement for the background research and made important suggestions on the content and organization of the guide: Alan P. Kendal, PhD. and Carol Hogue, PhD., MPH, at the Women’s and Children’s Center, Ann Salyer-Caldwell, RD, MPH, former president of the National Association of Local WIC Directors, and Lauren Waits, MSPH at the Child Policy Center, Georgia State University. Beth Atkins Clinton, MPH, edited the guide and advised on its design.

This document could not have been written without the assistance and support from numerous state and local WIC directors who generously shared their time and ideas about coordination and collaboration with state Medicaid agencies and with managed care organizations. Those individuals who helped by writing or editing descriptions of their collaborative efforts are listed as contacts under each example. In addition, staff from managed care organizations made many valuable suggestions on early drafts of the guide and shared their perspectives about collaboration with WIC.
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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Atlanta, Georgia
May 2001
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.¹ 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 information² 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)
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.”
1. Collaboration advances program goals

WIC, Medicaid, and the State Children’s Health Insurance Program (SCHIP) are federal programs recognized by Congress as essential to promoting the well-being and health of low-income pregnant women and young children. Expansions in eligibility and funding over recent years attest to the significance of these efforts. Managed care organizations with state Medicaid contracts have an important role to play in furthering this goal because the state agencies that administer public medical care assistance require most beneficiaries to enroll in managed care. This is a change that has created new relationships between public health programs, managed care organizations, private physicians, and low-income families.

These new relationships make collaboration desirable. First, in most states, eligibility for Medicaid and WIC overlaps considerably for pregnant women, infants, and children through age 4. Most Medicaid beneficiaries in this group are income-eligible for WIC, and conversely, the majority of pregnant women, infants, and young children enrolled in WIC are eligible for Medicaid (or SCHIP, in the case of a small proportion of 2-4 year olds). Second, the managed care organizations that assume responsibility for providing health care to Medicaid and SCHIP beneficiaries are assuming a role that is shared with state and local public health agencies, including WIC. Third, private health care providers that participate in managed care plans serving Medicaid and SCHIP beneficiaries are expected to follow federal and state guidelines for clinical and preventive services that meet quality standards, including referrals and coordination with public health programs. Finally, to get the services they need, families with members enrolled in WIC, Medicaid, and a managed care plan must follow rules and guidelines established by three different organizational entities.

Public health and managed care partners each have a great deal to gain from collaboration.

Enrollment in WIC, Medicaid and/or SCHIP occurs during some of the most vulnerable periods in the lives of low-income families, when nutritional, medical, and social service needs are at a maximum. While the managed care organizations and providers and the WIC programs are accountable to different sets of funding and regulatory agencies, they are ultimately in business to improve the health and well-being of the people served. The collaborative initiatives and coordination arrangements that we have documented in some states, between the WIC program and managed care organizations contracted with state Medicaid agencies, suggest that collaboration would improve access to services and have the potential to improve outcomes for women, infants, and children living in or near poverty. Public health and managed care partners
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each have a great deal to gain from collaboration in terms of shared expertise, resources, and achievement of common objectives.³

WIC  The US Dept. of Agriculture's WIC Program reaches more than 7 million people each month, including more than 1.5 million low-income women and over 5.5 million infants and children.⁴ Nearly 48 percent of all babies born in the U.S. receive WIC benefits, and most of these deliveries are covered by Medicaid. By federal law, since 1990, all of the pregnant women, infants, and children who are eligible for Medicaid are income-eligible for WIC.⁵ This provision also applies to young children who enroll in the State Children's Health Insurance Program (SCHIP) in states that used Medicaid expansions for SCHIP. Many states are now requiring pregnant women, infants, and children eligible for Medicaid to enroll in a managed care plan, creating substantial overlap in WIC and Medicaid/SCHIP managed care participants.⁶

Managed care organizations  As a result of state Medicaid program changes, low-income women and children are a growing proportion of the enrollment of managed care plans in the United States, the 1997 Balanced Budget Act gives state Medicaid programs the flexibility to mandate enrollment in managed care for most groups of pregnant women and children as a condition of Medicaid coverage.⁷ (See Glossary of Terms on page 4.) In this document, the term “managed care plan” refers to the scope of services and set of relationships, typically written in a contract issued by the state Medicaid agency, that determine how a plan enrollee obtains health care. The term “managed care organization” (MCO) refers to the organizational entity that holds the contract with the state Medicaid agency to administer one or more managed care plans for Medicaid and/or SCHIP beneficiaries. The MCO may administer more than one plan. More than half (56 percent) of all Medicaid beneficiaries are now enrolled in managed care, an increase from 40 percent in mid 1996.⁸ Delivering quality health care to this population poses new challenges for MCOs that have traditionally enrolled middle-income populations. Health care plans and providers must address issues of poverty, weak health care infrastructure, and cultural competence, as well as relatively short Medicaid coverage periods for many enrollees.

More than half (56 percent) of all Medicaid beneficiaries in the United States are now enrolled in managed care.

Most managed care enrollees who are also Medicaid beneficiaries are now in some type of comprehensive managed care organization or a prepaid health plan rather than in a primary care "gatekeeper" or case management arrangement. These arrangements give managed care organizations greater incentive to support initiatives that can improve health and nutritional outcomes for women and children. Indeed, the American Association of Health Plans for several years has sought to raise awareness about new health promotion initiatives that member organizations have undertaken. These are often targeted on the most vulnerable groups of women and children. For example, school-age fitness, smoking cessation, and violence prevention have been highlighted.⁹
Other MCOs have established strong partnerships with local boards of health to create a unified community health care system.\textsuperscript{10}

**Collaboration benefits WIC and managed care enrollees**

Local and state collaboration between WIC programs and managed care organizations that enroll Medicaid beneficiaries can benefit both partners by increasing enrollment in both programs, enhancing program benefits through early enrollments and care coordination, improving health outcomes, and increasing customer satisfaction. WIC programs serve pregnant, postpartum, and breastfeeding women and infants and children up to age 5 in public health or community-based settings. WIC is connected to a wide array of community resources, and staff know how to reach out to and communicate with vulnerable populations. Managed care organizations can supply expertise in provider relations, information technology, and finance.\textsuperscript{11}

Close to 2,000 local WIC programs have staff in about 10,000 locations, making them easily accessible to managed care patients. Many of the WIC programs are sponsored by health agencies, and between 20 to 25\% of local WIC sites are co-located with primary health care.\textsuperscript{12} WIC participants come to WIC sites every one to three months to receive food vouchers, nutrition education, and referrals to other services. During certification visits—approximately every six months—WIC staff identify participants who need more intensive services to help them comply with recommendations in areas such as diet, support in the home, and infant feeding.

For their part, managed care organizations frequently have a stated mission to serve the community in addition to enrolled members. Their marketing and communications expertise can contribute to collaborative projects when target audiences need to be identified and new materials created. Managed care organizations also have effective means of motivating providers to work toward improved patient outcomes. For example, MCOs may have quality assurance and monitoring systems that send providers timely feedback about the numbers of patients who receive selected preventive services. They may also have systems for communicating directly with enrolled members to remind them to go to their providers for preventive services or to let them know about new benefits and health promotion activities.\textsuperscript{13}

Congress has expanded funding and encouraged states to review enrollment procedures for WIC, Medicaid, and SCHIP in an effort to assure access to health and nutrition services for vulnerable women and children. To encourage all eligible persons to apply, most state programs have simplified application procedures, conducted outreach campaigns, and established referral systems. Activities to facilitate enrollment are much more important now that welfare reform has severed the "automatic enrollment ties" between Medicaid
and welfare. In addition, women with children who work or attend school find it difficult to comply with time-consuming requirements for program recertification. WIC programs, which see participants every two months on average, are potentially in an excellent position to assist people eligible for Medicaid and SCHIP to complete enrollment and recertification procedures. Without such compliance, managed care organizations contracting with Medicaid and SCHIP encounter barriers in serving members whose Medicaid enrollment is temporarily suspended. All WIC programs are required to give participants written information about how they can apply to Medicaid and where to go for help. Most programs now have partnerships with WIC/SCHIP agencies to distribute eligibility information to participants. State Medicaid agencies have the option of using outreach and enrollment funds to outstation eligibility workers at WIC programs to screen program participants for Medicaid and SCHIP eligibility and help them complete applications.

A February 1998 White House memorandum to seven federal department heads, including the Secretary of Agriculture, instructed them to prepare agency-specific MCOs to increase enrollment of uninsured children in Medicaid and the new State Children's Health Insurance Program. The USDA response, as summarized on the agency’s Web site, states that WIC programs must refer beneficiaries not enrolled in Medicaid to the program and give them written information about applying (if feasible, consolidating WIC, Medicaid, and SCHIP program applications). As more SCHIP beneficiaries enroll in managed care, more children will benefit from coordination mechanisms between WIC and MCOs.

In counties where Medicaid beneficiaries are required to enroll in managed care, they typically have to select one of two to five different MCOs, a process sometimes facilitated by neutral brokering organizations. Some states have encouraged brokers to come to WIC sites and explain these choices to participants enrolled in Medicaid. Women in many communities are accustomed to receiving referrals and advice from WIC program staff about health, nutrition, and other family needs.

**Maximize program benefits**

Participation in WIC and managed care can enhance nutrition and health benefits to women, infants, and children by improving utilization of preventive services and enhancing access to specialists, thereby decreasing the likelihood of poor birth outcomes, infant feeding problems, and unhealthy patterns of weight gain or loss. Such benefits can also reduce shorten or avoid the costly hospital stays that threaten the financial viability of MCOs. Managed care organizations and local WIC programs can jointly promote these types of benefits by conducting outreach to encourage program participation. They can also train providers about WIC and other services needed by low-income women, and can facilitate direct communication between WIC nutritionists and health care providers about the care of high risk patients.
Women who enroll in WIC during the first trimester of pregnancy gain more weight during pregnancy and are less likely to deliver small-for-gestational-age infants. Benefits from early WIC participation include increased consumption of food packages, early exposure to nutrition counseling, and more opportunities to participate in nutrition education and other health promotion interventions offered by WIC programs. Women with poor dietary habits and substance abuse are especially likely to benefit from such counseling and education during pregnancy. WIC staff discuss the benefits of breastfeeding with pregnant women prior to delivery, a topic that some obstetricians do not introduce.

Similarly, early enrollment in prenatal care is associated with better birth outcomes and lower costs of maternity and infant care. Evidence from multiple studies indicates that comprehensive prenatal care, including family supportive services and health education, has a positive impact on birth outcomes. Ideally, obstetricians and prenatal care nurses make sure that women needing additional services understand their importance. Many pregnant women can benefit from dietary counseling during WIC visits, especially when referred by prenatal care providers. In addition, WIC staff give pregnant women the extra time and assistance they need to comply with recommendations made by prenatal care providers.

Managed care organizations are increasingly held accountable for the achievement of preventive health service goals, such as the measures in the National Committee on Quality Assurance's Health Plan and Employer Data and Information Set (HEDIS). Achieving those goals with Medicaid beneficiaries requires extra attention to outreach, referral, and support services, including partnerships with other community agencies serving the same populations. WIC programs are in an ideal position to conduct outreach, screening, and referral for preventive services such as prenatal care, immunizations, and well-baby checkups. They also collect data about the health risks of participants as well as services received and Medicaid status.

The recent increases in immunization coverage among infants and toddlers have occurred in part because of WIC efforts to screen the immunization records of infants and toddlers, and refer those needing immunizations to their health care providers. In some communities, WIC programs refer caregivers and infants to immunization services onsite, a convenience that also underscores the need for coordination mechanisms with health care providers and MCOs. Mothers’ reactions to the role of WIC in promoting compliance with immunizations have generally been positive. They perceive screening and reminders as helpful in improving the health of their children.

WIC nutritionists ask pregnant women enrolling for the first time many questions about health risks, social and family supports, and eating habits. The lengthy interviews are conducted in a non-threatening environment, and WIC staff frequently identify...
issues or concerns that warrant referrals to other services or consultation with an obstetrician.

**Increase customer satisfaction**  Managed care organizations serving vulnerable populations need to develop new ways to reach out to families and provide incentives for them to participate in preventive services. WIC programs make it their "business" to support families to make healthy choices and link them to services, thus making them ideal partners for managed care organizations. Collaboration could range from encouraging primary care providers to offer space for WIC clinics to promoting and facilitating service integration.

A 1999 survey conducted by the National Quality Research Center at the University of Michigan (commissioned by the President's Management Council) found that WIC received the second highest consumer satisfaction rating from participants, when compared to other government programs. The index used is identical to that used by hundreds of private companies to measure the quality of their goods and services. WIC participants who go to WIC clinics that are co-located with health care services also report greater satisfaction than those who attend free-standing WIC sites. Approximately half of local WIC programs are co-located with health services, and many WIC activities are integrated with those of health care. Increasingly, these health care providers also participate in one or more managed care health organizations.

**Help families obtain supportive services**  Low-income women who receive services from WIC, and Medicaid providers that coordinate services or co-locate services, may find it easier to obtain the interventions they need to ensure better health outcomes for themselves and their children. One of the core WIC missions is to help link mothers and children to services during pregnancy and early childhood. Frequently, these families need help with food, housing, filling out application forms, and links to specialty medical care. WIC staff can help ensure that mothers actually follow through with the recommendations of their health care providers.

Many WIC programs are sponsored by or housed together with local agencies that do outreach and case management for high risk pregnant women and infants. Managed care organizations that serve Medicaid and SCHIP populations may already have contractual relationships with these local agencies. Such relationships should include WIC whenever possible to integrate nutrition services. If contractual agreements have not been established, MCOs should become familiar with WIC programs and the other services provided by their parent agencies and affiliates.

