DEPARTMENT OF HEALTH AND HUMAN SERVICES

# NEVADA MEDICAID
# COVID-19 PUBLIC HEALTH EMERGENCY
# OPERATIONAL UNWINDING PLAN

October 20, 2023

# Table of Contents

# Revision Control

| Published / Revised | Version # | Section / Nature of Change |
|---|---|---|
| September 6, 2022 | v1.0 | Initial Version |
| November 15, 2022 | v.1.1 | **Background and Overview, page 5**<br>▪ End of Public Health Emergency new dates inserted<br>**Extending Flexibilities, pages 9 and 10**<br>▪ Status update for SPA #22-0013 and #22-0012<br>▪ Added SPA #22-0013-A and #22-0014<br>**Nevada Medicaid reimbursement rate – Continuing, page 12**<br>▪ COVID-19 laboratory diagnostic and serology testing reimbursement rates approved<br>**How this works, page 17**<br>▪ Example revised with new dates<br>**Acting on Changes in Circumstance, pages 18 and 19**<br>▪ Examples 1 & 2 revised<br>▪ Appendix B: Nevada Renewal Periods revised<br>**Medicare Enrollment Period, page 20**<br>▪ Medicare enrollment and eligibility final rule information inserted, previously documented the proposed rule<br>**Federal Eligibility-Related Flexibilities & Strategies, page 23**<br>▪ Removed 2nd bullet regarding $0 income, moved to page 24<br>**Section 1902(e)(14)(A) Flexibilities/Strategies, pages 24 and 25**<br>▪ Added three waivers<br>o Ex parte $0 Income (1st bullet)<br>o NCOA-USPS (2nd bullet)<br>o Streamlined Asset Verification (5th bullet)<br>**Evergreen Disaster Relief, page 25**<br>▪ Status update<br>**Table: 12-month view of renewals, page** |

| | | |
|---|---|---|
| | | ▪ Nov. 2023 through Oct. 2023 data provided |
| **February 8, 2023** | **v.1.2** | **Background and Overview, pages 7- 9**<br>▪ The White House announces the End of the COVID-19 Public Health Emergency.<br>▪ Consolidated Appropriation Act, 2023 (CAA) overview inserted.<br>▪ Part II of this plan provides details regarding the state's readiness for completing Enrollment & Eligibility (E&E) actions when the continuous enrollment condition ends(…)<br>**Nevada Medicaid Global Unwinding Approach, pages 10 - 11**<br>▪ Added link to SHO #23-002<br>▪ Outlines requirements under CAA, 2023 provisions as described in SHO #23-002<br>**Extending Flexibilities, page 13 - 15**<br>▪ Status update for COVID ARPA SPA #22-0013<br>**Part II: Resumption of Normal eligibility Operations, pages 16 - 18**<br>▪ Inserted first paragraph: CAA, 2023 is the key driver of Part II of this plan<br>▪ Added link to SHO #23-002<br>▪ Added link to Key Dates Related to the Medicaid continuous enrollment Provision in the Consolidated Appropriations Act, 2023<br>**Guiding Principle: Maximizing Continuity of Coverage for Nevada Beneficiaries, page 19 - 20**<br>▪ Screen shot revised to reflect End of continuous enrollment condition three (3) options for 12-month unwinding period<br>▪ New ex parte information added<br>**How this works, pages 21 - 23**<br>▪ Added end of the COVID-19 end date<br>▪ CAA, 2023 provisions added<br>▪ Revised monthly process within the unwinding period to reflect Nevada's initiating renewal timeline (the month after the end of the continuous enrollment condition)<br>▪ Appendix B revised<br>**Acting on Changes in Circumstances, pages 24 - 26**<br>▪ Example 1 & 2 revised |

| | | |
|---|---|---|
| | | **Loss of Contact and Procedural Discontinuances, page 29**<br>▪ Medicaid population revised<br>**Section 1902(e)(14)(A) Flexibilities/Strategies, page 31 - 35**<br>▪ Added SHO #23-002 guidance<br>**Evergreen Disaster Relief, pages 36 and 37**<br>▪ Section revised<br>**Returned Mail, pages 37 and 38**<br>▪ Section revised to include CAA, 2023 requirements plan<br>**Program Operations: Nevada Medicaid/CHIP Program Policies during the Unwinding, pages 38 and 39**<br>▪ Section revised to include CAA, 2023 requirements approach<br>**COVID-19 Uninsured Group, page 41**<br>▪ Included population volume and termination effective date<br>**Transition to Nevada Health Link, page, 44**<br>▪ Added CMS Information and Insurance Oversight Temporary Special Enrollment Period (SEP) FAQs<br>**Unwinding Communication and Outreach Campaign, page 45**<br>▪ Phase 2 revised<br>**Managed Care Organization (MCO) Role, page 47**<br>▪ Revised CMS guidance link, updated January 2023<br>**Unwinding Renewal Workload, page 49 - 51**<br>▪ Section Revised to reflect latest workload report<br>**Tracking Nevada Medicaid/CHIP Coverage Trends During the Unwinding Period and Beyond, page 52**<br>▪ Medicaid population revised<br>**Medicaid Unwind Dashboard, page 52**<br>▪ Dashboard specific publish date added<br>**Unwinding and Beyond Federal Monitoring, pages 52 and 53**<br>▪ Section revised to include CAA, 2023 requirements |
| **October 31, 2023** | **v.1.3** | **Background and Overview, pages 9 and 10**<br>▪ Nevada responds to federal compliance issues |

| | | |
|---|---|---|
| | | **Guiding Principle: Maximizing Continuity of Coverage for Nevada Beneficiaries, pages 20**<br>▪ Compliance issue information included<br>▪ New unwinding timeline<br>**Nevada's Approach for Prioritizing Renewals: Maintaining Current Renewal Month, page,22**<br>▪ Information regarding reinstated individuals included<br>**How it works, pages 22 - 24**<br>▪ Example revised with new timeline dates<br>**Acting on Changes in Circumstances, pages 24 - 26**<br>▪ Example removed<br>▪ Continuous Enrollment examples added<br>**Anticipated Total Disenrollment, page 30**<br>▪ Additional information regarding Advanced Premium Tax Credits (APTC) added<br>**Section 1902(e)(14)(A) Flexibilities/Strategies, pages 31 – 35**<br>▪ New approved flexibilities added<br>**Program Operations: Nevada Medicaid/CHIP Program Policies during the Unwinding, pages 38**<br>▪ Added not regarding Nevada Medicaid and CHIP policies<br>**Transition to Nevada Health Link, page 41**<br>▪ Update to Temporary Special Enrollment Period (SEP) FAQs<br>**Unwinding Communication and Outreach Campaign, page 45**<br>▪ Special communications added<br>**Unwinding Renewal Workload, page 49 and 50**<br>▪ Section Revised to reflect latest workload report<br>**Unwinding and Beyond Federal Monitoring, pages 52 and 53**<br>▪ CMS revised their Unwinding website |

## Background and Overview

The Nevada Department of Health and Human Services (DHHS) is the Single State Medicaid Agency that oversees the Division of Welfare and Supportive Services (DWSS), the agency tasked with processing Medicaid eligibility decisions, and the Division of Health Care Finance and Policy (DHCFP), the agency responsible for administering the plan. Together they ensure health care coverage for eligible individuals and families with low incomes and limited resources. Although this is a coordinated effort, there are activities that are specific to each agency which will be identified throughout the plan.

During the national COVID-19 Public Health Emergency (PHE) Nevada Medicaid implemented program changes and other emergency flexibilities. In response to the public health emergency, DHCFP implemented 30 programmatic flexibilities to help minimize strain on the program and its members and Nevada health care providers and systems. These changes, implemented under a variety of federal and state authorities, impacted almost all aspects of the Nevada delivery system. While many of these programmatic flexibilities will terminate at the end of the PHE, some will be extended due to their positive impact to Nevada Medicaid members.

The White House has announced May 11, 2023 is the end of the COVID-19 PHE, the Statement of Administration Policy released on January 30, 2023, indicates the effective end date aligns with the Administration's previous commitments to give at least 60 days' notice prior to termination of the PHE. In preparation for the end of the federal PHE declaration, Nevada Medicaid developed this Operational Unwinding Plan. The purpose of this plan is to inform Nevada members, providers, managed care organizations (MCOs), dental benefits administrator (DBA), Silver State Health Insurance Exchange (SSHIX), and other valued stakeholders of the expected changes.

Most of the flexibilities Nevada Medicaid implemented were authorized through federal pathways in partnership with the Centers for Medicare and Medicaid Services (CMS). Examples of these pathways include the Disaster Relief State Plan Amendment (DR SPA), Disaster 1135 Waiver Authority (1135), section 1115 demonstration authority, and the Appendix K process for 1915(c) Home and Community-Based Services (HCBS) waivers. Each federal authority differs in

terms of the applicable policy, approval process, and unwinding requirements. The requests for federal flexibilities submitted by DHCFP, and approvals granted by CMS, are available on the DHCFPs website located ***here.***

Federal legislation authorized other significant changes to Medicaid programs. The Families First Coronavirus Response Act (FFCRA) authorized enhanced federal funding for Medicaid programs conditioned upon Maintenance of Eligibility (MOE) and continuous coverage requirements that prohibit disenrollment in most circumstances. This is commonly referred to as the continuous coverage requirement under the FFCRA. The act also authorized Medicaid coverage for an optional Medicaid coverage group, known in Nevada as the COVID-19 Uninsured Group, specifically for COVID-19 testing and testing-related services. Further, the American Rescue Plan Act (ARPA) extended coverage of COVID-19 vaccines and treatment services to limited benefit populations at no cost to states and provided an enhanced funding opportunity for state Medicaid programs to spend on increasing access to Home and Community-Based Services (HCBS). As with the flexibilities granted by CMS through the Disaster Relief State Plan Amendment (DR SPA) and waiver pathways, the FFCRA and ARPA also influenced Nevada Medicaid's unwinding plan. One of Nevada's top priorities is to maximize the continuity of coverage for Nevada members throughout the unwinding of the FFCRA continuous coverage requirement.

On December 29, 2022, the Consolidated Appropriation Act, 2023 (CAA) was signed into law. This omnibus "bill provides appropriations to federal agencies for the remainder of FY2023, providers supplemental appropriations for disaster relief (…), extends several expiring authorities, and modifies or establishes various programs that address a wide range of policy areas." The bill has direct impacts to some unwinding activities with the carve-out of the continuous coverage requirement at section 6008(b)(3) that take effect April 1, 2023. Under this section of the FFCRA, states claiming temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) have been unable to terminate enrollment for most individuals enrolled in Medicaid as of March 18, 2020, as a condition of receiving the temporary FMAP increase. The continuous enrollment ends effective March 31, 2023.

Separately, the CAA, 2023 also establishes a new subsection (tt) of section 1902 of the Social Security Act, to require all states to adhere to certain reporting requirements beginning April 1, 2023, and states that fail to do so may be subject to a reduction in FMAP. Additional guidance ono these requirements are forthcoming.

Nevada will be working to return to normal eligibility and enrollment operations as described in Part II of this operational plan.

The following sections are intended to provide a comprehensive view of Nevada Medicaid's plan to unwind the flexibilities implemented during the PHE. Nevada Medicaid Global Unwinding Approach outlines the guidelines set forth by CMS. Nevada intends to adhere to CMS requirements and adopt strategies and tactics that will benefit unwinding efforts impacting continuous coverage.

