Frequently Asked Questions on Marketing, Outreach, and Member Materials for ACEs and CCEs
Illinois Department of Healthcare and Family Services

The following are questions health plans have asked about marketing, outreach, and promotional and informational materials. Additional FAQs on these topics are in pages 1-21 of a FAQ from June 30, 2014.

1. **Are there any other requirements for a health plan to participate in a health fair event?**
   In order to participate in a health fair or similar event, the plan must contact the event planner and ask that all the health plans in that geography be invited. Each health plan should submit their list of health fair events for prior approval to HFS.HLTHPlanOutreach@Illinois.gov.

2. **What information does HFS require about these events?**
   The following information must be provided for each event:
   - Title of event
   - Description of event
   - Sponsor of the event
   - Date(s) and hours
   - Location
   - Estimated Project turnout
   - A list of all documents and other items to be distributed

3. **If a plan invites all other health plans to a health fair event, and one or more of the other plans declines, does the inviting plan have a responsibility to inform HFS of the declination?**
   No.

4. **If a plan invites all other health plans to a health fair event, but there is not enough room for all 17 plans to participate, what should the inviting plan do?**
   Plans should invite everyone, state a deadline for accepting the invitation, and if many plans accept in time and space is at a premium, ask plans to send one representative only and to share tables/space more closely.

5. **Marketing guidelines state that plans may not participate in health fairs and other community events unless all of the plans are given the chance to participate. Are plans allowed to participate in previously scheduled upcoming events?**
   Because HFS just released the Outreach Guidelines at the end of June, we are allowing Health Plans to participate in certain previously scheduled community health awareness events and health fairs through the month of August 2014. This is strictly for those events already submitted to the Department. HFS will notify plans of submitted events that the plan may not participate in. Effective September 1, 2014, every event must be prior approved by HFS and offered to all health plans in the region.

6. **Can a health plan market itself by displaying a banner in a provider facility?**
   No.

7. **When do providers or plans need to use the Department's contracted mail vendors?**
   Only when you are doing a mass mailing to **potential** members, must you use a mail vendor with a confidentiality agreement with HFS like Mail Sort.

   If you are mailing to the plan's current patients (using the provider flyer and letter template) or to members who already enrolled in your health plan, then you can use your own vendor. You

must still have a contract or agreement signed with that vendor holding them to the confidentiality provisions in the contract you have signed with HFS.

8. **Can a health plan send a mailing via a vendor other than Mail Sort?**
   The proposed vendor must have a confidentiality agreement with HFS. At this time Mail Sort is one of very few with this arrangement in place. Template language is available for use for this agreement, if the plan wishes to initiate the arrangement with a massing mail vendor of its choice.

9. **What is the return address on mailed items?**
   To preserve the privacy of addressees not yet enrolled with a given plan, the return address is the mailing vendor's address. Please see examples here and here.

10. **If we adhere completely to the flyer and letter templates, do we still need to get items approved?**
    Yes, we still need to approve the flyer or letter.

11. **When submitting flyers and letters for your approval, can we just submit the language and not the fully designed versions?**
    Yes, that's fine as long as the substance of the flyer or letter will not change.

12. **Does HFS need to approve all member communications?**
    No. We do not need to approve health-related communications to existing members.

13. **What are the purposes of a brochure?**
    It can be included in a mailing the plan sends outs or made available to people at a health fair.

14. **Will a list of all providers in a given plan be included in mailing materials?**
    No. However, the number of providers in the plan will be included in mailing materials. Names of providers will be listed on the client enrollment broker website.

15. **Are there deadlines by mailing cycle that a plan can provide updates to the network components of our comparison chart? What is the last point at which a plan must have a comparison charts finalized?**
    As the Department works with the Health Plans to develop comparison charts for future mailings, HFS will send the chart for the Health Plans review and approval and will give deadlines at that time. There is no set timetable. We also perform an annual review of all materials and incorporate updates at that time.

16. **What mailing will be sent out at the times identified on the mailing schedule?**
    This mailing will include an enrollment letter, a tip sheet and the comparison charts for the geographic areas identified. The timing will coincide with the first date of enrollment for plans in the identified area.

17. **Is there a time lag between when the mailing goes out and when enrollment can occur?**

There may be. The date on the mailing schedule is the first day that someone can call or go online to enroll. The mail may be delivered to the client's address a day or so later. The client enrollment broker website may not be fully updated for a few days after enrollment begins.

18. **Is there a schedule for other mailings that the plan chooses to do?**
    No. The plan may complete mailings for things such as outreach, health education to current enrollees, etc., at the time of their choosing.

19. **Can a plan choose to entirely forgo a mass mailing or other marketing opportunities?**
    Yes.

