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An Assessment of the Impact of Medicaid Managed Care on WIC Program Coordination With Primary Care Services

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Abstract

Coordination between the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Medicaid has been an important component to ensuring access to primary care services for WIC clients. This study examines how increased use of managed care in the Medicaid program has affected WIC program coordination efforts. According to the study sample, 72 percent of State Medicaid agencies report that Managed Care Organizations (MCOs) are required to inform their members about WIC. About 43 percent of State WIC agencies sampled in the study have a formal agreement with a State Medicaid agency, generally revolving around data sharing, referrals, and provision of special metabolic infant formulas. The agreements often lack specific details on how services should be coordinated, however. Some local WIC agencies and MCOs have implemented innovative approaches to coordination. These approaches include Medicaid staff at WIC clinics to help clients with enrollment, sharing information to promote targeted outreach efforts, helping clients identify providers and resources, and MCOs paying transportation costs of WIC clients to attend WIC appointments.

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Executive Summary

A. Introduction

The Food and Nutrition Service (FNS) has long recognized that a crucial link exists between the WIC program and primary health care services. Coordinating WIC services with primary care provided under Medicaid has significant benefits to both programs and is required by both Centers for Medicare and Medicaid Services (CMS) and FNS regulations. With the increase in Medicaid managed care, the potential exists for traditional relationships between WIC and primary care to be affected in both positive and negative manners.

Specific objectives of this study include:

- Identification and description of State-level efforts to establish policies in support of the coordination of WIC with primary care provided through Medicaid managed care
- Examination of the methods used by WIC and Medicaid officials to implement program coordination across various models of Medicaid managed care
- Assessment of best practices used to implement coordination efforts among different models of WIC service delivery and primary care services supported by Medicaid, including factors that support or inhibit coordination efforts
- Identification of outcome indicators and data sources that can be used to track and measure the impact of managed care on local efforts to coordinate WIC and primary care

This study seeks to make information available to State WIC officials and federal policy makers regarding the impact of Medicaid managed care on the coordination between WIC and primary care services. Data from this study can be used by State WIC officials to assess how well existing program policies and procedures facilitate coordination and referral between WIC and Medicaid managed care. State WIC agencies will be able to use the data to re-design their own referral systems to take advantage of successful practices in other States and avoid potential pitfalls that States have experienced.

B. Background on WIC and Medicaid

Because part of the WIC mission includes improved maternal and child health outcomes, WIC can play a crucial role in expanding access to health care for pregnant women and

children. WIC often represents the first health encounter for pregnant women, and WIC staff regularly refers participants to appropriate health care and social services. This level of coordination was expanded with the passage of a 1989 Federal law that created adjunctive eligibility for WIC based on a client's participation in other means-tested programs, such as Medicaid and the Food Stamp Program.

Medicaid serves a special role in maintaining the health of low-income families, who comprise 75% of its beneficiaries. Medicaid entitles these recipients access to basic medical services, many of which can be used to promote improved birth outcomes. This program is administered and designed by each State, within broad Federal guidelines dictated by Federal statutes, regulations, and policies. Although these guidelines permit States some discretion in determining which populations will be covered, States are required to provide Medicaid coverage for certain mandated groups, such as low-income pregnant women and children.

C. Policy and Guidance

Policy findings from this study indicate the following:

- Approximately 43 percent of WIC agencies in this study have a formal agreement with Medicaid at the State level, generally regarding data sharing and referrals, though often lacking specific details on how services should be coordinated.
- Agreements tend to focus on three major areas of coordination, including client referrals, data sharing, and protocols for providing metabolic special formula. In addition some agreements include limited reimbursement arrangements from Medicaid to WIC for special nutrition services or outreach.
- Seventy-two percent of Medicaid agencies report that Managed Care Organizations (MCOs) are required to inform their members about WIC, and in many cases (64 percent) MCOs are required to make appropriate referrals to other health and social service agencies, including WIC.
- Nearly three-quarters of Medicaid agencies have guidance in place for referrals to WIC.

D. Implementation of Coordination

Actual implementation of coordination varies both across States and within States. Several States establish the framework for coordination in their policy directives but

leave it up to local agencies to implement coordination. Some local WIC and MCOs have developed very innovative approaches to coordination. Some examples include:

- Having Medicaid enrollment staff located at WIC clinics to help clients with the application process
- Sharing information on client enrollment in both programs to promote targeted outreach efforts
- Allowing MCO representatives to set up information booths at WIC sites to help clients with identifying providers and resources
- Promoting coordination through MCOs paying for transportation costs of WIC clients to attend their WIC appointments
- Promoting coordination of well-child services, such as immunizations and lead screening.

Most WIC agencies provide information to clients about Medicaid enrollment but do not assist clients in identifying or enrolling in a managed care organization. Some local agencies allow MCO representatives to provide information about their plan at WIC sites, but are careful to limit promotion activities to ensure that WIC agencies do not appear to be biased towards one plan over another.

Most WIC agencies try to collect data on referrals made to Medicaid, but do not track the outcome of referrals. Very few WIC agencies actually share data across programs, with only 15 percent of the WIC agencies reporting that data are shared on a routine basis. When data are shared, it is usually data related to referrals.

E. Outcomes of Coordination

Overview of Outcomes

One of the key issues in measuring outcomes is the priority given to data collection in this area by State officials. Findings from this study indicate that:

- At the State level, WIC staff is more likely (84 percent of States) than Medicaid staff (29 percent of States) to indicate that data were collected about WIC/Medicaid coordination.
- Where Medicaid staff does collect data to assess WIC/Medicaid coordination, those data generally pertain to a count of referrals made to WIC.

- According to State WIC staff, Medicaid Managed Care has had a predominantly neutral (42%) or positive (19%) impact on WIC client's access to primary care services. State WIC staff members who responded also feel that access varies by type of WIC agency.
- Similarly, 41% of Medicaid staff indicates that the introduction of Medicaid Managed Care had a neutral impact on access to primary care services among WIC clients while 36% feels that it has had a positive impact.
- State WIC staff reports that co-location and organizational connection builds MCO staff affinity for WIC clients and boosts that staff's ability to support them. However, others report that it is the co-location rather than the fact that clients are part of the network that is more important.

Barriers to Coordination

1. Medicaid Agency Perspective

State Medicaid staff identified only a few challenges to coordination between WIC and Medicaid, but those challenges were viewed as important. Challenges include:

- Trying to get physicians to change their attitudes and behavior regarding data sharing. This challenge has deep roots, as individual physicians are not accustomed to and may object to sharing data – a concern that is aggravated by uncertainties generated from HIPAA regulations.
- Lack of contact between MCOs and County health departments. MCOs lack knowledge of the services to which they are asked to refer patients and feel that being asked to make referrals on good faith is not an effective approach.
- Lack of face-to-face contact or development of interdepartmental relationships. In the eyes of many State Medicaid agencies, much of the coordination work has been executed remotely and in writing. There is a need for the establishment of working relationships and the development of State-level implementation guidance.

2. WIC Agency Perspective

WIC agencies tend to cite more barriers to coordination than do Medicaid agencies. Those barriers include the following:

- The amount of time it takes to foster a successful working relationship with Medicaid and the MCOs is often cited as a barrier.
- Similarly, there is an attitude on the part of a small number of WIC staff that coordinating with Medicaid is not a high priority. Staff in these agencies

expressed that competing demands within WIC, such as developing new data systems and implementing new federal regulations are of a higher priority than trying to work on Medicaid coordination.

- High Medicaid staff turnover is cited as a major barrier to having a contact person and establishing working relationships with Medicaid staff.
- Differences in levels of automation and data systems. The varying configurations and requirements of different systems cause data sharing difficulties, and the costs of making these systems more compatible often are viewed as prohibitively high.
- Confidentiality issues and interpretations surrounding data sharing must be negotiated and resolved between State agencies.
- Differences between the State level and local level of commitment to WIC/Medicaid coordination. Even when State staff is committed to coordination, the local staff may not share that commitment (e.g., due to prior negative client experiences with an MCO) or may not have the manpower to foster coordination.

F. Findings and Recommendations

A number of Key elements to successful coordination were identified in the study. These include:

- A shared interest level between WIC and Medicaid officials to ensure successful coordination efforts are initiated and maintained
- The ability of WIC agencies to replicate some of the more successful models of WIC and Medicaid managed care coordination that have taken place in other States
- Coordination between WIC and Medicaid managed care to improve delivery of services to clients in areas outside of direct WIC services, such as immunization referral and lead screening
- State or national level initiatives to address issues related to information and data sharing and provide guidance, particularly those related to HIPAA.

Additionally, WIC and Medicaid officials identified two key recommendations that equate to successful coordination efforts. These were:

- **Strengthen communication efforts to improve coordination.** Ongoing communications at the State and local level are necessary in order to develop and maintain a successful coordination effort.
- **Develop outcome findings that support coordination.** Being able to show successes or cost savings through coordination would be useful in expanding coordination to more local WIC agencies and MCOs.

This report was designed to provide both information about coordination and examples of successes. However, ongoing measures of success need to be developed, and expanded promotion of WIC and Medicaid managed care coordination needs to be implemented for these successes to generate more interest and activities in this area. Both WIC and Medicaid agencies involved in successful coordination efforts are pleased with what they have accomplished and can serve both as inspirations and models for expanded coordination efforts.

Chapter 1: Introduction and Purpose of the Study

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) is one of the cornerstones of the Federal Government's efforts to promote healthy diets for low-income Americans. Administered by the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA), WIC services are available through over 2000 local WIC agencies covering all States and the District of Columbia, five U.S. territories, and 34 tribal WIC programs. The WIC program provides nutrition education and counseling, supplemental nutritious foods, and screening and referrals to other health and social services programs. This Chapter provides an introduction to the study, the rationale for conducting the study, and the methods used for data collection and analysis

A. Introduction

FNS has long recognized that a crucial link exists between the WIC program and primary health care services. Coordinating WIC services with primary care provided under Medicaid has significant benefits to both programs and is required by both Centers for Medicare and Medicaid Services (CMS) and FNS regulations. With the increase in Medicaid managed care, the potential exists for traditional relationships between WIC and primary care to be affected in both positive and negative manners.

Specific objectives of this study include:

- Identification and description of State-level efforts to establish policies in support of the coordination of WIC with primary care provided through Medicaid managed care
- Examination of the methods used by WIC and Medicaid officials to implement program coordination across various models of Medicaid managed care
- Assessment of best practices used to implement coordination efforts among different models of WIC service delivery and primary care services supported by Medicaid, including factors that support or inhibit coordination efforts
- Identifying outcome indicators and data sources that can be used to track and measure the impact of managed care on local efforts to coordinate WIC and primary care

B. Rationale for the Study

The relationship between the WIC program and primary care services is an important component of the program. Most studies of WIC program effectiveness cite the ability of WIC clients to access primary and preventive health services as a significant factor in

improving birth outcomes. In this regard, WIC client participation in the Medicaid program has become a cornerstone of the referral systems developed by States. However, there currently is a lack of data on the magnitude and direction of the impact managed care has had on Medicaid and WIC. For instance, no data have been systematically collected that can be used to track the changes that have occurred in referrals between WIC and Medicaid following the rise of Medicaid managed care. In its 2001 report to Congress, the General Accounting Office noted that FNS efforts to implement outcome-based measures of health referrals have been unsuccessful, as they have not been able to establish any measures to assess the impact of health referrals on desired outcomes (GAO, 2001). In particular, while current State WIC data systems can document that a referral to Medicaid or primary care services was made, the systems often lack the capacity to track outcomes related to client referrals to determine if the client took appropriate actions.

One method that might be used to assess the impact of managed care on coordination and referral is to use linked WIC and Medicaid enrollment and participation data to track whether or not WIC clients referred to Medicaid actually enrolled in the program. While this method has potential for future assessments, it is not a tool that is currently available. The main reason is that most States do not link their WIC and Medicaid data, and those that do only do so on a one-time basis for special studies. Only the States of Missouri and North Carolina link these data on a routine basis (L. Bell, 2002).

In addition, there has not been any significant information collected regarding State and local level policies, procedures, reporting requirements, or incentives that may influence the type or magnitude of the impact that Medicaid managed care has had on WIC. States currently have no requirement to report on any of their formal arrangements with Medicaid, nor do they report on incentives that might be in place to promote coordination or activities undertaken by local WIC agencies to implement coordination requirements, guidelines, or incentives. For example, the most recent study related to WIC/Medicaid coordination (K. Bell, 2001) focused on identifying individual activities States have undertaken to improve coordination between WIC and Medicaid. However, this project was not designed to examine specific impacts of managed care nor the impact of managed care on WIC service delivery. While providing valuable information regarding some of the contract language used by States to promote coordination, the actual implementation activities related to the contract language were not studied, nor was there any attempt to assess the differences in coordination activities of different types of local WIC agencies or models of managed care.

This study is focused on examining the impact on WIC program operations as more and more States use managed care to deliver primary care services to their Medicaid populations, and to identify those factors that contribute to the success of WIC and Medicaid managed care coordination. It is important to note that the term “impact” is used in this study to identify changes in operations or service delivery, rather than specific outcomes of clients. In addition, the study describes how States have been able to overcome barriers to improve services to both WIC and Medicaid clients that are enrolled in managed care. Specific areas of coordination, such as data sharing, referral

coordination, policy development and sharing of resources have been identified as activities that facilitate a strong interaction between the two programs, both at the State level and with local WIC clinics and MCOs.

C. Study Methodology and Outcomes

This study is designed as a cross-sectional review of State efforts to coordinate WIC services with Medicaid managed care. As such, it examines current practices where managed care has been implemented and coordination efforts have take place. States were selected for this study based on a number of factors directly related to the level of coordination. First, states with a high percentage of Medicaid clients enrolled in managed care were identified. Then, of those states with a high proportion of managed care enrollees, a subset was developed based upon whether or not enrollment in managed care was required or voluntary. A second separate list of States was developed that reflected diversity in approach to serving WIC clients. For example, states were classified as primarily providing services through local public health departments, those with State-run WIC programs, and those that used a diverse group of local WIC agencies, such as primary care clinics, hospitals, social service agencies and other types of non-profit providers.