**Promote health-enhancing behaviors**  Pregnant women eligible for both WIC and Medicaid suffer disproportionately from health and nutritional risks associated with poverty, including greater likelihood of delivering a low-
birthweight infant, of gaining insufficient weight during pregnancy, and poor diets. These high risk women can benefit substantially from participation in health education classes and from individual counseling that targets specific risk factors such as smoking and substance abuse, or poor diets and dental hygiene. Their infants are more likely to be under-immunized and have developmental delays, while their toddlers and young children are more likely to be overweight and underweight, exposed to high levels of lead in the environment, and have asthma or tooth decay.

All WIC programs offer nutrition counseling, and most now offer group education classes. WIC participants are not required to participate in the classes in order to receive food vouchers, but they are strongly encouraged to do so. The range of topics covered in group classes has expanded to include, in many cases, dental health, parenting skills, smoking cessation, and child safety. A rich variety of health education materials, including videos, are used in the group sessions conducted by nutrition assistants or nutritionists.

Offering health education interventions in collaboration with WIC presents many opportunities for managed care organizations wishing to document the cost-effectiveness of their efforts. WIC screens all participants for high risk health behaviors and conditions, and can tailor health education referrals appropriately. WIC staff see participants every two to three months, at a minimum, a program feature that permits multiple referrals and tracking with little added cost.

**Collaborative relationships meet formal requirements**

Both local WIC agencies and MCOs that contract with Medicaid/SCHIP are required to comply with federal and/or state regulations governing all aspects of program operations, in some cases including formal communications with other agencies serving the same population. Collaboration between WIC and Medicaid managed care organizations may involve three kinds of relationships:
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- Relationships between WIC programs and Medicaid/SCHIP agencies.
- Relationships between the local WIC program and primary health care providers that belong to managed care networks.
- Relationships between the state and local WIC programs and the managed care organizations that have contracts with state Medicaid agencies.

Medicaid providers have for many years been required to refer patients to WIC as well as provide medical information to WIC programs upon request, as part of nutritional and health status assessments. A 1995 directive from the Health Care Financing Administration to state Medicaid agencies makes it clear that managed care providers are included in these requirements, as specified in Public Law 103-448. In response, some state Medicaid agencies have begun to include language about WIC in their contracts with managed care organizations, specifying that MCOs must inform their members about WIC and encouraging them to use WIC services.

In New Hampshire for example, the Department of Health and Human Services has included WIC coordination requirements and documentation procedures in its model contract with MCOs. The model contract states:

*Coordination with the Supplemental Nutrition Program for Women, Infants, and Children (WIC). Provide documentation that demonstrates compliance with Exhibit A.3, Covered Services, Section II, E:*
  a. a systematic process for generating referrals;
  b. ongoing coordination efforts such as meetings, with (WIC); and
  c. flow charts and referral forms.

To fulfill this requirement, the MCO promises:

*MTHP and its providers currently refer and will continue to refer appropriate enrollees to the WIC program. This will be tracked and measured. Both Lahey Hitchcock Clinic providers and IPA providers utilize referral forms to appropriate Medicaid enrollees to the WIC program. Providers will continue to be educated regarding any changes in the program by MTHP’s social worker, just as the social worker will educate all providers and appropriate MTHP staff regarding all available State Supported Services as well as MTHP’s Special Programs and Education. A copy of the WIC referral form is available in providers’ offices for their use as needed.*

The 1998 model contract used by Kansas for managed care organizations contains the following provision:
States using managed care arrangements to service their Medicaid beneficiaries must assure that coordination exists between the WIC and Medicaid Managed Care Programs. This coordination should include the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by providers working within Medicaid managed care MCOs to the WIC Program. To accommodate the various ways a provider may determine nutritional risk, the attached form (Appendix G) provides for the release of information as requested by the WIC Program. The WIC Program in the State of Kansas is coordinated through the Local Health Departments. HMOs are expected to subcontract or coordinate with the Local Health Departments in their areas.

Florida’s 1998 HMO Contract contains provisions related to WIC and nutritional needs.

The plan shall refer all pregnant, breastfeeding, and postpartum women, infants, and children up to age 5 to the local Women, Infants, and Children (WIC) office by completing the Florida WIC program Medical Referral Form with the current height, weight, (taken within 60 days), hemoglobin, or hematocrit (taken within 90 days for members over six months of age), and any identified medical/nutritional problems for the WIC referral and for all subsequent certifications. The plan shall ensure the provider provides a copy of the WIC referral to the member and retains a copy in the member's record. The plan shall ensure the provider provides nutrition assessment and counseling to all pregnant members. Individualized diet counseling and a nutrition care plan is to be provided by public health nutritionists, nurses, or physicians following nutrition assessments.
COLLABORATION BETWEEN WIC AND MANAGED CARE


4 www.fns.usda.gov/wic/menu/FAQ


16 U.S. Code, 42 USC Sec. 1786, chapter 13A - Child Health and Nutrition., a), (4) A.


COLLABORATION BETWEEN WIC AND MANAGED CARE


34 [PDF 009]. Ibid.


2. **Collaboration promotes health goals**

By working together, WIC and managed care organizations contracted with Medicaid can promote better health outcomes for jointly enrolled low-income pregnant and breastfeeding women, infants, and children. For example, MCOs encourage early initiation of prenatal care and compliance with obstetrician recommendations, as do WIC programs. Managed care organizations also seek to increase early childhood immunization rates, and WIC programs provide immunization referrals for infants and toddlers who are not up to date. Collaboration between managed care organizations and WIC has the potential to make breastfeeding promotion initiatives more effective by improving outreach and reinforcing educational messages and services such as lactation consultation. Finally, recent studies and guidelines on early childhood nutrition highlight the need to reduce childhood obesity and educate mothers about infant feeding, an objective that no single program can easily achieve.

WIC can also work with health care providers and public health agencies to achieve national health objectives related to maternal and child health and nutrition. Many of the Healthy People 2010 objectives relate closely to WIC’s mission to assure adequate nutrition for pregnant women, promote breastfeeding, and teach healthy eating habits to mothers with infants and young children. All of the objectives listed in Table 2 are consistent with WIC food benefits and educational activities. Local WIC agencies reinforce the messages given by primary health care providers and public health clinics to their patients.

The following sections describe specific ways in which WIC agencies can work collaboratively with health care to promote healthier outcomes for low-income women, infants, and children. Copies of forms and materials developed by WIC agencies and managed care organizations appear in the final section of this document. Table 3 summarizes the roles of WIC agencies, managed care organizations, and managed care providers for each health objective.

**Enhance prenatal care and decrease likelihood of low birthweight**

There is a well-documented relationship between prenatal care and higher birthweight and lower risk of preterm delivery. Prenatal care ideally includes three important
components: early and continuing risk assessment, health promotion, and medical and psychosocial interventions and follow-up. Early initiation of prenatal care and participation in perinatal case management can increase the effectiveness of screening tests for genetic and metabolic disorders and increase the likelihood of detecting and reducing risks to the fetus from maternal smoking, alcohol use, or substance abuse. Health promotion activities and education received during pregnancy can also reduce risks to infant health by increasing the mother's awareness of safety hazards, the importance of breastfeeding, and increasing her confidence.

Low birthweight (LBW) is still a significant problem in the United States. It affected 7.6 percent of all births in 1998, and 13 percent of births to black women. Women with incomes below poverty level and low educational attainment are also at increased risk of having LBW babies. Low birthweight, defined as a birthweight of <2500g (5.5 pounds) is an important public health issue because of the relationship between LBW and infant mortality. LBW is also associated with increased risk of neurological problems, mental retardation, and lower respiratory tract disorders later in a child’s life. In addition to its relationship with infant mortality and morbidity, LBW’s cost to the health care system is significant. In one study medical costs for very low birthweight infants (<1500g) in the first 60 days of life were 9 to 12 times those of normal weight infants (2500+g).

WIC participation has been shown to be associated with reductions in low birthweight. A 1992 GAO report estimated that, for infants born in 1990, provision of WIC services could produce over $423 million in savings to private payers and hospitals, three-fourths of which would accrue in the first year of life. These reductions are due to a lower rate of preterm births as well as lower incidence of small-for-gestational age infants. Women who enroll early in WIC receive the maximum benefit from the food packages provided each month, as well as from the nutritional counseling and education initiated at the first WIC visit. Low birthweight is also associated with maternal behaviors such as smoking, which is one of the risk factors flagged by WIC programs for education and counseling. Women enrolled in Medicaid who are at high risk for low birthweight, and who receive perinatal high risk case management services within a managed care organization, should also be referred to WIC.

Low-income women, such as those served by WIC and Medicaid, and women with limited educational attainment may benefit substantially from early commencement of prenatal care and any associated interventions that can reduce risks to mother or fetus. Prenatal participation in WIC enhances the benefits of early prenatal care for this population. WIC visits reinforce the health promotion messages delivered by health care providers, and alert pregnant women to potential risks or topics they should discuss at their next prenatal care visit. For example, prenatal care providers can refer women at high risk for developing eclampsia or gestational diabetes to the WIC nutritionist for extra counseling about ways to reduce salt or sugar in their diets.
Perinatal case management is another effective way to improve birth outcomes for women in this population, and women participating in WIC are more likely to receive case management services. A study of a Medicaid-sponsored support service and case management program showed a reduction in low birthweight births among medically high risk women.

Close coordination between WIC and Medicaid managed care organizations can potentially increase the number of women who receive adequate, timely prenatal care through reinforcement of positive health messages and cross-referrals. When pregnant women enroll in WIC before their first prenatal visit, WIC staff routinely offer assistance and encouragement to make sure that they complete their application for Medicaid and obtain an appointment with a prenatal care provider. Similarly, managed care organizations and prenatal care providers need to make sure that all potentially eligible women are referred to WIC and that medical information reaches WIC clinics. Creation of direct links between WIC and the perinatal case management units of managed care organizations can help ensure that women who are at greatest risk for poor birth outcomes are identified and receive needed services.

**Partnerships to enhance prenatal care and reduce the likelihood of low birthweight call for each program or provider to play a role, such as:**

<table>
<thead>
<tr>
<th><strong>WIC</strong></th>
<th><strong>MCO</strong></th>
<th><strong>Health Care Provider</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer uninsured participants to Medicaid and/or SCHIP.</td>
<td>Provide free pregnancy tests and referrals to prenatal care.</td>
<td>Refer to WIC if not already enrolled.</td>
</tr>
<tr>
<td>Refer participants to managed care enrollment brokers or MCOs as appropriate.</td>
<td>Conduct orientation sessions at WIC sites.</td>
<td>Refer to WIC for nutritional counseling.</td>
</tr>
<tr>
<td>Refer participants to perinatal programs for high risk pregnancies, as appropriate.</td>
<td>Analyze delays in processing Medicaid applications.</td>
<td>Communicate with WIC about nutritional needs of high risk patients.</td>
</tr>
<tr>
<td>Refer participants to community-based services.</td>
<td>Provide case management and home visiting.</td>
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</table>
Coordination between WIC and health care providers both encourages early prenatal care and helps to reduce delays in processing Medicaid applications and contingent enrollment in managed care plans. In Solano County, California, the Partnership Healthplan of California (PHC) provides the Growing Healthy Together case management program. This program assists PHC members to access early prenatal care through California’s Comprehensive Perinatal Services Program (CPSP) and thereby secure a WIC enrollment appointment. The PHC Growing Healthy Together Program also promotes WIC attendance. PHC and WIC staff are on many committees together to network and coordinate services. In Massachusetts, some WIC sites are located at provider clinics where most patients are enrolled in Medicaid managed care. Prenatal care clinicians encourage pregnant women to visit WIC on the same day of their clinic appointment. The clinicians also give the clients a special referral form indicating all known risk conditions.47

**Improve maternal nutrition**

Many WIC participants have inadequate diets or nutritional and health concerns such as obesity, diabetes, and hypertension prior to pregnancy. Poor nutrition during pregnancy is associated with lower gestational weight gain, maternal anemia, neural tube defects, and gestational diabetes, all of which may affect birth outcomes.48,49,50 Anemia during pregnancy is a common and significant problem linked to low birthweight and preterm delivery, though a causal relationship has not been established.51 Women enrolled in WIC or in Medicaid are at even greater risk for anemia during pregnancy, as approximately 33% of all pregnant low-income women are anemic.52 WIC staff assess risks to pregnant women for conditions that can be modified through changes in diet and then develop individual care plans. WIC also helps postpartum participants to lose weight by promoting breastfeeding and dietary changes. Although WIC services do not include intensive dietary counseling or “medical nutrition therapy,” as it is termed by health plans, many WIC nutrition professionals are qualified to give this level of care. In some poor communities where medical nutrition therapy may not be readily available as a private service, WIC staff time for this purpose might be able to be expanded through service fee arrangements.

**Providers need continuous education about the health promotion role of WIC.**

Collaboration efforts between WIC and Medicaid managed care organizations can improve overall maternal nutrition by promoting long-term dietary changes that not only improve pregnancy outcomes but also help women attain personal goals of weight loss and reduce the risks of chronic health problems later in life. Managed care organizations can work with WIC agencies on achieving better communication with prenatal care providers to ensure that all pregnant women are screened for nutritional risks and receive appropriate dietary counseling. More than half of all states include nutritional counseling in their Medicaid managed care programs as part of enhanced services for
pregnant women. Health care providers need continuous education about the role of WIC as well as supplies of WIC referral forms and brochures. MCOs can facilitate better access to medical nutrition therapy for WIC participants by developing contractual arrangements with WIC programs and making providers aware of the new service.

