Rhode Island EOHHS Guidelines for Marketing Materials and Member Communications for Medicaid Managed Care Program, RIte Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (ad hoc)

Rhode Island Executive Office of Health & Human Services
(RI EOHHS)

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INTRODUCTION

Plans are required to comply with the information requirements and marketing guidelines under 42 C.F.R. Section 438.10 and 438.104, *Rhode Island EOHHS Guidelines for Marketing Materials and Member Communications for Medicaid Managed Care Program, RIte Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (ad hoc)*, as well as the Contract Between EOHHS and Health Plan for Medicaid Managed Care Program, Contract Between EOHHS and Contractor for Non-Emergency Medical Transportation (NEMT) and the Contract Between EOHHS and Medicaid RIte Smiles Program. EOHHS requires the review and prior approval of all materials related to or containing information that is intended to be used for education, outreach, or marketing purposes for Health Plan enrollees or prospective enrollees. For the purposes of this guidance, "Plans" refers to a managed care organization (MCO), non-emergency medical transportation (NEMT) vendor, and the Dental Plan that administers the RIte Smiles Program, including all sub-contractors, which include contracted Accountable Entities (AEs) and their respective sub-contractors and vendors. Plans are required to comply with the information requirements and marketing guidelines under 42 C.F.R. Section 438.10 and 438.104, *Rhode Island EOHHS Guidelines for Marketing Materials and Member Communications for Medicaid Managed Care Program, RIte Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (ad hoc),* as well as the Contract Between EOHHS and Health Plan(s) for Medicaid Managed Care Program, Contract Between EOHHS and the Non-Emergency Medical Transportation (NEMT) contractor, and the Contract Between EOHHS and Medicaid RIte Smiles Program. For the purpose of this guidance, MMP (ad hoc) materials refer to general health promotion materials that do not include MMP related information and are not included in the Medicare Managed Care Manual, Medicare Marketing Guidelines and Prescription Drug Benefit Manual.

In addition:

- Plans must comply with all contractual requirements related to marketing materials and member communications.

- Plan sponsors are responsible for ensuring compliance with current marketing regulations and guidance, including monitoring and overseeing the activities of their sub-contractors, downstream entities, and/or delegated entities.

- Interoperability: The Plan must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). The CHIP MCO must comply with the Patient Access API requirements in 42 C.F.R. § 457.1233(d) and the Provider Directory API requirements in 42 C.F.R. § 457.1233, including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01).

- **EOHHS reserves the right to conduct an audit of the Plan's advertising, marketing, outreach, or member materials at any time.**

These *Guidelines* are to be used for all marketing materials and member communications activities under Rhode Island's Medicaid Managed Care Program (MCO), Medicare-Medicaid Program (MMP) ad hoc enrollee communication materials, and Non-emergency Medical Transportation (NEMT) member communications. This includes the RIte Care, Children with Special Health Care Needs (CSHCN), Rhody Health Partners, and RIte Smiles.

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;
- Shall not seek to influence enrollment in the Health Plan in conjunction with the sale or offering of private insurance;
- Shall not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

DEFINITIONS

- **Accountable Entities:** An integrated network consisting of an inter-disciplinary provider organization that is financially accountable for member cost, quality and health outcomes for Medicaid populations within value-based payment arrangements.
- **Choice Counseling:** The provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Health Plans and Primary Care Providers. The term does not include making recommendations for or against enrollment into a specific Health Plan. [42 C.F.R. § 438.2]
- **Cold Call Marketing:** Includes any means of unsolicited personal contact by the Contractor with a Potential Member for the purpose of Marketing as defined under this Agreement and 42 C.F.R. § 438.104. This can include door-to-door, telephone, e-mail, texting, or other unsolicited forms of Marketing. [42 C.F.R. § 438.104(a)].
- **Contract Requirements:** Means that each MCO, NEMT and MMP must comply with all the contractual requirements related to marketing and member materials/communications.
- **Marketing:** Any communication from a Health Plan to a Medicaid beneficiary who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the beneficiary to enroll in that particular Health Plan's Medicaid product, or either to not enroll in or to disenroll from another Health Plan's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified Health Plan as defined in 45 C.F.R. § 155.20. [42 C.F.R. § 438.104]