The two lists were then blended to provide a framework for analysis and to help as a screening tool to ensure diversity of the study States. Initial calls were made to all state¹ WIC programs where at least 20% of all Medicaid clients were enrolled in managed care.² State WIC officials were then asked if they had made any efforts to coordinate WIC services with Medicaid managed care and, if so, were asked to participate in the study.

As a result of this effort, 40 State WIC agencies agreed to be interviewed for the study. Once this agreement was in place, the study team contacted Medicaid officials in each of the 40 States to ask if 1) they were aware of WIC efforts to coordinate services with managed care, and 2) if they would be willing to participate in the study. Many State-level officials were un-aware of efforts to coordinate with WIC other than routine referral agreements, and others declined to participate because of heavy workloads. Others indicated that coordination might occur between WIC local agencies and MCOs, but they were not aware of any formal agreements or activities. As a result, 24 State Medicaid officials agreed to complete our survey.

The study also included a content analysis of agreements developed to support coordination, and detailed case studies of the referral and service coordination relationships between local WIC agencies and Medicaid managed care organizations in

¹ Only “geographic” states and the District of Columbia were considered for the Study. Tribal WIC State Agencies and Trust Territories were excluded.

² States with less than 20% of their Medicaid population enrolled in managed care included Mississippi, Illinois, South Carolina, New Hampshire, Alaska, and Wyoming. Source: Kaiser Family Foundation, State Health Facts; www.statehealthfacts.org

six States. The case studies included semi-structured interviews with selected local WIC directors, managed care organization officials, and their staff responsible for coordination efforts. This final report will discuss the status of WIC and managed care nationally, factors that contribute to and/or inhibit program coordination, and potential process and outcome measures that can track the impact of managed care on WIC program coordination.

The study also includes information from case studies from six States³. These States were selected after interview with all 40 WIC agencies were concluded. The States were selected based upon a number of factors, including innovative approaches being used by State WIC, Medicaid, local WIC and MCOs to coordinate efforts, the likelihood that these models could be replicated by WIC and Medicaid programs in other States, and the willingness of those involved in these efforts to participate in the case studies. Multiple sites were visited in each State to be able to compare and contrast approaches used by providers.

This study seeks to make information available to State WIC officials and federal policy makers to help in understanding the impact of Medicaid managed care on the coordination between WIC and primary care services. Data from this study can be used by State WIC officials to assess how well existing program policies and procedures facilitate coordination and referral between WIC and Medicaid managed care. State WIC agencies will be able to use the data to re-design their own referral systems to take advantage of successful practices in other States, or avoid pitfall States have experienced.

The study focuses on coordination between various level of provider that is involved in serving the WIC client. Three particular relationship levels were identified and examined through the survey. These include:

- Directions or policies on coordination that were given to local WIC agencies by the State WIC agency that went beyond general WIC/Medicaid coordination, and address issues related to coordination with managed care. These directions have resulted in a range of local activities, from simply requiring local WIC agencies to refine their referral methods to requiring that they attempt to develop local coordination agreements with MCOs.
- Coordination between State WIC officials and State Medicaid officials that directly addressed issues related to managed care. These types of agreements have included information sharing policies and procedures, policies directly related to coordination of specific services among multiple WIC agencies and local MCOs, or agreements on provision of special infant formula.
- Directions of policies communicated from the State Medicaid office to MCOs related to responsibilities for coordinating with local WIC agencies. These types of directions ranged from how to conduct outreach at local WIC clinics to coordination of referrals.

³ States selected for the case studies were Arizona, Illinois, Iowa, Oregon, Texas, and Wisconsin.

In all cases, States were asked how these arrangements differed from regular WIC/Medicaid coordination efforts, and how the increased use of managed care influenced their decisions related to changing coordination approaches.

The information provided by this study will help Federal, State and local policy makers and WIC directors in a number of ways. First, the study not only provides information for the assessment of current practices it also provides baseline information for future studies. Second, the study collects information from local WIC providers and MCOs in selected States to examine the extent to which efforts to implement coordination requirements or incentives at the local level are affected by the type of local WIC agency and the approach used by the State to implement managed care. Finally, the study examines how States currently use performance and outcome measures to assess the success of their coordination efforts, and, if they do, what data are available that could be used to assess the impact of various forms of managed care on local WIC agency coordination efforts in the future.

Chapter 2: Overview of WIC and Medicaid

This Chapter provides an overview of both the WIC and Medicaid programs, and the development of managed care in the Medicaid program. The WIC program was originally designed as an adjunct to health care delivery systems, and coordination between WIC and primary care providers has always been a hallmark of the program. While WIC program operations have remained essentially constant over the years, there have been significant changes in how primary care services, particularly those provided by the Medicaid Program, are being delivered.

A. Background on WIC Program Structure and Operations

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was created in 1972 and is administered by the Food and Nutrition Service within the U.S. Department of Agriculture (USDA). A recent USDA report describes the purpose of WIC as follows:

WIC was established to counteract the negative effects of poverty on prenatal and pediatric health and provides a combination of direct nutritional supplementation, nutrition education and counseling, and increased access to health care and social service providers for pregnant, breastfeeding, and post partum women; infants; and children up to the age of five years. By intervening during the prenatal period, WIC seeks to improve fetal development and reduce the incidence of low birth weight, short gestation, and maternal anemia (USDA, 2006).

WIC is a Federal grant program but not an entitlement program, as Congress does not set aside funds to allow every eligible individual to participate in the program. Currently, WIC is serving almost 9 million participants in all fifty States, the District of Columbia, five Territories, and 34 Indian Tribal Organizations.

Services are delivered through a system of 2,000 local agencies in 10,000 clinic sites, including the following:

- Stand alone primary care clinics, such as community and migrant health centers, Indian Health Service centers, and other primary care clinics,
- County health departments, including those that provide primary care services and those that focus only on core public health functions,
- Hospital outpatient departments or special clinics that serve women and children,
- Social service agencies, such as community action councils or economic opportunity centers,
- Military health centers located on bases, and
- University sponsored health clinics and school-based health centers

B. The WIC Program's Connection to Primary Care

Because part of the WIC mission includes improved maternal and child health outcomes, WIC can play a crucial role in expanding access to care. Staff regularly refers participants to appropriate health care and social services. This level of coordination was expanded with the passage of a 1989 Federal law that created adjunctive eligibility for WIC based on a client's participation in other means-tested programs, such as Medicaid and the Food Stamp Program.

WIC can serve as a link between clients and providers and sometimes operates as the gateway into the health care system, as a WIC appointment may represent a pregnant woman's first health encounter. WIC and primary health care programs share a common interest, and increasing coordination has benefits for participants as well as for the programs. The USDA promotes greater coordination because it has found that improved coordination among public agencies can:

- Increase the utilization of programs that complement WIC services
- Expand the scope and range of services offered by the programs
- Provide more systematic, rational, comprehensive care to clients
- Eliminate duplication in administrative, clinical, and client support activities
- Result in the most effective utilization of the resources (USDA, 2001).

Access to primary health care and WIC services is affected by the way in which WIC clients are able to access primary and preventative health care. For those WIC sites sponsored by county health departments or primary health care providers, clients are able to access both WIC and many primary care services on-site. In other cases, WIC programs sponsored by other types of agencies developed agreements for the WIC agency to offer WIC services on the sites of primary care providers, usually on specific days or times. This allows clients to easily access both WIC and primary care services, and often schedule appointments at the same time. Other types of WIC agencies operate independently of any primary care setting, and clients will receive their WIC services through an independent WIC provider and primary care services from a different source. In these cases, referrals are usually made to clients attending one or the other to access needed services.

C. Background on the Medicaid Program

The Medicaid Program, mandated by Title XIX of the Social Security Act, was enacted in 1965 as a joint Federal and State venture to provide medical assistance for certain low income individuals and families and now covers over 40 million individuals. With annual expenditures totaling \$266 billion (FY 2003) Medicaid is the largest source of funding for medical and health-related services for America's poorest people and plays a major role in health care delivery system (CMS Website, 2006; KFF, 2006).

This program is administered and designed by each State, within broad Federal guidelines dictated by Federal statutes, regulations, and policies. Although these guidelines permit States some discretion in determining which populations will be covered, States are required to provide Medicaid coverage for certain mandated groups. The following list constitutes the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996
- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL)
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care)
- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI)
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time)
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL
- Certain Medicare beneficiaries (CMS Website, 2006)

Medicaid serves a special role in maintaining the health of low-income families that are served by WIC programs, as children and parents comprise 75% of Medicaid beneficiaries (KFF, Medicaid Budgets). Medicaid entitles these recipients access to basic medical services, many of which can be used to promote improved birth outcomes. The list below comprises some of the mandatory services available to these recipients:

- Inpatient hospital
- Outpatient hospital
- Laboratory and X-ray
- Certified pediatric and family nurse practitioners
- Physicians' services
- Medical and surgical services of a dentist
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- Family planning services and supplies
- Prenatal care
- Pregnancy related services
- Nurse mid-wife services
- 60 days postpartum pregnancy related services (CMS, 2005)

D. Background on Medicaid Managed Care

Due to a variety of factors, Medicaid has experienced tremendous growth since its inception. As Medicaid expenditures have grown annually, States have made attempts to offset this growth by implementing cost containment measures, including the use of managed care delivery systems. Whereas managed care organizations (MCOs) have previously covered only privately insured individuals, States have increasingly relied on MCOs to deliver health services to Medicaid populations. According to the latest Centers for Medicare and Medicaid Services (CMS) data, the percentage of Medicaid recipients enrolled in managed care has increased from 40% in 1996 to 60% in 2004 (CMS, 2005).

CMS describes this alternative delivery system as follows:

Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow Statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs (CMS Website, 2006).

Managed care organizations are contracted by State Medicaid agencies to provide the mandated Medicaid services and provide these services using managed care models and arrangements designed to reduce the unnecessary use of services. There are a number of models through which these services are provided, but they are usually a variation of the following two models:

- **Capitated** – Under the capitated or risk-based model, an MCO is paid a fixed monthly fee per enrollee (capitation) and assumes some (partial- risk) or all (full-risk) of the financial risk for the delivery of a broad range of services. Some plans contract on a more limited basis.
- **Fee-for-Service Primary Care Case Management (PCCM)** – Under the PCCM model, a provider, usually the primary care physician, is responsible for acting as a ‘gatekeeper’ to approve and monitor the provision of services to beneficiaries. These gatekeepers do not assume financial risk for the provision of services, and are paid a per patient monthly case management fee (KFF, 2006).

E. Description of Types of Managed Care in States Selected for This Study

States selected for interviews were screened to capture a variety of WIC service delivery methods and approaches to Medicaid managed care. Twenty-four State Medicaid programs were selected for interviews, based on the type of managed care program initiated, the penetration rate of enrollees, whether or not enrollment in managed care was optional or mandatory, and the total percentage of clients enrolled in managed care.

The following table displays this information for the States that agreed to participate in the study. The table displays the State that participated and the type of managed care (Capitation or PCCM) that is in place. Some States have both Capitation and PCCM, often for different categories of client. For example, they may have capitation systems in place for routine primary care, but PCCM in place for specialty care. States also may have geographic differences in the type of managed care provided, such as PCCM in rural areas and capitation in more rural areas.

Additionally, there may be geographic variance in whether or not managed care is mandatory or voluntary. Where this geographic variation exists, it is noted under the enrollment option as “both.”

Medicaid Managed Care Program, by State, 2004

	Type of Program	Penetration Rate	Enrollment Option	Percent in Managed Care
Arizona	Capitated	Statewide	Mandatory	89.1%
Colorado	Combined	Regional	Voluntary	97.6%
Connecticut	Capitated	Statewide	Mandatory	75.4%
Florida	Combined	Statewide	Both	65.7%
Georgia	PCCM	Statewide	Mandatory	96.2%
Iowa	Combined	Statewide	Mandatory	92.1%
Indiana	Combined	Regional	Mandatory	63.4%
Kansas	Combined	Regional	Voluntary	57.0%
Louisiana	PCCM	Statewide	Mandatory	78.8%
Maryland	Capitated	Statewide	Mandatory	67.5%
Massachusetts	Combined	Statewide	Mandatory	61.4%
Michigan	Capitated	Statewide	Mandatory	89.0%
Minnesota	Capitated	Regional	Mandatory	63.5%
Missouri	Capitated	Statewide	Mandatory	44.4%
Montana	PCCM	Statewide	Mandatory	67.1%
North Dakota	Combined	Statewide	Mandatory	63.0%
New Jersey	Capitated	Statewide	Both	67.9%
Ohio	Capitated	Statewide	Both	30.8%
Pennsylvania	Combined	Regional	Both	79.1%
Rhode Island	Capitated	Statewide	Mandatory	69.2%
Tennessee	Capitated	Statewide	Mandatory	100%

Utah	Combined	Statewide	Both	88.6%
Vermont	PCCM	Statewide	Mandatory	66.0%
Washington	Combined	Statewide	Both	77.3%

State Medicaid officials were also asked to describe the provision of case management services and for those States with a PCCM program, the role of the primary care case manager. More than half of the 24 State Medicaid officials described some level of case management services, most of which were provided through a primary care physician. These programs used case managers to act as a “gatekeeper” to the delivery service system, coordinate care, and make necessary referrals for specialty services.

Chapter 3: Policy

The purpose of this section is to explore the policies that have been put in place for WIC and Medicaid coordination at the State and local levels. It will include a review of the formal and informal State-level agreements between WIC and Medicaid, as well as the guidance given by State officials from both programs to local WIC sites, Managed Care Organizations (MCOs), and Primary Care Case Management providers. It will also highlight key elements of these agreements and guidance that have promoted program coordination.