- Part I: Unwinding Program Flexibilities provide details on the programmatic flexibilities Nevada implemented and defines flexibilities that will be terminated and those that will be extended beyond the end of the PHE. The section will also provide information on the Governor's State Declaration of Emergency Related to COVID-19, which terminated on May 20, 2022, and how the Directives and Declarations were addressed.
- Part II: Resumption of Normal Eligibility Operations describes the plan to resume normal eligibility operations. This section provides details regarding the state's readiness for completing Enrollment & Eligibility (E&E) actions when the continuous enrollment condition ends and state planning approach and strategies to complete renewals. Furthermore, CMS offered many flexibilities and/or strategies to resume renewals. This section will also address new flexibilities requested for the purposes of E&E. Nevada recently responded to the federal compliance issue in accordance with 42 C.F.R. § 435.916(a)(2) and 457.343, which requires states to complete redeterminations of eligibility based on available information for each individual in the household. Nevada's automated renewal process known as ex parte was not in full compliance with determining eligibility at an individual level and had to take immediate action to mitigate those impacts. This section will disclose the actions and mitigation plan to correct the issue.

# Nevada Medicaid Global Unwinding Approach

To support states through this challenging transition, CMS issued a robust set of guidance to Medicaid programs, providing details and requirements for unwinding each type of federal flexibility. CMS published four State Health Official (SHO) Letters specifically on unwinding federal flexibilities authorized during the PHE—SHO# 20-004, SHO# 21-002, SHO# 22-001 and SHO# 23-002 – and provided tool kits, presentation slide decks, and other materials. CMS hosts numerous all-state webinars and offers individual technical assistance calls. The latest guidance for unwinding the PHE can be found on CMS' website located ***here*** and in the Resources Section of this document. Nevada Medicaid has taken every opportunity to partner with CMS on the unwinding efforts.

SHO# 20-004, released on December 22, 2020, contains most of the guidance related to unwinding Medicaid flexibilities through the Disaster Relief SPA (DR SPA), 1135, 1115, and Appendix K processes. Nevada Medicaid is following this guidance closely to ensure compliance with all applicable requirements. This SHO letter provides details regarding timeframes associated with each authority and the requirements that must be followed when they expire, as well as the details if states choose to make eligible flexibilities permanent.

Appendix A of SHO# 20-004 describes the specific circumstances in which the expiration of an 1135 flexibility requires advanced notice to affected members. Nevada Medicaid is prepared to notify members of flexibilities that are expiring, specifically for the COVID-19 Uninsured Group. See page 26 for details on how this will be handled. The flexibilities that are expiring mainly impact Medicaid providers for which the state has already notified through web announcements and other provider communications.

SHO# 23-002 released January 27, 2023, outlines section 5131 of subtitle D of title V of division FF of the CAA, 2023. This section makes significant changes to the continuous enrollment condition and availability of the temporary increase in the FMAP under section 6008 of the FFCRA and establishes new state reporting requirements and enforcements authorities for CMS. Section 5131 includes the following changes:

1. Separates the end of the FFCRA continuous enrollment condition from the end of the COVID-19 PHE and ends

that condition effective March 31, 2023, thus enabling states to terminate Medicaid enrollment of individuals who no longer meet Medicaid eligibility requirements on or after April 1, 2023.

2. Amends the condition states must meet to claim and extends the availability of the temporary FMAP increase beginning April 1, 2023, gradually phasing down the increase until December 31, 2023.
3. Adds new reporting requirements for all states under section 1902(tt) of the Social Security Act (the Act).
4. Creates new enforcement authorities for CMS related to the new reporting requirements and to state renewal activities during the period that begins on April 1, 2023, and ends on June 30, 2024 (a time frame that will overlap with Nevada unwinding periods).

It is important to keep in mind that while Nevada Medicaid flexibilities were authorized in the form of DR SPAs and federal waiver approvals, Nevada Medicaid often implemented these changes through policy letters, provider web announcements, and other forms of sub-regulatory guidance. As Nevada Medicaid unwinds the temporary flexibilities of the PHE, guidance will be published and disseminated to ensure that Nevada Medicaid members, MCOs, providers, and stakeholders all understand the applicable Nevada Medicaid policies and procedures that are in effect. We will utilize the existing stakeholder groups and forums to share unwinding information as it becomes available. If existing forums are not sufficient, Nevada Medicaid will also host new stakeholder events to discuss the unwinding process.

The CAA, 2023 generally does not impact authority tied to the end of the COVID-19 PHE (e.g. 1135 waivers, disaster relief SPAs). Certain COVID-19 PHE related flexibilities can remain in effect for the duration of the COVID-19 PHE, including, but not limited to Medicaid and CHIP section 1135 waivers and disaster SPAs. As a reminder, the requirements under sections 9811 and 9821 of the ARP apply until the last day of the first calendar quarter that beings one year after the COVID-19 PHE ends. The ARP requirements include providing coverage, without cost sharing of: COVID-19 vaccinations; COVID-19 testing treatments for COVID-19. The next section of this plan will outline the flexibilities that will be addressed upon the end of the COVID-19 PHE.

# Part I: Unwinding Programmatic Flexibilities

In addition to the significant effort to prepare for resumption of normal eligibility operations described in Part II of this document, there are many programmatic flexibilities that DHCFP, DWSS, MCOs, providers, and other partners and stakeholders must now act upon to unwind. This section provides further details on these specific flexibilities, including those that DHCFP is in the process of pursuing permanently, and those that will expire at the end of the PHE.

Appendix A: DHCFP Flexibilities Requested due to COVID-10 PHE lists 30 flexibilities DHCFP obtained approval to implement. The table provides the Authority Path, Description, Disposition and Start – End Dates. There are 28 flexibilities with the disposition of "Terminate" which will expire at the end of the PHE (May 11, 2023). Flexibility Item #10 related to Provider Enrollment terminated September 2022 due to the process ending. DHCFP will move forward with extending Flexibility Items #16: Public Notice & Tribal Consultations via another 1135 flexibility waiver that is being submitted with the ARPA COVID-19 SPA and #29: Telehealth which is being requested to be permanently extended via SPA #22-0012.

## Terminated/Terminating Flexibilities

DHCFP identified all system changes tied to flexibilities that terminated and those that will terminate and is prepared to unwind. Most system changes implemented by DHCFP impact Nevada Medicaid providers. DHCFP is committed to notifying providers 30 days in advance of any changes related to COVID-19 and its unwinding endeavor through web announcements posted on the ***Provider Web Portal***.

## Extending Flexibilities

As identified above, DHCFP is applying to keep two flexibilities. DHCFP is prepared to extend these systematically and will notify providers of the extension, as necessary.

- **State Plan Amendment (SPA) Submission Deadlines, Public Notice, and Tribal Consultation**
  DHCFP submitted COVID ARPA SPA #22-0013 to CMS to attest that Nevada Medicaid covers COVID-19 testing, vaccines, and treatment from March 11, 2021, to the end of the ARPA period. This SPA also included a 1135 flexibility waiver to keep SPA submission requirements, public notice requirements, and tribal consultation. See bulleted list below for a definition of each. The public hearing was held on June 28, 2022, and CMS approved this SPA on November 21, 2022.

  DHCFP also submitted SPA #22-0013-A to rescind COVID-19 laboratory diagnostic and serology testing reimbursement rates approved in SPA #20-0009 from 100% of Medicare rate down to the State Plan rate of 50% of Medicare. SPA 22-0013-A was approved by CMS on October 25, 2022, with an effective date of June 1, 2022.

  An additional COVID-19 ARPA SPA #22-0014 was approved by CMS on July 28, 2022, for the CHIP state plan to attest that Nevada Medicaid covers COVID-19 testing, vaccines, and treatment from March 11, 2021 to the end of the ARPA period.

  - **Submission Deadlines:** Pursuant to section 1135 (b)(5) of the Act, allows modification of the requirement to submit the SPA by the last day of a quarter, in order to obtain a SPA effective date during that quarter (applicable only for quarters in which the emergency or disaster declaration is in effect) - 42 C.F.R. § 430.20.

  - **Public notice requirements**: Pursuant to section 1135 (b)(5) of the Act, allows a modification of public notice requirements that would otherwise be applicable to SPA submissions. These requirements may include those specified in 42 C.F.R. § 440.386 (Alternative Benefit Plans), 42 C.F.R. § 447.57(c) (premiums and cost sharing), and 42 C.F.R. § 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

  - **Tribal Consultation:** Pursuant to section 1135 (b)(5) of the Act, allows modification of the required Tribal consultation timelines specified in the Medicaid State Plan per section 1902(a)(73) of the Act.

- **Telehealth**
  DHCFP submitted a SPA to CMS to allow the ongoing use of the standard telephone to provide telehealth services. Due to CMS changing policy on allowable platforms for telehealth and the passage of Nevada Revised Statutes (NRS) 422.2721 and NRS 439.245, DHCFP is applying to CMS to extend telehealth services to allow telephone communication as an allowable telehealth platform. CMS approved SPA #22-0012 Telehealth on July 20, 2022, with an effective date of July 1, 2022.

## Nevada Medicaid Benefits and Reimbursements Rate Changes

DHCFP implemented several changes to Nevada Medicaid benefits policy during the PHE. Many of these changes were related to expanding coverage for COVID-19 testing, treatment services, and vaccine administration. However, additional changes were implemented to allow flexibilities in prescribing policy, prior authorization policy, and pharmacy benefits. These flexibilities were implemented through federal authority pathways including DR SPA, 1135 waiver, section 1115 demonstration, and Medicare Blanket Waivers, with other flexibilities as a result of now-expired State Declaration of Emergency Directives.

### Testing, treatment, and vaccine coverage - Continuing:

DHCFP has submitted an ARPA COVID-19 SPA to attest that Nevada Medicaid will continue to cover COVID-19 testing, treatment, vaccines and their administration, and COVID-19 standalone vaccination counseling for children under the age of 21 years old, without cost-sharing, for nearly all Medicaid members including the Uninsured Group. Treatment includes specialized equipment and therapies, preventive therapies, and conditions that may seriously complicate COVID-19 treatment. This SPA also includes coverage for COVID-19 at-home tests. Additionally, this SPA requests laboratory testing reimbursement rates to return to rates established in the State Plan for laboratories, starting June 1, 2022. DR SPA #20-0009 approved the rate at 100% of Medicare. Via this ARPA COVID-19 SPA, Nevada is requesting to go back down to 50% of Medicare rates.

This ARPA coverage period will be from March 11, 2021, and will end on the last day of the first calendar quarter that begins one year after the last day of the PHE. These coverage policies also apply to the COVID-19 Uninsured Group, but, only through the end of the PHE for this specific population.

Even after this ARPA COVID-19 SPA ends, Nevada Medicaid will continue to cover these services. Nevada Medicaid already covers laboratory testing, vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and medically necessary services. The only change is that DHCFP will reimburse for these services according to the State Plan.

The COVID-19 vaccine administration and standalone vaccination counseling for children under the age of 21 years old is covered by CMS at 100% Federal Medical Assistance Percentage (FMAP). For DHCFP to fully take advantage of this FMAP percentage, contracts with the Managed Care Organizations were amended in March 2022 to reimburse the MCOs directly through a non-risk arrangement.

**Nevada Medicaid reimbursement rates - Continuing:**

During the COVID-19 PHE, CMS approved two DR SPAs which enhanced reimbursement rates.

1. DR SPA #20-0009 allowed the DHCFP to reimburse providers at 100% of the Medicare rate for COVID-19 laboratory testing.
    a. DHCFP submitted SPA #22-0013-A to rescind COVID-19 laboratory diagnostic and serology testing reimbursement rates approved in SPA #20-0009 from 100% of Medicare rate down to the State Plan rate of 50% of Medicare. SPA 22-0013-A was approved by CMS on October 25, 2022 with an effective date of June 1, 2022.
2. DR SPA #21-0003 allowed the DHCFP to reimburse for COVID-19 vaccine administration at 100% of the Medicare regionally adjusted rate. Both DR SPAs will expire on the last day of the PHE.