**Partnerships to support better maternal nutrition could work like this**

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct nutritional risk assessment and make referrals based on nutritional risk determination.</td>
<td>Promote patient information sharing between providers and WIC through special forms and provider education.</td>
<td>Conduct case conferences with WIC staff.</td>
</tr>
<tr>
<td>Schedule participants for nutritional counseling as needed.</td>
<td>Support WIC-based interventions with pregnant women at risk.</td>
<td>Schedule frequent prenatal visits.</td>
</tr>
<tr>
<td>Provide nutritional counseling and communicate with prenatal care providers.</td>
<td>Reimburse medical nutrition therapy for high risk conditions.</td>
<td>Prescribe nutritional counseling and/or nutrition therapy and refer to WIC.</td>
</tr>
<tr>
<td>Develop individual care plans according to need and participant wishes.</td>
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**Reduce smoking and substance abuse**

Substance abuse is a risk factor in pregnancy identified through routine WIC certification. For this reason WIC programs often include prevention messages along with nutrition education. Excessive alcohol consumption during pregnancy is associated with poor fetal outcomes. Drug use is also a concern. In Solano County, California, WIC staff, with support from a special project grant awarded by the Partnership Healthplan of California, were trained to screen pregnant participants at each certification visit for problems and concerns related to use of illicit substances in their household. Women identified with problems were linked to treatment programs.
Smoking cessation is another common objective of WIC and Medicaid managed care organizations. For example, Contra Costa County WIC Program and Contra Costa Health Plan established a smoking cessation education program with funding from California's Proposition 10. When county WIC staff looked at health risk data from their participants, they discovered that smoking rates were higher than the average for California. WIC offered classes to pregnant participants and to any family member who smoked, and the Health Plan supplied nicotine patches and water bottles (for oral gratification) at no charge. WIC used its own data systems to evaluate the results of this intervention, and documented decreases in smoking. This collaboration is also an example of a joint health promotion effort between WIC and MCOs that has been established through letters of agreement that explicitly delineate expectations and provisions.

Partnerships to reduce smoking and substance abuse, when support for interventions is available, might work like this:

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen for smoking and substance abuse.</td>
<td>Support WIC-based interventions to reduce smoking.</td>
<td>Screen patients and refer to perinatal case management programs.</td>
</tr>
<tr>
<td>Train staff and offer classes such as smoking cessation to WIC participants and family members if program funding is available.</td>
<td>Inform providers about WIC educational activities in newsletters and memos.</td>
<td>Encourage patients to attend smoking cessation classes at WIC when available.</td>
</tr>
<tr>
<td>Schedule visits for high risk women on a monthly basis.</td>
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<td></td>
</tr>
<tr>
<td>Refer women for counseling and treatment for substance abuse when appropriate and contact MCO and providers as needed.</td>
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Contra Costa Smoking Cessation Program: Project Summary

A Smoking Cessation Program was initiated in 1998 by the WIC Program in Contra Costa County, CA, to reduce the rate of tobacco use and exposure to second-hand tobacco smoke among WIC participants and their families. Analysis of WIC Information System data had shown that 33% of WIC participants in the county were exposed to smoke, compared to an average of 24% statewide. The WIC agency received support from state Proposition 10 funds to launch a smoking cessation program in collaboration with the nonprofit, county-government-based Contra Costa Health Plan (CCHP). A smoking cessation curriculum and clinical support and encouragement from health care providers constituted the primary interventions. WIC staff screened all WIC participants for tobacco exposure, prepared individual treatment plans, and scheduled them for a series of six smoking cessation classes at the time of their monthly food voucher pickups. CCHP marketed the program to its Medi-Cal members and providers, and added nicotine patches and nicorette gum to its benefit package. Program evaluation after 17 months showed that the proportion of WIC participants who smoked was cut in half, and the proportion of those exposed to second-hand smoke had decreased as well. The total program cost to WIC was approximately $16,000 for each of the two years funding was available.

Contact: Beverly Clark, WIC Director, Contra Costa Public Health Division, 925-646-5376

Promote breastfeeding

Breastfeeding is considered the best source of nutrition for infants, providing nutrients needed for development and antibodies that protect against infection early in a child’s life. In addition to enhancing the closeness of mother and infant, infants who are breast-fed have lower rates of infant illness. A study of the health care costs of formula feeding in a managed care setting found that formula-fed infants experienced more episodes of otitis media and higher rates of respiratory and gastrointestinal illness, compared to breastfed infants. Investigators concluded that MCOs could improve infant health outcomes and also realize substantial cost savings by supporting and promoting exclusive breastfeeding. Breastfeeding advice and support from professional and peer counseling sources are important factors in the initiation of breastfeeding.

Women enrolled in WIC who wish to breastfeed are likely to need extra support.

Prenatal WIC participation has been found to increase the initiation of breastfeeding, but to date WIC participation has not been shown to increase the duration of breastfeeding. Low-income women nationally have much lower rates of sustained breastfeeding, when
compared to those with higher incomes and/or education. Possible deterrents include lack of flexible employment schedules and support at home. Women enrolled in WIC who wish to breastfeed are thus likely to need extra support through activities such as lactation referrals and access to consultants. A 1997 study found that about 45 percent of women enrolled in WIC initiated breastfeeding after their babies were delivered. 62

The new Healthy People 2010 goals include several breastfeeding objectives. They call for increasing the percentage of women who initiate breastfeeding from the 1998 benchmark of 64% to 75% in 2010, and for increasing the number who are still breastfeeding after 6 months to 50% from the current 29%. Women and children with higher levels of health risks have shown some of the greatest increases in breastfeeding rates over the past decade. Rates of initiating breastfeeding among African American women increased 65 percent, as did rates among women aged 20 years and under.

WIC programs encourage mothers to breastfeed, and breastfeeding mothers receive enhanced food packages for up to a year. Many local WIC programs have greatly increased their activities in support of breastfeeding over the past decade. WIC staff have actively promoted breastfeeding by training peer counselors, organizing support groups, offering special classes, and presenting written and audiovisual educational materials. They have also screened out materials and activities that would encourage bottle feeding from the moment of delivery. In many states, WIC staff have taken leadership roles in organizing coalitions to advocate policies that favor and promote breastfeeding and educate health care providers. Collaboration activities focusing on breastfeeding promotion have the potential to benefit both the WIC program and managed care organizations.

**Partnerships to promote breastfeeding could work like this:**

<table>
<thead>
<tr>
<th>WIC</th>
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<tbody>
<tr>
<td>• Offer pregnant women group and individual breastfeeding education.</td>
</tr>
<tr>
<td>• Sponsor breastfeeding hotlines.</td>
</tr>
<tr>
<td>• Offer lactation consultation and referrals.</td>
</tr>
<tr>
<td>• Provide breast pumps purchased with WIC food funds (new USDA policy).</td>
</tr>
<tr>
<td>• Participate in and sponsor breastfeeding coalitions.</td>
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</table>
The California Health and Welfare Agency issued a “Policy Letter” on breastfeeding to clarify the contractual responsibilities of managed care MCOs regarding breastfeeding education, counseling, and services. The letter states, “MCOs must refer all Medi-Cal eligible… members to… (WIC)… Breastfeeding promotion, education, and counseling services and/or activities must be coordinated with the local WIC agency.” In addition, MCOs are also required to ensure that postpartum women receive necessary breastfeeding counseling and support after delivery, including professional services when needed. They are encouraged to participate in local breastfeeding coalitions, many of which are based at WIC agencies. The letter requires MCOs to supply breast pumps and breast pump kits, and special infant formulas when deemed medically necessary (although WIC was recently authorized nationally to supply breast pumps).

Within the state, there are several examples of collaborative activities already in place.

**In Solano County**, WIC initiated a county-wide breastfeeding task force. The Partnership Healthplan of California (PHC) Growing Healthy Together perinatal case manager participates on the breastfeeding task force and works with WIC to develop PHC policies on breastfeeding, including the provision of breast pumps. Contact: Denise Blunt, 707-421-7231.

**In Contra Costa County**, the Contra Costa Health Plan began a pilot test of hiring a lactation consultant and later began an initiative to further encourage breastfeeding by supplying free breast pumps to lactating mothers and by paying for postpartum home visits between 24 and 48 hours after birth. (Contact Beverly Clark, 925-646-5376). The Plan’s written agreement with WIC has specific language with respect to breastfeeding promotion, including the following:
1. Plan will include in Medical Policy for all Providers: Artificial baby milk and/or coupons for this are not to be routinely distributed to pregnant or breastfeeding women. No member names will be distributed to manufacturers of artificial baby milk.

2. Providing continuing breastfeeding education and training to providers and health educators employed by the plan.

8b. Plan will collaborate with State and local WIC to provide (search out, review, modify or develop) culturally relevant breastfeeding materials. Text of any new material developed with WIC staff time will not be copyrighted nor proprietary.

Clinica Sierra Vista in Kern County, California, serves approximately 27,000 women, infants and children in its WIC program. A Breastfeeding Peer Counseling Program is available to help pregnant and breastfeeding moms. The Clinica WIC Program also employs 43 Certified Lactation Educators to encourage and assist breastfeeding moms, including two who work in the hospitals where WIC clients deliver their babies. The breastfeeding promotion activities receive partial support from California’s Comprehensive Perinatal Services Program. Clinica Sierra Vista WIC staff also participate actively in the Kern County Breastfeeding Promotion Coalition. Contact Leah Carter, 661-326-6490.

Improve infant feeding practices

Many new mothers do not have basic infant feeding information, as demonstrated by a recent study. They may erroneously believe, for example, that young infants need fruit juice in addition to formula, that sugar should be added to bottles, or that solids should be given to infants younger than four months of age. Although most mothers rely on their pediatricians or family physicians for definitive advice on infant feeding, time constraints and cultural barriers may not permit a full discussion of beliefs and family customs. WIC nutritionists, in contrast, have an explicit mandate to educate women about infant feeding, can give them attractive informational materials, and can refer caregivers with special concerns back to the infant’s health care provider.

Mothers and caregivers of infants enrolled in WIC are especially likely to benefit from education about infant feeding. Mothers who report receiving information from WIC about infant feeding are less likely to give cereal too early. A focus group study of low-income mothers enrolled in WIC found that many mothers believed that having a heavy baby was a sign of health, and they often feared that their infants were not getting enough to eat. Misconceptions such as these can lead to inappropriate feeding habits and eventually to childhood obesity. In some cases, WIC-enrolled mothers rely on their own mothers as their main source of information about infant
feeding. Educating both mothers and grandmothers with consistent messages can also improve infant nutrition.

Educational interventions are needed to prevent common practices not in accord with recommended guidelines, including giving cereal, fruit juice, and sweets or snack foods to infants younger than 4 months of age. Efforts to create materials and messages to be delivered and reinforced by both WIC and pediatric providers would help to ensure appropriate education on infant feeding practices.

**Partnerships to improve infant nutrition and infant feeding practices could work like this:**

<table>
<thead>
<tr>
<th><strong>WIC</strong></th>
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</table>
| • Reinforce breastfeeding routinely.  
| • Provide anticipatory guidance on infant feeding.  
| • Refer high risk infants and toddlers to primary care providers, and contact providers directly if appropriate.  |
| **MCO** |  
| • Inform providers about infant formula policies of WIC.  
| • Reimburse medical nutrition therapy either at a WIC site or another location.  |
| **Health Care Provider** |  
| • Contact WIC regarding prescription of infant formulas when special formulas are needed.  
| • Refer infants to WIC for nutrition education and management when high risk conditions require individual care plan.  
| • Refer infants with very high risk conditions for medical nutrition therapy by a registered dietician.  |

**Increase immunization rates**

In the past century, universal childhood immunization has been crucial to the reduction of morbidity and mortality due to vaccine preventable diseases. It is a cornerstone of primary preventive services for infants and children. WIC has been an active partner in raising and sustaining immunization coverage rates in the U.S. since the measles outbreaks of the late 1980s and early 1990s. Although childhood immunization rates have improved, constant efforts are needed to educate new generations of mothers and caregivers about the importance of complying with immunization schedules and of obtaining newly recommended vaccines. Interventions such as screening and referral for immunizations and monthly voucher pickups have
been successful, when used in demonstration projects, in getting WIC-enrolled infants and children the vaccinations they need.\textsuperscript{71,72}

The federal government has recognized WIC as a major focus of efforts to increase immunization rates among low-income preschool children. Federal immunization funding supported WIC-based immunization screening and referral projects over a period of several years, many of which documented successes. A December 2000 White House directive\textsuperscript{73} asked USDA and DHHS to develop a strategic plan that would assure immunization screening and referrals for all infants and children at WIC certification visits. In response, a public/private work group is elaborating action steps to train staff in all WIC agencies in standardized procedures for immunization assessment, education of caregivers, and referral to health care providers.

Managed care organizations can both contribute to and benefit from WIC’s activities to assure childhood immunizations. WIC screening and referral activities in connection with immunization can assist with applications for eligible children for Medicaid or SCHIP, where in many cases the parent must select a managed care plan and primary care provider. In addition, WIC immunization screening and referral can help MCOs meet quality assurance objectives. There are several means by which WIC programs and managed care organizations and providers can work together to ensure that all children jointly enrolled in WIC and Medicaid receive required vaccinations.

**Partnerships to increase immunization rates could work like this:**

<table>
<thead>
<tr>
<th><strong>WIC</strong></th>
<th><strong>MCO</strong></th>
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<tbody>
<tr>
<td>Screen for immunizations at each certification visit.</td>
<td>Reimburse WIC for immunizing children on site.</td>
</tr>
<tr>
<td>Refer newly enrolled infants and children to health care provider for needed immunizations.</td>
<td>Facilitate WIC linkage to an immunization registry.</td>
</tr>
<tr>
<td>Provide immunizations on site, with reimbursement, in coordination with primary care providers.</td>
<td>Contribute to the training of WIC staff in immunization screening and referral procedures.</td>
</tr>
</tbody>
</table>
Health Care Provider

- Screen for immunizations and provide immunizations.
- Reduce missed opportunities for immunizations.
- Document immunizations and update the patient’s history at each visit, including registry information.
- Provide immunization records to patients and WIC staff as appropriate.