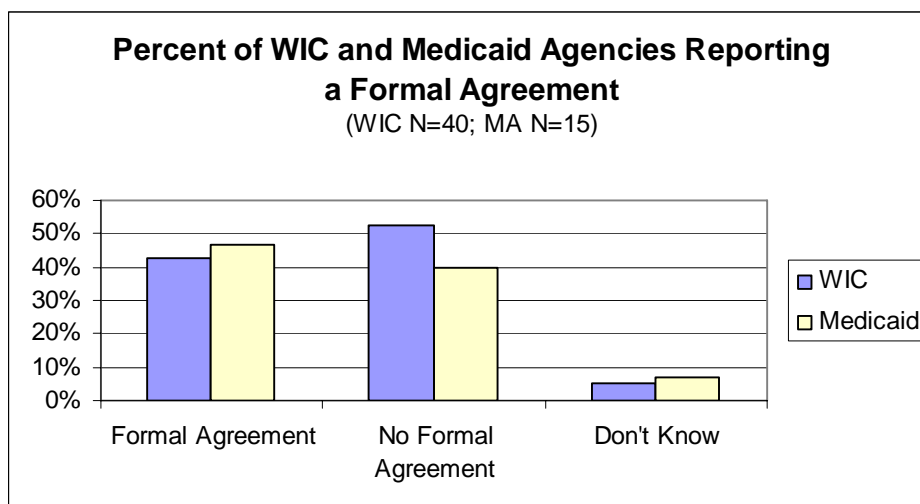
A. Nature of Agreements

Formal Agreements

Approximately 43 percent of WIC agencies stated they had a formal agreement with Medicaid at the State level. A similar percent of Medicaid agencies reported the same (Figure 3-A).⁴ In both cases, the WIC and Medicaid agencies described this agreement as being general or an umbrella-type agreement, which might state that data could be shared or that referrals should be made, but typically lacked specific details on how services should be coordinated.

“The document is helpful because it delineates responsibilities about sharing data with one another. Otherwise, it has no relevance to the way things really happen; it's not really followed.” -- State WIC Official

Figure 3-A. Percent of WIC and Medicaid Agencies Reporting a Formal Agreement



⁴ Medicaid agencies were asked to verify the existence of an agreement, as many agreements were developed several years ago, and some Medicaid officials were not aware that they continued to exist, thus the lower N= number for Medicaid agencies than the total that responded to the survey.

In some States, however, the agreement was more detailed, and served as a framework for coordination activities. For example, the Washington WIC agency reported a financial agreement with Medicaid, where WIC received Medicaid match for outreach provided through WIC's toll free 800 number. The toll free number referred potential clients to WIC, Medicaid, immunizations, and other services. This agreement was considered to be very useful in reaching people in need of services.

In Nebraska the Interagency Agreement stipulates that Medicaid include WIC staff in its quality assurance activities for Medicaid managed care. There also are provisions which allow sharing of data and reports regarding Medicaid enrollment for use in WIC outreach materials. Nebraska WIC views the sharing of data as core to the successful coordination of services.

The WIC and Medicaid agencies in Ohio and Vermont reported using a combined WIC/Medicaid program application. In addition, Vermont also had one referral form (Communication Tool) that was used by WIC, Medicaid, and all community agencies to refer clients to services, which facilitates coordination. Pennsylvania was in the process of exploring a common eligibility application as well.

Massachusetts did not use a common application, but the WIC-Medicaid agreement allowed for Medicaid to systematically share Protected Health Information. With the help of the Massachusetts Attorney General, a data sharing agreement was crafted to allow WIC and Medicaid to share client information that avoids confidentiality issues. WIC used this information to identify and follow-up with Medicaid members who are eligible for, but not using, WIC services.

Provision of special metabolic infant formula and specific high-risk nutrition services were also sometimes detailed in a formal agreement. In Iowa, for example, there was a formal agreement for providing special infant formula to combined WIC and Medicaid clients, where Medicaid paid when the client required more formula than WIC could provide.

As in Iowa, most States which described the agreement for special infant formula indicated that WIC was the first payer and Medicaid the second. However, California was one exception. Their agreement states that WIC payment for therapeutic formulas is secondary to the participant's health plan. According to the agreement, health care providers "may prescribe therapeutic formula and can use the Alternate and Therapeutic Formula Screening and Medical Justification forms" to enhance communication between provider and WIC.

In addition, a few agreements also described the provision of Expanded Nutrition Services. In Iowa, WIC agencies are required to have written agreement with the agency or private physician who will provide nutrition counseling reimbursable through Medicaid. There are contracts in place with Medicaid HMOs that specifically cover nutrition services and capitation payments.

Most WIC and Medicaid Agencies reported being satisfied with the agreement that was in place. Only one WIC agency described how they would like to be second payer for the special infant formula, but recognized that such a change was unlikely because of Medicaid funding restrictions.

Similarly, only one WIC agency reported any planned changes in the formal agreement. Virginia plans to expand data sharing to include online access between the two agencies. In addition, Virginia Medicaid will increase efforts to reach potentially eligible WIC populations, such as including WIC information in mass mailings to pregnant women. This will become a monthly effort. They also plan to expand referral services to Medicaid through the WIC 1-800 number and redesign printed materials that outline eligibility information so that materials are more eye-catching and easy to understand.

A few WIC agencies reported that in the past there had been an agreement for referrals, but that it had not been implemented and thus had fallen by the wayside and ultimately forgotten.

Only two WIC agencies reported having plans to enter into a formal agreement in the future. No Medicaid agencies reported the same.

Other Agreements

Of the twenty-one WIC agencies that reported having no formal agreement in place, seven (33 percent) reported that other, less formal agreements were currently in place. Such agreements seemed to pertain to the exchange of information and/or assistance with regard to outreach. For the remaining 14 WIC agencies interviewed, (approximately 35 percent of total) no agreement with Medicaid existed.

Other formal agreements existed that supported coordination even though they were not specifically designed for the coordination of WIC and Medicaid. For example a local organization in Iowa held the contract for WIC and also was contracted by the MCO to provide care coordination services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which is funded by Medicaid as a preventative health screening program for children. Similarly, one WIC clinic visited in Wisconsin was contracted by an MCO to provide case management services to pregnant women and EPSDT services to MCO clients receiving WIC services. These additional services had the positive benefit of integrating services and programs.

B. Coordination Requirements

State WIC and State Medicaid Agencies

In addition to the formal and informal agreements that WIC and Medicaid had in place at the State level, many State WIC manuals indicated that local WIC sites should establish agreements with local MCO providers. In such cases, the role of the State WIC was to help facilitate those relationships. For example, in Florida there was an agreement,

which allows for the disclosure of specific WIC information for the purposes of establishing eligibility of WIC applicants for health programs and for conducting outreach to WIC applicants and participants. At the local level, WIC guidance stated that local agencies would establish and maintain referral systems and coordinate WIC services with other health and social services, including Medicaid. The State WIC office and local agencies maintained and updated a statewide grassroots mailing list (Communications Network Listing) to be used for outreach purposes. In addition, the State WIC office provided technical assistance to local agencies to improve coordination.

California also had MOUs at the State and local level. At the State level, a liaison was appointed to coordinate activities with MCOs and to notify WIC staff members of their roles and responsibilities related to coordination. The liaison also acted as a consultant to the MCOs and Plan providers by updating WIC policies and guidelines as necessary, assisting the plan in conducting provider training on WIC program services and Federal regulations, and distributing WIC referral forms to plan. In addition, local agencies were encouraged to create MOUs more specific to the local situation to facilitate cooperation and coordination of provision of services.

In Arizona the State agencies required that Medicaid providers use a universal prenatal risk assessment form. If a woman was identified as being “high-risk” she was eligible for enhanced case management, which included coordination with WIC among other health and social services.

Local WIC Agencies

Other States had guidance that indicated local level agreements should exist. The District of Columbia provides a typical example of how guidance was provided to local agencies through the Policy and Procedure Manual. Key components of this guidance were that local agencies should establish a referral system with private health care providers to refer potentially eligible patients to WIC. The local agency is supposed to provide a WIC Information and Action Kit to potential referring health care providers with instructions on how to use the Private Physician Referral Form along with WIC brochures and information. There also was language in the Manual instructing local WIC agencies to provide WIC nutrition assessment data (blood work, nutrition info) to private physicians or providers, as deemed appropriate. The local agency was required to establish written formal agreement with any agency with which it intends to share participant information.

Managed Care Organizations and Providers

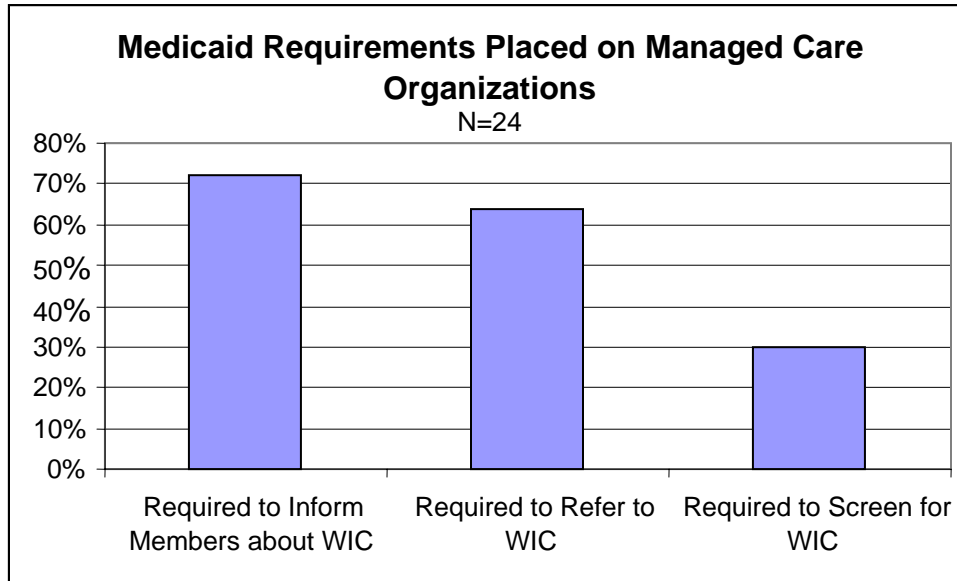
Almost all Medicaid agencies (72 percent) reported that MCOs are required to inform their members about WIC (Figure 3-B). The most commonly reported methods were through newsletters, brochures, and member handbooks.

Similarly, most Medicaid agencies reported that the contractual requirements with MCOs state that they must make appropriate referrals to other health and social service agencies,

including WIC (64 percent). Some State Medicaid agencies, like Maryland, require that their MCOs have contracts with the local health departments, which provide WIC.

Interestingly, however, only 30 percent of Medicaid agencies required their MCOs to screen for WIC. Louisiana is one such example that does require MCOs screening by requiring that the information on the WIC Participant Identification Folder be included in the MCO enrollment form to ensure that clients are enrolled in or are referred to WIC.

Figure 3-B. Medicaid Requirements Placed on Managed Care Organizations



Only two of the Medicaid agencies interviewed required Plans to share information with WIC agencies, and no Medicaid agency required Plans to follow-up on referrals. Furthermore, no State required MCOs to report the number of WIC referrals to the State Medicaid agency.

While about half of Medicaid agencies reported that case management included nutritional services and/or WIC, they were unlikely to require their Primary Care Case Management (PCCM) to screen for, or refer to, WIC. In fact, only two Medicaid Agencies reported that PCCMs were to screen for, or refer to, WIC. None were required to follow-up on referrals to WIC.

WIC as a Medically Necessary Service, One MCO's Policy in Wisconsin.

One of the large health plans in the Milwaukee area, which had multiple provider sites around the county, decided early on that having pregnant women and children enrolled in WIC would save the plan significant costs. As a result, the MCO created a provider policy that declared WIC a medically necessary service. This allowed the MCO to reimburse the WIC clinic and providers for providing transportation assistance for plan members to attend their WIC appointments. WIC officials noticed a decrease in the number of no-shows for their Medicaid clients once the policy was implemented.

C. Guidance and Training

While few requirements were placed on MCOs in regard to WIC coordination, almost three-quarters of Medicaid agencies had guidance in place for referrals to WIC. Most often this guidance was a part of the Plan contract (77 percent). In addition, just over half of the Medicaid agencies provided training to MCOs regarding WIC. This usually occurred through WIC presentations at regular meetings or during the plan/provider orientation. Training topics included general WIC program and procedures, eligibility to WIC, and addressing formula and payment issues.

Similarly, most WIC agencies reported that guidance was in place for referral to Medicaid (84 percent). Almost all of this guidance was included in the WIC policy and procedure manual (74 percent). In addition, 71 percent of WIC agencies trained their local staff in Medicaid eligibility and referrals. Such training most often occurred in new employee orientation (32 percent) or regular training sessions (25 percent). During site visits to Wisconsin and Oregon, officials reported receiving regular training from the State agencies on topics such as WIC/Medicaid program updates, breast pumps and infant formula.

While over half of the WIC agencies reported that the guidance and training provided was sufficient, a few identified issues that needed to be addressed. Most of these issues were about communication and procedures. Two WIC agencies described that there was much variation at the local level in terms of the relationship between local WIC agencies and local Medicaid offices. One WIC Agency described that it was a time consuming procedure to determine whether their client was enrolled in Medicaid.

In addition to the data gained through telephone interviews and site visits, HSR also reviewed State Plans and Policy Manuals. From such data sources, additional forms of coordination guidance were identified such as distribution of program information, use of common information and referral line, data sharing and details about the referral process. While most of the guidance is quite general, namely, that local agencies are supposed to distribute information, screen, and refer for other health and human services, some States' policies were more specific. For example, in Massachusetts, Medicaid provided quarterly data files to WIC which list contact information for women, infants, children

who have become Medicaid clients since the previous data transmission. It was the responsibility of local WIC agencies to follow-up on those not enrolled in WIC. A similar data sharing was done twice a year in Texas.

Chapter 4: Implementation, Mechanisms for Coordination

This chapter presents information on implementation strategies for coordination between WIC and Medicaid. Much of the actual implementation of coordination must take place at the local level between WIC agencies and MCOs. In this section, we will describe both State-level efforts to assist with implementation of coordination activities as well examples of local successes.

A. Screen, Inform, Refer and Follow-up

As described in the earlier Policy section of this report, most State WIC officials stated that guidance provided to local WIC agencies around coordination is very general in nature, most often included in the WIC policy and procedure manual, and typically instructs WIC staff to inform and refer WIC clients to Medicaid. One State WIC respondent (TX) explained that their State instructions for local WIC clinics are to provide a “description of the services Medicaid provides” as well as an explanation of the income guidelines for pregnant women and children.

Most State Medicaid agencies included in the survey reported that managed care organizations (MCO) were contractually required to refer members to WIC services. Most Medicaid policy or guidance related to the process of screening, informing, and referral are general in nature as well. They typically instruct MCOs to inform their members about WIC and to ensure that physicians make appropriate referrals to health and social services, including the WIC program. Most often this information is provided directly to a member during an office visit or through mailings conducted by the MCO.

