



**Executive Office of Health and Human Services
Guidelines for Marketing and Member Communications Materials
for
Rhode Island Medicaid Managed Care Program**

DRAFT / MODEL

This draft document does not contain any Final Rule requirements

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EOHHS Guidelines for Marketing and Member Communication Materials for the RI Managed Care Program.

Overview

EOHHS requires the review and prior approval of all materials related to or containing information regarding a contracted Health Plan that would be intended to be used for education, outreach or marketing purposes. For the purposes of this guidance, “Health Plan” means an MCO and their subcontractors including Accountable Entities and vendors. It is therefore imperative that the organization comply with the marketing guidelines under 42 C.F.R. Section 438.104, the *EOHHS Guidelines for Marketing and Member Communications Materials for the RI Managed Care Program* and the Contract between EOHHS and Health Plan for Managed Medicaid Services for an Integrated Population. Materials subject to these guidelines may be in any format including but not limited to written, audio, visual, digital or electronic format and includes but not limited to, welcome materials, health plan education materials, website content, brochures, posters, directories, member newsletters, identification cards, fact sheets, notices, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and any other marketing or member communication materials as identified by EOHHS. The Health Plan is contractually responsible for translating approved materials into alternate formats and languages.

EOHHS reserves the right to require an organization to withdraw advertising or other materials from distribution immediately or to publish at the Plans expense, a retraction and/or clarification in connection with any false or misleading statements or violations of these guidelines. In addition, EOHHS reserves the right to conduct an audit of the Health Plans advertising, marketing, outreach or member materials at any time.

These guidelines and protocols are to be used for all marketing and member communication activities under Rhode Island’s Managed Medicaid Programs specifically; Rlte Care, Children with Special Health Care Needs (CSHCN), Rlte Smiles, Rhody Health Partners, and Rhody Health Options Programs. In developing these Protocols, EOHHS strikes a balance between the need to actively promote enrollment into managed care and safeguarding the rights/interests of all Medicaid recipients.

When engaged in marketing its programs or in marketing targeted to potential or current members, the Plan:

- shall not distribute marketing materials to less than the entire service area
- shall not distribute marketing materials without the approval of EOHHS
- will not seek to influence enrollment in the Health Plan in conjunction with the sale or offering of private insurance;
- will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

Marketing Activities

As used in this guidance the following terms have the indicated meaning.

Cold Call Marketing

Cold call marketing means any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing as defined in 42 CFR 438.104

Marketing

Marketing means any communication, from the Contractor to a Medicaid recipient who is not enrolled in Medicaid Managed Care or the Contractor that can reasonably be interpreted as intended to influence the recipient to enroll in Medicaid Managed Care. CFR 438.104

Marketing Materials

Marketing materials means materials that are produced in any medium, by or on behalf of the MCO or their subcontractors that can reasonably be interpreted as intended to market to Potential Enrollees or Enrollees to change Health Plans.

Member Materials/Communications

Member materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS.

Contract Requirements

Each MCO must comply with all of the contractual requirements related to marketing and member materials/communications.

Submission of Marketing and Member Communications to EOHHS for Review and Approval

The Health Plan will submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed.

All materials should be submitted to EOHHS in accordance with the following procedure:

PROCEDURE: Member/Marketing Materials Request for Approval

PURPOSE:

Health plans are contractually obligated to seek approval of all member/marketing materials prior to release. This Procedure will identify the process taken by EOHHS and participating plans when requesting approval of member materials. Adhering to these procedures will ensure efficient approvals and comprehensive communication.

REQUEST PROCEDURE:

- 1) **Document Name:** Requests should be submitted with consecutive numbers. Include request number in document name and attach to email.

Document name: "Approval Request #XXX Material Name"

- 2) **Approval Request Form:** For each material request, please complete in its entirety a Request for Approval form and attach to email. Please name document "Request Form #XXX"

- 3) **Emailing Requests:** Submit approval requests to Joan Pillsbury joan.pillsbury@ohhs.ri.gov and cc OHHS OPS Unit OHHS.OpsUnit@ohhs.ri.gov

Email subject should contain 1) health plan name and 2) request #.