- **Marketing Materials & Member-facing Materials (Member Communications):** Materials that are produced in any medium, by or on behalf of the MCO or their sub-contractors that can reasonably be interpreted as intended to market to and/or educate Potential Enrollees or Enrollees.
- **Marketing Representative:** A Contractor's Representative who is engaged in a Marketing activity.
- **Member Materials/Communications:** Member materials that 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, text messages, emails, digital platforms, and other materials, as identified by EOHHS.
- **Member** is a Medicaid recipient enrolled in a Health Plan. The term member is used synonymously with the term "enrollee" or "beneficiary" in this Agreement. [42 C.F.R. § 438. 2]
- **Potential Member** or **Potential Enrollee** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a contracted Health Plan but is not yet a member of a specific Health Plan. [42 C.F.R. §438.2]

ATTACHMENTS

The enclosed attachments and their corresponding instructions shall be reviewed and used in accordance with these *Rhode Island EOHHS Guidelines for Marketing Materials and Member Communications for Medicaid Managed Care Program, RIte Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (ad hoc)*. They are referenced throughout these Guidelines.


Attachment A_Non-discrimintati


Attachment B_Marketing & Mem


Attachment C_Notice of RI EOHH

MARKETING MATERIALS & MEMBER COMMUNICATIONS SUBMISSIONS, REVIEW, & APPROVAL PROCESSES

1. Marketing and Member-facing Communication Criteria

EOHHS reviews all marketing materials and member-facing documents directed to current and potential enrollees to ensure compliance with applicable state, federal and contractual requirements.

The evaluation includes, but is not limited to:

- Readability; using (1) reading level criteria as a guide, (2) low literacy standards and best practices
- Presentation and font size
- Content that is clear, concise, accurate and appropriate
- Content that may be confusing, misleading or fraudulent
- Content that is culturally competent
- Explains information to the recipients in an understandable language
- Contains no prohibited marketing activities or information, as described in the previous section.
- Covers the prescribed information mandated by the State for that specific document (e.g. Model Member Handbook, Appeals & Grievance Notifications, and other model documents)

2. Model Documents

In accordance with the CMS Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), States are required to develop a Model Member Handbook, Appeal and Grievance Notice templates, and definitions of key terms for use by the managed care plans. Plans are required to add Plan-specific information; however Plans cannot alter or delete required information in the model documents. RI EOHHS will ensure Plans are in receipt of all model documents. Plans are required to submit to RI EOHHS, for review and approval, model documents containing Plan-specific information.

3. Submission Criteria

Marketing materials and member-facing communications will be reviewed by EOHHS for regulatory and contractual compliance, content accuracy and appropriateness.
All documents must be thoroughly proofread for spelling and grammar prior to submission. EOHHS reviews submitted marketing materials and member communications that include:

- Written materials written at no higher than a 6.5 grade level using the Flesch-Kincaid Readability Guide found at this link: https://readabilityformulas.com/free-readability-formula-tests.php. The specific metric the Plan shall use to verify an acceptable readability

score is the Flesch-Kincaid Grade Level.

- Language assistance services information (when appropriate for the document)
  - All written materials must be made available in alternate formats upon member request (e.g. audio, large font, Braille)
  - translation services for enrollees and potential enrollees with limited English proficiency (LEP)
  - tag lines in the prevalent non-English languages in the State
  - Nondiscrimination notice (see **Attachment A**).

- The Plan shall not alter or modify the EOHHS logo but may change the size so long as the logo remains visible and legible in all Marketing Materials. EOHHS, in its sole discretion, may move, resize, or otherwise alter the use of its logo as part of its approval.

Content that is:

- Culturally competent
- Clear, concise, appropriate, and must meet contractual and regulatory requirements
- Includes prescribed information mandated by the State when appropriate
- Free from confusing, misleading or fraudulent information
- Appropriate heading and/or naming convention
- Active and correct contact information, hyperlinks, URLs, and telephone numbers

4. Cobranding

Member communications sent in collaboration with any Plan's subcontractor(s) must be submitted through the standard marketing review process, and both entities' brand must be displayed on the marketing submission. Subcontractors include but are not limited to contracted Accountable Entities (AEs). Plans will be required to add a footer to all cobranded documents.

- Example: Sponsored by

5. State of Rhode Island 'File and Use' Process

File and Use documents are member communications or standard templates designed by the Plans to inform members of a change, such as formulary change, network changes, or a form letter used for membership, in general, to inform of vaccines, missed appointments, scheduled annual PCP and/or visits.