The health plans interviewed during the Arizona site visit stated that informing their members about WIC is an area of focus, particularly for high-risk prenatal and perinatal members receiving case management services. One plan instructs its case manager to coordinate with WIC to establish individualized care plans for its higher risk patients. Plans also regularly inform members by mailing out WIC brochures to potentially eligible women. Providers were reported as playing a key role in the referral process. Obstetricians and gynecologists often refer to WIC during pregnancy assessments, and as EPSDT providers, pediatricians also refer patients to WIC. Most of the MCOs interviewed in Illinois also believed their providers were educated about the WIC program and regularly refer to WIC. This is supported by a survey conducted by one Chicago WIC clinic that found that the primary source of referrals to WIC was the client’s physician. This WIC director has seen a growth in the WIC program over the past few years and credits the MCOs for contributing to this growth through increased referrals.

In Arizona, WIC staff typically screens for Medicaid but does not assist clients in completing Medicaid applications and instead provides them with contact information for the closest Department of Economic Security office or a phone number where they can

access information about Medicaid or SCHIP. Beyond this, most WIC clinics do not assist clients in the Medicaid or SCHIP enrollment process, although WIC does support enrollment efforts, such as those of outreach workers stationed at clinics and health departments. WIC also does not assist clients in their selection of managed care plans and instead refers clients to Medicaid when they have questions about a participating managed care plan or provider. Respondents also added that while many referrals are made to Medicaid, there are far fewer referrals to WIC, except in the case when a special infant formula is needed because WIC is the primary payer for infant formula.

Medicaid Enrollment Staff at WIC Clinics, the Marion County Approach.

One local WIC agency in Oregon worked out an agreement with the local Medicaid office to outstation a caseworker at the WIC clinic site to help clients enroll in Medicaid. The caseworker provides information to clients by conducting outreach sessions in the waiting room, and then was available to help individuals enroll in Medicaid and identify a potential health plan. She also conducts separate information sessions in English and Spanish. The caseworker provided information about Medicaid eligibility, helped clients complete enrollment forms, and provided information about MCO enrollment choices. She is also available to follow-up on applications to help clients who did not complete applications properly or if further information is needed to complete enrollment.

The Medicaid referral process was reported to be working very well in Illinois, and this was due primarily to the co-location of these WIC clinics within a community hospital and health centers. This was also the case in Iowa, where a WIC clinic was co-located with a Department of Human Services office – the office responsible for Medicaid enrollment in the State. The referral process was simplified because clients were able to enroll for Medicaid on-site, and it was assumed that because it was less burdensome on clients they were more likely to follow through with the referral.

Even without co-location, some States that have made additional efforts to facilitate clients' enrollment in Medicaid. Wisconsin is such an example. For those not certified on Medicaid, both WIC clinics selected for the site visit offer presumptive eligibility for pregnant women. They assist clients with applications and then fax the application information to the State for processing.

Although the WIC agencies visited in Illinois, Iowa, and Wisconsin assist with the Medicaid application process they do not play a role in the managed care enrollment process. This is also reflected in the interviews conducted with State WIC officials. A majority of States does not assist clients with the process of choosing either a managed care plan (70%) or primary care provider (62.5%). Typically, this was considered outside of the WIC role and the responsibility of other agencies, such as the Medicaid agency. Furthermore, some WIC agencies felt uninformed or uncomfortable with answering questions about the MCOs, especially when these WIC clinics had formed unfavorable opinions about one or more of the MCOs. This was mentioned during the site visits to Iowa and Illinois, when directors expressed that WIC should not be involved in the

selection of managed care plans and should not introduce their biases and influence their clients' choices. The Oregon WIC agency addressed this issue by working with "other office of family health programs (MCH) and have pooled money to support an (800) number so clients can call and request information on services."

About half of State officials interviewed (52.5%) reported not providing clients with information about the managed care enrollment process. Of the WIC agencies that did provide some information, ten (25%) States gave clients general program or plan information about enrolling in managed care, and six (15%) provided clients contact information for participating sites or providers. One respondent noted that "the Department of Human Services provides a packet of information that WIC staff gives out and in it there is information about the managed care system and how to select a plan/provider, but the WIC staff does not discuss these topics specifically with clients."

MCO recruitment and enrollment at WIC Sites, the New Jersey Experience.

One MCO in New Jersey recognized early on that the local WIC program might serve as a source for potential client enrollment into their MCO. The MCO entered into an agreement with the local WIC agency to provide on-site assistance with the MCO's enrollment process. A representative of the MCO attended WIC clinics twice a week and set up a booth by which he could pass out information about the MCO, its coverage areas, benefits, and provider network. He also answered questions about how to enroll in Medicaid and helped WIC clients complete Medicaid enrollment forms. The WIC clinic director felt that the presence of the MCO representative was very helpful to the WIC clients. Prior to the agreement, many WIC clients were unsure as to how to select a plan, or what to expect once they were enrolled. In addition, coordination between the MCO's provider network and the WIC clinic was significantly improved, as the MCO representative could trouble shoot if there were client access issues.

Although more specific questions about the managed care enrollment process were not asked during the interviews with State officials, some negative impressions of this process were communicated during the site visits. In Illinois, a WIC director mentioned that MCOs were previously permitted to solicit for members in WIC clinics, but this process created a lot of confusion. This led to a change in marketing strategies among the MCOs. Each of the managed care plans described intensive marketing efforts and explained that most of their recruitment is done in person and through word of mouth. Each plan has numerous marketing representatives actively recruiting at various locations including physician offices, day care centers, schools, and grocery stores and during community events such as health fairs. Several of the health plans mentioned that there is a negative perception of MCOs among WIC staff members and among some members of the community. A plan representative cited the competitive recruitment environment as having influenced this perception, which has challenged their ability to coordinate on medical management and quality issues. This belief was confirmed in interviews with the

WIC Directors, who felt that MCOs are very aggressive in their marketing efforts and have participated in unethical marketing practices.

Beyond the enrollment process, State officials were also asked about their role in helping clients access other needed services, including health services. States reported that referral to other social services was standard. Vermont shared that it had one referral form (Communication Tool) that was used by WIC, Medicaid, and additional community agencies to refer clients to services, which facilitated coordination among these agencies.

Many State WIC agencies reported a minimal role in health supervision. One respondent noted that at the time of WIC certification, “WIC staff asks about having a health care provider or medical home...if not, the staff provides clients with suggestions.” Another State “encourages clients to have and use medical home. It’s part of WIC culture.” If a health need is identified during the WIC intake appointment, then the client is referred to health services. Across the board, States reported that special health cases were the exception. WIC staff did play a greater role with clients that were at particular risk and required a higher level of coordination with physicians, such as a child with special health care needs.

Care Coordination in Wisconsin.

Although care coordination is not mandated by the Medicaid State agency, it does take place at the local level and involves WIC agencies, providers, and pediatric nurses within what are called “safety net clinics”. Referred to as ‘cocoon nurses,’ these nurses provide early intervention care, coordinate appointments, and act as liaisons to the WIC program. Care coordination between the Medicaid MCO and the WIC agency occurs for individuals deemed as at risk from ‘failure to thrive.’

B. Information

Data Collection

In addition to asking about the referral process, interviewees were also asked about the types of information collected regarding coordination, referrals, and follow-up to referrals. Thirty-two State WIC agencies (80%) reported collecting data regarding WIC and Medicaid coordination, while only seven Medicaid officials (28%) reported doing so.

The most common types of data are program participation rates and referral data. A total of 42.5% of WIC State agencies collect information on the Medicaid participation rates of their clients, and 27.5% of States track the referrals made to Medicaid. The New Jersey WIC agency collects both types of information and reported that they “collect the number of referrals, number of Medicaid clients enrolled in WIC and number of WIC clients enrolled in Medicaid.”

Very few (16%) State Medicaid officials reported the collection of referral data and only two Medicaid agencies track WIC program participation rates. Most States described that

referrals were captured by a particular field or ‘check box’ in the system to indicate a referral had been made to Medicaid or another program. Program participation information was also documented in a similar fashion, whereas the worker checked the boxes corresponding to all programs a client was enrolled in at the time of certification. Some systems are designed to automatically display these data screens, prompting a worker to review these items with a client before proceeding, but in other cases, documentation of this information is optional. Such is the case in Hawaii where it was reported that the “automated system used by WIC staff does have a field that can capture if a referral was made, but it is an optional field and this information usually isn’t documented.”

The Rhode Island Medicaid official detailed the process of data collection and explained that “any data collected on referrals (including WIC) is through the Rhode Island Family Resource Counselor (FRC) Program. This program operated by the RI Health Center Association is designed to screen and refer pregnant women and children to health and social services. These counselors operate out of Community Health Centers, hospitals and community based agencies. The program is funded by DHS and DOH with federal matching funds. These counselors help families by applying for assistance programs and provide referrals to services.”

Over half (56%) of State Medicaid officials surveyed reported that no information was collected regarding WIC and Medicaid coordination, although it was noted that managed care organizations were more likely to track data, often because they have a greater capacity for the collection and analysis of data. These results did not vary by whether or not managed care enrollment was mandatory or voluntary. While meeting with health plans in Arizona, several mentioned capturing referral information during patient visits. One plan asks its case management patients about WIC services and tracks this information using its maternal health data system. Another plan has clinical staff that follows up with EPSDT and WIC referrals, which are also captured in an automated data system.

When asked how data were collected and managed, there were vast differences in the data systems. Although a few agencies continue to document this information manually in paper records, most States have database or management information systems designed for this purpose. Even though most States use some form of automated system, the capacities of these systems varies considerably from State to State. Some State systems are outdated and not Web-based, while others are more sophisticated and linked to other data sources. In Iowa the WIC agency is working with a contractor to implement a new Web-based data system that will enable local agencies to create client reports, which currently can only be generated by the State office.

Data Sharing

Six State WIC agencies (15%) reported routinely sharing information with Medicaid. All of these States noted, however, that they had a long standing relationship with regard to data sharing, and simply updated agreements as managed care became more prevalent.

The remaining States did not have any type of data sharing agreement. One of the State respondents stated that WIC and Medicaid only share information related to eligibility of participants and with the implementation of HIPAA, even this level of information was difficult for some WIC agencies to obtain. The WIC sites interviewed in Arizona reported that generally no information is shared with the AHCCCS (Medicaid program) primarily due to confidentiality restrictions. The States of Ohio and Vermont are able to share client information, with the client's consent, by using a combined program application for WIC with Medicaid.

Only two of the State Medicaid agencies interviewed required managed care plans to share information with WIC agencies and almost half (47.5%) of the State WIC officials said that no information was routinely shared. Fourteen State WIC agencies (35%) and 28% of State Medicaid officials reported routine sharing of information between WIC and managed care organizations and providers.

Patient medical information such as test results was the most common type of information shared between WIC and managed care organizations by both WIC and Medicaid interviewees. One official shared that "sometimes a provider will request specific information on a client or WIC will provide info to a provider-but this is information release is authorized by the client." (SD) This process appears to vary on the local level. In some cases, this is accomplished through direct contact between providers and WIC staff, and in other cases, they communicate primarily through the client/patient. One of the Wisconsin sites did not contact PCPs for test results but did encourage their clients to bring in relevant test results (i.e. hemoglobin) to WIC appointments. In the Oregon site visit, WIC and providers are able to share screening information (lead, hematocrit) using a HIPAA waiver.

Twelve State WIC agencies (30%) reported providing information about WIC to primary care case managers. The South Dakota official noted that "the WIC program does not provide information to case managers, except in the case of certain clients because coordination is encouraged with high-risk participants." Another State WIC official shared that "in these cases, information sharing happens on a case by case basis, if physician is requesting medical information."

Data Sharing Between WIC and Medicaid in Arizona.

Information was typically shared between WIC and MCO providers on a case-by-case basis. Generally, it was for the purposes of coordinating a special infant formula for a child or to share nutritional assessment information such as blood work (hemoglobin), weight, and height. This information was most often communicated to providers through the patient. For instance, some clinics provide referral forms to women (pregnant, postpartum, breastfeeding) to obtain specific information from their physician at a subsequent medical appointment. In other instances, WIC clients signed waivers enabling the clinics and providers to share information directly. This process worked particularly well at one site that was co-located with a health clinic because WIC staff could directly access client charts and medical records. Another WIC clinic expressed an interest in having an information sharing agreement with managed care organizations and their providers. This WIC clinic has benefited from having this type of agreement in place with other community programs, such as a food program.

In the review of State policies, it was noted that many State WIC agencies mandated that local WIC sites establish agreements with local MCOs and providers. Although not common, some WIC agencies have data sharing agreements in place. One of the WIC sites visited in Illinois regularly shares client information with other agencies to improve the provision of case management services and has entered into a data sharing agreement to facilitate this process. In Florida there was an agreement, which allows for the disclosure of specific WIC information for the purposes of establishing eligibility of WIC applicant for health programs and conducting outreach to WIC applicants and participants.

Another mechanism for sharing information is to link data and provide several agencies or organizations access to a data source. Oregon links birth certificate data with WIC, and in Iowa both WIC and DHS offices have access to a shared database that contains county-specific certification information. The local WIC agencies are able to access monthly updates about new Medicaid certifications which are then used to identify potentially eligible clients and to conduct outreach activities. Other States, such as Vermont and Massachusetts have similar processes.

A number of States are using data matching to compare clients enrolled in WIC against those enrolled in Medicaid programs, which enables States to identify potentially eligible clients. “The Idaho WIC System is used to verify WIC enrollees' participation in Medicaid through name and social security number match. The WIC system is able to connect with the Medicaid data system in order to do this.” The Massachusetts Medicaid program (MassHealth) official explained that MassHealth has “provided WIC a list of enrolled clients. WIC compared this listing against its enrolled clients and mailed information to those not enrolled in WIC and potentially eligible-more clients were enrolled in Medicaid than in WIC. They plan to do this regularly.”

Some States have found this type of information exchange to be helpful but other States, such as Maryland, expressed that the view that it was not very useful. The Maryland interviewee explained that data matching was used in the past, but that was over 10 years ago. This individual felt that the WIC program was aware of how many of its clients were enrolled in Medicaid without this data. The Rhode Island interviewee also felt that data matching was not effective and preferred to have access to data in some other form.