Some WIC clinics are co-located with medical providers, and routinely refer clients to them for immunizations. Others have staff on site, usually from the local health department, who immunize children at the time of WIC visits when they are not up to date. If a managed care plan reimburses WIC for providing immunizations, several benefits can be realized. First, a child can be brought up to date as soon as it is clear that he or she lacks required immunizations. The child would not have to wait for an appointment at the provider’s office. Also, if a managed care plan reimburses WIC for administering shots, it can receive credit for giving the immunization in quality assurance audits, thus raising the MCO’s overall performance in administering childhood immunizations to its enrolled population.

Information sharing is another important area in which WIC has experience, particularly regarding referrals of clients to health and social support services. In some communities, WIC is linked to the immunization registry, which facilitates screening for immunization status at the WIC site. In areas without well-developed registries, information sharing between a Medicaid managed care organization and the WIC program could serve the same function.

Reports from demonstration programs suggest that optimal results occur when WIC programs receive dedicated resources for screening, outreach, services, and referrals. While the federal funding invested in these WIC enhancements has identified successful strategies for improving immunization compliance, sustained attention and resources are needed to apply them more widely. Initiatives to begin information sharing, for example, would require funding to put necessary infrastructure in place. Additional sources of funding and building capacity are other important issues to consider when building collaboration efforts.

Currently, there are several coordination efforts between WIC and Medicaid managed care organizations that illustrate how collaboration can improve immunization outcomes for this population.
**In Tarrant County, Texas,** WIC and MCO providers frequently cosponsor events to promote immunization compliance through the Tarrant County Immunization Collaboration.

**In Rhode Island, the KIDSNET enhanced immunization registry** (linked to some WIC sites) has information on immunizations, lead screening, and other public health preventive service data for children born from 1997. Improved linkage with MCOs results in coordinated quality assurance reviews to identify children behind in preventive services. Currently, all of the children in WIC born in or after 1997 are in KIDSNET. This represents 80% of WIC’s childhood population.

**The Wellness Plan in Detroit** responded to low immunization rates by enlisting the WIC program operating at its clinic sites. This managed care plan contracted with Medicaid added walk-in primary care and immunization services for children coming for regular WIC visits, and used the CASA software to track immunization records. As a result of coordination between WIC and Wellness, immunization levels increased 14.8% within six months.75

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**Improve early childhood nutrition**

The nutritional status of children ages 1 through 4 has improved significantly for all racial and ethnic groups in the past two decades.76 National surveillance has documented a decrease in growth stunting and iron deficiency anemia, accompanied by improvements in diet. Proper nutrition for young children is still a concern, however, as recent findings of diets deficient in iron, zinc, and vitamin E demonstrate.77 Risks for poor nutrition remain greatest in low-income children. Some studies suggest that parents who know more about proper nutrition can help their preschool children eat and enjoy healthful foods, a finding that increases the argument for educating parents through WIC nutrition education.78 More recently, an increase in the proportion of overweight children, especially in Hispanic and Native American populations, has been widely recognized.79

WIC screens infants and young children for nutritional risks and gives high priority to those with documented medical conditions that affect nutrition. WIC staff educate their caregivers about feeding small children in accord with the latest dietary guidelines, following national recommendations such as those issued by USDA (www.usda.gov) and DHHS (e.g., www.brightfutures.org). In addition, WIC food packages supplement the diets of targeted participant groups with needed nutrients and limit ingredients that should be curtailed.80 Young children who consume WIC food packages have higher intakes of protein, calcium, iron, folic acid, and vitamin E, compared to low-income children who do not receive WIC.81 Fat, sugar, and sodium content in food packages
available through WIC are limited, in accord with concerns about their contribution to health and nutrition problems.

**Partnerships to improve childhood nutrition could work like this:**

| WIC | • Complete dietary histories for toddlers.  
|     | • Monitor height for weight at each visit.  
|     | • Develop individual care plans for high risk children.  
|     | • Notify primary care providers about high risk children.  
| MCO | • Inform providers about the WIC role in child nutrition.  
|     | • Reimburse WIC for medical nutrition therapy when needed.  
| Health Care Provider | • Refer high risk children to WIC for individual care plans.  
| | • Prescribe medical nutrition therapy for children with very high risk conditions.  

**In Solano County,** California, the Partnership Healthplan of California (PHC) has created a medical nutrition therapy benefit in which the county’s Clinical Nutrition Services Program registered dietitians provide medical nutrition therapy for women and children. Young children diagnosed with conditions such as diabetes, lead poisoning, obesity, severe anemia, and failure-to-thrive are covered for medical nutrition therapy. Women who are compromised due to cancer, heart disease, diabetes, obesity, substance abuse and HIV are covered for medical nutrition therapy.

**In Contra Costa County,** California, representatives from WIC and Contra Costa Health Plan serve on an obesity task force. They also collaborate closely to make sure that families bring children in for preventive health examinations.

**Reduce risk of lead toxicity**

Lead toxicity, or lead poisoning, is recognized as one of the most serious environmental health risks facing children today. Lead poisoning affects the brain and nervous system tissues of children and can cause learning and developmental disabilities. Young children, those below the age of 5, are at particular risk because of their frequent hand-to-mouth activity. In 1991, CDC published a statement defining the maximum acceptable blood concentration of lead at 10 micrograms/dl. 82 CDC also recommended at that time that all children under the age of 5 be screened for lead.
toxicity. In 1997, however, CDC revised its recommendation to acknowledge that the scope of the problem of lead toxicity can vary by region and locality. The new recommendation is for state health officials to develop statewide plans for childhood lead screening and better target children who are known to be at increased risk.83,84,85

Although all children are at risk for lead poisoning, a greater proportion of those in low-income families have higher blood lead levels.86 National Health and Nutrition Examination Survey (NHANES 3) data from 1991-94 show that lead toxicity is a significant problem for children receiving care under Medicaid, and that Medicaid-eligible children constitute the majority of children with elevated blood lead levels.87 In February 1998, the GAO released a report documenting that, despite HCFA’s lead screening requirement for children enrolled in Medicaid, 81% of Medicaid children in the NHANES had not been previously screened for lead.88 As a follow-up, the GAO released another report in January 1999 highlighting possible reasons why Medicaid enrolled children are not being screened.89 To address these shortcomings, the GAO made several recommendations to the Secretary of DHHS, including coordinating lead screening and treatment activities among federal agencies, including Medicaid and WIC, that serve at-risk children.90 Coordination activities between Medicaid managed care organizations and WIC directly follows this recommendation, and they can have a positive impact on lead screening in this population.

In states that target low-income children for lead poisoning prevention efforts, local WIC programs may already participate in screening children for high blood lead levels. According to local WIC directors who responded to a recent survey, 19 percent of local WIC agencies currently screen children for lead exposure. Most of these agencies are affiliated with local health departments and work closely with the state lead poisoning prevention program. WIC agencies that play an active role in testing children’s blood lead levels often require additional funding and support. The National Association of WIC Directors (NAWD) recently published a position paper on lead screening that highlighted some of the costs and concerns associated with lead screening and tracking by WIC programs. The paper also recognized the indispensable role of a child’s primary health care provider.
In states with active programs to reduce lead exposure, partnerships involving WIC could work like this:

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Ask whether participant was screened for lead and make referral if needed.</td>
<td>▪ Promote universal lead screening and/or verification by provider.</td>
<td>▪ Conduct lead testing on all children referred by WIC.</td>
</tr>
<tr>
<td>▪ Provide information about lead poisoning prevention to participants.</td>
<td>▪ Notify enrolled patients about need for lead testing and availability of service.</td>
<td>▪ Verify blood lead screens conducted elsewhere.</td>
</tr>
<tr>
<td>▪ Develop individual nutrition care plans for children with high blood lead levels.</td>
<td>▪ Establish program to reimburse WIC for drawing blood for lead testing if feasible and needed.</td>
<td>▪ Notify state and local lead programs about children with high blood lead levels and refer them to WIC or registered dieticians for development of an individual care plan.</td>
</tr>
<tr>
<td>▪ Draw blood for lead testing, with reimbursement, in coordination with programs established by public health departments and MCOs.</td>
<td>▪ If services offered in setting that conducts blood lead testing, WIC can reimburse the testing program for the cost of drawing blood for WIC iron screening to determine anemia.</td>
<td>▪ Share results of blood lead (and iron) test with WIC to expedite certification.</td>
</tr>
</tbody>
</table>

State health officials may find that WIC involvement in lead screening can be useful both in assisting parents to obtain appropriate interventions for affected children and in targeting communities that are more likely to have lead exposure problems. For example, while Rhode Island’s WIC Program formerly conducted routine lead screening for young children at risk, pilot sites will soon be assessing the child’s lead screening status through KIDSNET. This change in strategy was due to two factors:
93% of RI WIC participants have health insurance and access to health care providers, and the availability of KIDSNET at WIC sites. Instead of WIC staff performing lead screenings, they now ensure access to health care through screening and referrals to Rite Care (RI’s managed care Medicaid Program), educating parents on the importance of lead screening, referring participants’ to their health care providers and providing follow-up. Coordinated quality assurance initiatives between WIC, the lead program, MCO’s and KIDSNET monitor compliance with screening requirements, and locate areas with higher or lower than expected rates of lead exposure. Consequently, they can target lead poisoning prevention initiatives in communities with the greatest need.

Recently WIC (using KIDSNET data) analyzed lead screening information for each WIC site. Overall, 75% of all WIC children had received lead screening, and 8% had blood lead levels greater than 10 µg/dl detected. According to the report, lead screening could be promoted at two or three of the WIC sites with screening levels at 65% or less. This type of quality assurance, when shared with providers and MCO’s, could focus efforts in underserved communities.
The Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP) and WIC Program has recently begun an initiative to promote collaborations between WIC, MCOs, and the WCLPPP. This effort was prompted by the realization that Wisconsin’s children have higher rates of lead poisoning (10.1%) compared to the national average of 4.4 %, that low-income children enrolled in Medicaid and WIC have the highest rates, and that more than one-third of infants and children are not being screened for lead poisoning. Lead screening in Wisconsin is done by private health clinics, public health departments, and WIC clinics. The WCLPP and WIC Programs are seeking ways to promote dialog and partnerships between MCOs and WIC in order to promote screening for lead for all children enrolled in WIC and managed care organizations. The Program is addressing issues that could pose obstacles including:

- Billing and information sharing practices between public health departments, providers, and MCOs.

- Reimbursement mechanisms for lead screening services.

- Outreach and referral for WIC services.

- Roles and relationships of managed care, WIC, and public health in conducting lead screening.

The Wisconsin WIC Program Director, Immunization Program Director, and WCLPP staff have jointly made numerous presentations to managed care organizations in Wisconsin and explained the benefits of collaboration with WIC on lead screening and immunization. The Wisconsin Public Health Division prepared a document titled “Partnerships for Healthy Kids” to aid this process.

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COLLABORATION BETWEEN WIC AND MANAGED CARE


COLLABORATION BETWEEN WIC AND MANAGED CARE


Ball (1999). Ibid. ???.


COLLABORATION BETWEEN WIC AND MANAGED CARE


87 Kaufmann R (2000), ibid.


90 Ibid.
3. How to collaborate?

Collaborations between WIC and managed care organizations may begin in a variety of ways. Most frequently, they occur: 1) in response to a legal requirement; 2) to fulfill a prerequisite for public or private funding; or 3) as an initiative to work toward common objectives. Many collaborations go beyond the arrangements that WIC programs and Medicaid agencies have worked out to make sure that managed care enrollees are referred to the WIC program, either at the time of Medicaid enrollment, at the time of enrollment in a plan, and/or when Medicaid beneficiaries see medical providers. These basic arrangements are required by PL 103-448, as stated earlier, and require cooperation and mutual understanding of the roles of the other agencies. Successful collaborations involve commitment of time and leadership from both organizations, a willingness to understand each other’s strengths and limitations, and a focus on working toward common goals.

In the case of WIC and managed care organizations serving large numbers of Medicaid beneficiaries, collaborations can occur at any time, but opportunities for communication arise most frequently as a plan begins to enroll members in the county or metropolitan area served by a local WIC agency. The enrollment process often involves WIC directly when, for example, enrollment brokers station workers at WIC sites to help participants select a managed care plan. In other cases, WIC programs make special efforts to contact managed care organizations and providers to inform them about WIC locations and services and leave referral forms.

WIC programs have partnered with managed care organizations and providers to improve and document immunization coverage, promote breastfeeding, and increase well-child exams. Some of these collaborations involve the WIC parent agency, most commonly a local health department.

Managed care organizations might find it easier to establish a formal agreement with a public health department or large community service agency that includes WIC as one of several programs. Case studies of such partnerships suggest that important factors for success include shared ownership, common expectations, a formal process or agreement, and effective use of limited resources. Failures can occur if top management does not support the collaborative effort, if money is the primary motivating factor for one of the collaborators, or if key individuals responsible for the activity are not fully committed to the collaboration.

The following section describes steps that local WIC agencies and managed care organizations can take to establish collaborative relationships. Copies of sample forms and materials that have been used by local WIC agencies and managed care
organizations are noted in the footnotes and appear as [internet links]. Table 4 contains checklists based on information presented in this section. These checklists are for local WIC agencies and MCOs to use in self-assessments of their collaborative efforts.

Get to know key partners and their missions

All of the key partners in health care delivery face new challenges in a managed care system. To meet them successfully, staff may need extra information and training.

Public agencies face special challenges as their staff assume new responsibilities related to contracting with managed care organizations.92 Medicaid agencies have new tasks, including developing RFPs and contracts for managed care organizations, monitoring the quality of and access to services offered by MCOs, and coordinating with other agencies as managed care is implemented. Managed care organizations and health care providers that have not traditionally worked with low-income populations need to become familiar with the system of publicly funded health-related services and begin to establish referral and information-sharing procedures.