These templates are directed to inform all members rather than individual members of applicable change. If RI EOHHS issues approval of the template the Plan submits for review, the boilerplate language enclosed in the template can be used on an ongoing basis with information the Plan inputs depending on the context of the member-facing communication.

Please note that member surveys, questionnaires, forms, health assessments, etc., such as

CAHPS, HEDIS or NCQA, are also considered 'File and Use,' as no changes can be made to these by either the Plan or the State. These templates are directed to inform all members, rather than individual members, of the applicable change(s). Once initially approved, these documents may be submitted to EOHHS as 'File & Use'. If the Plan makes any changes to the previously approved File and Use template, it must be submitted to EOHHS with a Marketing and Member Communications Request for Approval form [Attachment B] as a revised document. The Health Plan(s) shall not use the document unless it has been approved by EOHHS.

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 but should be submitted for 'File and Use'.

Any member satisfaction surveys, questionnaires, forms, health assessments, etc. **developed by the Plans** require review and approval by EOHHS.

Please note that EOHHS 'File and Use' is **NOT a CMS designation: ***CMS "File and Use Certification" process allows organizations to begin market distribution of certain marketing materials 5 calendar days after they have been submitted to CMS and requires that the CEO or CFO of the organization certify that the materials meet CMS requirements.*

6. Plan Submission Process

Health Plans are contractually obligated to receive 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**.** Each Plan shall provide EOHHS the Plan's designated Marketing contact(s).

Request Procedure:
Plans must submit all marketing and member communications via email that contains two (2) attachments:

- Member material(s) needing approval
- Marketing and Member Communications Request for Approval form [Attachment B]

If EOHHS requests changes to a document, Plans shall resubmit the material with changes using the same request number. Plans should submit all documents for review in Microsoft Word for ease of review via Track Changes to OHHS.MCOOversight@ohhs.ri.gov and the designated EOHHS Marketing Team, as noted in **Attachment B**.

7. EOHHS Approval-Rejection Process

EOHHS Review Timeframe: EOHHS will acknowledge receipt of review request within two (2) business days via email.

Plan(s) are not allowed to use or distribute any marketing or member communications that have not been approved by EOHHS.

EOHHS will review materials within the designated timeframes, as follows:

- Standard (std): up to 30 business days from date of receipt
- Expedited (exp): up to 3 business days from date of receipt*

  *EOHHS has the right to dispute expedited requests

Annual or quarterly documents, such as Handbooks and newsletters, do not constitute an expedited request(s). Expedited requests are most often notifications of a change in benefits, formulary, provider network or an occurrence that has a time-sensitive impact.

EOHHS will approve, conditionally approve (with edits, questions, and feedback enclosed), or reject submitted materials and return to the Plan with Notice of RI EOHHS Approval, Conditional Approval, or Rejection of MCO Marketing & Member Communications Request for Approval [Attachment C].

Please note that, when resubmitting for review a document(s) previously 'conditionally approved' or 'rejected' by EOHHS, the clock restarts at 30 days (within EOHHS' discretion).

Please note EOHHS' Subject Line naming conventions, as follows:

- **Conditional Approval:**
  - Conditional Approval_MKT_<Plan>_#_<Document Name>_<EOHHS Reviewer Initials>_<date>
- **Approval:**
  - Approval_MKT_<Plan>_#_<Document Name>_<EOHHS Reviewer Initials>_<date>
- **Rejected:**
  - Rejected_MKT_<Plan>_#_<Document Name>_<EOHHS Reviewer Initials>_<date>

If EOHHS rejects or edits documents submitted by Plan, Plan should resubmit document in Word with Track changes and the Notice of RI EOHHS Approval, Conditional Approval, or Rejection of MCO Marketing & Member Communications Request for Approval [Attachment C].

EOHHS will review resubmissions in accordance with the standard turnaround timeframe unless otherwise indicated.

GENERAL MARKETING APPROACHES AND ACTIVITIES

The Health Plans may utilize 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.

Once the Plan seeks and receives EOHHS' approval, 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' Managed Care Programs
- Develop brochures, leaflets and posters to be distributed by the Plan(s) 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 & NEMT programs, so long as 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 fifty (50) feet of any location established by the State to conduct eligibility and enrollment activities for the RI Medicaid Managed Care Programs.