20. **Are providers permitted to call existing patients to discuss the enrollment packets they will receive?**
    No, providers may not contact their patients to discuss enrollment. Per 42 CFR, Part 400, 438.104, this would be considered cold-call marketing. Providers may contact current Plan enrollees, but not potential enrollees. This is true even if the potential enrollee is their patient. Providers may contact their patients for other reasons, but not for enrollment.

21. **What can providers tell their patients about the process?**
    Providers should use the flyer to walk through/talk to their patients – that will ensure compliance. You don't need to have the whole list of plans in Cook County, but it should have the plans that the provider participates in. If the provider prefers one plan over another, then you must include a paragraph about why. If you want to distribute the comparison chart, that's fine too. The flyer should be sure to include the standard language that directs the client to call the client enrollment services to get information about all of their choices.

22. **Can a hospital or clinic that owns or participates in the plan mention the plan on its own website, in its newsletter, or in an annual report?**
    Yes. Please use language found in the template document. If a link is included, it should go to the client enrollment broker website. If the hospital or clinic participates in more than one health plan, it should mention *all* of the health plans. This is also subject to HFS approval.

23. **Can a hospital or clinic that owns or participates in a plan send out a press release about the plan?**
    Yes. This must be submitted to HFS for approval in advance.

24. **If a client does not have a phone or a computer to use the client enrollment broker website, can the plan provide this?**
    The plan can provide the person with the use of a phone, but not a computer.

25. **If a healthcare facility associated with the plan has computers available for public use, can clients use those computers to access the client enrollment broker website?**
    Yes, but providers and plan employees may not assist with accessing or using the website.

26. **What language should we use about PCP changes in outreach materials?**
    Below is some recommended language for the manual: "It is important to find a PCP you like and stay with them. If you have a problem with your PCP, we want you to talk to your PCP

first to try to work it out. If you are not able to work things out, you can change your PCP. We can help you find a new PCP in our plan, call us at XXX or XXX (TTY), or go onto our website and find a PCP in our plan network. To officially change your PCP with Medicaid, you must call the Illinois Health Connect Helpline at 1-877-912-1999. For TTY users, call 1-866-565-8577. It may take up to 30 days to change your doctor and transfer all of your medical records. You will receive a new ID card with your new doctor's name and telephone number."

27. **What language should we use in outreach and member materials on the subject of choice of plan and ability to change plans in first 90 days?**
"You may change health plans once in the first 90 days if you want. After that, you need to stay with your plan for one year, until your annual enrollment period. To learn more about your Health Plan choices, contact Illinois Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576) or http://enrollhfs.illinois.gov"

28. **What standards apply to readability level of outreach and member materials?**
We will be using https://readability-score.com/ to assess the readability level of your documents. All documents should be at or below a sixth grade level.
If you need help reducing the reading level, see
    - Maximus Communications Tune-Up
    - Health.gov, "What is health literacy?"
    - Medline Plus, "Health Literacy" website
    - CDC's "Clear It Up: Plain Language in Government Health Information" website

Make sure the language you use is consistent throughout your documents. Repeating standard terms helps the members understand and remember content.

29. **Is it permissible to provide members with an incentive to complete a health screening survey or other document?**
Yes, once approved by HFS, it is permissible to give these types of incentives to members for health related activities.

30. **Can incentives be something like a chance to win a $200 gift card?**
Yes. Incentives can include raffles.

31. **How is HFS measuring the five-day standard for sending welcome packets to new enrollees?**
The member handbook must be sent within five business days after the first time the member shows up on a Daily Panel Roster. We may ask for proof a plan has met this contract requirement.

32. **Do plans have to have their own plan Member ID cards?**
This is optional. The Medicaid "card" is just a regular 8 1/2 X 11 piece of paper that has their RIN and basic information about appeals, etc. Members are strongly encouraged to carry their card since some providers require the member to show their card before receiving services. However, all member information is available on MEDI. However, a plan may choose to issue its own card to members. You can also give members a sticker to put on the Medicaid card that includes a PCP's name and copay information, as long as it does not cover up any of the HFS information. If the member changes PCPs, you will need to send a new sticker.

33. If a plan chooses to send its own Member ID card, should the card include co-pay information?
If the ACE plans to cover the Family Health Plan population, copays should not be included. This is because of the All Kids population and the different copay levels that families pay depending on the program their kids are in. Here is a link to the HFS copay chart. If you would like to put something about co-pays on your card, please use the following: "Medicaid co-pays may apply." This lets the provider know to check for Medicaid co-pay limits.

34. Is there any other information that must be on a Member ID card?
Yes, each Member ID card should include: "This card does not guarantee eligibility or payment for services. Medical providers must verify identity and eligibility when you need care."