### State Declaration of Emergency Termination

On March 12, 2020, Nevada Governor Steve Sisolak announced a State Declaration of Emergency to facilitate the state's response to the COVID-19 pandemic. The Declaration and subsequent directives ensured the State of Nevada could effectively prevent infections, reduce the impacts on patient care in the health care system, and reduce the number of Nevadans dying from the disease caused by the virus. A complete list of Directives and Declarations can be found ***here***. Guidance for the end of the Declaration of Emergency was updated on May 19, 2022 and can be found ***here***. Governor Sisolak issued a Proclamation Terminating Declaration of Emergency Related to COVID-19 on May 20, 2022.

DHCFP has evaluated the directives as a result of the end of the Nevada State Emergency. No issues were identified that would impact the Nevada Medicaid program, Medicaid Management Information System (MMIS), or members.

## Part II: Resumption of Normal Eligibility Operations

Under the continuous enrollment condition in the FFCRA, states were required to maintain enrollment of nearly all Nevada enrollees through the end of the month in which the PHE ends. This has changed with the CAA, 2023 provisions, which carved out the continuous coverage condition and the temporary increased FMAP. The continuous enrollment condition expires effective March 31, 2023, states will need to conduct a full renewal for all members who would have otherwise been subject to a renewal.

The Division of Welfare and Supportive Services (DWSS) is the agency tasked with processing Medicaid eligibility decisions throughout the State of Nevada. DWSS maintains a workforce of over 1,800 staff, comprised of case managers, supervisors, and administrative supportive staff.

At the start of the Public Health Emergency, DWSS's policy team and Eligibility & Payments (E&P) Unit were tasked with interpreting the required federal regulation changes and writing state policy to support the new mandates. In addition, DWSS identified any potential system changes, and reviewed case processing methodologies to minimize the PHE's effect on staff to keep applications moving in the most expeditious manner possible. E&P, in partnership with other DWSS units including Administration and Field Services, made minor adjustments in case processing which allowed DWSS to require no system changes to keep Medicaid members enrolled throughout the PHE. Because minimal changes were made, Field Services were able to focus on new applications.

The process changes developed by the various DWSS teams worked well enough that DWSS staff could assist other sister agencies, such as the Department of Employment, Training, and Rehabilitation (DETR) to process the massive influx of unemployment claims filed in the early days of the PHE.

Nevada does not have a backlog of pending eligibility and enrollment actions to address at the unwind of the PHE because of the concerted actions taken at the beginning of the PHE. Instead, Nevada is working to inform all Nevadans that, with the end of the continuous enrollment condition, individuals and households will be reviewed for continued Medicaid eligibility. This message includes the importance of providing current contact information and mailing addresses so that DWSS can reach all Medicaid members to ensure continuity of coverage. To support this effort, DWSS is partnering with the Division of Health Care Financing and Policy (DHCFP), Medicaid Managed Care Organizations, the Division of Public and Behavioral Health (DPBH), the Aging and Disability Services Division (ADSD), the Silver State Health Insurance Exchange (SSHIX), and community partners. All are focused on informing Nevadans of the need to reestablish contact with DWSS to ensure Medicaid eligibility can be renewed for those who remain eligible once continuous enrollment condition ends.

CMS released guidance to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in returning to normal operations through a series of SHO letters. SHO guidance released in January 2023 (SHO 23-002), December 2020 (SHO 20-004), August 2021 (SHO 21-002), and March 2022 (SHO 22-001) sets out federal expectations and requirements related to case processing timelines and member communications for redetermining Medicaid coverage

for those who had their coverage continuously maintained. The March 2022 guidance builds upon the August 2021 SHO letter, where CMS clarifies that it will consider a state in compliance with resuming normal eligibility operations if it has: (1) initiated all renewals for the state's entire Medicaid and CHIP caseload by the last month of the 12-month unwinding period; and (2) completed all such actions by the end of the 14th month after the end of the PHE. These rules will be applied to renewals initiation in accordance with CAA, 2023 as described in CMS Informational Bulletin released January 5, 2023: Key Dates Related to the Medicaid Continuous Enrollment Provision in the Consolidated Appropriations Act, 2023.

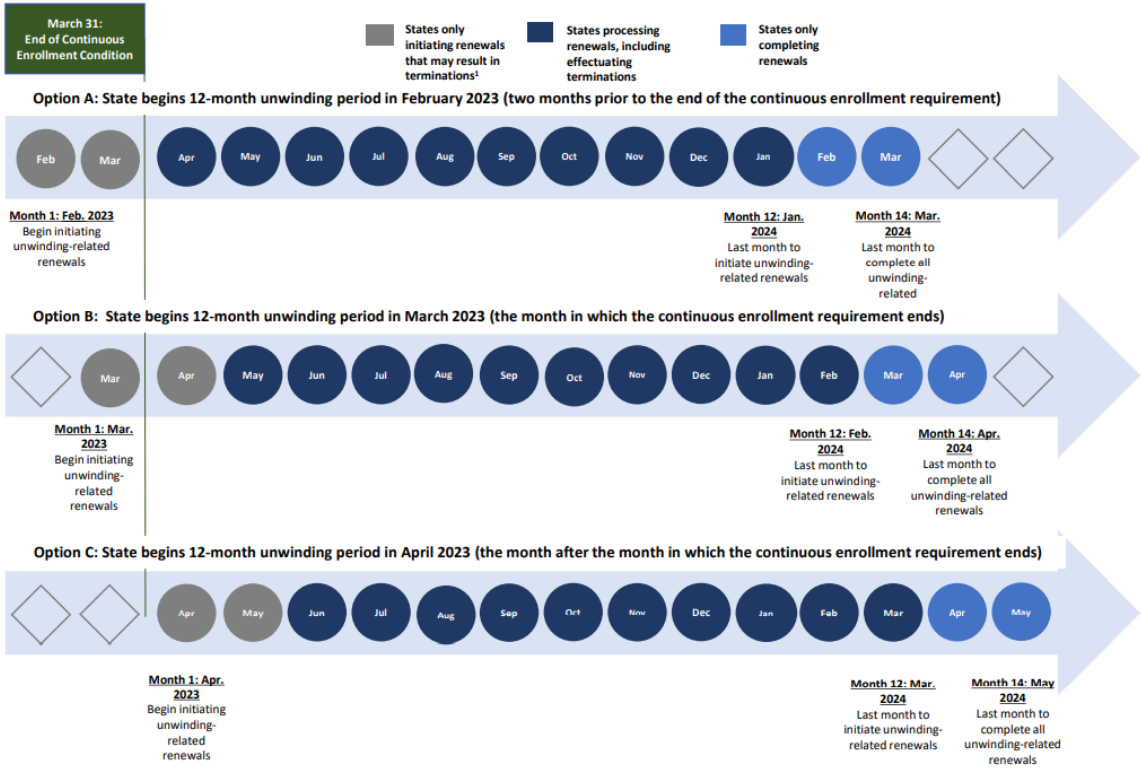
The following section of the Unwinding Operational Plan provides an overview of the guiding principles and implementation approach in preparing for the resumption of normal eligibility operations, specifically in the areas of renewals, eligibility coverage retention strategies, member communications and outreach, system readiness, and data reporting. This Operational Unwinding Plan, in part, reflects the federal requirement of an operational plan that describes how states will address outstanding eligibility and enrollment actions in a way that reduces erroneous loss of coverage and enables a sustainable distribution of renewals in future years.

## COVID-19 Impacts to Enrollment

Two primary factors influenced Nevada Medicaid caseloads during the PHE: the continuous coverage condition and a volatile labor market. The federal FFCRA requirement implemented a continuous coverage requirement, under which Nevada Medicaid members may be disenrolled only under very limited circumstances. Without Nevada Medicaid's naturally occurring disenrollment and attrition, the caseload continued to grow. Difficult labor market conditions related to COVID-19 resulted in individuals experiencing the loss of income, employment, and health coverage, which led to more individuals qualifying for and enrolling in Nevada Medicaid. As the continuous enrollment condition and member protections established during the PHE begin to unwind, and normal operations resume, it is likely that Nevada Medicaid caseload will begin to level off and start to trend downward toward pre-PHE levels.

## Guiding Principle: Maximizing Continuity of Coverage for Nevada Beneficiaries

Nevada is committed to maximizing continuity of coverage for beneficiaries through the course of the continuous enrollment condition unwinding period. A key goal is to keep the unwinding process **as simple as possible.** When the continuous coverage condition expired (March 31, 2023), CMS guidance to states was that they could have up to 14 months to return to normal eligibility and enrollment operations. This meant that Nevada had a total of 14 months to initiate and complete renewals for nearly all of Nevada's beneficiaries. Nevada had opted to begin the 12-month unwinding period the month after the CAA, 2023 continuous enrollment condition ended (option C), April 1, 2023. These recommendations and graph were issued by CMS. Due to noncompliance issue in accordance with 42 C.F.R. § 435.916(a)(2) and 457.343, the timeline has changed. The Unwinding period has been extended through September 2024 previously set to end June 2024.




Appendix B: Nevada Renewal Periods – Describes the new unwinding timeline for Nevada.

Nevada has enhanced the ex parte renewal process through automation with the first full run completed December 2022.

The automation of  ex parte renewals will ensure eligible individuals retain coverage, minimizing gaps in coverage that can increase cost over time. This will also help DWSS significantly reduce administrative burden by automating renewals and minimizing reapplications from eligible individuals who lost coverage.

In late August 2023, Nevada learned that its ex parte process was not in full compliance per federal regulations and outlined in the CMS letter to State Medicaid Directors. In the letter CMS identifies the common issue in that states may have had sufficient information during the ex parte process to renew Medicaid or CHIP coverage, some individuals in a multi-member household, states, including Nevada, were sending renewal forms requesting information for all household members, and, if the renewal form was not returned, Nevada disenrolled all individuals in the household, including those who should have been determined to be eligible through the ex parte process. Nevada took immediate action to remedy this issue. First, a self-assessment was conducted to understand the gravity of the issue. Secondly, to avoid the continuation of improper disenrollments, we paused procedural terminations until the ex parte process is corrected, the pause went into effect October 1, 2023. We also reinstated coverage for all affected individuals who had been procedurally disenrolled due to failure to account for the individual's eligibility status, independent of that of others in the household. Reinstatements were completed for approximately 114,000 beneficiaries on September 14, 2023, for June, July, August, and September. Beneficiaries were notified of their reinstatements through a notice of decision which included information about next steps, including what actions, if any, the beneficiary must take to obtain payment for unpaid medical bills and/or ensure that eligible services are covered for the period while the individual was disenrolled.

A mitigation plan was created and submitted to CMS on September 13, 2023, the immediate actions described above were part of the mitigation plan. The plan also includes our short and long-term solution to correct the ex parte process:

Short-Term Solution: Will be implemented by October 2023 to meet all ex parte at an individual requirement. This fix will be in place in time for renewals due December 31, 2023.

Long-Term Solution:  Nevada is targeting a September 2024 implementation date for the long-term solution.