The Plan must create a Marketing plan for EOHHS approval submitted on the templates provided in Chapter 3 of the Managed Care Manual, Marketing Policies & Procedures. The Plan must update their Marketing Plan(s) annually, revise the plan as needed, and readily make the marketing plan available to EOHHS upon request.

- Approval of content is specific to each medium. For example, 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).

Health Plans may develop materials that educate potential enrollees about their specific health. 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.**

1. Face to Face Outreach

Face-to-face outreach by the Health Plan that is 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. For example, at health fairs, a Health Plan representative is prohibited from approaching individuals to offer information about the Health Plan. An individual must approach the Health Plan representative and/or table/booth to request information.

Targeted marketing efforts, including having Marketing Representatives answering questions by phone or in-person from Members or potential enrollees, is not considered cold call marketing.

2. 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.

Plans may use a full range of marketing approaches to promote their Plan. Marketing materials should include information necessary to enable the member to make an informed decision about enrollment based on the services provided.

Marketing or distributing marketing materials, including member handbooks, and soliciting enrollees in any other manner, inside, at the entrance or within fifty (50) feet of check cashing establishments, public assistance offices, DHS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), provider locations (including health care facilities, freestanding urgent care centers, store-based clinics), pharmacies, Medicaid Eligibility Offices, and/or certified Medicaid Application Centers without prior approval from EOHHS.

With the approval of EOHHS, Plans may conduct the following pre-enrollment activities:

- Marketing campaigns including advertisements in newspapers, TV, radio, billboards, and other media;
- Develop and distribute brochures and posters;

- Sponsor health fairs and special events;
- Conduct presentations

The pre-enrollment marketing materials provided to potential Medicaid-eligible individuals 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 primary care provider (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 and 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.

3. Materials and Communications Requiring State Review

Materials requiring State review include but is not limited to:

- Welcome materials, identification cards
- Health Plan education materials
- Website content, directories
- Member handbooks
- Brochures, posters, member newsletters, fact sheets
- Surveys
- Notices, form letters, mass mailings, system-generated letters
- Call scripts
- TV, radio, and newspaper advertisements
- Any other marketing or member communication materials as identified by EOHHS.

Formats

Formats subject to these *Guidelines* may be in any format including, but not limited to:

- written
- audio
- visual
- digital or
- electronic format

4. Communication with Media Source

- Plans can communicate with the media when contacted by a media source.
- All Plan press releases must be reviewed and approved by EOHHS prior to distribution or release.

5. Limited English Proficiency (LEP) Requirements

All Plans written materials, that are essential to enrollee's obtaining services, (including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices), must contain an explanation that the following alternative forms of communication are available upon request and at no cost, to the potential or current enrollees.

Written materials must include the following:

- Taglines in the State's prevalent non-English languages [Attachment A]
- The availability of alternative formats
- A conspicuously visible font size
- Translated versions that include Portuguese and Spanish, at a minimum
- Oral interpretation and other auxiliary aids and services.
- The toll-free telephone number, language line telephone number and the TTY/TDD telephone number of the MCO's member/customer service must be made available on all written information.

6. Nondiscrimination Provisions

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 and its implementing regulation (Section 1557) require covered entities to post – in their significant publications and communications – nondiscrimination notices in English, as well as taglines in at least the top 15 languages spoken by individuals with limited English proficiency (LEP) in the State(s) served.

The following are not significant publications communications under Section 1557:

- Radio or television ads;
- Identification cards (used to access benefits or services);
- Appointment cards;
- Business cards;
- Banners and banner-like ads;
- Envelopes; or
- Outdoor advertising, such as billboard ads.

Significant publications and communications that are small-sized, covered entities must post at least a nondiscrimination statement in English and taglines in at least the top two languages spoken by individuals with LEP of the State(s) served. Examples of documents that are "small-sized" include:

- Postcards
- Tri-fold brochures
- Pamphlets

Significant publications and significant communications that are presented on 8.5 x 11-inch paper are not considered "small-sized," even if the information conveyed fits on one side of a page.

Non-Discrimination enclosure must include all **boldfaced language outlined below**, at a minimum. Plans can add language and format at their discretion. The language below that is **not boldfaced** is not required to be included verbatim, all points are communicated. Plans can draft this language within the parameters of their respective style guidelines.

