

**MARKETING AND APPROVAL
OF
WRITTEN MATERIALS PROTOCOLS**

**FOR THE RITE CARE,
CHILDREN WITH SPECIAL HEALTH CARE NEEDS,
RITE SMILES
RHODY HEALTH PARTNERS PROGRAMS**

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I. INTRODUCTION

This document describes the protocols to be used for marketing and member communication activities under Rhode Island's Rite Care, Children with Special Health Care Needs (CSHCN), Rite Smiles and Rhody Health Partners Programs. Marketing includes all activities developed and undertaken by the State of Rhode Island or by each contracting Health Plan (HMO) with the following goals:

- To promote the Rite Care, CSHCN, Rite Smiles and Rhody Health Partners Programs
- To promote and generate goodwill for participating Health Plans
- To encourage eligible individuals to enroll in or remain in specific Health Plans
- To provide information on plan benefits, costs, access and operational rules
- To ensure that existing and prospective members receive accurate and understandable information

In developing these Protocols, DHS strikes a balance between the need to actively promote enrollment into managed care and safeguarding the rights/interests of Medicaid recipients.

Specifically this document covers; (II) Marketing and Member Communication Summary Guidelines indicating (a) Health Plan Responsibilities and (b) DHS Responsibilities; (III) Member Incentives; and (IV) Prohibited Marketing Activities.

II. MARKETING AND MEMBER COMMUNICATION SUMMARY GUIDELINES

(a) Health Plan Responsibilities:

(i) Health Plan Marketing

The Health Plans may use a full range of marketing approaches to: (1) promote the Health Plan, (2) inform Medicaid recipients eligible for this program that they may enroll and remain in a Health Plan. 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 DHS'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 DHS's 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 RIte Care and associated 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 RIte Care and associated managed care programs.
- The Health Plan may not offer gifts of any kind or value to State employees or representatives of the DHS's managed care programs such as consultants, or Family Resource Counselors (FRCs).
- Marketing Plans must be made available to DHS 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 other 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).

(ii) Member Communications

- The Health Plan will process the information from the State’s daily listing and provide all new managed care enrollees with a new member packet which includes:
 - Identification card
 - New Member handbook materials specific to DHS’s managed care programs containing:
 - Instructions on how to access services
 - How to choose a PCP and change PCPs
 - How to obtain transportation services
 - How to obtain all referral and emergency services
 - Grievance, appeals and disenrollment procedures
 - List of contact phone numbers
- The Health Plan may provide an introductory packet of information to potential enrollees only upon their written or verbal request after the State has completed the eligibility interview process. This packet must be approved by DHS and might include:
 - Brochures, flyers or handouts describing benefits and how to access services
 - Items of nominal value ((no more than \$2.00 per item) which depict RItE Care, CSHCN, RItE Smiles and Rhody Health Partners and/or the Health Plan but do not mislead or provide defrauding information (Optional)
 - Information about primary care and or specialty providers
- Advise enrollees of the contract renewal date for the RItE Care, CSHCN, RItE Smiles and Rhody Health Partners Programs.

(iii) MEMBERSHIP 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 DHS, 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 surgical opinion
- Provider network listing (may be included as an insert)

- 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 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)

(b.) Department of Human Services (DHS/State) Responsibilities

The following summarizes the responsibilities of DHS for determining whether an individual qualifies for Medicaid and/or the RItE Care and associated managed care programs, providing non-biased information about the contracting Health Plans.

- DHS will provide a number ("Info Line") for individuals to call during business hours to get information about the RItE Care and associated programs and how to be eligible for enrollment.
- DHS will provide prospective enrollees with a description of the program and the following items either through the mail or by a DHS field worker:

- Enrollment Application(s)
 - General information on how to select a Health Plan and a PCP
 - Description of the RItE Care and associated managed care program's health care benefits and access to services
 - General instruction on how to access the RItE Care, CSHCN RItE Smiles, and Rhody Health Partners Program's services
 - List of contact phone numbers and primary address for contracting Health Plans
 - Explanation of the time constraints in place for selecting a Health Plan and a PCP
- DHS will review all marketing activities and materials directed specifically to RItE Care and associated managed care programs 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:
 - Language: English, Spanish, and others
 - Reading level: sixth grade mark using SMOG index criteria
 - Presentation: Large, plain type fonts, nothing below point 10
 - Content: Clear, accurate, concise, appropriate information about benefits and process
 - Information that might be confusing, misleading or defrauding
 - DHS will review marketing activities and materials which are specific to the RItE Care and associated managed care programs, These may include, but not be limited to:
 - Advertising layouts and/or scripts – audio, video, print, TV, Website, etc.
 - Member Handbook, includes access and process instructions
 - Instructions about obtaining services and benefits
 - Lists of providers, locations, hours; primary, specialty, or other designation, bi-lingual capability etc.
 - Flyers and other handouts

- Subscriber contract – evidence of coverage (does not have to meet 6th grade reading level, but must meet legal requirements)
- Identification card
- Forms completed by the recipient/enrollee
- Descriptions of benefits offered other than those stipulated by DHS for the RItE Care and associated managed care programs (enhanced benefits)

Note: The above are representative of items that might be created specifically for this population and are not meant to be all inclusive of State requirements.

- DHS will provide a monthly list of members newly enrolled to each Health Plan as appropriate.

Materials and activities approved by the State for commercial contracts, which will be used for RItE Care, CSHCN, RItE Smiles and Rhody Health Partners without change, do not require an additional review by DHS if all the information contained is pertinent to the Rite Care and associated 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 DHS. Each marketing activity and membership document submitted to the DHS for review and approval will be assessed to determine whether it:

- 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.)
- Provides accurate information about the content of the DHS managed care programs and the Health Plan
- 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 DHS approval of such item(s).
- DHS approval of a request is specific to the item and the medium it is conveyed in. If the health plan wishes to use this in another venue it must seek specific DHS approval on the item in that venue.
- Health Plans should individually number Requests for Approval and not bundle these.

DHS 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 the RItE Care and associated, 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 DHS's 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 DHS.
- 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.

III MEMBER INCENTIVES

(a.) A Health Plan may offer the general public a gift or reward as a means to promote healthy behaviors and outcomes. The maximum value of such gifts shall be dictated by whether or not the incentive is offered proximate to a members' enrollment.

(i) 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;

(ii) 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.

(b.) 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 DHS. 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.

IV PROHIBITED MARKETING ACTIVITIES

The following marketing practices are prohibited for the Health Plans/HMOs 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/DHS's 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 DHS's 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" 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, 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/or RItE Care 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.
- When engaged in Marketing its RItE Care, CSHCN, RItE Smiles and Rhody Health Partners program or in marketing targeted to persons eligible for these programs, the Health Plan:
 1. shall not distribute marketing materials to less than the entire service area;
 2. shall not distribute marketing materials without the approval of the Department
 3. will not seek to influence enrollment in any DHS managed care program in conjunction with the sale or offering of private insurance; and

4. will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities. (BBA)
- 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 DHS. Similarly, Health Plans are prohibited from distributing marketing materials that DHS has disapproved in writing.