## Nevada's Approach for Prioritizing Renewals: Maintaining Current Renewal Month

To simplify the complexity of the PHE unwinding process, DWSS will maintain the beneficiaries' current renewal month in their case records and conduct a full renewal at the next scheduled renewal month following the end of the continuous enrollment condition under CAA, 2023. Beneficiaries who were reinstated between June 2023 and September 2023 were given a 12-month renewal and will be absorbed within the new timeline from June 2024 to end of August for September 2024 eligibility. Beneficiaries whose eligibility continued during the procedural disenrollment (terminations) period (October 2023 to December 2023) were given a 6-month renewal period and will be evaluated from March 2024 to May 2024.

This approach achieves the following:

1) Least disruptive to workloads on both an initial and ongoing basis,
2) Aligns, to the greatest extent possible, when Nevada Medicaid and CHIP beneficiaries usually expect to receive their auto-renewal letters or packets requesting additional information if auto-renewal is not successful. This familiarity is critical as we rolled out communications and outreach described further below.
3) Retains a similar pre-COVID-19 renewal caseload distribution across the state, adjusting for the growth factor of individuals who enrolled into coverage and were protected through the continuous enrollment requirements and ex parte mitigation plan.

***How this works.*** Per federal and state guidelines, the annual renewal process occurs in several steps, spanning multiple months.

The COVID-19 PHE expired May 11, 2023 and the new provision under CAA, 2023 which carved out the continuous enrollment condition ended effective March 31, 2023. As described above Nevada had begun initiating unwinding related renewals the month after the CAA, 2023 continuous enrollment condition ended. This means that renewals were initiated April 1, 2023, for individuals with a May 31, 2023, renewal date for June (renewal month) eligibility. Due to the ex parte mitigation plan, Nevada has reworked the unwinding renewal periods which includes reinstatement renewals between June 2024 to September 2024 and 6-month renewal push for those who continued eligibility from October to December with new renewals set for March 2024, April 2024 or May 2024. Effective January 1, 2024, disenrollments will start again.

The same process described below applies to each month within the unwinding period.

- **October 2023 –** The short-term solution will be implemented in time for the ex parte run for renewals due December 31, 2023, for January 1, 2024 eligibility. Around October 15th, 2023, ex parte initiates the determination of which renewals can be completed automatically and which renewals cannot. The identified cases that can be completed automatically will be separated from the paper renewals at an individual level and marked for auto-completion beginning November 1, 2023.
- **November 2023 –** Ex parte will approve the January 2024 eligibility renewals for all identified individuals and generate a notice of decision informing each individual of their continued eligibility. All remaining renewals will have a paper renewal packet mailed out on November 1, 2023, with a submission due date of December 31, 2023.
- **December 2023 -** If the paper renewal packet for the individual who was not successfully ex parted is not received by December 15, 2023, a Notice of Decision (NOD) is sent automatically to beneficiaries advising them their eligibility will end if no contact or renewal packet is received. NOTE: December 31, 2023, is the restart of the final day of Nevada Medicaid eligibility for unresponsive beneficiaries. Any renewal packet received by December 31, 2023, is processed, and evaluated for eligibility. A notice of decision is sent to these beneficiaries advising of the eligibility determination.
- **January 2024 -** If the beneficiary (individual) failed to return the renewal packet and is determined ineligible for Medicaid starting January 1, 2024, they will have 90 days after January 1st to submit the completed renewal packet to be re-evaluated.

Appendix B: Nevada Renewal Periods – Provides a visual of how the renewal process works and the new unwinding timeline in Nevada.

Nevada will ensure renewals are conducted in accordance with all applicable federal requirements, which includes using strategies approved under section 1902(e)(14)(A) of the Social Security Act. Nevada's approved strategies under this authority is fully described later in this plan. Section 5131(a)(4) of the CAA, 2023 establishes section

6008(f) of the FFCRA, which makes following these requirements a condition of receiving the FMAP increase from April 1, 2023, through December 31, 2023. Nevada will be required to meet, additional conditions related to conducting eligibility renewals, including using certain specific sources to attempt to ensure that the state has up-to-date contact information for everyone for whom it conducts a renewal, and undertaking a good faith effort to contact using more than on modality for any individual who is determined ineligible based on returned mail prior to disenrolling that person. Nevada has been focused and committed to assuring Federal renewal requirement at 42 C.F.R. §§ 435.916(a)(2) and 457.343 are met to maximize eligibility for those in vulnerable populations, such as, children.

## Acting on Changes in Circumstance

Beneficiaries have reported, and will continue to report, changes in their households, such as having a new job during the PHE. However, any changes in circumstance reported during the PHE that could have led to a negative action were paused, in accordance with the continuous enrollment condition. Negative actions resumed when the continuous enrollment condition unwinding period began, as of April 1, 2023, based on reported changes in circumstance. If no changes are reported before a beneficiary's annual renewal is initiated, eligibility will be re-evaluated and updated based on the renewal for Nevada Medicaid. DWSS will process reported changes and/or annual renewals using traditional case processing procedures. During and after the end of the continuous eligibility condition, changes that result in a positive change will be processed upon receipt of the change.

- ***Example 1:*** The continuous enrollment coverage expired on March 31, 2023, and a beneficiary has a renewal month of January 2024, and the annual renewal is completed in January 2024—In March 2024, the beneficiary reports new employment. DWSS would process the change in circumstance using existing case processing rules because a full post-continuous enrollment condition annual renewal has been completed.

SHO# 23-004 was released on September 29, 2023, which outlines 5112 requirements for all state to provide Continuous Eligibility (CE) to Children in Medicaid and CHIP under CAA, 2023 which permanently requires all states to

implement 12 months of CE for all children under age 19 in both Medicaid and CHIP. This requirement takes effect January 1, 2024. CMS has provided additional written guidance, Scenarios: The Intersection of Continuous Eligibility and Individual Level Renewal Process. Based on the guidance there are two options, Nevada has decided to go with Option 2: Treat the ex parte determination as a final determination effective following the end of the current coverage and CE period. CE begins at the child's initial application on or after January 1, 2024, or if the child currently enrolled eligibility period ends after January 1, 2024, the child's new 12-month CE period will not begin until the current 12-month period is over.

- Information submitted by the parent after the child's ex parte determination does not affect ongoing eligibility for the child.
- Once a child is found eligible via the ex parte process, that decision is final.
- The child's new 12-month continuous eligibility period will not begin until the current 12-month period is over.

***Example 1:*** Susan (age 35) lives with her child, Marco (age 4). Susan and Marco each have a Medicaid MAGI household of 2, consisting of each other. Their current renewal dates are aligned. Nevada's MAGI Medicaid eligibility threshold for adults is 138% of the Federal Poverty Level (FPL); the separate CHIP eligibility threshold is 205% of FPL. The renewal is initiated for all individuals in the household at the beginning of the ex parte process. The available data and reliable information show household income is 200% of FPL.

**Marco:** The household income of 200% is below Nevada's CHIP level of 205% FPL. Marco continues to be eligible for Medicaid therefore Marco's coverage is renewed based on the ex parte determination.

- The ex parte determination is final for Marco. When Susan returns the renewal form, the information within the form does not impact Marco, he will receive another 12-month CE, beginning the month after the last month of his current CE period. Nevada will wait until enough information is received to determine Susan's eligibility and send a single eligibility determination notice for the household, including both Marco and Susan's eligibility determination.

**Susan:** The household income of 200% is above Nevada's MAGI Medicaid for adults of 138% FPL. Susan's eligibility cannot be redetermined through ex parte. Additional information is needed to renew Susan's eligibility. A prepopulated renewal form requesting for information is sent.

- Susan completes and returns the renewal form with income documentation that verifies the

household income that verifies the household income is 205% FPL which is above the state's adult Medicaid eligibility level of 138% FPL. Susan is not eligible and is determined ineligible. A minimum of 10 days advance notice and fair hearings rights before Medicaid eligibility is terminated must be provided to Susan. Nevada will then transfer her account to the Marketplace.

***Example 2:*** Using Example 1's household composition. Susan does not return the renewal form within the required timeframe and submits her information during the 90-day reconsideration period.

**Marco:** Eligibility was renewed based on an ex parte determination; he is eligible. The information returned on Susan's renewal form does not impact Marco's eligibility even though such information is above the Medicaid and CHIP eligibility levels because the information was received after the start of Marco's 12-months CE period.

**Susan:** A renewal form is mailed to Susan, and she does not return it by the due date, she will be determined ineligible and disenrolled. A minimum of 10 days advance notice and fair hearings rights before Medicaid eligibility is terminated must be provided to Susan. Nevada will then transfer her account to the Marketplace.

- Susan responds to the renewal during the 90-day reconsideration period and reports that her household income is 205% FPL, which is above the state's adult Medicaid eligibility level of 138% FPL. Susan is not eligible and is determined ineligible. A minimum of 10 days advance notice and fair hearings rights before Medicaid eligibility is terminated must be provided to Susan. Nevada will then transfer her account to the Marketplace.

## Population Priorities

To keep the PHE unwinding process simple, DWSS is not prioritizing any populations. Individuals will be redetermined using their current renewal month.

DWSS has identified a small subset of the renewal population that may benefit from having eligibility redetermined prior to their scheduled annual renewal date. Supplemental Security Income (SSI) individuals are pulled 90-days early instead of 60-days to process the case prior to their renewal date. The effective date of their renewal remains the same, however. With ex parte automation, this population is included for possible automated renewal.

## Medicare Enrollment Period

Individuals have multiple opportunities to apply for Medicare: their initial enrollment period, open enrollment, Medicare and a Special Enrollment Period. Go to ***Medicare.gov*** to find more information on when to sign up for Medicare.

- **Initial Enrollment Period.** When a beneficiary first become eligible for Medicare, can join a plan.
- **Open Enrollment Period.** From January 1 – March 31 each year
- **Special Enrollment Period (SEP).** Beneficiaries can make changes to Medicare Advantage and Medicare prescription drug coverage when certain events happen, like if the beneficiary moves or loses other insurance coverage. Rules about when a beneficiary can make changes and the type of changes that can be made are different for each SEP.

Individuals 65 years old and not enrolled in Social Security or Railroad Retirement Board (RRB) benefits are not

automatically enrolled in Medicare; they must apply. During COVID-19 PHE, individuals may have not known they needed to apply, or may have chosen not to apply for Medicare during their initial enrollment period because they understood that they would not lose their Nevada Medicaid during the PHE. Per Medicaid Operations Manual (MOM) Chapter 900, Nevada Medicaid applicants/beneficiaries are required to apply for Medicare. Normally, this does not pose a problem as the requirement only goes into effect when an individual could apply for Medicare (during their initial enrollment period or during a Special Enrollment Period). However, individuals who have not applied for Medicare at all during the PHE, and whose initial enrollment period has passed, may not have an opportunity to apply for Medicare until the open enrollment period (January 1 – March 31). This may create a risk for individuals who should have signed up for Medicare but did not.

On October 28, 2022, CMS issued a final rule that updates Medicare enrollment and eligibility rules to expand coverage for people with Medicare and advance healthy equity. The final tule, which implements changes made by the Consolidated Appropriation Act, 2021 (CAA), makes it easier for people to enroll in Medicare and eliminates delays in coverage. Among these changes, individuals will now have Medicare coverage the month immediately after their enrollment, thereby reducing any delays in coverage. In addition, the rule expands access through Medicare special enrollment periods (SEPs) and allows certain eligible beneficiaries to receive Medicare Part B coverage without a late enrollment penalty,'' as detailed in the CMS Press release. DHCFP administers the Medicare enrollment (buy-in) program and will ensure the final rule is adhere to and provide education and outreach on available SEPs for those who may qualify.

DHCFP and DWSS are working together to identify Nevada Medicaid members who may be impacted and will urge members to apply for Medicare. DHCFP will send out notifications to members who must apply for Medicare to continue Medicaid coverage.