Public health agencies and WIC programs need to understand the new requirements with which their clients must comply to access health care services. They must also be aware of the financial and organizational stresses that managed care organizations experience in a competitive marketplace. WIC agency directors should prepare background information describing their program to share with potential collaborators.93 For example, an excellent starting point is the USDA website that describes WIC programs (www.usda.gov).

State Level State agencies can play key roles in promoting local collaborations between WIC programs and Medicaid-contracted managed care organizations and providers. By law, one state agency administers the Medicaid program and oversees contracting arrangements with managed care organizations. Figure 1 displays the funding and organizational relationships for WIC, Medicaid, and MCOs. The state health department, state WIC program director, and state Medicaid agency can facilitate collaborations in a variety of ways—by dedicating special resources, initiating planning activities, including WIC provisions in the managed care contracting or regulatory process, monitoring compliance with requirements, and evaluating outcomes.

State health departments administer WIC programs and related programs such as the Title V Maternal and Child Health Block Grant and nutrition services. In some states, a single department administers both health services and Medicaid. The state health department's oversight of WIC and close working relationships with the local agencies that operate WIC services assure, in most states, that WIC is coordinated with other health and nutrition programs. Coordination might include, for example, uniform eligibility, referral arrangements, co-location, and information-sharing mechanisms. The state Title V director and other public health officials may be able to
facilitate collaborations undertaken by state and local WIC agencies with Medicaid managed care organizations, often by providing information, taking on quality improvement roles, or contributing financial support.94

The organizational structure and proximity of agencies may influence the degree to which leaders in the state health department consider WIC to be an active participant in publicly funded health insurance programs for mothers, infants, and children. Their views are typically shaped by the process that accompanies the transformation of fee-for-service Medicaid programs into comprehensive managed care programs. If the state health department has worked closely with the state Medicaid agency to incorporate WIC and other essential public health services into the managed care contracting process, then the state WIC program is more likely to be involved in managed care coordination activities.

State and Territorial WIC Programs. WIC is administered at the state level by 88 state, territorial, and Native American tribal organizations, through the state health department or equivalent. Each state has established a system for delegating or contracting operational responsibility at the local level. In some states, WIC is administered by a unit that also has responsibility for nutrition services, while in others WIC programs are integrated with maternal and child health programs. (See Figure 1.) Placement in the state agency can influence the extent to which the state WIC program director coordinates directly with counterparts in the state Medicaid agency and with Medicaid MCOs. For example, the state WIC program director may find it difficult to communicate with counterparts in the state Medicaid agency because he/she is in a separate department or division, and WIC is two or three reporting levels down from the director of the health department.

State WIC directors reported recently on their efforts to coordinate with managed care organizations contracting with Medicaid. On the whole, coordination between WIC and the Medicaid agency occurs more frequently than coordination between WIC and managed care organizations. The following highlights from the 2000 Emory survey show that approximately 1 of every 4 states has specific arrangements for coordination between WIC and managed care organizations.
COLLABORATION BETWEEN WIC AND MANAGED CARE

- WIC and Medicaid agency representatives meet at least twice a year --- 53%.
- WIC has designated a liaison person to coordinate services with managed care organizations --- 32%.
- WIC and managed care plan representatives meet to develop coordination mechanisms --- 24%.
- WIC obtains feedback from local agencies about coordination of services with managed care organizations --- 21%.

Overall survey comments from state WIC directors suggested a wide variation in knowledge of and involvement with managed care organizations. In some states, such as California, Iowa, and New Jersey, the WIC program actively sought coordination with managed care organizations and providers, while in other states WIC directors had little information about managed care.

State Medicaid agencies have been coordinating with state WIC programs since 1989, if not earlier, when federal legislation required all Medicaid programs to refer beneficiaries to WIC and all Medicaid beneficiaries were considered income-eligible for WIC. Formal agreements, when they exist, cover the provisions of the 1989 legislation and list steps that each agency will take to assure that Medicaid beneficiaries and WIC participants are referred to Medicaid. For example, in Massachusetts, the Medicaid agency agrees to be responsible for including information about WIC in its enrollment materials, in its mailings to providers, and in any Medicaid and EPSDT outreach materials. The written agreement is reviewed annually and signed by the WIC director and counterpart within the Medicaid agency, plus their direct supervisors in the Massachusetts Department of Public Health. The activities actually carried out, however, may go well beyond provisions contained in the letter.

The Balanced Budget Act of 1997, which created the new Children's Health Insurance Program (SCHIP), also allows states to require that most Medicaid beneficiaries enroll in managed care. The legislation, which establishes minimum standards for organizations that contract with state Medicaid agencies to provide managed care, effectively gives Medicaid agencies new oversight and management responsibilities for the health care system serving low-income populations. The rapid transformation, in many states, from a fee-for-service health care system to managed care has created many challenges for state agency administrators, including establishing relationships between managed care organizations and traditional public health providers and assuring access to primary care and specialty services for vulnerable populations. Most state Medicaid agencies have established a special unit to handle relationships and contracts with managed care organizations. These units handle purchasing issues and oversee reporting requirements.
Some Medicaid agencies have taken special steps to promote coordination between managed care organizations and public health agencies like WIC. As described earlier, approximately one-third of all Medicaid agencies have included requirements in their contracts with managed care organizations that require their providers to make referrals to WIC and to provide medical nutritional information to WIC programs; but other states are silent on these issues. Still other states require managed care organizations to contract with public health departments or traditional providers, which may also, in some cases, sponsor WIC programs. Special initiatives that involve WIC programs are normally worked out between Medicaid and the health department unit or division that oversees WIC.

Many state Medicaid agencies hold discussions with the WIC program about managed care only if particular issues of mutual concern arise, such as special infant formula reimbursement and breastfeeding. For example, state WIC programs purchase infant formula in bulk from manufacturers at tremendous savings to the public, but this can be done only with a limited number of brands. When pediatricians prescribe special infant formulas not supplied by WIC (but not specifically covered in the managed care plan’s list of approved medications and supplements), the state Medicaid agency and WIC program must work out a compromise. On other occasions, managed care organizations contracted with Medicaid assign families to primary care providers who do not live within reach of public transportation, and families turn to staff in traditional public health or WIC clinics to help them get reassigned. Under these circumstances, where confusion is likely, state agencies need to make sure that all local programs serving Medicaid beneficiaries are familiar with the new rules and can refer families to responsible sources for help.

**Local Level**

Nationally, more than half of the 2,000 local WIC programs are sponsored by a county or district health department, and many others are sponsored by community-based agencies. Approximately one-third of the 10,000 WIC sites are co-located with health services. By federal law, organizations receiving USDA support to deliver WIC services must have nonprofit status. Additional requirements for program delivery apply; 80 percent of WIC support comes in the form of food benefits, and 20 percent is to be used for administrative costs, of which at least one-sixth must be dedicated to nutrition education. [in FY 2001, 73% was for food benefits – Clara will clarify.] These requirements, in addition to WIC eligibility and certification requirements, add to the perception that WIC programs are somewhat inflexible partners in coordination efforts. However, in reality, the majority of local agencies that sponsor WIC programs use funding from non-USDA sources and/or obtain in-kind resources from local partners to enhance WIC operations.

Health care providers or other public agencies often donate space for WIC services.

**Local WIC programs** frequently coordinate with Medicaid and SCHIP programs on outreach and referral services. Medicaid eligibility workers may be outstationed at WIC sites, and in a few states WIC staff are authorized and trained to certify WIC applicants.
as presumptively eligible for Medicaid. The majority of programs coordinate with other public health programs such as immunizations, Healthy Start, and lead screening. All programs have developed some type of relationship with private health care providers, and many have some WIC sites located in large provider offices or clinics. In some cases WIC and primary health care services are fairly well integrated, sharing staff and resources for some tasks. Co-location of WIC and health care services can facilitate service coordination, but it does not assure that referrals, information sharing, and case consultation will actually take place. Health concerns commonly addressed through referrals, service integration, or special initiatives include smoking, breastfeeding, family planning, and EPSDT examinations. Non-health issues include substance abuse, domestic violence, food stamps, transportation, and child care.

The proliferation of Medicaid managed care has changed the ways in which low-income pregnant women learn about and enroll in WIC. In many states, private providers affiliated with managed care plans are delivering prenatal care to pregnant women enrolled in Medicaid, care formerly delivered by public health agencies, many of which have WIC programs on site. In addition, welfare reform and an expanding economy have propelled many women into the workforce, causing declines in WIC caseloads. These changes have stimulated many WIC programs to step up their outreach and recruitment efforts, sometimes through "marketing" the program in collaboration with local media, other agencies, and private health care providers. In other cases WIC programs have begun to seek new locations for WIC services as traditional public health providers have curtailed direct health care. They have been slower to develop formal relationships with managed care organizations, although some promising models have been reported

Local Government Agencies. In more than a dozen states, local governments play major roles in the administration of Medicaid managed care organizations. Local government agencies contract with MCOs and/or function as MCOs in some states, as in California and New York. They may also monitor managed care quality and access. Large local governments frequently finance a portion of the Medicaid program funding for “safety net” public hospitals and health departments. In communities where local governments have a prominent role in administering Medicaid managed care programs, the MCOs may be more responsive to the concerns of local beneficiaries and providers.

Managed care organizations (MCOs) that contract with Medicaid are also commonly known as health plans or health maintenance organizations. While their organizational arrangements and histories vary widely, they all provide inpatient as well as outpatient care and offer comprehensive health benefits covered under Medicaid. (See Glossary of Terms on page 4.) More than 400 managed care organizations provide health care nationally to Medicaid beneficiaries. MCOs may offer health plans that provide comprehensive services to non-Medicaid members as well as Medicaid beneficiaries in more than one state, such as Blue Cross and Kaiser. They may be
managed care organizations that serve Medicaid/Medicare beneficiaries only and that operate in more than one state, such as Americaid or UnitedHealthcare. Or they may be health MCOs that operate only in one county or state or county, like Colorado Access or the Santa Clara Valley Health Plan in California. In some cases the MCOs originated from an association of community health centers, such as the Neighborhood Health Plan, which serves members in New England.

Managed care organizations have varying capacities for coordination with public health agencies, including WIC. Their responsibilities extend to their enrolled members and do not usually include public health services. Although their stated mission is to provide quality services to members, their financial stability depends on the degree to which they can keep service utilization down and enrollment high. However, as many MCOs have learned that serving Medicaid beneficiaries poses new challenges, they have either begun to provide services such as case management and lead screening to beneficiaries, either directly or through subcontracts or capitation arrangements with public health and community-based agencies. They may also offer health promotion and disease prevention programs to members, sometimes in collaboration with community-based organizations. Many health organizations have begun initiatives on their own to improve prenatal care, reduce smoking, manage pediatric asthma, and increase immunization rates.

MCO leadership does not always find it easy to support community-oriented health prevention efforts such as collaborations with WIC. Increasing financial pressures from health care purchasers, lower reimbursements, mergers, and competitive markets have made them wary of increasing their investments in activities they often regard as community-benefit projects rather than as integral to their service package. In this cost-conscious environment, managed care organizations respond to quality improvement mandates from state agencies and health care purchasers by issuing guidelines and helping providers to meet them. WIC programs, therefore, should make sure that language requiring coordination with or referrals to WIC to achieve health goals is included in all relevant contracts or policy memoranda issued by state Medicaid and public health agencies to health care providers and managed care organizations.

In communities where Medicaid beneficiaries are required to enroll in managed care, there may be, at least initially, organizations contracted by the state to serve as neutral enrollment "brokers." Brokers help beneficiaries select from two or more MCOs with provider networks in the community, and help them understand their rights and obligations subsequent to enrollment. In many instances, beneficiaries will be able to choose a network that includes their current providers. In other instances MCOs might offer enrolled Medicaid beneficiaries a new choice of providers who are relatively unfamiliar with public health and other community agencies involved in the continuum of health care.
MCOs may establish a local office in large communities or assign representatives to visit providers (or provider groups) on a regular basis. MCO staff with the authority to establish collaborations with WIC and public health agencies may have responsibilities in the areas of prenatal and pediatric care, social services, or community/public relations. They typically have formal titles in the provider relations, marketing, or member services units of MCOs. In considering potential collaborations, MCO decision makers will be influenced by the size of the population served in common, the importance of the health problem, the cost and availability of an effective intervention, and the perceived potential benefits—both financial and public relations.

**Establish outreach and referral relationships between WIC and managed care**

Health care system changes affect public health as well as private health care providers and organizations. Each must spend more time on efforts to market services to populations in need, and each must develop new relationships. These efforts are especially important in light of recent expansions in state Medicaid and federal-state Children’s Health Insurance Programs that make virtually all WIC participants income-eligible for Medicaid or SCHIP. WIC programs in some states have initiated outreach activities to inform staff in managed care organizations and health care providers about the ways that WIC can benefit their members and patients, and to encourage the referral of members to WIC. The materials they have developed may be useful for other states and local agencies.

