

## CKF Coalitions Propel Policy and Procedural Changes

**A**dvocates and funders seek effective ways to modify state policies and procedures. Findings from the Covering Kids & Families® (CKF) program, sponsored by the Robert Wood Johnson Foundation (RWJF), indicate that coalitions of community-based organizations, government agencies, health plans, providers and advocates can be developed by grantees to support and shape policy and procedural changes in state Medicaid programs and the State Children’s Health Insurance Program (SCHIP), even after grant funding ends. This brief summarizes the following types of findings relating to state CKF coalitions:

1. Ways in which state grantees built coalitions that achieved policy changes;
2. The types of changes coalitions supported; and
3. The sustainability of capacity and change after the grant period.

### **BACKGROUND**

RWJF developed the Covering Kids® program in 1999 to increase enrollment and retention in Medicaid and the recently formed SCHIP program (Wooldridge 2007). In 2002 RWJF expanded Covering Kids to include families, renaming it Covering Kids & Families (CKF) (see insert on page 2). In all, RWJF funded 46 state CKF grantees; advocacy groups, health care and social service agencies, government agencies, academic institutions and health care providers housed these grantees.<sup>1</sup> The 46 state grantees in turn funded 152 local grantees. RWJF required each grantee to form and work through a coalition, in order to achieve desired changes as well as build “lasting capacity in states and communities to continue progress toward the initiative’s objectives even after the funding period” (RWJF 2001).<sup>2</sup>

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CKF had two goals:

- To increase Medicaid and SCHIP enrollment among eligible but uninsured children and families;
- To retain Medicaid and SCHIP coverage for eligible enrollees.

CKF specified three strategies to achieve these goals:

- Outreach to those uninsured but eligible for the programs to encourage enrollment;
- Simplification of SCHIP and Medicaid policies and procedures to make it easier for families to enroll and stay enrolled in programs; and
- Coordination between SCHIP and Medicaid to ensure that families transition easily between programs if they apply for the wrong program or if their eligibility changes.

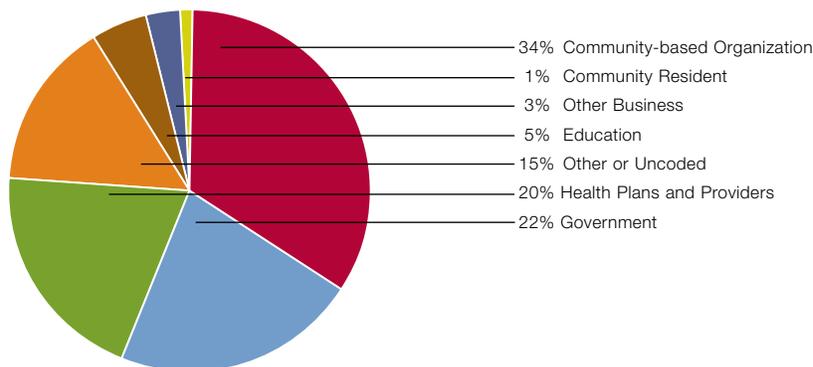
## BUILDING COALITIONS TO ACHIEVE POLICY CHANGE

**State CKF grantees built diversified coalitions; this diversity gave coalitions advantages in pursuing CKF goals.**

State CKF coalitions are diverse: the most common type of members are community-based organizations, such as children’s health and other health advocacy groups. Other members include health plans and providers, government officials, educators, business people and others (Figure 1).<sup>3</sup>

FIGURE 1

### Types of State Coalition Members



Source: Lavin et al. 2004. Data extracted on October 7, 2003.

Note: Government includes TANF, Medicaid, SCHIP and other government agency officials.

Different types of coalition members played different types of roles. For example, providers and school officials interacted with uninsured individuals through their work, and so became important sources for outreach work. Organizations representing ethnic communities, as well as other advocacy organizations, identified language or translation barriers to enrollment that might otherwise be unknown to state officials, leading to language simplifications in applications, renewal forms and other state notices.

