Collaboration between WIC and Managed Care: A Resource Guide

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

© Women’s and Children’s Center
Rollins School of Public Health
1518 Clifton Road NE
Phone 404-727-8095 • Fax 404-727-8744
EXECUTIVE SUMMARY—RESOURCE GUIDE

Rationale for collaboration ................................................................. 5
Current Situation ................................................................................. 6
Examples of collaboration ................................................................. 7
Barriers/solutions for collaboration .................................................... 9
Specific Actions Needed ................................................................. 10

1.  COLLABORATION ADVANCES  PROGRAM GOALS ............................... 13

Collaboration benefits WIC and managed care enrollees .................. 15
Collaborative relationships meet formal requirements .................... 19

2.  COLLABORATION PROMOTES HEALTH GOALS ................................ 24

Enhance prenatal care and decrease likelihood of low birthweight ........ 24
Improve maternal nutrition ............................................................... 27
Reduce smoking and substance abuse .............................................. 28
Promote breastfeeding .................................................................... 30
Improve infant feeding practices .................................................... 33
Increase immunization rates ............................................................. 34
Improve early childhood nutrition ................................................ 37
Reduce risk of lead toxicity ............................................................. 38

3.  HOW TO COLLABORATE? .................................................................. 46

Get to know key partners and their missions .................................... 47
Establish outreach and referral relationships between WIC and managed care .................................................. 53
Co-locate WIC and health care services whenever possible ............. 57
Develop partnerships ....................................................................... 58
Formalize agreement ....................................................................... 61
Identify additional resources ............................................................ 63
Establish contractual agreements .................................................... 63
Change or establish information systems ....................................... 68
Resolve issues that pose obstacles .................................................. 70
Assess collaboration potential now ................................................ 71

CONCLUSIONS AND RECOMMENDATIONS ........................................... 76

Managed Care Glossary of Terms* ..................................................... 79
Tables and Figures .......................................................................... 82
Collaboration between WIC and Managed Care: A Resource Guide

Executive Summary

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

© Women’s and Children’s Center
Rollins School of Public Health
1518 Clifton Road NE
Phone 404-727-8095 • Fax 404-727-8744
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.

Karen N. Bell
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)
Breastfeeding promotion

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

Partnerships to promote breastfeeding could work like this:

**WIC agencies could:**

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

**Medicaid managed care organizations** could:

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

**Health care providers** could:

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

Early childhood nutrition

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

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

WIC could:

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

Managed care organizations could:

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

Health care providers could:

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

Barriers/solutions for collaboration

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

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

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

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

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

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

Specific Actions Needed

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

WIC staff can refer uninsured participants to Medicaid or SCHIP, assist high-risk participants to obtain health care or social services, and counsel them about nutritional problems in coordination with managed care providers. Managed care organizations can assist health care providers to supply medical information to WIC, refer patients to WIC for nutritional counseling, and work with WIC to implement health promotion initiatives.
Collaboration between WIC and Managed Care

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
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.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.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.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.13

**Increase program enrollment**

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.

In 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:
COLLABORATION BETWEEN WIC AND MANAGED CARE

- 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.