# Anticipated Coverage Loss with Continuous Enrollment Condition Termination

Throughout the PHE and during the unwinding, Nevada has worked to connect with Medicaid members to ensure contact information is correct to prevent coverage losses for eligible individuals and to remind members that they may update information online, by phone, by mail, or in person. Nevada offers several online methods to update contact information: Address Change Request Webform available on the UpdateMyAddress webpage and through Access Nevada. Maintaining complete and accurate contact information is critical to ensuring beneficiaries get renewal forms and program information timely to promote retention of coverage or facilitate seamless coverage transitions to Nevada Health Link.

## Loss of Contact and Procedural Discontinuances

Nevada's Medicaid population is over 900,000 members, an approximate 35% increase in total enrollment since March 2020, largely due to the continuous enrollment requirements put in place during the PHE. We recognize that during the PHE, there has been minimal or no contact with many members for an extended period, as many have not completed a renewal. As such, there is an inherent risk that eligible individuals may lose coverage once the continuous enrollment condition ends and because they have a new address or other contact information, that may not have been updated since their last completed renewal (in most cases prior to the PHE). Additionally, the transient nature of Nevada's population means that maintaining proper contact information has been difficult.

The possibility of procedural discontinuances, such as those for failure to complete renewals, will not be fully known until annual renewals are processed during the unwinding period.

### Anticipated Total Disenrollment

It is challenging to estimate how many members may be disenrolled for many reasons outlined in this recent ***report from the Kaiser Family Foundation.*** We anticipate that the sheer volume of renewals, compounded by the beneficiary loss of contact, and other normal churn of individuals moving to the state marketplace, will potentially lead to ***approximately 200,000 disenrollments*** over the course of the unwinding period. This estimate would bring the Medicaid total enrollment closer to the pre-COVID-19 PHE caseload levels.

Urban Institute published ***What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?*** The report conveys, "Many of those losing Medicaid coverage would be eligible for other sources of subsidized coverage. Of the adults who would lose Medicaid, we estimate about a third would be eligible for Marketplace premium tax credits (PTCs) if the enhanced tax credits in the American Rescue Plan Act (ARPA) were made permanent." This is true for Nevada, PTCs known as Advanced Premium Tax Credits (APTC's) are offered to consumers monthly. The report goes on to state, "Of the children losing Medicaid, 57 percent would be eligible for the Children's Health insurance Program (CHIP), and additional 9 percent would be eligible for Marketplace coverage with tax credits. Thus, good coordination between state Marketplaces and Medicaid agencies is essential to reduce unnecessary losses of health coverage.

As a result of the reinstatements completed September 14, 2023, for June through September of 2023, some beneficiaries were covered dually with the Marketplace and Medicaid or CHIP program. Beneficiaries can rest assured they will not be responsible to pay back APTCs which was clarified by CMS on August 2023 and referenced IRS Questions and Answers on the Premium Tax Credit: Q30 in this document, which states that individuals enrolled in a Qualified Health Program (QHP) and Medicaid are eligible for APTCs.

## Federal Eligibility-Related Flexibilities & Strategies

CMS has offered many flexibilities and/or strategies to resume renewals. Many of these flexibilities/strategies being offered are already in place on a permanent basis in Nevada as follows:

- Use income determinations from SNAP or other human services programs managed within the integrated eligibility system to renew eligibility.
- Maximize automation of electronic verification, including expanding the number and types of data sources used.
- Dedicate specialized staff to complex households or applications.

Nevada Medicaid has submitted various federal eligibility related flexibilities requests to CMS. These requests will assist with managing the significant volume of disenrollment related actions that were paused due to the continuous enrollment requirements and will help mitigate coverage losses to the greatest extent possible. Below are three additional flexibilities that we opted to pursue.

## Adjusting Reasonable Compatibility Income Threshold to 20% for Modified Adjusted Gross Income (MAGI)

Nevada Medicaid uses a standard to determine whether the income in federal data sources is compatible with the information an individual reports. When income is reasonably compatible with federal data sources, the beneficiary does not need to provide proof of their income. DWSS is working with CMS to increase the reasonable compatibility threshold from 10% to 20% through an updated MAGI Verification Plan. The MAGI Verification Plan was submitted on June 1, 2022, and is pending CMS approval.

## Section 1902(e)(14)(A) Flexibilities/Strategies

SHO 22-001 outlined additional targeted strategies under Section 1902(e)(14)(A) authority of the Social Security Act for states to leverage to mitigate churn and ensure eligible individuals remain covered. Specifically, Section 1902(e)(14)(A) of the Social Security Act allows for waivers "as are necessary to ensure that states establish income and eligibility determinations systems that protect beneficiaries." The COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals list the waivers. Under this waiver authority, CMS lays out nine potential targeted enrollment strategies that

can be used to facilitate renewals that lead to fewer disenrollments during the 12-month unwinding period. In accordance with SHO 23-002, the effective and/or expiration of approved waivers are linked to the end of the COVID-19 PHE. Given that the CAA, 2023 has de-linked the end of the continuous enrollment condition and the start of the unwinding period from the end of the COVID-19 PHE, the effective dates of section 1902(e)(14)(A) waivers granted for the purpose of assisting states in their unwinding efforts may no longer align with the states' unwinding timeline. To minimize administrative burden on states as they begin their unwinding process, CMS has provided specific guidance to allow states to implement modified effective dates, without needing to submit a revised request to CMS. Nevada Medicaid requested and received approval for thirteen targeted enrollment waivers, which temporarily permit the following:

- ex parte Renewal for Individuals with No Income and No Data Returned. Under this authority, Nevada is permitted to complete the income determination for ex parte renewals without requesting additional income information or documentation if: (1) the most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the COVID-19 PHE (i.e., March 2019) and was based on a verified attestation of zero-dollar income; (2) the state has checked financial data sources in accordance with its verification plan and no information is received.
- Renew Medicaid eligibility for individuals with income at or below 100% of Federal Poverty Level (FPL) and no data returned. To complete the income determination for ex parte renewals without requesting additional income information or documentation if: (1) the most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the COVID-19 PHE and was based on verified income at or below 100% of FPL; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received.
- Facilitating Renewal for Individuals with No Asset Verification System (AVS) Data Returned within a Reasonable Timeframe: Under this approach, CMS has granted Nevada the authority to permit renewal of beneficiaries for whom no information is returned by the AVS within a reasonable timeframe.
- Renewal eligibility for individuals with only Title II or other stable sources of income without checking required data sources. This authority allows Nevada to temporarily complete the income determination for ex parte

renewals without requestion additional income information or documentation if: (1) the most recent income determination(either at initial application or most recent renewal ) was no earlier than 12 months prior to the beginning of the COVID-19 PHE; and (2) the individual only had the following sources of stable income at the most recent determination: Title II Social Security income and/or pension income.

- Renewal eligibility without regard to the asset test for non-MAGI beneficiaries subject to an asset test. This authority waives the beneficiary asset test for renewal for non-MAGI eligibility groups subject to an asset test, as otherwise required per 42 C.F.R. § 435.916(a)(2), incorporated by cross reference in 42 C.F.R. § 435.916(b).
- Using the U.S. Postal Service (USPS) National Change of Address (NCOA) Database and USPS Returned Mail to Update Beneficiary Contact Information. Under this authority, Nevada will treat updated in-state contact information received from NCOA or USPS returned mail as reliable and will update the beneficiary's case record with the new contact information without first sending a notice to the beneficiary address on file with the state in order to provide them with the opportunity to dispute the address change. The authority provided in accordance with this letter does not apply to out-of-state addresses received from NCOA or USPS returned mail.
- Partnering with Managed Care Organizations to Update Beneficiary Contact Information: The acceptance of updated individual contact information provided by Medicaid managed care plans without additional confirmation removes administrative barriers and allows timely updating of the case file. This allows beneficiaries to receive important mail from the DWSS with the correct address.
- Permit managed care plans to provide assistance to enrollees to complete and submit Medicaid renewal forms, including completing certain parts of the renewal forms in order to help reduce the number of procedural terminations during the state's new unwinding period. Nevada will ensure that:
    - Managed care plans may offer their assistance in completing renewal forms, but only provided such assistance if the enrollee chooses to accept the plan's assistance. Consistent with the Medicaid managed care marketing regulations at 42 C.F.R § 438.104, managed care plans are prohibited from engaging in all forms of marketing and potential conflicts of interest and must protect managed care enrollees' confidentiality related to providing assistance with renewals.
    - When assisting enrollees with completing renewal forms, managed care plans will limit their assistance

to completing fields with information provided by the enrollee relating to eligibility criteria which the enrollee must meet to retain coverage. Plans cannot assist enrollees with completing any fields associated with managed care plan selection and may not sign the renewal form on the enrollee's behalf. Any assistance provided to enrollees in completing their eligibility renewal forms is purely an administrative activity offered by the managed care plan; managed care plans are prohibited from acting as an enrollee's authorize representative as defined in 42 C.F.R § 435.923.

  - Managed care plans will not take actions that could influence the enrollee to select the managed care plan that is providing the assistance or not enrolled in another managed care plan.
  - Managed care plans will not perform activities that must be provided by an enrollment broker (as defined in 42 C.F.R. § 438.810(a)), including choice counseling (as defined 42 C.F.R. § 438.2). As specified in 42 C.F.R. § 438.810(b)(1)-(2), enrollment brokers must be independent and free from conflict of interest from all managed care plans in the state.

- Extend Timeframe to Take Final Administrative Action of Fair Hearing Request: On the condition that states provide benefits pending the outcome of a fair hearing, including reinstating benefits, regardless of whether a beneficiary has requested a fair hearing prior to the date of the adverse action. DWSS anticipates the volume of fair hearing requests will increase significantly. Allowing additional administrative time to complete the fair hearing process ensures beneficiaries remain in coverage pending a decision and ensures that the State remains in compliance with fair hearing processing time frames.
- Permit the designation of an authorized representative for the purpose of signing an application or renewal form via the telephone without a signed designation from the applicant or beneficiary as required by 42 C.F.R. § 435.923(a)(1). The state will use this authority for applications and renewal. This request is based on systems and/or workforce challenges and/or to accommodate applicants and/or beneficiaries who remain uncomfortable with or unable to meet in person with application assistors or others who assist with the enrollment process. This authority applies to Medicaid and CHIP populations. In exercising the authority provided in this letter, the state will ensure that:
  - The state will limit the scope of the authorized representative designated under this authority to

signing and submitting an application or signing and submitting a renewal form, consistent with the applicant or beneficiary's request; and
    - A record of such authorization must be submitted by the authorized representative, along with the application or renewal, and must be included in the applicant or beneficiary's case record held by the state Medicaid agency.
- Suspension of the requirement that beneficiaries cooperate, this approved authority permits to complete eligibility determinations without requesting additional information or documentation from individuals related to medical support cooperation, codified at 42 C.F.R. § 435.610, 433.147, 433.145, and 433.148, implementing Section 1902(a)(45) and Section 1912 of the Act. This strategy will reduce the workload for eligibility staff who otherwise must follow up with beneficiaries whose coverage was continued despite not having met medical support cooperation requirements while the continuous enrollment condition described in section 6008(b)(3) of the Families First Coronavirus Response Act, as amended by CAA, 2023, was in effect.

Nevada received approval for two other mitigation strategies through the Mitigation plan submitted to CMS March 2023 to support compliance with provisions in section 5131 of the CAA, 2023:

- "Back-end" process to check AVS manually after the renewal form is sent for non-MAGI populations with assets. This strategy was put in place before the May 31, 2023, terminations.
- Nevada is faced with the challenge of not being able to record and store the conversation. As a mitigation strategy, we will continue to assist members over the phone by completing the renewal form and sending it to the member for signature.