Face-to-face meetings are essential to initiating partnerships between managed care organizations and WIC programs. Deciding how to arrange the meeting and who should participate may require prior consultation and some consideration as to timing. For example, when the WIC director in Houston, Texas, wanted to introduce the program to MCOs that had begun to enroll new members in her county, she invited their marketing representatives to a meeting.  They responded eagerly to the invitation and have met periodically since then. State-sponsored workshops organized for training purposes are another way for Medicaid, WIC public health, and managed care staff to meet each other and explore mutual interests.
Tarrant County WIC Program’s Relationships with Managed Care

The Tarrant County WIC program currently enrolls about 39,000 clients, including the county and Ft. Worth city WIC sites, now merged into a single program. In Tarrant County, MCO – WIC coordination began when the contracted MCOs began their enrollment drives. Upon learning that MCOs had announced in-service provider training, the County WIC Director contacted each of them to say that WIC should participate in the training sessions because MCOs would find WIC to be an invaluable partner in helping Medicaid beneficiaries obtain care from private health care providers. With the advent of managed care, private practitioners agreed to become the primary care providers for newly enrolled Medicaid patients, many of whom did not understand how to contact their providers for appointments or for consultations, or the responsibilities and benefits associated with belonging to a managed care plan. Since enrollment began, MCO staff have promoted WIC with their providers and members and stressed the importance of referring patients to WIC. As a result, WIC staff have become familiar with MCO case managers and call them if they have concerns about particular patients. WIC has invited private provider staff to attend breastfeeding promotion training sessions.

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By working together, WIC Programs and managed care organizations contracted with Medicaid and SCHIP can assist clients eligible for both programs to enroll and comply with certification or recertification requirements. Approaches such as those described below can prevent patients and clients from losing benefits and promote continuity of health care.

1. **Supply WIC referral forms to health care providers**

   Health care providers that serve Medicaid beneficiaries may already be referring their patients to WIC or supplying medical information to WIC. Local WIC staff may visit providers’ offices periodically and leave display materials, or providers may participate in statewide outreach campaigns for WIC. For example, staff members of a Los Angeles WIC agency visit health care providers to explain the referral process and to leave materials that present WIC program information.109

   WIC staff also leave referral forms for health care providers to use upon identifying potentially eligible WIC participants or when requested to supply medical information for WIC certification. Referral forms used by state and local WIC agencies across the
country are very similar. They contain spaces for recording blood test results, immunization history, and any nutritional risk factors. Referral forms from several state WIC agencies are illustrated in the attached internet links.\textsuperscript{110}

2. Market WIC to health care providers and health plan members

MCO staff and health care providers who have not traditionally served Medicaid beneficiaries or who have experienced recent restructuring may not be familiar with the WIC program. Consequently, local WIC agencies need to find the most effective ways to inform MCO management and clinical staff about WIC. Most MCOs have a regular schedule of meetings with physicians' organization such as IPAs. When MCOs plan joint conferences with IPAs and MD groups, WIC can use these events as opportunities for marketing WIC, and to plan other opportunities for informing providers and MCOs about the program. Visits to provider offices are another good way for WIC staff to distribute informational flyers (see Massachusetts example\textsuperscript{111}) and to obtain copies of their patient brochures and newsletters. MCO and provider group newsletters are a natural place to inform providers about WIC services.

Marketing the Virginia WIC Program to Managed Care

In 1996 the Virginia WIC program realized that new referral relationships had to be created, because a growing proportion of WIC participants were receiving health care from managed care providers. The Virginia WIC program received a USDA discretionary grant to improve outreach with Medicaid managed care providers. The purposes of the grant were to increase the visibility of the WIC program, facilitate referrals to WIC by managed care providers, and design a new marketing campaign. The resulting colorful brochures proclaiming the "Real Meal Deal" were distributed to private health care providers to promote WIC, and four managed care organizations published information about WIC in their client newsletters. Meetings were held between state WIC staff and health educators and administrators from managed care organizations.

Contact: Jeanie Goldberg, VA Dept. of Health, 757-552-1240

Virginia as well as other state WIC programs have taken special steps to market WIC services to managed health care organizations and providers.\textsuperscript{112} The Virginia Health Commissioner and Medicaid Agency Director sent a joint letter to health care providers informing them of WIC benefits and asking them to refer patients potentially eligible for the program to WIC.\textsuperscript{113} They sent a separate letter to office managers for private practices asking them to display WIC brochures and use the referral form.\textsuperscript{114} The Massachusetts WIC Program, which established a special HMO Project, asked the Massachusetts Association of HMOs to send out a mailing to members, including
COLLABORATION BETWEEN WIC AND MANAGED CARE

preferred provider organizations, about WIC. They included a brochure about WIC services.\textsuperscript{115}

Many MCOs send newsletters and health promotion materials to members, informing them about opportunities to participate in classes or special activities. They can include WIC brochures or stories in these mailings, as Omnicare Health Plan in Michigan has done.\textsuperscript{116} Some state Medicaid agencies such as Massachusetts, include WIC brochures in all mail-in application packets.\textsuperscript{117}

**3. Assist uninsured WIC participants to apply for Medicaid and/or SCHIP**

More than one-third of all women delivering babies in the United States have Medicaid coverage at the time of birth.\textsuperscript{118} Nearly all of these infants are also income-eligible for WIC or one of the new state SCHIP programs, creating substantial eligibility “overlap” between the three programs. As stated earlier, pregnant women, infants, and young children with family incomes below 185\% of the federal poverty level are income-eligible for WIC, and the methods used by WIC to calculate income are generally more flexible than those used by state Medicaid agencies. The consequence is that virtually all uninsured WIC participants should be referred to Medicaid or a SCHIP program. Table 1 displays Medicaid and SCHIP eligibility levels for all 50 states as of late 1999.

Unfortunately, some families cannot get help completing the Medicaid or SCHIP application or certification requirements to keep infants and young children enrolled in Medicaid and/or SCHIP through age 5. Mothers in some states who lose Medicaid coverage following delivery may continue to be eligible for Medicaid family planning services under new waivers granted by HCFA to states that wish to reduce unplanned pregnancies.

Local WIC agencies should review their procedures to make sure that they identify and refer uninsured participants to Medicaid or SCHIP. State funds may be available to station outreach workers for Medicaid and/or SCHIP at local WIC sites to assist participants with the application process.

**4. Strengthen Medicaid - WIC coordination and referrals**

Most states require the WIC programs to refer participants to Medicaid, and a few state Medicaid agencies allow WIC staff to make presumptive eligibility determinations for pregnant women. Formal agreements between the two programs frequently contain provisions for exchanges of program eligibility information, listings of local offices, and distribution of Medicaid application information to potentially eligible individuals.

Conversely, many states have taken steps to assure that the Medicaid agency gives all applicants and beneficiaries information about their potential eligibility for the WIC program, together with application information. California, for example, includes this requirement in Title 22 of its Code of Regulations.\textsuperscript{119}
Section 50157 (f) (5) (A) specifies that the county welfare department notify all Medi-Cal beneficiaries who might be pregnant, breastfeeding or postpartum women or a parent/guardian of a child under the age of five, of benefits provided under the Special Supplemental Food Program for Women, Infants, and Children (WIC) program, by giving the applicant a WIC information brochure.

Massachusetts requires all EPSDT providers to incorporate WIC referrals into their screening service protocol:120

A referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC) for any child who may be eligible for WIC. Such a referral must be made using the WIC Medical Referral Form (MRF), which will be provided by the Massachusetts WIC Program.

The Massachusetts state WIC program and state Medicaid agency have a formal letter of agreement121 which is updated and signed annually. WIC agrees to provide written information about the Medicaid program to WIC applicants and refer WIC participants to Medicaid enrollment centers at each certification visit. The Medicaid agency assumes responsibility for including information about WIC benefits in all materials given to prospective Medicaid applicants, in all EPSDT materials, and for supplying WIC staff with Medicaid enrollment locations, policies, and procedures. Other states have similar formal agreements between WIC and Medicaid, a few with special provisions for notifying MCOs about WIC program benefits.

Co-locate WIC and health care services whenever possible

WIC has been co-locating services with health care and community agencies for many years. The majority of WIC programs locate at least some of their sites in facilities donated by other public or private organizations, including health care providers. Such donated space has allowed WIC programs to stretch their non-food budget and improve cost-effectiveness. Yet in recent years, finding adequate space has been a concern for many local WIC programs, as demographic changes, health care reform, and welfare reform have altered the ways services are delivered to low-income populations.122

Health care providers have also experienced uncertainty and changes with increased enrollment in managed care, changing reimbursement structures in Medicare and Medicaid, and the accompanying turmoil in the physician management industry.123 WIC programs with sites in space donated by private providers have been forced to relocate in some instances, as new profit-oriented management takes over real estate and discovers that WIC programs pay no rent.124 Observers of the managed care industry expect that the situation will stabilize fairly soon, making it easier for
community-service agencies like WIC to seek new space-sharing agreements with health care providers.

Co-location of services is a necessary but not sufficient step to achieving service integration. Other features of a comprehensive service model include co-eligibility for programs, integrated patient records, and co-scheduling. Nevertheless, co-location by itself, when accompanied by coordination in key areas, or “cross-training” staff, can greatly improve access to services from the client's perspective. For example, in Massachusetts, a WIC program occupying space in a large private health care clinic can order blood sample analyses for WIC participants directly to speed up the certification process, without requesting a physician to order the bloodwork and then send the results. The blood test results remain in the patient's chart as well.

WIC can and does enter into informal agreements to share space with private health care providers, but in an era of increasing financial accountability, a written letter of agreement may be more acceptable to business managers. A formal letter of agreement can be drafted by the WIC program along the lines of this sample. Key features of the agreement include:

- Open-ended time frame; either party can terminate the agreement with 120 days notice.
- Utilities, telephone, and routine cleaning/maintenance are donated to WIC at no charge along with space.
- Clinic provides patient medical blood test results to WIC staff.
- WIC services are not restricted to people receiving health care from the clinic that is sharing space.

**Develop partnerships**

The overarching goal of collaboration between WIC and managed care organizations is to improve the quality of health care and nutrition for participants jointly enrolled in both programs. Agencies should start by identifying specific objectives that can be accomplished within a limited time frame, typically one year. The earlier section of this document identifies multiple common objectives that might be achieved through a partnership, but realism and caution would suggest selecting one or two objectives initially. These should be selected through a process that brings peers from each organization together to explore mutual objectives and identify common target populations.
On the WIC side, the local WIC program director and the director of the parent agency might both need to be involved in discussions. If a large health department is the sponsoring agency, the director of nutrition services, if different from the WIC director, should participate as well. On the managed care plan side, the appropriate key individual might be the plan's health educator, prenatal case management director, clinical services director, or public relations director, or someone with a combination of these roles. If the plan does not have an office or representative located near the WIC agency, then WIC might consider strengthening its relationship with larger providers who participate in the plan. They may be able to facilitate a formal agreement with the plan once objectives for collaboration have been identified.

For example, in Rhode Island, the State Health Department has been instrumental in facilitating greater coordination between MCOs and WIC. The Rhode Island WIC Program's Director and Client Service Manager met with the CEO of a major Medicaid MCO to discuss mutual interests and resolve coordination issues. Following the meeting, WIC staff prepared a table summarizing roles and relationships and follow-up when needed.128
WIC and Managed Care Partnership for Child Health Promotion in Contra Costa County

The WIC program and the Contra Costa Health Plan, a nonprofit managed care plan contracted with the California Medicaid Agency, have worked together since the 50,000-member Plan began operations 25 years ago. Both WIC and the Plan are part of county government, but the Plan’s network of providers includes many physicians in private practice. All of the five WIC sites, serving approximately 16,000 participants annually, are co-located with primary care providers. Half of the WIC participants are enrolled in Medicaid. The WIC program and the Plan have signed a formal memorandum of understanding, and representatives of each serve on task groups that address obesity, anemia, and breastfeeding. In addition to the smoking cessation project described earlier, the Plan and WIC have developed an active Child Health Project that seeks to increase immunization rates and promote preventive screenings for infants and children. The Plan’s high risk infant nurse developed a system of reminders, tracking, and incentives for mothers to bring their children in for preventive health visits, working in conjunction with WIC immunization screening at all sites. The Plan’s health educator distributes a newsletter in English and Spanish for Plan members that contains many messages targeted at concerns of high priority to WIC, including anemia prevention, breastfeeding, and immunizations.

Contact: Beverly Clark, Contra Costa Public Health Division, 925-646-5376

Beyond initial meetings, a regular process helps to continue discussions and move a collaboration forward. This process might be an agreement to set a regular meeting schedule that enlists all of the potentially interested parties, and to prepare brief written summaries of meetings. If cooperation from a wider circle of providers is desired, then principal collaborators might design and conduct a survey of providers. For example, if the local WIC agency and the pediatric director of an MCO wish to promote breastfeeding, they might survey breastfeeding promotion practices among larger pediatric providers. Later, as needs for additional resources to carry out the collaboration are identified, the partners might identify outside funding sources and work together to write a proposal.
Formalize agreement

Once mutual interests have been established, collaborating organizations should identify lead individuals or key contacts to take responsibility for developing a formal agreement. Each self-identified partner should be prepared to work within his/her respective organization to develop a process for achieving the objectives. These steps initially might be outlined by one of the partners in draft form, and then discussed with specific attention as to how each might be accomplished. If changes in normal procedures, additional staff time, or other resources are required, these should be spelled out together with needed approvals. Resources contributed by each of the partners should be noted, even if these are listed informally. Information about the population of interest to both partners should be considered a resource, especially if it exists in an accessible database.

Formalizing the relationship through a letter of agreement or a memorandum of understanding will help to legitimize the time and resources that each partner dedicates to the collaboration. The letter of agreement should be signed by the people making policy and resource decisions for each collaborating organization, a process that will help to legitimize time and resources dedicated to the activity. A formal agreement will not, however, assure that the relationship continues beyond the departure or retirement of the lead individuals from their respective organizations. If relationships involve continuing or periodic actions on the part of one or both partners, then the formal agreement should be reviewed and renewed annually or biannually. This process reacquaints leadership within each collaborating agency with the partnership—especially important in situations where turnover is frequent.