Although data matching was successfully used in some States, other States like California experienced some challenges with this process and had problems properly matching up clients. Because social security numbers are not required, officials were using other fields to match up records and found the process to be more complex than initially conceived. Furthermore, it was suggested that this level of data sharing should be coordinated at the State level and not by local agencies.

WIC agencies used the data match process for outreach purposes. WIC used this information to identify and follow-up with Medicaid members eligible for but not certified for WIC. Like Massachusetts, many States indicate using data matching activities to target outreach activities. In addition to aggregate data sharing, much of the data sharing took place locally between individual WIC staff members and providers. This level of data sharing was used to coordinate care or to resolve payment issues.

Generally, the MCOs that were interviewed expressed an interest in sharing information to reduce duplication of services and to improve the health outcomes of its members. Like the WIC clinics, the MCOs can see a benefit in data sharing and knowing what services are received through WIC. During the Illinois site visit, WIC coordinators expressed the opinion that it would be beneficial to share information about such things as immunization, because both WIC and providers are immunizing children. One of the plan administrators also supported this conclusion and remarked that school age children are probably over-immunized, because there is no effective system in place to compare with WIC records, such as a Statewide immunization registry that many States have in place.

C. Other Mechanisms for Coordination

When asked about other coordination efforts, almost half (45%) of State WIC officials and one third (32%) of State Medicaid officials said that there were other mechanisms in addition to contract provisions through which coordination takes place.

Some of the State WIC and Medicaid officials used meetings as a collaboration tool. WIC in New Jersey requested initial meetings with the MCOs, which the respondent felt legitimized WIC as a contributing partner with “benefits and money to bring to the table...rather than someone asking the plans for something without tangible benefits for their enrollees.” Arizona has quarterly meetings that include WIC, EPDST coordinators and managed care organizations to address cross agency communication and collaboration. The managed care plans reported that although they may not have formal

relationships with WIC agencies, most plan representatives felt comfortable in approaching a WIC director should a question or problem arise. Although it took place at the State level in Arizona, this type of collaboration was more likely to take place locally.

The State WIC respondent from Hawaii described minimal coordination efforts between WIC and managed care and none specific to address referrals. Instead, these agencies worked together through committees on issues relating to children's health. Arizona is also an example of a State where local collaboration has been successful. Although the local WIC sites did not meet regularly with MCOs, they did coordinate as opportunities arose. For example, in some locations of the State, WIC works with health plan representatives while jointly serving on coalitions and alliances assembled to work on maternal and child health issues. Both WIC and Health Plan representatives serve on a Head Start Health Services Advisory Board, which was initiated by Head Start to improve the coordination of services and in Phoenix they also serve on a workgroup that is addressing child obesity.

Even though only three State Medicaid officials (12%) said that Medicaid funded WIC agencies to conduct outreach or case management, there were a number of examples where these activities were taking place. Co-sponsoring outreach activities is also another mechanism for coordination at the local level. One WIC respondent in Pima County (AZ) mentioned that several plans participate in the Care Fair held before the start of the school year. This is an annual event that reaches close to 2,000 families, where they can receive health services such as dental screenings and health education, and access other services such as energy assistance. Some MCOs in the county sponsor and participate in this event. The MCO interviewed during the Wisconsin site visit performs onsite outreach at three WIC sites, where representatives speak with members and identify high-risk participants and assist them with the enrollment process. Also, this MCO offers its members transportation to WIC appointments (within Milwaukee County) because WIC is considered a "medically necessary" service. One of the State officials from Tennessee described how a "contract between the State of Tennessee, Department of Finance and Administration Bureau of TennCare and Tennessee Department of Health funds WIC to conduct outreach activities that are conducted by the Department of Health through their 95 county offices."

There also were examples of WIC clinics expanding their role to include other functions such as care coordination. Two of the WIC clinics visited in Iowa have established a formal relationship with a managed care organization to provide EPSDT services in several counties and are trying to enter into a formal contract with the MCO to be reimbursed for care coordination as well. Even though only three State Medicaid officials (12%) said that Medicaid funded WIC agencies to conduct outreach or case management, there were several examples where this model was used. One State official in Washington described coordinating through the First Steps program, a maternity management program. Another official in Michigan went into depth to describe the State's coordination mechanism, the Building Bridges program, which involves WIC, MCOs, and health departments. This model recognizes that WIC is a great point of entry for patients to access Medicaid and health services. An example of what is delineated in their

arrangement is regarding lead testing. The blood test is completed by either the WIC program or health department and paid for by the MCO. The test results are sent to the PCP and/or MCO, and if there are elevated levels, the MCO will do the follow-up. This process was established through a collaborative effort by all those involved and has not become policy. They also have arrangements covering immunizations and EPSDT screenings. Additionally, the plan is required to provide transportation to WIC appointments. Since the implementation of this initiative, there have been increased rates of lead screenings and immunizations.

Iowa Site Visit, Leveraging Coordination Efforts.

Agencies that receive Title V funds have greater flexibility in their ability to assist clients and connect them with services. One office has a Title V funded social worker that assists clients in applying for Medicaid or in resolving a problem with DHS. Another WIC clinic affiliated with a community action agency oversees satellite WIC clinics within a county also conducts outreach for HAWK-I (SCHIP). Because this worker is already helping clients complete applications for this program, she has recently extended her responsibilities to include assisting clients with Medicaid applications as well. She explains the application process, helps gather the necessary documentation and mails the completed applications to the Medicaid office for processing. Soon she will begin assisting clients with Food Stamp applications, because it would require additional minimal effort since DHS has a joint application that enables clients to apply for these programs in one application.

Half of State Medicaid officials (52%) said that Medicaid did not reimburse WIC agencies for nutrition support, counseling, or education services for pregnant women. One official noted that “Medicaid does not reimburse WIC directly...it reimburses public health staff that provides nutrition support/counseling at WIC clinics.” Another respondent mentioned that there was “no direct reimbursement, but help WIC agencies determine what should be covered.”

Another mechanism for coordination is the use of a liaison. Several States including California and Illinois use a liaison that can coordinate any issues between WIC and Medicaid. Private funding in California funds two positions, one within the WIC agency and another in the Medicaid office. This model operates on a local level in Illinois, where one of the WIC clinics hired an LPN to work as an MCH coordinator, who also serves as primary WIC liaison to MCOs and other organizations. This individual represents WIC at joint meetings and has contributed to a greater level of coordination.

D. Monitoring, Incentives and Sanctions

Even when coordination requirements were in place, States either did not enforce requirements or had few measures in place to do so. Most States communicated that the means to evaluate and monitor referrals is not within the capacity of existing data

systems. When State Medicaid agencies were asked about how requirements were monitored, only five agencies reported that monitoring activities took place. The standard monitoring tool used by Medicaid agencies or MCOs in these States is the annual or financial review process but States described it has limited application. For example, health plans in Arizona mentioned that referrals are assessed during chart reviews and the case management notes and that a number of items are reviewed during this process. And although appropriate referrals is typically reviewed, referrals to WIC may not be specifically reviewed and could be captured under the broader category of referrals to social and health services. Also mentioned, was that data reviewed through such a process not compiled in aggregate form and only reviewed on a case by case basis.

When asked about the use of sanctions or incentives to encourage coordination activities, only one State responded that sanctions are used; and no State agencies communicated the use of incentives. In fact, several plan administrators felt that incentives to coordinate are unnecessary since coordinating with WIC is in the best interest of the plan and has the potential to improve health outcomes of its members.

Chapter 5: Coordination Results and Outcomes

This chapter describes the results of coordination efforts such as referrals and data sharing and the methods and measures in place to evaluate these efforts. In particular, this chapter explores the issues around coordination and highlights the barriers and supports to coordination as reported by both Medicaid and WIC. The findings of this chapter have been informed by interviews with both State WIC and Medicaid officials as well as with local WIC agencies and managed care organizations, gathered during site visits.

It must be remembered, however, that only 24 Medicaid agencies were interviewed for this study. This means that there are a number of State WIC agencies that take the initiative to coordinate WIC and managed care services through local WIC offices than through working with State Medicaid agencies. Therefore, the results can not be seen simply as coordination between two State-level organizations, but rather the results of broad-based efforts to coordinate at both the State and local level.

A. Measures and Indicators

As a first step in analyzing coordination results and outcome it is important to identify what concrete measures and indicators have been established by State WIC Agencies and State Medicaid Programs to help the track the progress and success of their coordination efforts. Thus this section addresses the following questions regarding measures and indicators:

- What are the outcome indicators and data sources that define successful coordination and can be used to measure the impact of various forms of managed care on local efforts to coordinate?
- Do States currently use performance or outcome measures to assess the success of coordination efforts, either on an ongoing, periodic, or one-time basis?
- What data do States use to monitor the coordination and referrals process?

Data Collected about WIC/Medicaid Coordination

One of the key issues in measuring outcomes is to understand the degree of priority given to data collection regarding WIC/Medicaid coordination by State officials. In this study, it was found that at the State level, WIC staff was more likely than Medicaid staff to report collecting data about WIC/Medicaid coordination. Of the WIC staff responding to the question, 84 percent (32 States) reported that some data were collected to assess WIC/Medicaid coordination. In contrast, only 29 percent (7 States) of the Medicaid staff responding to this question indicated that these data were collected.

Of the States where Medicaid staff reported collecting data to assess WIC/Medicaid coordination, those data most often reflected a count of referrals made to WIC. In

contrast, State WIC program staff was more likely to report the collection of program participation rate data as a measure of WIC/Medicaid coordination.

Data Collected	Number of States Collecting, By Program	
	Medicaid	WIC
Referrals made	4 States	11 States
Program participation rates	2	17
Encounters	1	--

A few States indicated that they had entered into a data sharing arrangement, whereby the Department of Health provided WIC with a list of enrolled clients on a regular basis to be compared to WIC roles and returned. This list both allowed WIC and Medicaid to determine the impact of referrals and also permitted Medicaid to develop lists of individuals to target.

It is important to note that State referral data reflects referrals to programs (i.e., Medicaid or WIC) and not to specific primary care providers. In addition, those data reflect referrals that have been made but not necessarily those that have been completed. Respondents universally cited issues such as lack of time, limited manpower, privacy issues, and the sense that it was not their responsibility as reasons for not following up on referrals and tracking how many had been completed.

State Medicaid staff members indicated that they did have a means by which they could retrospectively evaluate whether MCO client referrals actually resulted in the clients enrolling in WIC. Several States cited that one of the elements they examined in operational financial reviews or other types of audits was the outcome of referrals. More often however, States cited that these activities were undertaken by WIC, not by Medicaid or the MCOs, and that WIC data were used for the assessment. States did make clear that most MCOs saw the financial advantage to having their clients on WIC. They noted, for example, that WIC clients had healthier babies and that in some cases WIC paid the cost of special formula. Several States indicated that they had no hard data to show whether or not there was follow up to referrals and could only rely on anecdotal evidence. In addition, approximately half of the Medicaid staff interviewed (12 of 25) indicated that the State Medicaid program did not have any means to evaluate the results of MCO client referrals to see if clients actually enrolled in WIC.

On the local level, WIC staff members, in particular, indicated that they frequently made referrals to Medicaid but seldom to a particular MCO or health care provider. Their WIC database routinely had a place to note referrals made, making it possible for the State to tally the results. However there was not similar spot in the database for keeping track of whether or not the referral was carried through.

Several MCOs indicated that their case note forms did include a place to capture whether a client had been referred to WIC. However, they also explained that in most cases their clients knew about WIC and already were enrolled, especially if they were a post-partum enrollment.

States also indicated that some EPSDT data were used to assess the impact of WIC/Medicaid coordination.

In general, States that reported reviewing data also reported that referrals were more likely to be made to Medicaid than to WIC. Child care chart reviews were reported to have shown that referrals are made very consistently. In States where MCOs analyzed maternal and child health indicators, all reported that they improved with the implementation of Medicaid Managed Care.

How Data on WIC/Medicaid Coordination are Collected

The State WIC staff members uniformly reported that data that could be used to assess WIC/Medicaid coordination were produced using the WIC data system. Medicaid Staff indicated the use of slightly more diverse the sources of information on WIC/Medicaid coordination. Some States cited using data collected through the Department of Health Systems – including data accumulated by the State from local health departments. Some States required reports from MCOs citing referral numbers on a quarterly basis. However, one of the reasons cited for why it was hard to obtain the type of referral information from Medicaid that is available from WIC was associated with difficulties in collecting referral data from individual providers.

How WIC/Medicaid Data are Used

According to State Medicaid staff, WIC/Medicaid data are used in a number of ways. The first, as discussed above, is to monitor whether or not referrals are being made, regardless of the State's ability to monitor follow-through of those referrals. In some States, where formal data sharing arrangements were in place, Medicaid was able to use the combined Medicaid/WIC data to target potential Medicaid eligibles. In yet other cases, combined WIC/Medicaid data were not used to target specific individuals but rather were used to develop strategies to improve targeting and outreach.

State WIC staff indicated that data were used for retrospective analysis of program outcomes (6 of 23) and evaluation of WIC client referrals (11 of 38).

Routine Information Sharing

Of the 20 State Medicaid agency staff that responded to questions regarding information sharing, 7 (35%) indicated that information was routinely shared between WIC and MCOs and/or their providers; 8 (40%) said that information sharing did not occur; and 5 (25%) did not know.

When data were shared, according to the State Medicaid staff, it was to support the coordination of care or to resolve payment issues. The majority of the data that were shared between WIC and MCOs involved patient test results. Other examples of data sharing involved health coordination for other issues and regarding special formula

information. State Medicaid staff did not see the type of MCO involved as playing any particular role in data sharing.

Fourteen (39%) of the State WIC staff responding to the question indicated that information was routinely shared between WIC and MCOs and/or their providers. The majority of State WIC staff cited that the information sharing between WIC and MCOs and/or their providers involved the sharing of patient medical information (10 States). Also shared were WIC program information (5 States), special formula information (3 States) and client certification information (2 States).

On the local level, the desirability of sharing patient information was frequently discussed. Some sites had determined ways that they felt were HIPAA compliant while others had not. For example, at one local WIC agency, a medical information release form cover sheet had been developed for the client to sign while they were at the WIC agency. This release form was faxed to the health care provider. The specific data required were then faxed back, alleviating the need for the WIC clinic to perform blood tests that had recently been performed by the health care provider.