In order to complete the ex parte renewal, the state must take appropriate steps to review the non-financial components of eligibility consistent with the state's existing policies and procedures outlined in the state's verification plan implementing 42 C.F.R §§ 435.916 and 435.956 or through a renewal strategy authorized under section 1902(e)(14)(A) of the Act or other alternative processes and procedures approved by the Secretary of Health and

Human Services.

## Evergreen Disaster Relief

CMS approved the Evergreen Disaster Relief SPA #22-0018 on October 7, 2022. This allows provisions for temporary adjustment to enrollment and renewal policies and cost sharing requirements for children in families living and/or working in state or federally declared disaster areas effective July 1, 2022, through the unwinding period. This SPA specifically allows Nevada to enact any of the flexibilities outlined within the document with a quick notification to CMS.

During a state or federally declared disaster, and at the state's discretion, the state may implement the following changes to its enrollment and redetermination policies for beneficiaries living and/or working in a state or federally declared disaster area:

- The state will temporarily use the regulatory timeliness exception for timely processing of CHIP applications under 42 CFR 457.340(d)(1).
- The state will temporarily use the regulatory timeliness exception for timely processing of CHIP renewals under 42 CFR 457.340(d)(1).
- The state will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by the state or federally declared disaster such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance discussed in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).
- The state will temporarily execute the exception to Disenroll for Failure to Pay Premiums: During a state or federally declared disaster, and at the state's discretion, the state may waive premiums for CHIP applicants and/or beneficiaries who reside and/or work in state or federally declared disaster areas. Therefore, the state will not disenroll beneficiaries for failure to pay premiums. Additionally, the state may waive any unpaid premium balance and waive the premium lock-out period for CHIP beneficiaries who reside and/or work in state or federally declared disaster areas.

This SPA provides Nevada with the flexibility to waive premiums for 365 days post PHE. Additionally, the state will waive

any unpaid premium balance and waive the premium lock-out period during this period.

## Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) Programs

Eligibility and enrollment actions delayed as a result of the PHE will **not be considered untimely** for the purposes of PERM or MEQC programs if a state complies with the timelines outlined in SHO 22-001. SHO 22-001 also clarifies that states with approved 1902(e)(14)(A) waivers will be considered in compliance with the Medicaid statute and regulations for the purposes of PERM and MEQC reviews.

## Returned Mail

Nevada Medicaid has developed multiple strategies to assist with obtaining updated contact information for beneficiaries who may have changed their address during the PHE and through the unwinding period. Key strategies include:

- Requiring DWSS to request updated contact information at all points of contact.
  - The MCOs & DBA are also conducting this activity concurrently.
- Created a dedicated unit to process contact information changes, known as the Returned Mail Unit (RMU).
- Conducting ongoing outreach campaigns to relay the importance of sharing updated contact information with DWSS.
- Engaging with managed care organizations and Nevada Health Link to improve the process by which they communicate updated beneficiary contact information.
- Members are being polled to gauge their knowledge of the renewals, to inform them of the steps they need to take at renewal and the importance of updating contact information. As part of the poll, contact information is also being collected, if applicable.
- Adding key messaging to state websites reminding consumers to update their contact information.
- Working with the State Mailroom to obtain address changes through the United States Postal Service (USPS) National Change of Address (NCOA).
  - The RMU is taking proactive steps to ensure contact information is updated before renewals are initiated,

the NCOA process begins approximately 120 days prior to the date the renewal is due (i.e., 2/1/23 for 5/31/2023 renewals).

- Nevada Medicaid is also leveraging other projects/activities with mailings (returned mail) to update contact information other mailing projects/activities include but are not limited: 1095B, and MCO Open Enrollment.

Nevada is prepared to use mail, telephone, email and online as primary modalities to attempt to ensure up-to-date contact information for everyone on a case when conducting the renewal and making a good faither effort to contact using more than one modality for any individual who is determined ineligible based on returned mail prior to disenrolling the individual as outlined in SHO 23-002, which includes taking required steps for:

- Returned Mail has Completed Information
- Returned Mail with No Forwarding Address
- Returned Mail with a Forwarding Address
- Lack of Alternative Contact Information

## Program Operations: Nevada Medicaid/CHIP Program Policies during the Unwinding

Recognizing the varied program rules, this section of the Plan reviews how the Medicaid and CHIP programs will be handled through the course of the Unwinding Period. Of note, DWSS is not changing any current Nevada Medicaid and CHIP policies and is instead utilizing existing procedures and temporary 1902(e)(14)(A) approved authorities to process all renewals including ex parte renewals whenever possible. Nevada is equipped to meet all federal regulations under 42 CFR, 435.916, related to redetermination of eligibility including:

- Ex Parte Renewals: Begin the renewal process for all members, including those whose financial eligibility is based on modified adjusted gross income (MAGI) ('MAGI based beneficiaries) and those whose financial eligibility is not based on MAGI ("non-MAGI beneficiaries") by redetermining eligibility without requiring information from the

individual. This automated process started effective December 2022.

- Renewal Form: Provide a renewal form that requests information needed to determine eligibility when eligibility cannot be renewed on an ex parte basis at an individual level. This renewal form must be pre-populated for MAGI-based beneficiaries. Nevada pre-populates the form for non-MAGI beneficiaries as well.
- Reasonable Timeframe and Modalities to Return Form: Provide MAGI-based beneficiaries with a minimum of 30 days to return their pre-populated renewal form and any requested information. Nevada is allowing 60 days for both MAGI-based and non-MAGI based beneficiaries and can submit their renewal form online, by mail, or in-person.
- Determine Eligibility on All Bases: Consider all bases of Medicaid eligibility prior to determining an individual is ineligible for Medicaid and terminating coverage. This is normal practice for Nevada, a process set in place prior to PHE.
- Advance Notice and Fair Hearing Rights: Provide a minimum of 10 days' advance notice and fair-hearing rights prior to terminating or reducing Medicaid eligibility, in accordance with 435.917 and 42 CFR Part 431, Subpart E. This is also standard practice for Nevada.
- Assess Eligibility for Other Insurance Affordability Program (IAPs and Transfer Accounts as Appropriate: For individuals determined ineligible for Medicaid, assess eligibility for other IAPs and transfer the individual's account to the appropriate program. Nevada's approach is further detailed in the Nevada Transition to Nevada Health Link section within this plan.
- Reconsideration Period: Reconsider eligibility without requiring a new application for MAGI-based beneficiaries who coverage is terminated for failure to return their renewal forms or necessary information if the individual's renewal form of information is returned within 90 days after coverage is terminated. Nevada will be abiding by this requirement and evaluating for reinstatement of eligibility if the necessary information is received within the 90 days post eligibility termination.

## Modified Adjusted Gross Income (MAGI)

MAGI method uses federal tax rules to determine if individuals qualify based on how taxes are filed and on their

countable income. Most individuals in MAGI will go through an automated ex parte process at the time of their annual renewal to receive a full renewal at the end of the PHE. Members that are unable to be redetermined through the automated ex parte process will be sent a pre-populated annual renewal form. MAGI renewals will occur during the members' next post-unwinding annual renewal. MAGI Medical categories include:

- Family Medical Groups: Cover individuals, families, pregnant women and children in Medicaid and Nevada Check-Up
- Specialized Medical Groups: Cover Individuals in specialized groups such as, Aged Out, Rite of Passage and Breast & Cervical

## Non-MAGI

Non-MAGI uses the verification plan to count property, household income and size to determine if individuals qualify. Individuals in Non-MAGI SSI categories of Nevada Medicaid will go through an automated ex parte process at the time of their annual renewal.

Retirement, Survivors, and Disability Insurance (RSDI) members will receive a full renewal at the end of the PHE. DWSS will expand use of various electronic data sources to increase the use of ex parte during the non-MAGI annual renewal. Non-MAGI renewals will occur during the members' next post-unwinding annual renewals. Non-MAGI categories include Medicaid Assistance for the Aged, Blind and Disabled (MAABD) Groups: Covering aged, blind, and disabled individuals using SSI budgeting methodologies. Nevada is the first state to implement the use of ex parte for the MAABD population.

## COVID-19 Uninsured Group

On March 18, 2020, the FFCRA authorized Medicaid programs to provide access to coverage for medically necessary COVID-19 diagnostic testing and testing-related services for specific uninsured individuals. Nevada Medicaid elected coverage for the COVID-19 Uninsured Group Program which is a temporary Medicaid program that only covers medically necessary COVID-19 testing and testing-related services. The American Rescue Plan Act (ARPA) extends

coverage of this group to include COVID-19 related treatment services and COVID-19 vaccines and administration fees. Individuals enrolled in the COVID-19 Uninsured Group will be discontinued at the end of the month in which the PHE ends. At the end of the PHE, individuals will receive a notice informing them that their coverage is ending. The notice will encourage these individuals to apply for ongoing Medicaid or to shop for coverage through Nevada Health Link. As of February 2023, Nevada has identified 12 cases statewide. This group was terminated effective May 31, 2023, with proper notification sent prior to the termination of coverage.

## Transition to Nevada Health Link

NevadaHealthLink is the online state-based insurance marketplace operated by Silver State Health Insurance Exchange (SSHIX), which was established per Nevada Revised Statues in 2011 and began operations in 2013 on the belief that all Nevadans deserve access to health insurance. NevadaHealthLink connects eligible Nevada residents to budget-appropriate health and dental coverage and is the only place where qualifying consumers can receive federal tax credits to help cover premium costs.

SSHIX has been safeguarding health care coverage in Nevada, exhibited during the most recent Open Enrollment Period (OEP) where they experienced record-braking enrollment numbers of 101,000 Nevadans insured. SSHIX is prepared to assist those who will no longer remain on Medicaid transition to affordable health insurance through the online marketplace offering 126 plan options across seven brand-name insurance carriers.

SSHIX is collaborating with its vendor GetInsured (GI) in ensuring access to affordable health insurance, activities to promote coverage include:

- Assessing the current data received electronically from DWSS as part of Account Transfer (AT) process
- Working with DWSS to obtain the contact information for Exchange referrals that were denied/terminated for Medicaid
- Conducting outreach to consumers with contact information
- Connecting consumers to one of the representatives from Nevada who can assist the consumer in enrolling in a qualified health plan
- Following up as needed to help consumers who started an application but did not complete enrollment.

Specifically, SSHIX and GetInsured will conduct the following tasks and activities:

1. Identify and collect contact information (phone number and email address) for consumers who have recently been determined ineligible for Medicaid and/or CHIP, but may be eligible for coverage on the Exchange, using AT data from DWSS.

    - Assess current AT data from DWSS to SSHIX to determine what contact information is collected and if duplicate data is received.
    - In partnership with DWSS, assess contact information provided in the application for Medicaid/CHIP and determine if these fields are mandatory.
    - Conduct a gap analysis to determine what contact information is collected in the application for Medicaid/CHIP but not included in the AT data sent by DWSS to SSHIX, and if duplicate data is sent, how to de-duplicate AT data.
    - In partnership with DWSS, revise AT data protocols and data crosswalk to ensure contact information (phone number and email address) is included in the AT data sent to SSHIX.

2. Conduct direct outreach to identified consumers to connect them with In Person Assisters (IPA) or certified brokers to help them enroll in coverage: GetInsured will provide increased call center staffing support to conduct outreach to consumers.