Email subject line: "Health Plan Name Request #XXXX"

Email should contain two attachments:

- i. Member material needing approval
- ii. Request for Approval form

Note: Please send only one approval request per email, except in the case that multiple items of similar purpose are being submitted (i.e. appeal letters).

EOHHS PROCEDURE:

Upon receiving your member material and *Request for Approval* form, the materials will be reviewed as quickly as possible, but may take up to 30 days. EOHHS will reach out with any questions/concerns either in an email, phone call or both. When materials are approved, an approval memo will be sent as a formal notice. EOHHS suggests not translating materials until they have been approved in English.

HANDLING OF REVISIONS:

If EOHHS requests changes to a document, you will need to resubmit the material with changes using the same request number.

- a. *Revised Document*: Please highlight in yellow the changes that have been made in the document. Change document name to “Revised Approval Request #XXXX Document Name”
- b. *Approval Request Form*: Provide a brief description and location of changes in the Approval Request Form. Name form “Revised Request Form #XXXX”

Emailing Revised Requests: Change email subject line to read “Health Plan Name Revised Request #XXXX”

Electronic copies of the Procedure and associated documents is included below.



Member-Marketing Health Plan Member
Material Review SubrMaterials Request for

Review of all marketing and member communications shall be completed by EOHHS on a timely basis not to exceed thirty (30) calendar days after the date of receipt. Requests for expedited review of materials will be considered on a case by case basis. Formal notice of EOHHS approval or disapproval shall be provided to the Plan within thirty (30) calendar days of receiving the materials. Plans shall not use any outreach material until it has received formal approval from EOHHS.

General Marketing and Member Communication Criteria

EOHHS will review all marketing and member communication materials directed to current and potential enrollees to ensure that all existing and applicable State, Federal and Contract requirements are met. The review will include, but is not limited to, evaluation of the following:

- Reading level: sixth grade using SMOG index criteria as a guide
- Presentation: large, plain type fonts, nothing below 10 point-exceptions include:
 - Member ID Cards
 - Logo's and tag lines
 - Internal tracking numbers
- Content: clear, accurate, concise, appropriate information regarding benefits and process.
- Information that may be confusing misleading or defrauding
- Cultural competency of content
- Covers the prescribed information mandated by the State for that specific document (e.g., new member handbook specifies how to choose a PCP, appointment procedures, etc.)
- Conforms to all applicable Federal and State requirements

- Explains information to the recipients in an understandable and readable manner
- Contains no prohibited marketing activities as described in the previous section.
- Health Plans must provide design layout copies of newsletters, advertisements, scripts, flyers, letters etc. as a condition of final EOHHS approval of such item(s).

The Health Plans may use a full range of marketing approaches to:

- Promote the Health Plan,
- Inform Medicaid recipients eligible for a program that they may enroll and remain in a Health Plan.

With the approval of EOHHS the following pre-enrollment activities may be used to promote a Health Plan.

- Conduct mass media marketing campaigns such as advertisements in newspapers, TV, radio, billboards, health plan website, or yellow pages which announce participation in EOHHS's managed care programs
- Develop brochures, leaflets and posters to be distributed by the Plans or by third parties
- Sponsor health fairs and special events
- Distribute health educational materials to promote EOHHS' managed care programs and the Health Plan
- Conduct speaking engagements with presentation materials such as slides, charts, handouts, etc.
- The Health Plan may conduct mass marketing and advertising activities which have been approved by the State that announce their participation in the RI Medicaid Managed Care programs providing that they do NOT include:
 - Mass mailings to low-income individuals who have not yet been determined by the State to be eligible for enrollment
 - Door-to-door or telemarketing activities to low income individuals
 - Confusing or misleading information about the coverage or benefits offered

The Health Plan may display marketing materials and conduct marketing activities at their sites, private locations and public buildings. These displays and activities must not occur within (50) fifty feet of any location established by the State to conduct eligibility and enrollment activities for the RI Medicaid Managed Care programs

- The Health Plan may not offer gifts of any kind or value to State employees or representatives of the EOHHS' managed care programs such as consultants, or Navigators.

