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. 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. 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 assures, 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.\textsuperscript{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.
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
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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.
Collaboration Between WIC and Managed Care

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.

Contact: Ann Salyer-Caldwell, Tarrant County WIC Director 817-871-7577

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.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 example111) 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.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.113 They sent a separate letter to office managers for private practices asking them to display WIC brochures and use the referral form.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
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}

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.

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:

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 agreement 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.

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. 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. Observers of the managed care industry expect that the situation will stabilize fairly soon, making it easier for
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

Larger providers may be able to facilitate a formal agreement with the MCO.
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.
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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.\textsuperscript{129} 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. 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>Pregnant and Postpartum Women</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>
</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, KidsNet, 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.


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