According to the State WIC staff, information from providers and MCOs was predominantly used for medical reasons, such as to establish nutritional risk and determine immunization status. It also was used for outreach purposes (e.g., to determine what type of outreach is needed). In addition, several States saw the sharing of information as a way to promote the mutual exchange of materials for describing services. Data sharing did not vary by type of MCO or by type of WIC agency, according to State WIC staff.

B. Success and Challenges

This section describes the challenges encountered by WIC agencies in their attempts to work and coordinate with Medicaid programs. Also explored are coordination successes and the factors associated with them.

According to State WIC staff, Medicaid Managed Care has had a predominantly neutral (42%) or positive (19%) impact on WIC clients' access to primary care services. State Medicaid staff views the situation the same way, with 41% indicating that the introduction of Medicaid Managed Care has had a neutral impact on access to primary care services among WIC clients and 36% feeling that it has had a positive impact. Half of State WIC staff who responded felt that access varied by type of WIC agency but not by type of MCO.

Coordination Supports

Organizational Co-location

One important approach for supporting coordination between WIC and Medicaid that seems to work well is organizational in nature – where the local WIC local agency

sponsors are in fact part of an MCO. This organizational co-location is said to improve communication, support easier referrals for health care services, and make the work of outreach workers more efficient. However, even this seemingly optimal approach is not without criticism associated with continued variability in the performance of agencies, available services, and populations served at the local level. In addition, some critics say that this organizational co-location does not change anything since the WIC agency will see anyone, not just people associated with the MCO. However, the opposite problem was suggested in one case study site visit, where to use a county WIC clinic located in a very central location individuals had to be enrolled in the county-sponsored health plan rather than an MCO. Those who were not part of the county health plan had to go elsewhere for WIC services.

State WIC staff reported that co-location and organizational connection do build MCO staff affinity for WIC clients and helps in their efforts to support the clients. However others reported that it was the physical co-location rather than being part of the network that was important. These contrasting views were clear during two site visits in the same State; one where the office in which to apply for Medicaid was across the street from the WIC clinic and the other where a case worker who was part of a Federally Qualified Health Center would help fill out the Medicaid forms on site. In the first case, loss to follow-up was cited as a frequent problem, whereas in the second case the coordination by the case worker, which included a phone call to Medicaid letting them know to expect a certain client, seemed to increase the probability that the client did in fact follow through with the referral.

Guidance

A specific guidance (DHHS/HCFA, 1995) was issued to lay the foundation for coordination between WIC and Medicaid. This guidance specified that WIC and Medicaid should attempt to coordinate, but it did not dictate what that coordination should entail nor in which areas it should occur.

For the most part, this lack of specificity was not seen by State Medicaid staff as creating particular problems. As one State staff person put it, “If WIC wants to talk to MCOs, Medicaid is happy to arrange meetings. We rarely get this request so we assume that all is going very well.” However, some State Medicaid staff members indicated that they had heard of concerns, particularly the perception that coordination and sharing was quite one-sided, all flowing from Medicaid and posing a burden on MCOs.

Challenges to Coordination

State Medicaid staff cited few challenges to coordination. However, one challenge that they did cite was quite fundamental; namely that of trying to get physicians to change their behaviors regarding the sharing of data. This challenge is associated with the fact that individual physicians are not used to being asked to share data and object to doing so. This reticence has intensified with uncertainties generated by HIPAA.

Another challenge to coordination that was cited by Medicaid was the MCOs' general lack of contact with county health departments. It was noted that MCOs feel that they are being asked to make referrals on good faith but without sufficient knowledge regarding the agencies to which they are referring. This lack of understanding hinders coordination and makes for an approach that is not effective. However, this challenge could be addressed directly through greater sharing of information about WIC and WIC agencies to MCOs.

In the eyes of many State Medicaid agencies, much of the coordination work has been executed remotely, in writing, without the development of interdepartmental relationships or face-to-face contact. In their view, this remote coordination does not lay the groundwork for the development of strong working relationships. In addition, because the Federal guidance is not a working or functional guide, it is all the more imperative for working relationships to be developed at the State level to facilitate the development and promotion of State level implementation guidance.

From the WIC staff perspective the most commonly cited challenges to coordinating with Medicaid included the amount of time it took to foster a successful working relationship with Medicaid and the MCOs, high Medicaid staff turnover, and issues around data sharing and confidentiality restrictions.

The first two of these challenges, the time constraints and issues of staff turnover were also interrelated. WIC staff explained that as a rule, collaborating with Medicaid, indeed any agency requires a considerable investment of time. The establishment of a working relationship is not an easy task, but rather one that involves a level of exposure and the need to share information to determine what each agency can do for the other. It is a process which, under the best of circumstances, takes much time. The time challenge is further aggravated by staff turnover; indeed several State WIC agency staff members noted that their State Medicaid agency seemed to experience a high level of turnover, making it difficult to establish relationships or maintain a point of contact. Moreover, without strict definitions of how coordination should take place, the State WIC agency staff members report that their ability to coordinate is dependent on the interest of the Medicaid management – and that this is quite variable.

Without having a specific person designated as the Medicaid contact for WIC, staff turnovers at Medicaid mean that there will be a need to establish new relationships and find new sources of information.

Data sharing, which should represent one of the easiest areas in which to achieve cross-program coordination, is complicated by a series of technical and logistic factors. Some of these factors include differences in levels of automation, data systems, and data systems requirements. For example, WIC, Medicaid, and the MCOs that send data to Medicaid do not share common systems and can have very different data configurations and requirements. The costs associated with moving that data in ways that would make them more compatible are often viewed as prohibitive. In addition, while it may be possible to share data at the State level, this can be much more difficult at the local level, due to issues of structure, staffing, and variable (or non existent) levels of automation.

Another challenge related to data sharing involves interpretations of confidentiality rules and changes with those rules. As a result, before any data sharing can take place, the two agencies within the State are obliged to negotiate rules and interpretations governing confidentiality issues. The conclusions of these negotiations appear to vary from one State to another.

Several other barriers also were cited by WIC staff. One of these was the attitude expressed by some WIC staff members that with time lacking to do all of the direct WIC activities that are needed, coordination with Medicaid is neither necessary nor appropriate.

Bureaucratic realities were cited as another barrier to the coordination between WIC and Medicaid. Compared to Medicaid, WIC is very small, which to some connotes an uneven terrain for coordination. In addition, the inter-program coordination is not necessarily seen as a bureaucratic a priority at the State level; and in some cases the State bureaucratic climate is described as more competitive than collegial. As an added challenge, effective coordination often requires a financial investment from the State, where priorities often will not support coordination unless the parties can present a united front.

Yet another challenge that was cited was associated with the difference between State-level and local-level commitment to coordination. In some cases, even if the State level staff is committed to coordination between Medicaid Managed Care and WIC, this may not translate into a similar degree of commitment at the local level, or the local-level staff may have the commitment but lack the local staff resources to implement coordination efforts. An example of this disconnect between State and local-level staff was evident during one set of site visits. In this case the State was committed to developing close working relationships with Medicaid but the WIC clinics, having had bad experiences with MCOs in the past, dissuaded clients from enrolling in MCOs, either actively or passively.

Further challenges to coordinating with Medicaid included:

- Difficulties keeping information up to date. Much time is required to assure that information about WIC is current – and that it reaches all those who need it (e.g., MCOs and providers)
- System incompatibilities. WIC clients may face difficulties obtaining proof of enrollment due to the inability of one system to read the enrollment cards of another system.

Keys to Coordination

Many common themes regarding what works to develop and sustain coordination between WIC and Medicaid emerge regardless of who is responding. Chief among these themes is the importance of establishing strong relationships, both formal and informal.

Another is the inclusion of the other parties (Medicaid with WIC, WIC with Medicaid) in the planning process. While not all parties found formal agreement to be critical, many did find that it built the foundation for sustained WIC-Medicaid coordination.

Several sites felt that including WIC leaders and staff from both the State and local level in discussions of EPSDT would help both sides understand their shared interest. By highlighting their common responsibility for the health outcomes of infants and children this effort was seen as helping to support coordination. Some States included State WIC staff when developing EPSDT and lead screening policy. States also worked with MCOs to hold training sessions for WIC staff on EPSDT to encourage them to work with MCOs.

In some cases, States attempted a more structural coordination so that the entry point for both MCOs and WIC was potentially through the local health departments. This was thought to facilitate referral and coordination.

States also have established committees that bring together programs with common participants or goals, or they invite one group speak at the meetings of the other. Often the State agencies make sure that the groups come together on a regular basis (e.g., quarterly) in order to maintain contact – whether or not they need to make any joint decisions. Additionally, many States use coordination around special formulas as a jumping off point – because it tends to be very concrete.

Most of the State WIC staff indicated that coordination between WIC and Medicaid on the State level occurred because of good communications (18 of 30), while 2 attributed the strength of coordination to coordinated policy changes, and 1 to strong State guidance.

Good communications between WIC and Medicaid were clearly identified as being critical. States repeatedly cited the need for people to be open and clear about what they wanted and what they could do. They also indicated that it was important to have a point of contact with whom to communicate – and some States indicated that a Medicaid person was a sitting member of the State WIC advisory board. Also discussed were periodic scheduled meetings and shared work groups.

Effective Strategies for Promoting Coordination between WIC and Medicaid

- Having a long-standing history of good relationships and working together that can be used to undertake coordination in the advent of managed care.
- Having communications structures (e.g., WIC staff communicates with Medicaid staff, WIC staff sits on EPSDT advisory Board, forums provided to talk about coordination issues).
- Holding quarterly meetings between WIC and EPSDT coordinators at the State level. Including communication and collaboration as part of the discussion.
- Promoting early communication between WIC and MCOs to establish what WIC provides and how it can be a way for MCOs to cut costs.
- Conducting on-going meetings with Medicaid staff to work on joint initiatives (e.g., developing obesity prevention guidelines for providers and a prenatal quality improvement program)

In addition to formal communications, often cited was the fact that WIC and Medicaid staff had taken the time to get to know each other and become informed of the issues and priorities of the other program.

Another very important factor was the existence of clear direction from above. When this occurred WIC and Medicaid staff were able to sit down and identify common goals. Often it was found useful to help Medicaid view WIC as a means to enrolling all eligibles. This was often supported if WIC and Medicaid worked under a common State administrative structure. Indeed, when this occurred they were frequently less competitive and more cooperative.

WIC State agency staff members who worked with Medicaid were asked what they had found to be most effective in working with and establishing coordination between WIC and Medicaid. Communications and either establishing or working from a long-standing history of good relationships was critical. Additionally, identifying and conducting joint projects was found to have a cementing and mutually supportive effect on the relationship.

Making sure to understand what the other does and how they do it was also found to be critical for collaboration. The State agencies often found that they had some, but not enough knowledge about each of the others' departments. They also did not always understand the guidance that each group received about similar or the same issues. In working through these explicitly it became easier for the groups to work together as well as to establish mutually acceptable guidance. This was particularly true about special infant formula.

In at least one instance, the State reorganized so that Medicaid and WIC were in the same agency. This had a positive impact on collaboration, enhanced their natural opportunities to communicate, gave them more reason to coordinate, and strengthened the feeling that they had organizational sanction to work together.

The coordination of data and referral systems has the potential to strongly support collaboration if technical incompatibilities can be addressed. In one instance where these have been made compatible, WIC has been able to use Medicaid data for program evaluation and to put a coordinated referral system into place. Data sharing has been used for program outreach to help identify qualifying individuals who could be served by one program or the other. Data also have been shared in a non-electronic fashion between providers, provider organizations, and WIC to minimize redundancy, share costs, and increase the amount of specialized time each has to spend with a client. Though this sharing has only occurred at a minimal level it holds the promise for many of how a coordinated system would ultimately maximize the impacts of each of WIC and Medicaid.

Focusing on special infant formula has often been a good place for coordination efforts to begin, since it generally offers a clear benefit to Medicaid from coordinating with WIC. This can serve as the basis for establishing relationships and promoting a greater understanding of systems and common goals.

One of the important lessons to emerge from this study is the recognition that it is not enough to coordinate at the State level. Local level coordination is clearly essential as well though it is potentially difficult to codify. State officials recognize that they need to find a way to get local WIC agencies to work with local MCOs and their providers. However, given the ways that laws regarding such things as marketing, outreach, and contact are set up, the ability to promote greater local coordination varies from one State to another. Several States have recognized (though not operationalized) the use of local or regional WIC and Medicaid contact people who help to coordinate and support cross-program relationships. One potential method for promoting this type of local coordination that has been suggested is to issue a local level mandate for WIC staff to work with Medicaid waiver staff and case managers. Other states have used WIC clinics as enrollment points for CHIP – bridging the outreach coordination system. This coordination offers the benefit of capitalizing on the fact that the WIC program is broadly known and there is widespread understanding of who is eligible to enroll.

WIC State agency staff members also have identified the following successful coordination approaches:

- Conducting outreach through WIC mailings to Medicaid clients (and the reverse)
- Stressing to MCOs that they know WIC nutritionists, that they are well respected, and that they know communities and clients and thus can help promote recruitment and coordination
- Having local WIC staff provide MCOs (OB-GYNs & Pediatricians) with WIC information – physicians are receptive and will refer further patients to WIC
- Making direct contacts with managed care through outreach coordinators

Quality of WIC Relationship with Medicaid

All told, 27 of 40 WIC State agency respondents (68%) reported that they had a good relationship with Medicaid. Ten percent said that they had a poor relationship with Medicaid, while 15 percent indicated that they had no relationship.

The following box describes comments from respondents regarding the types of communication and coordination barriers encountered, which highlight the challenges and potential strategies for improvement discussed above.

Comments from Respondents Regarding Cross-Program Coordination

- Hard to get things in writing from Medicaid. They don't call back and it is difficult to get correct information. It is a very bureaucratic organization and people are afraid to put their names on anything. Means we are uncertain about the quality of our relationship
- There is rarely any communication – and when there is communication it is not formal. Communication is on an “as needed” basis and is based on personal relationships between specific staff, not a relationship between agencies
- Pretty much non-existent. WIC staff has made efforts to establish relationships but have not been successful
- Limited mutual dependency but no formal relationship
- There is a relationship to get things done – but not on-going
- Have a formal relationship – quality of the relationship depends upon the Medicaid liaison.