- Marketing Plans must be made available to EOHHS upon request.
- Approval of content is specific to each medium. Thus wording in a written advertisement intended as a flyer to members may not be used in a TV or radio ad. The Health Plan is required to submit separate requests for content approval to each media.
- Giveaways/trinkets of nominal value, such as pencils, magnets, plastic pillboxes, etc. may be used in health plan promotions. The value of each item should not exceed \$2.00.

The marketing materials should include information necessary to enable the member to make an informed decision about enrollment based on the medical services provided. (e.g., a telephone number through which the enrollee may obtain a list of contracting providers and data on their location and availability, such as operation and accessibility of public transportation).

MEMBER MATERIALS

Health Plans must adequately explain the rules, conditions, rights and responsibilities to each individual enrollee that selects their organization for coverage both verbally and in writing. The following need to be included in membership materials

- All benefits provided under the contract with EOHHS, including additional benefits which have State approval;
- How to choose and change Primary Care Physicians (PCPs);
- How and where to obtain services from or through the organization, including a list of contracting providers, and explanation of the role of the PCP and written authorization procedures, a discussion of the use of the Health Plan's identification card, and instructions for accessing emergency and urgently needed care;
- What to do when family size or coverage status changes;
- All services must be provided by an in network provider, with the exception of emergency services and post stabilization, or if authorized by the Health Plan;
- The Health Plan's obligation to assume financial responsibility and provide reimbursement for emergency services and urgently needed services, including procedures and time limits for filing claims for these and other out-of-plan services;
- Appointment procedures and what to do in a medical emergency;
- Any services the organization chooses to provide from outside sources, other than emergency services and out-of-area urgently needed services, including a discussion of beneficiary liability and responsibility in each case;
- Information on Member's rights and responsibilities, including, in conformance with State and Federal law, the rights of mothers and newborns with respect to the duration of hospital stays

- Information on Member Services, and how to register a complaint with the Health Plan or file a formal grievance, including filing grievances with the Department of Human Services
- Information that a Member may disenroll during the first 90 days following the effective date of the individual's initial enrollment with the Health Plan
- Information on cost-sharing responsibilities (if applicable; may be included as an insert)
- Information on non-covered services
- Right to a second opinion
- Information on how to obtain a Provider network listing
- Information that a Member may change Health Plans during open enrollment.
- The extent to which, and how, after-hours and emergency coverage are provided
- Advance directives, as set forth in 42 CFR 438.6(i)(2)
- Internal and State grievance and appeals procedures. These procedures should be described separately (i.e., how to register a complaint not with the plan or file a formal grievance).
- Notice that your organization is authorized by law to terminate or refuse to renew the contract, that the State may also terminate or refuse to renew the Health Plan's contract Termination or nonrenewable of the Health Plan's contract may result in termination of the individual's enrollment in the Health Plan;
- Disenrollment rights and procedures;
- Policies regarding coordination of benefits;
- A Subscriber Contract or Evidence of Coverage at the HMO's option

In addition, the permanent identification card must be issued within 10 calendar days of notification of enrollment and should contain the following information:

1. Enrollee's Name,
2. Plan's name,
3. Telephone number to access behavioral health,
4. Telephone number for 24 hour emergency care services,
5. Telephone number for Member Services,
6. PCP's name and telephone number (this can be affixed by a sticker)
7. Relevant cost-sharing/ co-payment info
8. Phone number for pharmacy benefits manager (if different from member services)

Communications with the Media and Press Releases

Health Plans are allowed to communicate with the media when contacted by the media source. All Health Plan press releases must be reviewed and approved by EOHHS prior to distribution/release.