7. Marketing Activities by Providers

- For purposes of this section any reference to a Provider also includes Accountable Entities.
- The Plan is responsible for any Marketing Activities engaged in by contracted Providers, including any Provider distribution of the Plan's Marketing Materials that have not received EOHHS approval. The Plan may not allow the Provider to distribute any Marketing Material not created by the Plan and approved by EOHHS.
- In addition to the Marketing guidelines in Chapter 3 of the Managed Care Manual, the Plan must ensure Provider compliance with the following Marketing policies:
    - Providers must distribute or display Marketing Materials for all contracted Managed Care Organizations or choose not to distribute or display for any contracted Managed Care Organizations. The Provider may choose which Marketing Materials to distribute or display so long as the Provider does not give the appearance of supporting one Managed Care Organization over another.
    - Providers may inform Members and potential enrollees where they are contracted.
    - Providers may educate Members and potential enrollees of the benefits and services, including value-add services, that each contracted Managed Care Organization offers. Providers must not recommend one Managed Care Organization over another, offer Members or potential enrollees incentives to select a particular Managed Care Organization, or assist the Member or Potential Member in deciding to select a particular Health Plan.
- The Plans are responsible for including language in their provider contracts to strictly prohibit providers from comparing MCOs or advocating for one MCO.
- If a Member or potential member requests contact information for a Managed Care Organization or assistance with a Managed Care Organization application, the Provider may distribute that information or refer the potential enrollee to HSRI or navigators. It is strictly prohibited to have the Plan, any of its employees, or subcontractors, or providers assist the potential enrollee with the application.

The Plan, in its sole discretion, may institute additional policies around Marketing and Marketing Materials, so long as those policies do not conflict with the one in these *Guidelines* or the Managed Care Manual. The Plan is responsible for educating contracted Providers of and enforcing those additional policies and procedures.

8. MANDATORY LANGUAGE

DISCRIMINATION IS AGAINST THE LAW

<Plan Name> complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. <Plan Name> does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact <Plan Specific>.

If you believe that <Plan Name> has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

<Plan Specific Contact Information>

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the <Plan Name> Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH
Building Washington, D.C.
20201
Phone: 800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We can give you information in other formats, such as braille and large print, and in different languages upon request.

9. Social Media & Other Digital Content

All social media content must be submitted to RI EOHHS for review and approval, as follows:

At a minimum, the Plan must submit:

1) A Microsoft Word document that includes content and indicates where and how it will be included in the social media post;
2) Confirmation of which social media platform(s) will include the content;
3) The active URL. If the URL has not been developed or confirmed, the Plan must submit it at a later date for RI EOHHS' review and approval.
4) Content and platform meets 508 Compatibility requirements.

10. Mobile Applications

Any mobile apps that are cobranded with the Plans must adhere to Interoperability and these *Rhode Island EOHHS Guidelines for Marketing Materials and Member Communications for Medicaid Managed Care Program, RIte Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (ad hoc).*

MEMBER INCENTIVES and/or REWARDS

Plans may offer incentives and/or rewards to their **enrolled members** to promote and reward healthy behaviors, e.g., compliance with immunizations, prenatal visits, or participating in disease management programs. Member rewards may only be offered for a member's participation in preventive care or completing a health-related activity. All incentives or incentive reward packages must be approved by EOHHS prior to use. The Plans are encouraged to consider items that can be used to promote healthy behaviors, e.g., toothbrushes, immunization schedules, or booklets to keep track of blood sugars.

- If the reward for healthy behavior is offered **within thirty (30) days** of an individual's enrollment, the value of the reward **may not exceed ten ($10.00) dollars**;

- If the 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 ($25.00) dollars**;

- The only occasions in which the value of the reward may exceed $25.00 is for discounted gym membership or for diapers provided to mothers who have given birth.

- Member rewards or incentives cannot be in the form of cash or an item that can be sold and converted to cash. Gift cards must have specific retailer associated with them. Examples of prohibited gift cards: American Express, Visa cards may not be used.

- Plans may sponsor raffles for its members, but they 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.

- **These incentives cannot be offered to any individual not yet enrolled in the Plan.**

1. Gifts

Plans may not offer gifts or payments as an inducement to enroll in their plan.

Some giveaways of nominal value may be allowed on a limited basis when approved by EOHHS prior to use. Giveaways or trinkets of nominal value, such as pencils, magnets, plastic pillboxes, etc. may be used in Plan promotions. The value of each item should **not exceed $2.00**

- Plans may provide gifts or incentives to prospective enrollees if those gifts or incentives are also provided to the general public and **do not exceed ten dollars ($10)** in value per individual gift or incentive.