C. Impact

The impact of the coordination of WIC and Medicaid is very difficult to assess – except anecdotally. Very few systematic reports exist that are able to associate changes in Medicaid Managed Care or WIC that are due to an increasingly close coordinated relationship with each other.

No State represented in this study specifically required reporting of the effects of WIC/Medicaid coordination. Closest perhaps were States that required counts of referrals from one program to the other – though none of these required follow-up verification.

While there are some States that have made no effort to enhance or establish coordination between Medicaid and WIC, most feel that they have made some State level effort to promote coordination – and that these efforts have had concrete impacts. Since there are no real data to assess the coordination efforts, the best potential sources for identifying their impacts would be at the local level, where respondents are in a better position to understand what the causal relationships might be.

Sometimes it was difficult for both WIC and Medicaid Managed Care respondents on the local level to address how Medicaid managed care had affected access to primary care services, because managed care has been in place for an extended period of time.

However, State WIC administrators in one State reported that they believe that most clients have a regular source of health care. The Health Plan administrators in this same State also felt that access to care was high among the WIC population of pregnant women and children. One plan stated that 80% of children on Medicaid had yearly visits with a primary care provider and another plan cited a comparable utilization rate for children under 3 years of age. While not direct evidence of WIC children having a regular source of healthcare, the plan administrators felt that there coverage among the WIC population was very high.

One administrator felt that access to care was facilitated for high risk populations, such as high risk pregnant women. This may include pregnant adolescents, women that smoke or use drugs, or women that have experienced multiple miscarriages. These women were identified through a risk assessment mandated by the State and conducted by the OB/GYN during the initial pregnancy intake. The Health Plan administrators explained that it was in their best interest that their members receive ongoing preventive care. One plan provided transportation to assist members in keeping their prenatal and post-partum medical appointments.

In another State, local agency WIC respondents expressed mixed feelings when asked about the impact of Medicaid managed care on access to services. Medicaid managed care has permitted a broader range of services to be offered to clients, reduced duplication of services, and offered opportunities for collaboration with PCPs. However, there is a perception that clients are unclear about their options when faced with choosing a plan and about the different services offered by each plan. Confusion has been further increased by the changes in the managed care market, which has led to fewer plan choices and changes in the scope of services covered by existing plans.

In a largely rural State, the local WIC agencies located in larger counties have not noticed a change in access to care or an increase in complaints about accessing care since the advent of managed care. The view of access in the rural communities was in sharp contrast. These respondents feel that managed care had compromised access to care and expressed concerned about future access due to instability in the managed care market.

In one environment where Medicaid recipients have an option between managed care and fee-for-service, local WIC clinic directors felt that while their clients had not been adversely impacted by managed care neither had there been major changes in the delivery of care. But they did feel that their clients had adequate access to health care. The MCOs at that location believed that the use of managed care models and the PCP as a gatekeeper was a more efficient way of providing medical care with increased continuity of care. They implemented tools such as reminder notices and newsletters to have a positive impact on the utilization of preventive and primary care.

For WIC sites co-located with a health department or clinic, directors reported that most clients received primary care services on site. In these clinics clients were able to access a range of health services such as immunizations, family planning/pregnancy tests, smoking cessation, health screenings, HIV/STD testing and primary care services. One

clinic also had MCH workers that provided breastfeeding support services and lactation counseling through home visits – a compliment to WIC lactation education.

Chapter 6: Findings and Recommendations

In this Chapter we present the general findings and recommendations from both the surveys of WIC and Medicaid officials and the local site visits. This study examined the coordination of WIC and Medicaid managed care at the policy, implementation, and outcome levels. Specific findings for each area were presented in prior Chapters. In this Chapter, we present findings related to the overall success of WIC and Medicaid managed care coordination, and we offer recommendations made by State and local officials to maintain and improve coordination.

A. Findings Related to the Success of Coordination Efforts

While somewhat limited nationally, the coordination efforts that have been discussed in this report seemed more likely to meet with success when both parties have found it in their interest to do so. At the local level, efforts to coordinate WIC services with managed care organizations also are reflecting some levels of success. However, it is important that both parties see the benefit of coordination, and make ongoing communication efforts to ensure a successful partnership. Specific issues that should be addressed to engage and improve upon coordination are discussed below.

1. **There must be a shared interest level between WIC and Medicaid officials to ensure that successful coordination efforts are initiated and maintained.**

One of the key issues examined in this study was the extent to which all States were involved in WIC and Medicaid coordination, particularly in States where managed care has been implemented. It became very clear from the start of the study that, in general, WIC State agencies seemed more interested in conducting coordination activities than are Medicaid officials. Interviews with WIC officials in States where coordination was either very limited or non-existent indicated that most efforts to engage in coordination activities were initiated by the WIC program.

The reason for the WIC program's apparent leadership role in coordination appears to be threefold. First State-level Medicaid officials do not necessarily see the value of the coordination between WIC and Medicaid as a high priority for their program. Most Medicaid officials viewed WIC as a nice adjunct program for Medicaid clients, but did not seem to feel that coordination efforts particularly benefited the Medicaid program policy or operations. For example, most Medicaid officials interviewed felt that data sharing was something that provided a benefit to the WIC program, but saw little value to Medicaid. Additionally, policy agreements on such topics as payment for special infant formulas were viewed by Medicaid officials as small pieces of much larger policy issues, while WIC officials saw the same agreements as important program components that helped to better serve WIC clients. Finally, while WIC referrals from Medicaid are "official policy", little seems to be done to track the success of referral efforts at the local level.

Second, because of the complexity of the administration of Medicaid and the changing nature of the program as States modify and adapt managed care policies and procedures over time, WIC coordination is viewed as a small piece of a much larger effort. Ensuring that MCOs are following federal rules and contract clauses, along with attempting to assess overall quality of care provided, takes a significant amount of time and effort on the part of Medicaid staff. Most Medicaid officials indicated that they worked with a limited number of staff members and had to prioritize their efforts based upon changing workload demands, which often meant that WIC coordination was a lower priority.

Finally, from the WIC standpoint, local WIC agencies tend to encounter more questions about Medicaid and managed care than do MCOs regarding WIC services. Local WIC agencies and State officials both reported that clients who are referred to Medicaid by WIC often have a number of questions about the eligibility process, provider selection, and coordination of care. As a result, WIC officials need to have information about Medicaid and MCOs to be able to assist clients. This means that WIC agencies are more likely to seek out and promote coordination between their program and Medicaid to ensure that clients receive accurate and timely information.

It must be said, however, that once Medicaid officials become engaged in the coordination process, they do make strong efforts to support coordination through information sharing and policy support. Several State-level Medicaid officials indicated that providing information about WIC to MCOs and providers was an important role for their agency, and that ongoing communications to MCOs and providers about the importance of WIC referrals should be the State's responsibility. Efforts to include WIC officials in MCO training, asking WIC directors to submit articles about WIC for provider newsletters, and issuing policy reminders to MCOs are viewed by Medicaid officials as appropriate efforts to support coordination.

This effort can also be well supported at the local level by MCOs that become engaged in WIC coordination. In the sites visited for this study, the MCO officials interviewed believed that clients enrolled in their plans should receive WIC services and that these services both helped the client and were potentially cost-saving for the MCO with respect to pregnancy and well-child related costs. The MCO officials interviewed for this study all agreed that working with WIC agencies was a high priority and that ongoing coordination required efforts by both parties to maintain a successful relationship.

2. Successful models of WIC and Medicaid managed care coordination exist and should be promoted.

When examining both State- and local-level coordination efforts, many State officials in both the WIC and Medicaid programs were interested in hearing about successful models of coordination. In many cases, State officials were not especially aware of successes going on in their own State, as the level of detail of local coordination did not funnel up to their level. For example, in three of the States where site visits were conducted, State officials were asked to identify local successes. Most of these officials could identify local WIC agencies or MCOs that they knew worked together in some capacity, but they

were not entirely aware of what activities might be taking place to support coordination. In addition, local WIC agencies within States were justifiably proud of their own coordination efforts, but they were unfamiliar with other efforts going on in the State that might be duplicated.

A number of excellent coordination models were examined in this study, and there seemed to be interest on the part of State WIC and Medicaid officials to learn more about these efforts. Finding the proper forum and method for transferring knowledge, however, remains a challenge. For example, several State WIC officials felt that increased Federal efforts were needed to promote coordination and that knowledge transfer should be a priority for national meetings and information-sharing Websites. However, Medicaid officials generally believed that the dissemination of information worked best when shared through joint WIC and Medicaid trainings at the State level.

It is likely that a combination of training and information transfer technologies can be used to provide information about successful coordination models. However, one key element in this process must be ongoing support at the State level for any local efforts. In all of the interviews with local WIC and MCO officials, the issue of State-level support was presented as necessary for any successful local coordination.

3. Coordination between WIC and Medicaid managed care can improve delivery of services to clients in areas outside of direct WIC services, such as immunization referral and lead screening.

One of the interesting offshoots of WIC and Medicaid managed care coordination is the efforts being made by some MCOs to coordinate the delivery of well child services, such as immunization and lead screening activities with WIC agencies. This effort seems to be working at two levels. First WIC agencies have been successful in monitoring immunization schedules of children attending WIC clinics. As such they can serve as a valuable client support to refer children back to the MCO to ensure that appropriate services are provided and received. Second, in some of the sites visited, MCOs have contracted with WIC sponsoring agencies (County health departments in particular) to provide some of these services and receive reimbursement.

4. Issues related to information and data sharing should be dealt with at the State or national level.

One of the key issues related to coordination was the ability of WIC and Medicaid agencies to share information about clients. Two areas of information sharing stood out; sharing enrollment information to promote outreach and referral and sharing medical information for WIC eligibility determination and care coordination. Of major concern to State officials is crafting information sharing agreements that comply with HIPAA regulations while still providing the type of information needed by both programs.

Several States expressed frustration with trying to craft such an information sharing agreement. Some States have successfully addressed this issue, and the agreements

crafted in those States may serve as models for other States. In other cases, State officials believe that a model information sharing agreement should be developed at the Federal level and provided to States as a template for crafting their own agreements. In either case, crafting information sharing agreements that facilitate program coordination and at the same time protect the confidentiality of the client are seen as essential to any coordination effort.

B. Recommendations from State and Local Officials on Improved Program Coordination

State and local officials were asked to identify those factors that worked to promote program coordination. They also were asked what advice they would give to other States that were interested in promoting WIC and Medicaid coordination. Two recommendations were mentioned most often by these officials.

1. Strengthen communication efforts to improve coordination.

The most common recommendation made by both WIC and Medicaid officials was that strong ongoing communication was necessary for coordination to be successful. Communication must take place frequently, and it must be directed at promoting desired outcomes. Specifically, communication at the following levels was cited as most important:

- **Policy-level communication.** Many of the State officials felt that policies needed ongoing review and assessment to ensure that coordination is properly promoted. Several officials indicated that quarterly meetings to discuss policy-making and implementation were necessary to ensure quality coordination. In addition, review of policy outcomes was necessary to decide if existing policies need to be revised or scrapped and to determine if new policies are needed.
- **Strong educational efforts.** Providing information about WIC to Medicaid providers and providing information about MCOs to WIC agencies were viewed as key to supporting coordination. Most of the successful coordination efforts focused on providing information and training to each program. In particular, WIC agencies strongly advocated for providing information to MCOs through newsletters, meetings, and trainings. At the same time, MCOs appreciated the opportunity to provide information both to WIC agencies and to WIC clients. Supporting these ongoing educational efforts is an important component of coordination.
- **Local-level communications.** Most local WIC agencies and MCO officials interviewed for this study had regularly scheduled meetings to discuss coordination. In addition, some WIC agencies have asked MCO officials or provider representatives to serve on WIC advisory committees, and MCOs have

reciprocated by asking WIC officials to serve on their own committees. Strong local-level communication seemed to be important for maintaining a good relationship and promoting coordination.

- Creating information packets around WIC and Medicaid coordination efforts at the local level might encourage more MCOs and WIC agencies to enter into coordination agreements. State officials can help local WIC and MCO coordination by providing information packets that promote coordination between WIC and MCOs. The packets could provide information about policy and requirements for coordination, but they must go further in providing practical information on the benefits of coordination and methods by which it can be accomplished. Such promotional material can then be used as a starting point for discussions.

2. Develop outcome findings that support coordination.

Having outcome data that show the positive results of coordination could be very helpful in ongoing attempts to promote coordination. Most WIC agencies and almost all Medicaid MCOs do not track client outcomes related to coordination, and thus successful “outcomes” are often viewed as process outcomes. However, some States have used data from coordination efforts to show the value of these strategies in improving client services or decreasing unnecessary costs. For example, conducting studies on cost savings for pregnancy outcomes for WIC clients compared to non-WIC clients can go a long way in showing a direct benefit to MCOs. In addition, tracking outcomes of referrals can help local WIC and MCOs examine the success of their efforts and help them modify approaches that are not working.

The key barrier to conducting any sort of outcome study or evaluation seems to be limited funding. Neither MCOs nor WIC agencies are funded to examine coordination outcomes. To truly examine outcomes, special funding would have to be found to support these activities. Some State and local officials are exploring funding from foundations, universities, or from other Federal and State sources to conduct some outcome assessments.

C. Conclusion

The impact of Medicaid managed care seems to be either neutral or positive with regard to WIC services. A number of WIC State agencies and Medicaid programs have taken steps to ensure that coordination between the two programs takes place, and that local efforts to support coordination are provided. Local coordination efforts that were examined for this study appear to be both innovative and successful. However, for more widespread coordination to take place, both for the benefit of WIC and Medicaid programs, additional States and local agencies need to become involved.

This report was designed to provide both information about coordination and examples of successes. However, ongoing measures of success need to be developed, and expanded promotion of WIC and Medicaid managed care coordination needs to be implemented for these successes to generate more interest and activities in this area. Both WIC and Medicaid agencies involved in successful coordination efforts are pleased with what they have accomplished. They can serve both as inspirations and models for expanded coordination efforts.

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Appendix A – WIC/Medicaid Survey: State Medicaid Officials

WIC/Medicaid Survey: State Medicaid Officials

State: _____

Name: _____

Phone: _____ Fax: _____ Email: _____

Hello, my name is _____ and I am with Health Systems Research, Inc. HSR is conducting a study for the Economic Research Service (ERS) of USDA of coordination between State WIC and Medicaid programs. ERS is very interested to understand the impact Medicaid managed care is having on the WIC programs' ability to coordinate with primary care services. In particular the government is interested in which types of arrangements foster and support coordination between WIC and Medicaid managed care, what formal arrangements work best for different types of local agencies, and the barriers WIC programs have faced in working with managed care organizations that accept Medicaid clients.