Health Plan Education Materials

Health Plans may develop materials that educate potential enrollees about their health plan in particular. The materials must be sent for review and approval. Approved materials may be made available at education events in the community such as health fairs. These materials may not be used at provider offices.

Face to Face Outreach

Face-to-face outreach by the Health Plan directed at participants or potential enrollees, including direct or indirect door-to-door contact, telephone contact, or other cold-call activities is strictly prohibited.

Cold call outreach is prohibited (both in person and by telephone) in all outreach activities. At no time shall a Health Plan representative approach an individual to offer education or information about the Health Plan. An individual must approach or contact the Health Plan representative directly and request information on the Health Plan. For example, at health fairs, a Health Plan representative is prohibited from approaching individuals to offer information on the Health Plan. An individual must approach the Health Plan table/booth and request information.

Other Materials

Materials and activities approved by the State for commercial contracts, which will be used for Rite Care, CSHCN, Rite Smiles, Rhody Health Partners and Rhody Health Options without change, do not require an additional review by EOHHS if all the information contained is pertinent to the Medicaid managed care plan enrollees. Also clinical or member education materials designed to provide information on good health practices that have been approved by the Centers for Disease Control (CDC) or National Institutes of Health (NIH) do not require additional review by EOHHS.

Pre-Enrollment

EOHHS must review and approve all pre-enrollment marketing activities and membership materials used by the Health Plans, and or their subcontractors, which mention or are specific to managed care programs. The pre-enrollment marketing materials provided to potential Medicaid eligibles that have applied for enrollment into managed care and are interested in a Health Plan should include:

- Eligibility requirements that indicate an individual's eligibility is based on his/her eligibility for Medicaid and/or EOHHS' managed care programs only.

- A written statement that the Health Plan may neither refuse enrollment based on an individual's health status, or prior use or anticipated use of health services, nor impose restrictions for preexisting conditions.
- Description of benefits provided under the Rite Care and associated managed care programs, including any additional benefits approved by EOHHS.
- Information on application and enrollment procedures.
- How and where to obtain services from or through the Health Plan, including an explanation of the role of the PCP and prior authorization procedures, i.e., instructions for accessing emergency and urgently needed care.
- Notice that the Health Plan is authorized by law to terminate or refuse to renew its contract with the State that the State may also choose not to renew its contract with the organization and that termination or non-renewal may result in termination of the individual's enrollment in the Health Plan. (Usually in the subscriber agreement).
- Disenrollment rights and procedures

Discussion of applicable premiums, co-payments and deductibles: Include statements that premiums and benefit packages may change at the beginning of each contract period, but may not change during the contract period unless the change is to the advantage of the enrollee or is required by Federal or State law.

MEMBER INCENTIVES

Health Plans may offer incentives to their enrolled members for the purposes of rewarding for compliance in immunizations, prenatal visits, or participating in disease management, etc. All incentives must be approved by the EOHHS prior to use. The Health Plan is encouraged to consider items that promote good health behavior, e.g., toothbrushes or immunization schedules. This incentive shall not be extended to any individual not yet enrolled in the Health Plan. The Health Plan must submit all incentive award packages to EOHHS for approval prior to implementation.

- If the gift or reward for healthy behavior is offered within thirty (30) days of an individual's enrollment, the value of such gift may not exceed ten (\$10) dollars;
- If the gift or reward for healthy behavior is offered after thirty (30) days of an individual's enrollment, the value of such gift may not exceed twenty-five (\$25) dollars;

Gifts or rewards to members may only be offered as a direct result or outcome of that member having participated in or completed a health related activity. The only occasions in which the value of the gift may exceed \$25 is for providing free gym membership or for diapers provided to mothers who have given birth.