- Plans may not offer gifts or gratuities of any kind or value to State employees or representatives of EOHHS ,such as consultants or navigators, as outlined in Rhode Island's Code of Ethics.

- Plans shall not provide cash to prospective or current enrollees, except for reimbursement of expenses and/or stipends, for participation on committees or advisory groups in an amount approved by EOHHS.

PROHIBITED MARKETING ACTIVITIES

Plans are prohibited from distributing marketing or utilizing membership materials that have not been approved by EOHHS or that EOHHS has disapproved in writing.

EOHHS reserves the right to require an organization to withdraw advertising or other materials from distribution immediately or to publish, at the plan's expense, a retraction and/or clarification relating to any statements that may be interpreted as false, misleading or fraudulent or that the state deems violates these *Guidelines.*

An individual must approach or contact the Plan representative first to request information about the Plan. A Plan representative approaching an individual to offer information about the Plan is forbidden.

> For example: Health Fairs: a Health Plan representative is prohibited from approaching individuals to offer information, the individual must approach the Health Plan table or booth and request information.

Plans and/or Plan's Subcontractors Prohibited Activities

- Inducing providers or employees of EOHHS, the Department of Human Services (DHS) or any other State Agency to reveal confidential information about beneficiaries or otherwise use such confidential information in a fraudulent manner to promote or enhance Plan

- Seeking to influence enrollment with the sale of any private insurance to potential or current enrollees.

- Sending direct mailings to low-income individuals who have not yet been determined eligible by the state

- Conducting face-to-face outreach directed at current or potential enrollees, including direct or indirect door-to-door contact, telephone contact, or cold-call marketing

- Sending deliberately confusing, misleading or fraudulent information about covered benefits.

- Using Health Plan-specific education materials at provider offices

- Activities that mislead, confuse, or misrepresent Health Plan benefits

Activities that could mislead or confuse current or potential enrollees or that misrepresent EOHHS' Managed Care Programs or the Health Plan are prohibited

- Claiming recommendation or endorsement by the state or CMS or claiming the state or CMS recommends enrollment in your Health Plan;

- Using terms, such as "Official U.S government", "Official Rhode Island government"

- Using identifying labels such as: Medicaid, RIte Care, CSHCN, RIte Smiles, Rhody Health Partners" on envelopes or in other marketing materials in ways likely to confuse current or potential enrollees;

- Using coupons or cards requesting additional information from current or prospective enrollees for enrollment screening or to activate enrollment;

- Omitting information necessary for the enrollee to make an informed choice, whether the individual specifically requests the information or not;

- Making overstatements about the Health Plan's coverage;

- Implying of perpetual coverage;

- Incorrectly describing Medicaid and associated managed care plans' covered services;

- Attempting to persuade or 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 covered 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 his/her panel is closed to new patients.

Discriminatory activities

Any marketing, communication or activity whose purpose, in full or in part, is to discourage participation in their specific plan based on actual or perceived economic or health status. Such activities include but are not limited to:

- 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 its service area who are newly eligible for Medicaid/EOHHS' Managed Care Programs over other people

- Engaging in outreach activities which target prospective enrollees based on health status.

- Engaging in marketing activities that are non-compliant with applicable State and Federal civil rights*

**The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.*

Health Plan Marketing Representatives

- Health Plan marketing representatives must clearly identify themselves as representatives of a specific Plan when engaging with a member or prospective member.

- Health Plans may, however, explain that your organization has a contract with the State of Rhode Island.

- Health Plan representatives may not identify themselves as an agent of Medicaid, RIte Care, CSHCN, RIte Smiles, Rhody Health Partners, or the Federal government. Health Plan representatives may represent themselves to be employees of EOHHS or DHS.

Policy End Page Summary

Policy Owner:	Medicaid Managed Care Director		
Policy Reviewers:	Managed Care, Compliance		
Effective Date:	September 2021		
Policy Approved:	**Name:** Mark D Kraics Digitally signed by Mark D Kraics Date: 2021.09.13 08:25:15 -04'00'	**Date:**	9/8/21
Policy Reviewed:	**Name:** Ave Houston Digitally signed by Ave Houston Date: 2021.09.13 09:50:39 -04'00'	**Date:**	9/13/21
Policy Retired Date:			