**State coalitions provided a place for working with Medicaid and SCHIP officials to change policies and procedures.**

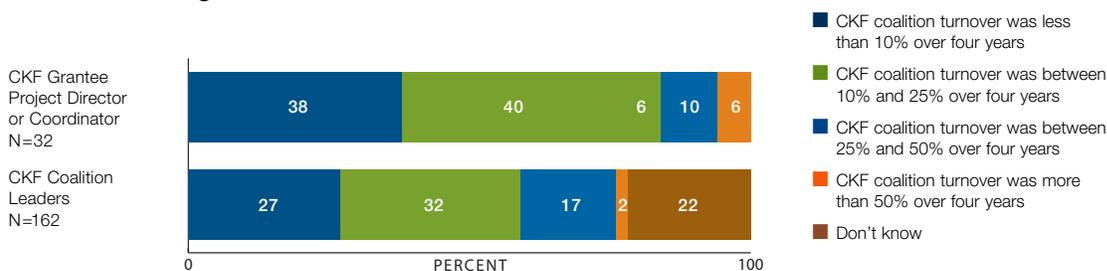
As a condition of funding, RWJF required grantees to include state Medicaid and SCHIP officials as participants in the state coalitions. State CKF grantees named state Medicaid and SCHIP officials their most important collaborators, because of officials’ control over and ability to change Medicaid and SCHIP policies and procedures (Hoag and Stevens 2005). Moreover, coalitions had the greatest success implementing the CKF strategies if they included among their members those SCHIP and Medicaid officials who had the authority to make program changes (Wooldridge 2007). State Medicaid and SCHIP officials likewise valued the coalitions, noting that CKF coalitions created a communication network and a forum for policy dialogue, both important legacies of the program (Duchon, Ellis and Gifford, forthcoming 2008).

**Coalition membership remained stable over time.**

Throughout the four-year CKF grant, turnover among individuals and organizations participating in most state CKF coalitions was low, allowing the coalitions to focus on goals without the distraction of constant recruiting (Figure 2). Low turnover suggests that members had a high level of commitment to CKF issues.

FIGURE 2

**Turnover Among State CKF Coalition Members**



Source: 2007 CKF Online Survey of Project Directors, Coordinators and Coalition Leaders, in response to the question "During the course of your four-year CKF grant, approximately how much turnover among members (either organizations or individuals) did you have in your coalition?" Preliminary data as of July 30, 2007.

## CREATING POLICY CHANGE

### State coalitions pursued CKF strategies to increase coverage, resulting in policy and procedural changes.

In the last year the coalitions operated under the RWJF grant, 63 percent of coalition leaders said outreach was their coalition's highest priority, 26 percent said simplification was the highest priority and 28 percent said coordination was the highest priority.<sup>4</sup> CKF grantees noted numerous ways their coalitions supported their achievements on each of these fronts. For example:

- Many coalitions pursued **outreach**. For example, after members of the Massachusetts coalition helped eliminate and enrollment freeze, coalition members conducted intensive outreach to eliminate the waiting list of 15,000 within two months. In Maine, coalition members helped secure an eligibility expansion to childless adults, and then, working independently and with the state, initiated outreach to this group, resulting in 24,000 fewer uninsured individuals in Maine.
- CKF coalitions often supported **simplification** activities. The Oregon CKF coalition, for example, included attorneys with Medicaid expertise who helped state officials understand how the state's existing Medicaid application could be simplified and still meet federal requirements. Other coalitions focused on simplification of renewal policies and processes. For example, members of the Connecticut coalition collected data to support their interest in simplifying renewals, such as by using pre-populated and shorter renewal forms, which the state then implemented. In Washington, the coalition won reinstatement of 12 months' continuous eligibility by showing the state the higher costs of churning associated with six-month eligibility rules, as well as by documenting the numerous administrative barriers resulting from the more restrictive policy.
- Thirty CKF grantees said their most promising coordination activity was to identify or eliminate barriers that were interfering with coordination of policies; coalition members helped to identify these coordination gaps.