California is one of several states to specify detailed requirements for coordination between MCOs and public health agencies at the local level, including WIC. Each MCO contracted with MediCal is required to develop an agreement with the local WIC program, and many have signed a written memorandum of understanding (MOU). To facilitate the process, the state WIC program issued a model MOU using a framework or table format. The framework includes the following general categories: liaison; client referral and outreach; appointment scheduling; tracking and follow-up; health requirements; provider network; community nutrition services; breastfeeding promotion and support; quality assurance; federal/state mandates; and monitoring and conflict resolution.

The MOU between the Contra Costa County WIC program and Contra Costa Health Plan (CCHP) specifies collaborative efforts in detail, including sharing of aggregate data, referral of eligible participants between WIC and CCHP, developing consistent breastfeeding messages, semi-annual liaison meetings, and annual reviews of performance. Specific responsibilities of CCHP are listed, include the provision of prescribed formula not provided by WIC, supplying training to providers on WIC program services (WIC acts as consultant), providing case management to clients
experiencing breastfeeding problems, and developing an exchange mechanism for the timely delivery of required data to WIC sites. WIC responsibilities include provision of dietary guidance for conditions not requiring medical nutrition therapy, reinforcing nutrition counseling recommendations of the Plan’s registered dietician (RD), distributing WIC forms and recertification schedules, and providing updated lists of WIC clinic sites, addresses, and dates/hours of operation.

Other state WIC programs have found that formal coordination agreements between MCOs and WIC are easier to establish if the MCO signs an MOU with the state WIC program or WIC Directors Association. Iowa opted for a statewide agreement when managed care plan directors complained that their legal departments could not cope with the extra burden of reviewing separate MOUs with each local WIC program. The Connecticut WIC program, in similar fashion, created a uniform MOU that it signs with each MCO. This document, while not as detailed or specific as the California MOUs, also stipulates that the MCO must designate an individual to serve as liaison to the WIC program.

**Iowa Health Solutions Partnership with WIC**

Iowa Health Solutions, with over 3,000 affiliated providers, operates in 26 counties throughout Iowa. Most of its health plan members are eligible for WIC, and most are enrolled in the Medicaid and the Healthy and Well Kids in Iowa (HAWK-I) programs. This managed care organization (MCO) has signed a contract with the Iowa WIC Association, which extends to the 10-15 local WIC agencies. Collaboration with WIC is "a very important part of our member’s lives and an absolute necessity," explains Joan Gilson, director of Medical Management at Iowa Health Solutions. The MCO’s contract with WIC allows plan members to get nutrition and preventive health services in several places around the state, where MCO health care providers allocate space, computer and laboratory equipment for WIC services. The WIC staff also has access to patient records as needed. When pregnant women, infants, and children first enroll in Iowa Health Solutions, the enrollment counselors screen for WIC eligibility and refer them to WIC. A referral form then is filled out and sent to WIC, either by providers or an enrollment counselor.

**Contact:** Quality Assurance Department, Iowa Health Solutions, 319-359-8999.
Identify additional resources

To make any collaborative relationship work, partners need to identify resources. Resources include all existing staff time, materials, and space dedicated to collaborative activities, as well as new staff, equipment, materials, and space that are required to carry out the activity. Collaboration may not require new resources initially, and efforts that are dedicated to the collaboration might also be useful for more than one purpose. For example, if a local WIC program is considering an outreach campaign with primary care providers in the area, then MCOs are logical partners. MCOs can place an item about WIC in their newsletter to providers, on their web site, and include it in enrollment information given to new members at no extra cost. If an MCO wishes to refer members to antismoking resources and knows that WIC offers classes and educational materials, it might purchase and donate extra materials to WIC sites and make the antismoking classes known to members.

Once a relationship between MCOs and WIC exists and planning for a new initiative begins, additional resources may be needed. In this case the partners will want to identify all resources that they can dedicate, and consider applying to outside funding sources as well. Some MCOs designate funding for community initiatives, and this should be tapped first. For example, the Partnership Healthplan of California (PHC) in Solano County, California, created an annual grant application process for small amounts of money called enhancement funds. Programs, such as WIC, can apply for these funds as start up money for special projects. The Solano County WIC Program has been awarded several of these enhancement grants. If more than one MCO provides health care to participants enrolled in a local WIC program, they should share in funding the new initiative, although this might be difficult to achieve in practice. The state health department, local foundations, or businesses might also have resources available to dedicate to health promotion initiatives sponsored by WIC programs (or their parent agencies) and MCOs. For example, the Wisconsin Division of Public Health encourages collaborations between the State Immunization Program, State Lead Poisoning Prevention Program, WIC, and MCOs.

Establish contractual agreements

In states where local public health agencies have traditionally provided primary care and personal preventive care services to low-income populations, new mandatory enrollment of Medicaid beneficiaries in managed care has often been accompanied by confusion about the extent to which managed care organizations are supposed to pay for preventive services like STDs, immunizations and lead screening. Managed care has also caused loss of revenue to public health agencies and nonprofit community-based agencies that have supported preventive health services with Medicaid reimbursements, such as perinatal case management and family planning. Some WIC programs and their parent agencies face similar challenges supporting the clinical and
case management services needed by high risk WIC beneficiaries that are beyond the scope of traditional WIC services. For example, medical nutrition therapy, often prescribed for high risk conditions such as gestational diabetes, severe obesity, or failure to thrive, can be provided by registered dietitians employed by WIC.

Resource Manual for MCH Service Contracts with Managed Care

The National Center for Education in Maternal and Child Health (NMCHC) commissioned an excellent resource manual with many helpful tips for community-based health agencies interested in developing contractual service agreements with managed care organizations. The publication is free of charge and can be ordered through the NMCHC website, [http://www.nmchc.org/html/cf/fullrec.cfm?ID=3615](http://www.nmchc.org/html/cf/fullrec.cfm?ID=3615). The title is *Collaboration with Managed Care Organizations, The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction, Volume V*. The suggestions in the manual, together with sample contract language, provide useful models in cases where the WIC agency participates in community-wide maternal and child health initiatives.

1. Establish agreement to obtain reimbursement for medical nutrition therapy

A few states report that local WIC programs have established agreements with managed care organizations to reimburse the parent agencies for medical nutrition therapy when referred by a plan provider. In order to function as intended, these agreements need to be accompanied by education of plan providers, referral forms, and follow-up communication to ensure that the physicians receive information about the treatment and results. The reimbursements for medical nutrition services can only be used to support salaries of qualified staff, usually a registered or licensed dietitian. The agency administering the contract must be prepared to track WIC funding and MCO reimbursements separately, to comply with USDA WIC program requirements. Examples A and B illustrate two types of reimbursement arrangements.
Example A: Solano Partnership Health Plan & Solano County WIC Program

The Partnership Health Plan of California (PHC), working with the Solano County Nutrition Services Program, created a medical nutrition therapy benefit. Physicians refer WIC participants and other patients to the Clinical Nutrition Services Program (CNSP) for medical nutrition therapy provided by a registered dietitian. Pregnant women with conditions such as diabetes, certain eating disorders, cancer, heart disease, HIV, obesity, and substance abuse may be referred for medical nutrition therapy. Young children diagnosed with conditions such as diabetes, lead poisoning, obesity, severe anemia, and failure-to-thrive are referred to the Clinical Nutrition Services Program.

Once referral criteria and procedures were developed, the CNSP hired additional registered dietitians to provide services. A two-page information guide was created and distributed to PHC physicians that describes the CNSP services, referral criteria for children and for adults, ICD-9 codes, eligibility criteria, and appointment procedures. Physicians requesting medical nutrition therapy for PHC members are required to fill out a "Referral Authorization Form" and fax it to the CNSP office. WIC staff help participants get a referral from their physician. CNSP registered dietitians hold several sessions with clients coming for medical nutrition therapy. The CNSP registered dietitian consults with the WIC registered dietitians and advises them on appropriate follow-up measures in patients' subsequent visits to WIC.

Staff of the Comprehensive Perinatal Services Program (CPSP) complete a "nutrition assessment and care plan" for each enrolled women on the WIC referral form. The referral form documents the CPSP program's work so that nutrition services are not duplicated between the WIC Program and the CPSP Program.

Contact: Denise Blunt 707-421-7231.
Example B: Heritage National Health Plan &
Family and Community Health Alliance WIC Program

In Cedar Rapids, Iowa, the local WIC Program is operated by the Hawkeye Area Community Action Program (HACAP). In 1996, HACAP and 5 other agencies formed a partnership, the Family and Community Health Alliance, to coordinate and reduce duplication of services. They have fully integrated WIC, maternal health, and preventive and developmental child health services, employs social workers, dietitians, nurse practitioners and dental hygienists among other specialists. Clients have responded very positively to the new arrangements, which include many “one-stop” services and newborn pre-certification for WIC before leaving the hospital. The Alliance sends letters to primary care physicians to inform them of the preventive services offered and to explain how to refer patients who have high risk nutrition problems (e.g., obesity, anemia, anorexia) for nutritional counseling. The Alliance has contractual agreements with the MCOs responsible for providing health care to Medicaid-enrolled clients. For example, the agreement with the Heritage National Health Plan, Inc. lists nutritional counseling for children ages 0-4 and maternal nutrition services for high risk patients as allowable charges for reimbursement.

Contact: Valerie Campbell, 319-366-7875.

Some WIC and Plan participants have risk conditions that require interventions more intensive than those normally provided by the WIC program, and whose severity justifies medical nutrition therapy reimbursable by the state Medicaid program. These conditions correspond to Level 4 Risk Conditions described in a California State WIC document. The California WIC Nutrition Intervention Committee published a report that clarified the types of nutrition services that WIC staff can provide to participants with diagnosed high risk conditions and recommended ways to ensure that such services are received. The report states: “Utilization of professional nutrition staff in many different programs and development of reimbursement mechanisms will enable health care MCOs to provide comprehensive (basic and specialized) nutrition care services to their members. WIC programs offer a unique resource to health care systems in the form of RD (registered dietitian) staff who may be contracted to provide the specialized services with reimbursement.”
Some managed care organizations may wish to provide WIC services directly to their members, either by contracting directly with the state health department or by subcontracting with a local WIC agency. Although very few MCOs provide WIC services directly at present, there is no reason why more could not explore this possibility more frequently in the future, provided that they meet regulatory and funding requirements. First, federal WIC program regulations prohibit for-profit organizations from delivering WIC services, but this would not constitute a barrier to not-for-profit managed care organizations. Second, WIC contracts may not fully cover operating costs, but in practice the sponsoring agencies often rely on health care providers to contribute in-kind services. In Massachusetts, for example, the Massachusetts General Hospital Corporation (part of Partners HealthCare System) is a local WIC contractor that provides WIC services at its satellite health centers. In Michigan, a nonprofit federally qualified MCO, OmniCare Health Plan, has been delivering WIC services in the Detroit area for the past 25 years.

**OmniCare Health Plan**

The OmniCare Health Plan, begun in 1974, is a federally qualified health maintenance organization and a subsidiary of United American Healthcare Corporation. OmniCare’s 100,000 members receive health care from a network of approximately 2,100 affiliated physicians located in 3 Detroit-area Michigan counties. Close to half of all members are enrolled in Medicaid or another state medical assistance program. OmniCare has offered WIC services for over 24 years at participating health care provider offices through a subcontract with the City of Detroit Health Department, one of the local WIC agencies in Michigan. WIC services are provided to approximately 2,500 participants on a weekly schedule at 22 different offices by a staff of 5 employed by OmniCare, including a supervisor (registered dietitian), a clerk, and 3 nutrition technicians. Most pregnant members of OmniCare participate in the Plan’s WIC program, receiving WIC services at the sites managed by OmniCare WIC staff.

Funding to administer the WIC program is reimbursed to OmniCare, according to the number of WIC participants using vouchers, through a standard personal services contract administered by the City of Detroit. OmniCare agrees to provide WIC nutrition services to a minimum caseload, issue food coupons, and maintain WIC records and files. The Detroit Health Department agrees to supply computer equipment, WIC forms and literature, and staff training. [PDF 010] displays sections of the contract.
OmniCare Health Plan, continued

OmniCare conducts outreach for WIC by informing employers, health care providers, and plan members of the availability of services at provider sites. A newsletter posted on the plan's web site and distributed to members informs the public about opportunities to receive WIC services at OmniCare locations. [PDF 022]. WIC staff make sure that eligibility information is given to all new OmniCare members and is available at all affiliated health care provider offices.

The OmniCare WIC program has been directed by Kathy Smith since 1976. OmniCare nutrition staff have space assigned to them at each of the 22 locations offering WIC. They obtain clinical nutrition laboratory test results for WIC participants directly from medical charts and use standard WIC forms and the electronic data system of the state of Michigan. WIC staff also refer high risk participants to their primary care provider or to maternal support available through OmniCare or the Detroit Health Department. Families with asthmatic children are referred to OmniCare's asthma management program. WIC and health care providers also collaborate on breastfeeding promotion, making sure that infants and toddlers are appropriately immunized, receive well-child care, and other health screenings.

Contact person: Kathy Smith, Supervisor, WIC and Nutrition Services, phone: 313-393-4532; fax 313-393-4560; email: ksmith@ochp.com

Change or establish information systems

WIC and MCO information systems have been established to meet the needs of funding agencies for program administration purposes and service delivery. They do not usually contain common information fields that allow identification of individuals enrolled in both systems. The WIC information system contains a field for Medicaid status, which is recorded at the time of each WIC certification or recertification. However, it does not contain a field for recording the name of the managed care plan responsible for providing health care to Medicaid beneficiaries. Even if recorded, this information could change by the time of the next WIC certification, and WIC participants do not always know their specific health plan affiliation. MCOs do not usually keep electronic medical records of enrollees, something that individual providers maintain. They may not have any information about the number of members participating in WIC, or be able to identify members who have been referred to WIC. Changing the existing information systems may be difficult to do without extensive study, approvals, and reprogramming and retraining activities for people who
input data. Blank or flexible information fields may be available, however, for special short term purposes.