Any answers you provide for this study will be kept confidential and your name will not be identified with any answers you provide. Also, your interview with me will not affect your program status with any agency, now or in the future.

According to the Paperwork Reduction Act of 1995, a Federal agency may not conduct or sponsor any information collection activity, nor is any person required to provide information, unless a valid OMB control number is obtained. The control number for this data collection is 0536-0064. The amount of time required to complete this data collection effort is estimated to be 30 minutes, including reviewing instructions, searching existing data sources, gathering needed data, and completing the interview.

As part of this study, we are interviewing both State WIC and Medicaid officials regarding policies and guidelines developed between WIC and this State's Medicaid program to coordinate services. I want to thank you for taking the time today to answer my questions.

I. An Overview of the State's Managed Care System

I'd like to begin by gathering some information about your State's Medicaid program.

1. Your income eligibility standards are _____% of the Federal Poverty Level for pregnant women and newborns and _____% of the Federal Poverty Level for children under age 6.
2. I understand that [State] uses a _____ system in conjunction with its Medicaid programs for the vast majority of pregnant women and women and their children under age 6.

Capitated
Primary Care Case Management
Combined capitated and PCCM

3. Enrollment in managed care is

Voluntary
Mandatory

If enrollment is voluntary, what percent choose to enroll?

4. Within the Medicaid eligibility categories of pregnant women and children, are any groups excluded from mandatory Medicaid managed care?

No Exclusions

Exclusions within the following categories: (Please describe).

5. And that the Medicaid managed care program is

Statewide

Regional within your State (list counties or regions: _____)

6. As of December 31, 2003, the total enrollment in managed care was _____ or _____ percent of enrollees. (*For States with both capitated and PCCM programs, ask about enrollment in each.*)

7. For capitated systems: How many plans are currently under contract for this program? How has this number changed over the past three years?

8. What types of plans do you currently contract with?

_____ For-profit HMOs

_____ Not-for-profit commercial HMOs

_____ Plans made up of public-sector providers

_____ Other (please describe) _____

9. For PCCM programs: Are case management services provided through contracting agencies or through state or local employees? What is the role of the primary care case manager in this system? How much is the case management fee? What services are primary care case managers expected to offer for this fee?

II. Coordination with WIC

Next, I'd like to discuss your managed care program's provisions for coordination with the WIC program.

I would like to start by asking you questions regarding the operational aspects of WIC and Medicaid coordination. In particular, we are interested in agreements you may have with the State WIC program, instructions you provide to MCOs with regard to referral and coordination, and the extent to which you evaluate WIC/Medicaid coordination. We are also interested in how WIC/Medicaid coordination has been effected by the implementation of Medicaid Managed Care.

1. With regard to the referral of potentially eligible WIC clients for *enrollment*, we recently asked you to provide us with copies of any interagency agreements between the State WIC office and the State Medicaid program for referral of Medicaid clients between the two programs.
 - A. (*For agencies with formal agreements*) We would like to thank you for providing us this copy. Do you anticipate any changes in the agreement prior to the end of 2004? If so, what types of changes? What aspects of the agreement do you find particularly core to the successful coordination of services, and why? What about the document that you do not anticipate are going to be changed should be changed? What else should be addressed in this formal agreement to make it more useful/to increase its effectiveness? *Insert Questions from Document Review.*
 - i. For capitated systems (if not seen upon review of document):
 - a. Are plans required to **inform** potentially eligible pregnant women and children of the availability of WIC? How?
 - b. Are plans required to **screen** pregnant women and young children for WIC enrollment or potential eligibility? Are they required to use a standard screening or risk assessment form?
 - c. Are plans required to **refer** potentially eligible enrollees to WIC for eligibility determination? (If so, within what time frame?) To **follow up** on these referrals?
 - d. Are plans required to maintain Memoranda of Understanding or other **agreements** with local WIC agencies? What should these agreements contain?

- e. Are plans required to **share information** with WIC agencies about common clients?
 - f. Are any **other** requirements included in your State's contracts regarding WIC? What are they?
- ii. For PCCM programs (if not seen upon review of document):
- a. What requirements are included in PCCM contracts with regard to WIC?
 - b. Are PCCMs required to **screen** or **refer** pregnant women and children for WIC eligibility? Are they required to **follow up** on these referrals?
 - c. Does the case management function required of PCCMs include management of nutritional and other support services, such as WIC?
 - d. Are there any **other** requirements or expectations of PCCMs regarding coordination with WIC? What are they?
- iii. For both:
- a. How are these requirements enforced?
 - b. What data are plans or providers required to report to document screening or referrals to WIC?
 - c. What sanctions, if any, are imposed on plans or providers that fail to comply with the contract requirements? What has been the effect of these provisions?
 - d. What incentives for compliance are included in the contract? What has been the effect of these incentives?
- B. *(For agencies without formal agreements)* We did not receive any information regarding formal agreements. Does this mean you do not have any? If not, do you plan on entering into any formal agreements in 2004? If you do have an agreement, may we obtain a copy for review?

- C. *(For agencies without formal agreements)* What types of guidance do you provide MCOs who handle Medicaid clients with regard to referral of potentially eligible WIC clients to enrollment services? (Ask questions i - iii above)
- D. To what extent do you provide training to MCOs with regard to referral of potentially eligible WIC clients to the WIC program. What type of training is provided? What topics are covered? What are MCOs supposed to do after the training?
2. With regard to referring enrolled Medicaid participants to WIC, we also recently asked you to provide us with copies of any written guidance you have prepared for MCOs who have Medicaid clients.
- A. *(For States that provided us with copies of guidance)* Thank you for providing us with copies of your State's guidance for referrals for WIC. Do you anticipate any changes to this guidance in 2004? If so, What type of changes? What works well about the document and what doesn't work so well? What changes would you like to make that are not part of the anticipated changes? What questions are you frequently asked/problems repeatedly faced by MCOs? *Insert Questions from Document Review.*
- B. *(For States that did not provide any guidance information)* Our records indicate that you did not provide us with copies of any written guidance to MCOs regarding referral for WIC services. Do you plan on developing any guidance in this area during 2004? If there are no formal requirements, how is such coordination encouraged? What questions are you frequently asked/problems repeatedly faced by MCOs?
3. What data does your State collect regarding WIC and Medicaid coordination? How are these data collected? How are these data used on a routine basis? Are these data used for any sort of retrospective analysis of program outcomes or impacts?
4. Does your State Medicaid program have any means to specifically evaluate MCO Medicaid client referrals to determine if clients actually enrolled in WIC? If yes, please describe.
5. What types of information are routinely shared between local WIC agencies and MCOs/health care providers? How is this information used? Does this vary by type of MCO?
6. In addition to contract provisions, are there other mechanisms through which the Medicaid program coordinates with WIC agencies?

- A. For example, does Medicaid fund WIC agencies to conduct outreach or case management? If so, what activities are conducted? How are agencies reimbursed for these activities?
- B. Does Medicaid reimburse WIC agencies for direct nutrition support, counseling, or education services for pregnant women? Under what circumstances?

III. Evaluation Results

1. In your opinion, what has been the general impact of Medicaid managed care on the ability of WIC clients to access primary and preventive health services?
 - A. What do data collected on referrals to WIC show about referral patterns?
 - B. How have contract incentives affected coordination between WIC and managed care plans or providers?
 - C. How does the degree and success of coordination with WIC vary across types of plans (commercial HMOs, public-sector plans, etc.)?
2. What aspects of your efforts to foster coordination between WIC and Medicaid managed care have been the most effective in fostering coordination (why)? The least effective (why)?
3. What recommendations would you make to improve the coordination between WIC and Medicaid?

Thank you for your time.

Appendix B – WIC/Medicaid Survey: State WIC Officials

WIC/Medicaid Survey: State WIC Officials

State: _____

Name: _____

Phone: _____ Fax: _____ Email: _____

Hello, my name is _____ and I am with Health Systems Research, Inc. HSR is conducting a study for the Economic Research Service (ERS) of USDA of coordination between State WIC and Medicaid programs. ERS is very interested to understand the impact Medicaid managed care is having on the WIC programs' ability to coordinate with primary care services. In particular the government is interested in which types of arrangements foster and support coordination between WIC and Medicaid managed care, what formal arrangements work best for different types of local agencies, and the barriers WIC programs have faced in working with managed care organizations that accept Medicaid clients.

Any answers you provide for this study will be kept confidential and your name will not be identified with any answers you provide. Also, your interview with me will not affect your program status with any agency, now or in the future.

According to the paperwork reduction act of 1995, a Federal agency may not conduct or sponsor any information collection activity, nor is any person required to provide information, unless a valid OMB control number is obtained. The control number for this data collection is 0536-0064. The amount of time required to complete this data collection effort is estimated to be 35 minutes, including reviewing instructions, searching existing data sources, gathering needed data, and completing the interview.

As part of this study, we are interviewing both State WIC and Medicaid officials regarding policies and guidelines developed between WIC and the Medicaid program to coordinate services. In addition to these interviews, six States will be selected at a later date for in-depth case studies of local program efforts to coordinate services. I want to thank you for taking the time today to answer my questions.

I. WIC Program Relationship with Medicaid and Referral for Health Services

I would like to start by asking you questions regarding the operational aspects of WIC and Medicaid coordination. In particular, we are interested in agreements you may have with the State Medicaid program, instructions you provide local WIC agencies with regard to referral and coordination, and the extent to which you evaluate WIC/Medicaid coordination. We are also interested in how WIC/Medicaid coordination has been effected by the implementation of Medicaid managed care.

1. With regard to the referral of potentially eligible Medicaid clients for *enrollment*, we recently ask you to provide us with copies of any interagency agreements between the State WIC office and the State Medicaid program for referral of WIC clients between the two programs.
 - A. (*For agencies with formal agreements*) We would like to thank you for providing us this copy. Do you anticipate any changes in the agreement prior to the end of 2004? If so, what types of changes? What aspects of the agreement do you find particularly core to the successful coordination of services, and why? What about the document that you do not anticipate are going to be changed should be changed? What else should be addressed in this formal agreement to make it more useful/to increase its effectiveness? *Insert Questions from Document Review.*
 - B. (*For agencies without formal agreements*) We did not receive any information regarding formal agreements. Does this mean you do not have any? If not, do you plan on entering into any formal agreements in 2004? If you do have an agreement, may we obtain a copy for review?
 - C. (*For agencies without formal agreements*) What types of guidance do you provide your local WIC agencies with regard to referral of potentially eligible Medicaid clients to enrollment services?
 - D. To what extent do you provide training to local WIC agencies with regard to referral of potentially eligible Medicaid clients to the Medicaid program. What type of training is provided? What topics are covered? What are local WIC agencies supposed to do after the training?
2. With regard to referring enrolled WIC participants to health services, we also recently asked you to provide us with copies of any written guidance you have prepared for local WIC agencies.
 - A. (*For States that provided us with copies of guidance*) Thank you for providing us with copies of your State's guidance for referrals for health care. Do you anticipate any changes to this guidance in 2004? If so, what type of changes? What works well about the document and what doesn't work so well? What changes would you like to make that are not part of the anticipated changes? What questions are you frequently asked/problems repeatedly faced by local WIC agencies? *Insert Questions from Document Review.*
 - B. (*For States that did not provide any guidance information*) Our records indicate that you did not provide us with copies of any written guidance to local WIC agencies regarding referral for health services. Do you plan on developing any guidance in this area during 2004? If there are no formal

requirements, how is such coordination encouraged? What questions are you frequently asked/problems repeatedly faced by local WIC agencies? What incentives are used?

3. What data does your State collect regarding WIC and Medicaid coordination? How are these data collected? How are these data used on a routine basis? Are these data used for any sort of retrospective analysis of program outcomes or impacts?
4. Does your State WIC program have any means to specifically evaluate WIC client referrals to determine if clients actually enrolled or were able to receive health care? If yes, please describe.
5. What types of information are routinely shared between local WIC agencies and MCOs/health care providers? How is this information used? Does this vary by type of local WIC agency?

II. Coordination and Referral Between WIC and Medicaid Managed Care

These next questions address coordination and referral arrangements between WIC and Medicaid in the context of Medicaid managed care programs. We understand that your State uses (capitated/PCCM/both capitated and PCCM) models of managed care to serve pregnant women and children enrolled in Medicaid, and that enrollment in these programs is (mandatory/voluntary/mixed).

1. How are local WIC agencies structured in your State? (located in health departments, stand-alone agencies, integrated or co-located sites)
2. Are any of your WIC local agency sponsors part of a Medicaid managed care provider network? If yes, which local agencies? How well has that worked? To what do you attribute this?
3. When referring WIC clients for Medicaid enrollment, what information do WIC agencies give clients about enrollment in managed care organizations? About choosing a plan? About choosing a primary care provider?
4. Once a client has chosen a plan and/or a provider, what is the WIC agency's role in referring the client for health care services? What is its role in ongoing supervision of the client's health care?
5. How do these processes differ across the different types of local WIC agencies? (local health departments, stand-alone agencies, integrated or co-located sites?)

6. If your State uses primary care case management (PCCM) does the State WIC program provide any information about WIC services to the case managers? If so, what types of information?

7. For local WIC agencies that are part of Medicaid managed care provider network, which of the following best describes how WIC services are provided:
 - ___ WIC services are provided to currently enrolled plan members only.
 - ___ WIC services are provided to any client that is willing to sign up for the plan.
 - ___ WIC services are provided to anyone, without regard for plan enrollment.
 - ___ Some WIC agencies serve only plan members, while others will serve anyone.
 - ___ Other

8. In your opinion, what has been the general impact of Medicaid managed care on the ability of WIC clients to access primary and preventive health services? Do you think this varies by the type of local agency?

9. What aspects of your efforts to coordinate between WIC and managed care have been the most effective in fostering coordination? The least effective?

10. How would you describe the quality of the relationship you have developed with the State Medicaid program? What factors do you believe contribute to a successful working relationship? What barriers have you faced in developing your relationship?

11. What recommendations would you make to improve the coordination between WIC and Medicaid?