Raffles and Drawings:

A Health Plan may offer its members an opportunity to have their names placed in raffles or drawings. Each raffle or drawing proposed must be prior approved by EOHHS. The total value of gifts made available to winning tickets may not exceed \$25.00 per winning ticket and a maximum of \$75.00 for three (3) drawn tickets.

INNAPPROPRIATE MARKETING ACTIVITIES

Unless prior approval is provided by EOHHS, a Health Plan and its staff shall not:

- Provide cash to potential enrollees, prospective enrollees or current enrollees, except for reimbursement of expenses and stipends, in an amount approved by EOHHS, for participation on committees or advisory groups
- Provide gifts or incentives to potential enrollees or prospective enrollees unless 1) such gifts or incentives are also provided to the general public and, 2) do not exceed ten dollars (\$10) in value per individual gift or incentive. (All such gifts must be approved by the Department prior to use.)
- Provide gifts or incentives to enrollees unless such gifts or incentives 1) are provided conditionally based on the enrollee receiving preventive care or other health related activity; and 2) are not in the form of cash or an instrument that may be converted to cash.
- Induce providers or employees of EOHHS or Department of Human Services (DHS) to reveal confidential information regarding participants or otherwise use such confidential information in a fraudulent manner.
- Conduct outreach activities at the local DHS office
- Represent themselves to be employees of EOHHS or DHS.
- Engage in outreach activities which target prospective enrollees on the basis of health status

The following marketing practices are prohibited for the Health Plans or their subcontractors:

- Discriminatory Activities—These include attempts to discourage participation on the basis of actual or perceived health status, such as:
 - Attempts to enroll individuals from a high income area if the Plan is not making a comparable effort to enroll people from lower income areas in its service area: or
 - Attempts to give enrollment priority to those in your service area who are newly eligible for Medicaid/EOHHS' managed care programs over other people.
- Activities that mislead, confuse, or misrepresent—Activities that could mislead or confuse current or potential enrollees, or activities that misrepresent EOHHS' managed care

programs, or the Health Plan are prohibited. Health Plan marketing representatives must clearly identify themselves as such when engaging with a member or prospective member. The following are examples of activities considered to fall within this type of activity:

- Claiming recommendation or endorsement by the State of the Health Plan or claiming the State or CMS recommends enrollment in your Health Plan;
 - Using terms, such as “official U.S”. Or “Rhode Island government” or “Medicaid”, “Rite Care” or “CSHCN” or “Rite Smiles” or “Rhody Health Partners” or “Rhody Health Options” on envelopes or in other marketing materials in ways likely to confuse current or potential enrollees;
 - Using coupons or cards seemingly intended for requesting additional information for the purpose of enrollment screening or to activate enrollment;
 - Identifying a Health Plan representative as an agent of Medicaid, Rite Care, CSHCN, Rite Smiles, Rhody Health Partners, Rhody Health Options, or the Federal government. You may however, explain that your organization has a contract with the State of Rhode Island;
 - Omitting information necessary for the enrollee to make an informed choice, whether or not the individual specifically requests the information;
 - Making overstatements about the Health Plan’s coverage;
 - Giving implications of perpetual coverage;
 - Using enrollment forms which are not accompanied by sufficient other information to allow for an informed choice;
 - Incorrectly describing Medicaid and associated managed care plans covered services;
 - Attempting to persuade (steer) an enrolled member to disenroll from one Health Plan and enroll in another;
 - Not offering benefits approved by the State or CMS;
 - Indicating that benefits are **free or at no cost** to the enrollee; and
 - Implying that the individual’s current or desired physician is affiliated with the Health Plan when that is not the case, or their panel is closed to new patients.
- Gifts or Payments to Induce Enrollment—Offers of gifts or payments as an inducement to enroll in your Health plan are prohibited.

In addition, the Health Plans are prohibited from distributing marketing or membership materials that have not been approved by EOHHS. Similarly, Health Plans are prohibited from distributing marketing materials that EOHHS has disapproved in writing.