WIC routinely collects data at the time of certification about the health risks affecting enrolled pregnant women, infants, and children, as well as their Medicaid enrollment status. As the attached form from the Connecticut WIC program illustrates, information for each WIC site might include the following risks:

<table>
<thead>
<tr>
<th>Health Risks Documented by WIC at Certification (typical data fields)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnant and Postpartum Women</strong></td>
</tr>
<tr>
<td>Height</td>
</tr>
<tr>
<td>Prepregnancy weight</td>
</tr>
<tr>
<td>Smoking</td>
</tr>
<tr>
<td>Gestational diabetes</td>
</tr>
<tr>
<td>Age at conception</td>
</tr>
<tr>
<td>Breastfeeding</td>
</tr>
<tr>
<td>Alcohol or drug use</td>
</tr>
<tr>
<td>Oral health problems</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

This health risk information, when aggregated by site, can help in identifying locations where higher proportions of children lack Medicaid ID numbers, and can assist Medicaid agencies to target outreach efforts. Information about specific health risks, such as smoking and gestational diabetes, can help MCOs determine whether to develop special interventions for certain health conditions affecting women and young children.

Over the longer term, state public health leaders may be able to introduce changes to information systems for publicly funded health care. If this happens, health/immunization registries like Rhode Island's KIDSNET might eventually contain information about MCO membership. KIDSNET reports have been used to assess health risks or program management at different provider locations, including WIC.
Rhode Island's KIDSNET Child Health Data System

In Rhode Island, infants are entered into KIDSNET through the Developmental Risk Assessment (done at birth). Health Insurance information is also collected at this time. (Note that RI Medicaid enrollees eligible for the managed care program must choose a managed care plan upon enrolling: either Neighborhood Health Plan, United Health Care of New England or Blue Cross/Blue Shield). The KIDSNET database, an enhanced immunization registry, tracks Newborn Developmental Risk Assessment Screenings, Early Intervention and Family Outreach Program (Home Visiting) services, newborn hearing assessments, lead and immunization data. With parental permission during WIC certification, select WIC information is linked directly to the statewide KIDSNET database.

At enrollment, WIC participants are asked to sign an "eligibility agreement" that gives permission a) for their health care providers and WIC to transfer medical information (for coordination of care) and b) for WIC to release information from the WIC record to the Rhode Island Departments of Human Services, Education, and Mental Health, Kids Net, the University of Rhode Island extension program, and any other programs designated by the local WIC agency for purposes of facilitating referrals. With consent, data for WIC infants and children is downloaded into KIDSNET, including the WIC ID number, hemoglobin/hematocrit blood test results, heights and weights, and risk factors used to determine eligibility.

Each of the KIDSNET participating programs has access to different levels and types of information guided by the KIDSNET policy manual (containing detailed guidance about confidentiality, types of access to the information fields and the options available to parents or guardians to block some information from being shared with some providers). WIC staff have access to information fields from Immunization and Lead Programs, Newborn Risk Assessment and demographics.

Contact person:  Becky Bessette, MS, RD, WIC Program Chief, Rhode Island WIC Program, email: beckyb@doh.state.ri.us; phone, 401-222-3940; fax, 401-277-1442.

Resolve issues that pose obstacles

A growing number of local WIC agencies and managed care organizations have established excellent working relationships to improve care for jointly enrolled
participants, despite obstacles that appear formidable at the outset. Most of these obstacles originate in the distance between the two professional cultures, and the lack of information about the other organization. Information from surveys of state and local WIC directors suggest that WIC agencies and managed care organizations can find ways to resolve issues that constitute barriers to coordinating efforts with managed care organizations. Barriers identified by state WIC directors included the following:

- State Medicaid agencies may not require managed care organizations or providers to make referrals or supply medical information to WIC.
- As managed care implementation increases the number of private providers available to Medicaid recipients, coordination with providers can be more difficult.
- WIC staff do not understand managed care systems, and managed care organizations do not understand what WIC does.
- Coordination and communication with managed care organizations are difficult when plan ownership changes, when the plan terminates the Medicaid contract, or when the plan’s headquarters are located in a different state.

Collaborative relationships between WIC and medical care have heretofore always been between WIC and medical providers directly, not WIC and the managed care organization. As a result, WIC agencies may not perceive a need to coordinate with MCOs. Managed care organizations contracted with Medicaid have much more to learn about the system of public health-related services utilized by their members in order to coordinate care and make referrals. Programs like WIC can help them meet short-term quality indicator and customer satisfaction goals as well as address longer-term health promotion goals.

Assess collaboration potential now

Local WIC agencies and MCO staff should review the questions listed on table 4 in order to assess the current status of coordination between WIC and MCOs, and to identify specific action steps that might be needed. Table 4 provides a convenient “yes – no” checklist of questions that quickly allow WIC and MCOs to determine where they stand in terms of collaborative efforts, and what specifically they can each do to increase the potential for productive collaborations. Questions are listed under the following objectives:

Local WIC Agencies
- Reduce number of uninsured WIC participants
- Improve coordination with managed care organizations
- Improve coordination with managed care providers
COLLABORATION BETWEEN WIC AND MANAGED CARE

- Create effective health promotion partnerships with MCOs

Managed Care Organizations

- Increase coordination with WIC
- Improve coordination between health care providers and WIC
- Create effective health promotion partnerships with WIC
- Establish contractual relationships with WIC
COLLABORATION BETWEEN WIC AND MANAGED CARE


93 (PDF 040) (1998) Sample, program description, Massachusetts WIC Program.


95 (PDF 064) Sample letter of agreement (1999). Commonwealth of Massachusetts, between WIC and Medicaid.


108 Salyer-Caldwell A (2000). Personal communication. A Salyer-Caldwell called the marketing directors of MCOs beginning to enroll members in Tarrant County, and told them "You may not know it yet, but you need WIC to be successful."


110 (PDF 023, 027, 028) Sample referral forms. WIC referral forms from Alabama, Massachusetts, and New Hampshire.
COLLABORATION BETWEEN WIC AND MANAGED CARE


113 [PDF 017] Sample outreach letter (1997). Letter to health care providers from VA Health Commissioner about WIC.


121 [PDF 064] Sample agreement (1999). Letter of Agreement between the WIC Program, Department of Public Health and the Division of Medical Assistance, Massachusetts.


124 Personal communication (1999). Denise West, Director, Dade County WIC Program, Miami.


128 [PDF 045]. Sample meeting summary (1999). Memorandum and table outlining relationships between an MCO and the Rhode Island WIC Program.

129 [PDF 016] Sample agreement (1998). Memorandum of understanding between Connecticut WIC Directors’ Association and [name of managed care organization].

130 [PDF 038] Sample program description (1999) Solano County Health and Social Services Department Clinical Nutrition Program.

131 [PDF 042] Description of integrated WIC and family health and support services center (1999). Iowa Family and Community Health Alliance, “Agency Spotlight Article, FY 1999.” Cedar Rapids, IA.
COLLABORATION BETWEEN WIC AND MANAGED CARE


Conclusions and Recommendations

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is the largest single program working to promote the health and nutrition of the most vulnerable groups in the United States. WIC is characterized by extensive outreach to low-income communities, regular contact with mothers and children, relatively simple enrollment procedures, and linkages with health and other social support programs. These features make WIC an ideal partner for the health systems now being developed in many states.

WIC programs have long worked in coordination with public health agencies and private physicians, but the rapid enrollment of many WIC participants in Medicaid managed care plans has introduced new private and public organizations to WIC. The managed care organizations (MCOs) that contract with Medicaid are generally not familiar with WIC, yet they have a federal mandate to assure coordination with WIC by referring potentially eligible members to the program and supplying medical information to WIC staff. A few MCOs have gone beyond the mandate to develop collaborations with WIC that hold promise for addressing the health risks of vulnerable families.

Surveys of WIC directors show that the coordination mandate has been implemented unevenly across the country. Some states do very little to promote or facilitate coordination, while others offer guidance, incentives, and directives for promoting collaboration between WIC programs and managed care organizations. More WIC-MCO coordination efforts are generally reported in states that have specific managed care contract requirements and in those with greater numbers of comprehensive MCOs. Most WIC directors report that managed care has not adversely affected WIC operations or health outcomes for WIC participants. However, WIC program directors need more support, information, and training from state health departments and Medicaid agencies to coordinate effectively with managed care organizations.

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. Many of the new 2010 health objectives for the nation developed by the U.S. Public Health Service are related to dietary practices, preventive health services, and health guidance recommended for mothers, infants, and children. Local WIC programs can contribute greatly to promoting these goals if given appropriate support and guidance. Similarly, managed care organizations can also promote the new health objectives with
guidance to physicians and health education for plan participants—if given appropriate incentives and guidance.

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 funding comes through state health departments, and many local health departments administer WIC programs. WIC staff can refer uninsured participants to Medicaid or SCHIP, help high risk participants obtain health care or social services, and counsel them about nutritional problems in coordination with managed care providers. Managed care organizations can help health care providers to supply medical information to WIC, refer patients to WIC for nutritional counseling, and together with WIC implement health promotion initiatives.

**Specific recommendations** for state Medicaid agencies and health departments, state WIC programs, and managed care plans are listed below.

1. State Medicaid agencies and health departments should take steps to promote and facilitate coordination between WIC and managed care organizations, including:
   - 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 WIC-MCO coordination and overcoming obstacles.
   - Facilitating joint health promotion and breastfeeding initiatives.

2. State WIC programs should provide more support and information to assist local WIC directors coordinate with MCOs. 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 the referral and supply of medical information to WIC.
- Supporting joint health promotion initiatives.
- Encouraging co-location of WIC and health care services.

Not all coordination activities involving WIC and managed care organizations require additional resources, especially those that are limited to referrals. However, additional resources are needed for successful collaborations that involve additional WIC staff time for screening, nutritional counseling, or education, and training of managed care providers. Likewise, sustained attention and support from state health agency and WIC program leaders is also necessary. Such attention can often identify and target resources to make collaboration a win-win situation. Local WIC directors often feel that they are being asked to perform public health and quality improvement tasks with USDA funding alone, a situation that leads to resentment and misunderstanding.

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 contribute to improve the health of communities and establish models for managed care systems.
Managed Care Glossary of Terms*

General Definition

The phrase “managed care” refers to a variety of financing and delivery arrangements (plans). Nearly all of them require that the people enrolled obtain their care through a network of participating providers. These providers are selected by the managed care organization (MCO) and agree to abide by the rules of that organization. This is in contrast to fee-for-service arrangements, in which patients typically may seek care from any licensed health care professional or organization, and in which providers may perform services based on their individual judgments about what is appropriate or needed.

Managed care organizations (MCOs) limit the providers available to patients enrolled in plans. A single MCO may administer several or even many different plans. The limit on providers is twofold: to control the patient’s access to services and to exert some kinds of control over the behavior of health care providers (commonly to limit services provided unless special permission is granted). By controlling access to and use of health care services, plans can better manage health care costs.

The ways in which managed care plans control access and utilization vary among the different managed care models. For example, most HMOs do not provide coverage for services outside of their networks. Plans also differ in terms of (1) the degree of financial risk that is placed on the physicians, as opposed to the plan or the payer; (2) the relationship among the physicians within the network; and (3) the exclusivity of the relationship between the plan or intermediary and the medical group.

Types of Managed Care Plans Common in Medicaid Managed Care

Preferred provider organization (PPO) plans have three defining characteristics. First, they normally pay physicians on a fee-for-service basis, often at a rate discounted from usual, customary, and reasonable charges. Second, PPO enrollees usually receive services from a network of solo or small-group physicians and a network of hospitals that have nonexclusive relationships with the PPO (although some enrollees may receive services in large-group practices). Third, there are provisions for plan members to receive services from non-network providers under certain circumstances.

Capitation plans involve a set dollar payment to the health care provider per patient per unit of time (usually per month) to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include a physician's own services, referral services, or all medical services.
MCO/FQ or HMO/FQ-- a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and that is federally qualified.

MCO/state plan defined or HMO/SPD-- a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and has been defined by the State’s Medicaid managed care agency in the plan approved by the federal government.

Prepaid health plan (PHP)-- an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

Primary care case management (PCCM)-- a program where the State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing services on a fee-for-service (FFS) basis.

Types of Provider Organizations

Independent practice association (IPA)-- an organized form of prepaid medical practice in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and private-pay patients. Participating physicians may be reimbursed by the IPA on a fee-for-service basis or a capitation basis.

Preferred Provider Organization (PPO)-- formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

Provider sponsored network (PSN) or provider service organization (PSO)-- formal affiliations of providers, organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs, or other health plans, may contract for health care services to covered individuals. Some models of integration include physician hospital organizations (PHOs) and management service organizations (MSOs).

Physician-hospital organization (PHO)-- a legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market
objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. Doctors maintain ownership of their practices and agree to accept managed care patients according to the terms of a professional services agreement with the PHO. The PHO serves as a collective negotiating and contracting unit. It is typically owned and governed jointly by a hospital and shareholder physicians.

**Management services organization (MSO)** -- The management services organization provides administrative and practice management services to physicians. An MSO may typically be owned by a hospital, hospitals, or investors. Large group practices may also establish MSOs to sell management services to other physician groups.

**Sources:**

*This glossary is adapted from and is based on the following sources:

HCFA website:


http://www.hcfa.gov/medicaid/glossary.htm


See: http://www.academyhealth.org/publications/glossary.htm
Tables and Figures

Table 1: Medicaid and SHIP eligibility levels by state

Table 2: Healthy People 2010 selected objectives

Figure 1: Funding for WIC and Medicaid-contracted MCOs

Table 3: Possible roles for Wic and managed care in promoting health objectives for enrollees

Table 4: Collaboration checklist for local WIC agencies