For example, the Florida grantee and state coalition developed an organizational flow chart showing the gaps in coordination among the four state agencies that administer Florida Medicaid and SCHIP eligibility, benefits and programs, helping the state to identify areas in which coordination improvements were needed. Coalitions in Pennsylvania and Wyoming worked on aligning Medicaid and SCHIP policies to make it easier for beneficiaries to understand the two programs and to move from one to the other when their circumstances changed.

- Coalitions in Maryland, Massachusetts, Louisiana and California, among others, worked to expand coverage policies in SCHIP to include additional groups of children, parents and pregnant women.

**CKF coalitions helped grantees confront barriers they faced.**

RWJF implemented CKF to overcome barriers to enrollment and retention. Forty percent of CKF grantees interviewed in 2006 reported that their coalition helped them overcome the greatest overall barrier they faced to achieving CKF goals, while 75 percent said their coalitions were helping them overcome the greatest current barrier they were facing. Coalitions provided help through their expertise and their contacts in the state, and by providing direct outreach, communicating accurate information to constituents when policy changes occurred and identifying resources when needed. For example, when the Deficit Reduction Act (DRA) citizenship and identity documentation requirement was implemented in 2006, several grantees reported that their coalitions were an important source of information for state officials. The coalitions provided stories about barriers their clients encountered under the new rules, such as conflicting instructions about the documentation that applicants needed to provide, or whether new rules applied only to Medicaid or also to SCHIP. The coalitions were also an important conduit for sharing and clarifying information about new state policies.

## **SUSTAINING CAPACITY AND CHANGE**

### **Coalitions can outlive initial funding and continue to work on increasing insurance coverage.**

Before RWJF funding ended, more than half of grantees and state coalition leaders interviewed expected that their state coalitions would be sustained after the funding ended, even though funding constraints would limit their activities (Stevens and Hoag 2005). An early look at an ongoing survey of CKF project directors and coordinators whose CKF grants ended between six and 14 months before the survey was fielded, along with findings from a survey of state Medicaid and SCHIP officials in December 2006 and January 2007, suggests that most coalitions are continuing their roles as agents of change even though grant funding ended. Despite resource limitations, coalition members have found ways to continue pursuing CKF goals, whether by taking on an activity themselves or as a group, or by promoting policies that support CKF goals through continued coalition meetings. Their successes in CKF—creating awareness of the number of uninsured children and adults, facilitating enrollment, simplifying processes, coordinating coverage and resisting reductions in coverage—demonstrate the relevance of coalitions for sustaining projects after funding ends.

## **CONCLUSIONS**

Through their coalitions, CKF grantees brought interested and influential parties together to help bring about desired change. State officials and other coalition participants initially valued the coalitions because they established a forum for dialogue among these parties, in many cases for the first time. Over time, coalition members used this new platform to advocate for policies that support CKF goals. They particularly benefited from their members' expertise and experience about how various policies and procedures function in doctors' offices, emergency rooms, schools and workplaces throughout their states.

A new survey of coalition members conducted in mid-2007 will provide updated findings on sustainability. An early look at this data, together with findings from a survey of state Medicaid and SCHIP officials in December 2006 and January 2007, suggests that most coalitions are continuing their roles as agents of change; how long this work can continue without an identified, sustainable source of funding remains unknown. In a world of ongoing policy changes, from the 2006 implementation of the DRA to the continuing uncertainty of SCHIP reauthorization, the coalitions' work remains critical.

## Endnotes

1. In addition to the 46 state grants, RWJF funded small liaison grants in the remaining five states (Wooldridge 2007).
2. Each state had at least two local grantees, each of which formed a local coalition. RWJF specified that "...local coalitions should serve as learning laboratories for the statewide CKF coalitions." (RWJF 2001). Local coalitions thus provided information to state coalitions on effective outreach strategies and barriers to enrollment.
3. Local coalitions are similarly diverse, with most members coming from community-based organizations (38 percent), health plans and providers (22 percent), government agencies (13 percent) and educators (11 percent), among others (Lavin et al. 2004).
4. From an ongoing survey of CKF coalition leaders, as of July 30, 2007. Sample size of coalition leaders was 162. Leaders could rank more than one objective as "first;" thus, the numbers sum to more than 100 percent.

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