- As of January 15, 2022, GetInsured has hired and will train up to five (5) Consumer Services Representatives (CSRs) to conduct direct outreach to consumers identified on the Outreach List.
- CSRs will make a minimum of three (3) attempts at outbound phone calls to the consumers identified on the outreach list and record the outcome of the attempt in the disposition report.
- If a consumer is contacted, the CSR would connect them with a certified broker or IPA who can assist them with submitting a financial application in SSHIX. GetInsured will work with SSHIX to determine how best to make the connection considering data availability on broker/assister schedules, consumer zip code, consumer preference and existing BrokerConnect capabilities. Regardless of the type of connection that is ultimately made such as setting up an appointment with the grantee or providing a window of time when the grantee may call the consumer. GetInsured CSRs will record the disposition in the system for each outreach.

3. Reduce barriers to enrollment by conducting direct outreach to consumers who have started an application but not enrolled.

- On a monthly basis at a minimum, CSRs will conduct follow up outreach to those consumers who were 1) successfully connected to a broker, but did not start an application, 2) started an application, but did not enroll.

4. Generate monthly performance reports that can be shared with CMS

- GetInsured will provide a monthly report on the outreach performance from SSHIX that can be shared with CMS that will contain the following types of information:
  - Total number of Medicaid denials and/or terminations received in the previous month.
  - Number of consumers for whom an outreach was performed in the current month.
  - Total number of consumers grouped by Outreach Disposition in the current month.
  - Number of consumers who answered but did not want to talk to a broker (including reason for not wanting to talk)
  - Number of consumers who were successfully connected to a broker.
  - Number of conversions (considered a consumer enrollment in a subsidized health plan who was denied and/or terminated from Medicaid for whom an outreach was conducted).

SSHIX evaluated flexibility described in the Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition – Frequently Asked Questions (FAQs). This will help beneficiaries maintain continuity of coverage as the transition of Medicaid or CHIP coverage and into a Marketplace qualified health plan (QHP) takes place. As of March 28, 2023, a 16-month PHE Unwinding SEP reporting window. Nevada Health Link's PHE Unwinding SEP is effective April 1, 2023, to July 31, 2024, and has a retroactive coverage date up to 60 days if an application is submitted within 60 days of a Medicaid end date. For more detailed information on this approved SEP click here.

## Unwinding Communication and Outreach Campaign

The end of the PHE and the Nevada Medicaid continuous enrollment condition necessitate a coordinated, phased communication campaign. This campaign will reach members with messages across multiple channels using trusted community partners. As Nevada plans to resume normal Nevada Medicaid eligibility operations, members will need to know what to expect and what they need to do to keep their health coverage. Most members will either remain eligible for Nevada Medicaid or qualify for tax subsidies that allow them to buy affordable coverage through the Silver State Health Insurance Exchange, some will have employer sponsored plans. Nevada Medicaid in partnership with Trusted Community Partners are communicating and providing outreach according to the phased approach. Each respective agency has tailored communications to their roles in Nevada Medicaid.

### Communication Two-Phase Approach

A PHE Unwind Communication and Outreach Campaign/Plan was rolled out in two phases to prioritize and sequence strategies, tactics, and messages across the state to prepare for the resumption of normal eligibility operations. Nevada is currently on Phase 2 of the Campaign/Plan.

- **Phase 1** – This phase was designed to encourage members to provide DWSS with any updated contact information such as: name, address, phone number, and email so DWSS can contact members with important information about keeping their Nevada Medicaid. This phase is underway.
- **Phase 2** – This phase is designed to encourage members to continue to update contact information with DWSS, to report any change in circumstances, as well as check for upcoming renewal packets for members whose cases have not been auto–renewed. Nevada sent the first message regarding renewals to over 330,000 Medicaid members and will continue to send out "update your contact information", renewal and transition messages weekly until April 1, 2023, and monthly thereafter. DHCFP is also working on texting recipients. New materials will be posted on our member outreach plan as they become available.

Nevada continues with its Communication and Outreach/Plan even with the temporary pause of procedural terminations. Special communications were issued and released to inform the public and those directly impacted by the reinstatements and/or the pause of procedural terminations. Communications included: notice of decisions, text messages, press release 9/15, Web Announcements 3165 and 3184.

## DHCFP Unwinding & PHE Resource Webpage Communications, Outreach Communications & Messages

CMS toolkits serve as communication guides and provide resources to support ongoing preparations for the end of the continuous enrollment condition. The tool kit can be accessed ***here***.

Trusted Community Partner messengers and Medicaid members can download the updated Nevada continuous enrollment resources (including language translations) from the website to educate members and disseminate information. The latest information and updated communication and messages will be added to the website as they become available and can be accessed ***here.*** DHCFP has created a Public Communication Plan that will be directly shared with the Managed Care Organizations, DWSS and SSHIX. This plan can be provided upon request.

Recently an Address Change Request webform was developed and is housed on the DHCFP webpage: UpdateMyAddress. The webpage provides access to the form in English and Spanish. Nevada Medicaid members can complete the form and submit the change request that will be sent by email to DWSS. The webpage also contains Quick Response (QR) codes; these codes can be used by the MCOs, DBA, SSHIX and other Trusted Community Partners to embed in their communications.

## DWSS Unwinding Communications & Messages

All communications to households have been updated in accordance with CMS templates and suggestions, including providing communications in required languages. The current communications focus has been on the importance of updating contact information. DWSS, DHCFP, and trusted community partners continue to encourage the use of electronic communications, including opting into texting.

DWSS' ***Access Nevada*** is a one stop portal for state residents to apply for assistance, report changes in household circumstances, check their case status, receive online communication, and other account management tools. DWSS posts critical announcements for Nevada residents and other public entities. This platform will continue to be used and many of the messages to date direct Medicaid members to update their addresses though Access Nevada.

All Notices of Decision (NOD) were revised to include "Update Your Contact Information" flyers and encourage Nevada Medicaid members to download the NVMedicaid application (MDP) to access health information, including selected managed care organization, claims, Nevada Medicaid ID cards, and any broadcast messages from Medicaid.

### Trusted Community Partners Messengers

Anyone can help disseminate messaging. Please see the website to access communications and messaging ***here.*** We will engage community partners to assist in delivering important messages to members about maintaining Nevada Medicaid coverage after the PHE ends. The Trusted Community Partner Messengers currently is made up of diverse organizations that can communicate in culturally and linguistically appropriate ways. Trusted Community Partners may include, but are not limited to:

- Local DWSS and DHCFP Offices
- Health Navigators
- Managed Care Organizations
- Community Organizations
- Advocates
- Stakeholders
- Providers
- Clinics/Health Care Facilities
- Legislative Offices/other State Agencies
- Schools

A comprehensive list can be provided upon request.

## Managed Care Organization (MCO) Role

MCOs are a trusted source that will communicate important outreach messages to members. To underscore the importance of MCOs during the Unwinding period, CMS released guidance in December 2021, and updated in January 2023 ("Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations"), to highlight three key strategies to maximize continuity of coverage at the end of the continuous enrollment condition. . DHCFP has been working the MCOs on several strategic

approaches, these key strategies include:

1. Obtain and update members contact information and ensure it gets forwarded and/or captured by DWSS.
2. Conduct outreach and provide support to individuals enrolled in Nevada Medicaid during their renewal period.
3. Assist individuals to transition to, and enroll in, Nevada Health Link if ineligible for Nevada Medicaid.

Health Navigators from the Managed Care Organizations serve as Communicators/Messengers during the unwinding period. The Health Navigators will focus on proactively engaging members using the communication and outreach tool kits and modifying materials to provide a localized outreach campaign message.

The Health Navigators will use existing outreach events and provide materials. Additionally, Health Navigators will use targeted outreach campaign materials that community organizations can use to connect members with Health Navigators for assistance with completing annual renewal packets and responding to DWSS requests to maintain coverage.

## DWSS Readiness

This section outlines DWSS' readiness for initiating and completing renewals when the continuous enrollment condition ends. Under federal requirements, states must renew eligibility for individuals enrolled in Medicaid and CHIP whose eligibility is determined using MAGI based financial methodologies once every 12 months, and no more frequently than once every 12 months, pursuant to 42 C.F.R. §§ 435.916(a) and 457.343. For individuals excepted from MAGI-based financial methodologies under 42 C.F.R. § 435.603(j) (non-MAGI enrollees), states must renew eligibility at least once every 12 months in accordance with 42 C.F.R. § 435.916(b).

## Unwinding Renewals Workload

DWSS plays a significant role in the unwinding as the agency determines Nevada Medicaid eligibility on behalf of DHHS. At the start of the unwinding period, April 2023, it was expected to redetermine the full Nevada Medicaid population during the 14-month period after the end of the continuous enrollment condition. Due to the ex parte at an individual level mitigation plan Nevada will be completing redeterminations end of August 2024, originally scheduled to be completed by the end of May 2024. DWSS continued conducting renewals while the continuous enrollment condition was in effect for both MAGI and non-MAGI SSI populations using a manual verification process, all other MAGI and non-MAGI groups were sent pre-populated renewal forms.

All renewals continue to be spread out over the entire calendar year based on the case renewal due date. Renewals where there has been no contact have been dispersed over a 12-month period with a monthly average per the latest 12-month workload as described below of 46,333 renewals out of the 555,993 medical cases. The 1/9th per month threshold requirement will be exceeded October 2023, March 2024 and potentially April 2024, because of reinstatements that occurred June 2023 to September 2023. At the time the 12-month caseload view was pulled, April 2023 did not include reinstated numbers. CMS has been notified of this through Nevada's Ex Parte Mitigation Plan Amendment, September 25, 2023. Nevada is implementing an automated ex parte process to reduce the burden on caseworkers and to streamline the renewal process. It is expected that all continuously extended cases will be addressed with ease within the new unwinding period after the end of the continuous enrollment condition due to these planning efforts.

Since DWSS maintained a normal renewal process, there was no singular unworked group of renewals to redistribute. Using the continuous enrollment methodology, the renewal count has remained normal over the last two years. The current 12-month caseload has heavier renewals numbers in the spring/summer months (Feb – Jul). DWSS does not currently have a backlog. In addition, DWSS utilizes an internal Quality Assurance team that works closely with the business process team and eligibility policy team to identify and mitigate any trends. Trends may include re-occurring issues in both case processing and in the type of information being reported by applicants which may cause ineligibility. Monitoring of these trends allows DWSS to respond quickly by correcting any discrepancies in policy or to make changes in case processing procedures.

*A 12-month view of renewals from October 2023 to September 2024*

*The numbers change as cases are processed or added to the caseload.*

| Program | 23-Oct | 23-Nov | 23-Dec | 24-Jan | 24-Feb | 24-Mar | 24-Apr | 24-May | 24-Jun | 24-Jul | 24-Aug | 24-Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medicaid/CHIP** | 57698 | 21964 | 23765 | 21815 | 34297 | 62294 | 31714 | 45805 | 47407 | 45564 | 34513 | 17563 |
| **MAABD** | 11901 | 7961 | 8400 | 7935 | 9569 | 14462 | 8015 | 8923 | 9539 | 9996 | 9996 | 4897 |
| **Total** | 69599 | 29925 | 32165 | 29750 | 43866 | 76756 | 39729 | 54728 | 56946 | 55560 | 44509 | 22460 |

## Policy Guidance

During the PHE, DWSS issued guidance and instructions on maintaining continuous enrollment for members. DWSS will issue written policy guidance updates as needed to assist with completing renewals after the continuous enrollment condition ends including guidance on approved 1902(e)(14)(A) authorities. The updated written policy guidance related to the unwinding of the continuous enrollment condition will also serve as a foundation for DWSS' statewide Nevada Medicaid training.

## Training

DWSS will continue to train new hires through a 3-month training academy where all aspects of Enrollment & Eligibility (E&E) are covered, including any new policy guidance and instructions. Caseworkers who have been conducting renewals during the PHE period will continue to process renewals once the unwinding period beings using the normal case processing methods.

In anticipation of increased hearings and pre-hearings, DWSS is planning to focus its hearings unit and ensure it is fully staffed. Furthermore, additional staff training will include ways to assist households on mitigating the hearing (pre-hearing) before it escalates to a formal hearing.

Note: Staffing shortages are affecting all state agencies in Nevada. DWSS struggles with retaining staff with more than 1/3 of staff being newly hired (less than one year). As noted above, training for new hires (caseworkers) takes 3 months. The hiring and training process is an ongoing challenge; however, DWSS is confident renewals will be completed timely, within

the new unwinding timeline as evidenced by Nevada being able to conduct renewals during the PHE without a backlog.

## Medicaid Enterprise Systems and T-MSIS Changes

In response to the PHE, Nevada's statewide Welfare system, Application Modernization & Productivity Services (AMPS), did not require any system changes. DWSS Eligibility & Payments (E&P) in partnership with other DWSS units, including Administration and Field Services, made minor adjustments in case processing.

This allowed DWSS to not need system changes to keep Medicaid members enrolled throughout the PHE and allowed Field Services staff to focus on new applications.

AMPS interfaces with DHCFP's Medicaid Management Information System (MMIS). DHCFP is responsible for maintaining and reporting Transformed Medicaid Statistical Information System (T-MSIS) data. With the ongoing changes to the national health care environment, CMS has made significant investments to meet the organizational and information technology (IT) infrastructure to adequately represent CMS' role in the health care marketplace. T-MSIS is a critical data and system component of the CMS Medicaid and CHIP Business Information Solution (MACBIS). Through MMIS, DHCFP reports required data sets as required by CMS.

DHCFP, in coordination with DWSS, will meet CMS requirements to implement the 22 stop reasons codes for Medicaid and CHIP eligibility which will be reported to CMS through T-MSIS data. DHCFP realized the stop reason codes could help with targeted outreach to Nevada Medicaid members by sharing this information with the MCOs and DBA and was implementing early 2023.

# Tracking Nevada Medicaid/CHIP Coverage Trends During the Unwinding Period and Beyond

The PHE has had a profound impact on Nevada with over 900,000 individuals receiving health insurance coverage from Nevada Medicaid and CHIP. State and federal policies implemented important member protections during the PHE and allowed individuals to maintain coverage. Tracking trends and monitoring renewal timeliness will be of upmost importance.

## Medicaid Unwind Dashboard

An Unwinding Eligibility Data Dashboard was released publicly on the DHCFP webpage. Dashboard metrics include Medicaid and CHIP enrollments; call center metrics and state workload level with total applications; pending applications; account transfers; annual renewals due; and account transfer (Nevada Health Link) throughout the Unwinding Period. The Dashboard will be updated monthly.

## Unwinding and Beyond Federal Monitoring

SHO 22-001 requires all states to submit monthly data for a minimum of 12 months through a CMS-developed reporting template. CMS will require all states to report on specific metrics described in this "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report). These metrics are designed to demonstrate states' progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees consistent with the guidance outlined in SHO 22-001. Subsequent CMS guidance requires states to complete a baseline and subsequent monthly Unwinding Data Reports and to submit these reports to CMS. In addition, states will complete and submit to CMS a summary of the states' plans for initiating renewals for its total caseload within the states' 12-month unwinding period (Statewide Renewal Distribution Plan).

CMS recently updated their webpage Unwinding and Returning to Regular Operations after COVID-19, the information

has been categorized making it easier to navigate. Information within the webpage includes Data Reporting, all state's data, including Nevada is documented and shared with the public.

CMS revised due dates for certain state deliverable due to the continuous enrollment condition ending effective March 31, 2023, in accordance with SHO 23-002 Nevada's reporting deadlines with the plan of initiating renewals April 1, 2023, are as follows:

- **Renewal Redistribution Plan:** due no later than February 15, 2023
- **System Readiness Artifacts** (Configuration plan, testing plan and test results) due no later than February 15, 2023
- **Baseline Unwinding Data (Unwinding Data Report):** due April 8th and on the 8th of each month thereafter.

Nevada submitted all documents and reports by their due date.

SHO 23-002, clarifies the new reporting requirements under the CAA, 2023, are currently captured in existing data sources, including the unwinding data report and State Base Marketplace (SBM) priority metrics. As such, CMS does not anticipate that states will need to submit a separate report (or additional reporting) to CMS to comply with section 1902(tt)(1) of the Act. Nevada will be able to submit the data metrics required through the appropriate existing CMS data tool as follows:

| New (CAA, 2023) Reporting Element | Data Source |
|---|---|
| Total number of Medicaid and CHIP beneficiaries for whom a renewal was initiated | Unwinding Data Report, Monthly Metric |
| Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed | Unwinding Data Report, Monthly Metric |
| Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, those whose coverage is renewed on an ex parte basis | Unwinding Data Report, Monthly Metric |
| Total number of individuals whose coverage for Medicaid or CHIP was terminated | Unwinding Data Report, Monthly Metric |
| Total number of individuals whose coverage for Medicaid or CHIP was terminated for | Unwinding Data Report, Monthly Metric |

| | |
|---|---|
| procedural reasons | |
| Total number of beneficiaries show were enrolled in a separate CHIP | T-MSIS, CHIP-CODE |
| For each state call center, total call center volume | Medicaid and CHIP Eligibility and Enrollment Performance, Indicator |
| For each state call center, average abandonment rate | Medicaid and CHIP Eligibility and Enrollment Performance, Indicator |
| Number of individuals whose accounts are received by the SBM | SBM Priority Metrics, Monthly |
| Number of individuals whose account are received by the SBM and are determined eligible for a QHP | SBM Priority Metrics, Monthly |
| Number of individuals whose account are received by the SBM and are determined eligible for QHP who make a QHP plan selection | SBM Priority Metrics, Monthly |

For states that are out of compliance, CMS may require the submission of a corrective action plan and include detailed strategies and timeline for coming into compliance.

Nevada prioritizes the continuity of health coverage during the unwinding period and Nevada Medicaid appreciates the efforts of its many stakeholders and community partners in meeting this goal. We hope this resource is helpful and questions, comments, or suggestions may be submitted to dhcfp@dhcfp.nv.gov with the subject: COVID19 Operational Unwinding Plan.

# Appendices

Appendix A:  DHCFP Flexibilities Requested due to COVID-10 PHE

Appendix B:  Nevada Renewal Periods

# Resources & References

**Resources**

| | | |
|---|---|---|
| FAQs | January 31, 2023 | Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition – Frequently Asked Questions (FAQs) |
| Statement of Administration Policy | January 30, 2023 | H.R. 382 – A bill to terminate the public health emergency declared with respect to COVID-19 |
| SHO 23-002 | January 27, 2023 | Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023 |
| System Readiness Artifacts Refresher | January 6, 2023 | System Readiness Artifacts: A Refresher on Medicaid Enterprise System Artifact for Unwinding |
| CIB | January 5, 2023 | Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023 |
| SHO 20-004 | December 22, 2020 | State Health Office Letter: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency |
| Declarations of PHE | | Administration for Strategic Preparedness & Response (ASPR) |
| All State Call Presentation | June 16, 2020 | Additional information on federal requirements for retaining Medicaid State Plan flexibilities |
| CIB | December 4, 2020 | Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements |

| | | |
|---|---|---|
| All State Call Presentation | January 7, 2021 | Overview of December 2020 State Health Official Letter |
| All State Call Presentation | January 19, 2021 | Overview of eligibility and enrollment provisions in December 2020 State Health Official Letter |
| Presentation | July 29, 2021 | Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 1 |
| Presentation | August 3, 2021 | Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 2 |
| SHO 21-002 | August 13, 2021 | Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency |
| All State Call Presentation | August 19, 2021 | Overview of August 2021 State Health Official Letter |
| Issue Brief | November 24, 2021 | Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies issue brief |
| Issue Brief | November 24, 2021 | Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations |
| All State Call Presentation | November 30, 2021 | Strategies for retaining eligible individuals and engaging managed care plans |
| Presentation | December 8, 2021<br>Updated -March 3, 2022 | Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations |
| All State Call Presentation | February 15, 2022 | Sunsetting Medicaid and CHIP disaster relief SPAs and section 1135 waivers and options for disaster relief SPA provisions |
| All State Call Presentation | February 22, 2022 | CMS Office of Communications consumer research on preventing churn during unwinding |

| | | |
|---|---|---|
| SHO 22-001 | March 3, 2022 | Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP)<br>Upon Conclusion of the COVID-19 Public Health Emergency |
| All State Call Presentation | March 8, 2022 | CMS Unwinding Resources |
| Proposed Rule | April 22, 2022 | Implementing Certain Provisions of the Consolidated Appropriates Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199 – P) |
| Unwinding and Returning to Regular Operations after COVID-19 | December 2022 | Unwinding and Returning to Regular Operations after COVID-19 \| Medicaid |
| Medicare.gov | | When can I sign up for Medicare? |
| DHCFP Website | | DHCFP Flexibilities – Nevada's Approved COVID-19 Waiver Request |
| DCHFP Website Members | | Member Outreach Page |
| Access Nevada | | Access Nevada – Get Access to All The Benefits Provided by the State of Nevada |
| DHCFP Provider Web Portal | | DHCFP Web Portal |
| DWSS Website | | DWSS Website |
| Update My Address Webpage | | http://dhcfp.nv.gov/UpdateMyAddress/ |

## References

| | | |
|---|---|---|
| Nevada's approved flexibility letter from CMS | April 7, 2020 | https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/COVID-19/1135Approval.pdf |
| Nevada's approved Appendix K letters from CMS | April 15, 2020<br><br>Updated August 18, 2020 | https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/COVID-19/Appendix-K-Approval.pdf<br><br>https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/COVID-19/2nd%20Approval%20Letter%20Appendix%20K.pdf |
| Disaster SPA #20-0009 | June 18, 2020 | https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/COVID-19/NV%20SPA%2020-0009%20Approval%20Package%20(ADA)%2006-23-20.pdf |
| Disaster SPA #21-0003 | March 25, 2021 | https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/COVID-19/NV21-0003ApprovalPackagesigned03252021.pdf |
| COVID-19 FAQ for State Medicaid and CHIP Agencies | April 2020 | COVID-19 FAQs for State Medicaid and CHIP Agencies |
| Kaiser Family Foundation Report | May 10, 2022 | Unwinding the PHE: What We Can Learn From Pre-Pandemic Enrollment Patterns |
| Urban Institute | September 2021 | What Will Happen to Unpresented High Medicaid Enrollment after the Public Health Emergency? |
| Regulations Sites | | FFCRA<br>ARPA<br>eCFR<br>Social Security |
| Nevada Health Response | | Governor Directives and Declarations |
| Guidance for the end of the declaration of | May 20, 2022 | End of the COVID-19 Declaration of Emergency |

emergency

| | | |
|---|---|---|
| Consolidated Appropriations Act, 2021 (CAA) | April 22, 2022 | Implementing Certain Provision of the Consolidated Appropriations Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199-P) |
| 1902(e)(14)(A) Waivers | October 6, 2022 | COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals \| Medicaid |
| CMS.gov Newsroom | October 28, 2022 | Biden-Harris Administration Strengthens Medicare with Finalized Policies to Simplify Enrollment and Expand Access to Coverage |