



DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA MEDICAID

COVID-19 PUBLIC HEALTH EMERGENCY

OPERATIONAL UNWINDING PLAN

February 8, 2022





Table of Contents

Revision Control.....	4
Background and Overview	7
Nevada Medicaid Global Unwinding Approach	9
Part I: Unwinding Programmatic Flexibilities.....	12
Terminated/Terminating Flexibilities	12
Extending Flexibilities	12
Nevada Medicaid Benefits and Reimbursements Rate Changes.....	14
State Declaration of Emergency Termination	16
Part II: Resumption of Normal Eligibility Operations	16
COVID-19 Impacts to Enrollment.....	18
Guiding Principle: Maximizing Continuity of Coverage for Nevada Beneficiaries	19
Nevada’s Approach for Prioritizing Renewals: Maintaining Current Renewal Month	20
Acting on Changes in Circumstance.....	22
Population Priorities	23
Medicare Enrollment Period	23
Anticipated Coverage Loss with Continuous Enrollment Condition Termination.....	25
Loss of Contact and Procedural Discontinuances	25
Anticipated Total Disenrollment	26
Federal Eligibility-Related Flexibilities & Strategies	26
Adjusting Reasonable Compatibility Income Threshold to 20% for Modified Adjusted Gross Income (MAGI)	27
Section 1902(e)(14)(A) Flexibilities/Strategies.....	27
Evergreen Disaster Relief	29
Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) Programs	30



Returned Mail.....	30
Program Operations: Nevada Medicaid/CHIP Program Policies during the Unwinding	31
Modified Adjusted Gross Income (MAGI)	33
Non-MAGI.....	33
COVID-19 Uninsured Group	33
Transition to Nevada Health Link.....	34
Unwinding Communication and Outreach Campaign	37
Communication Two-Phase Approach	37
DHCFP Unwinding & PHE Resource Webpage Communications, Outreach Communications & Messages.....	38
DWSS Unwinding Communications & Messages	38
Trusted Community Partners Messengers	39
Managed Care Organization (MCO) Role.....	40
DWSS Readiness	41
Unwinding Renewals Workload	41
Policy Guidance	42
Training.....	42
Medicaid Enterprise Systems and T-MSIS Changes	43
Tracking Nevada Medicaid/CHIP Coverage Trends During the Unwinding Period and Beyond	44
Medicaid Unwind Dashboard	44
Unwinding and Beyond Federal Monitoring	44
Appendices.....	47
Resources & References	48



Revision Control

Published / Revised	Version #	Section / Nature of Change
September 6, 2022	v1.0	Initial Version
November 15, 2022	v.1.1	<p>Background and Overview, page 5</p> <ul style="list-style-type: none"> ▪ End of Public Health Emergency new dates inserted <p>Extending Flexibilities, pages 9 and 10</p> <ul style="list-style-type: none"> ▪ Status update for SPA #22-0013 and #22-0012 ▪ Added SPA #22-0013-A and #22-0014 <p>Nevada Medicaid reimbursement rate – Continuing, page 12</p> <ul style="list-style-type: none"> ▪ COVID-19 laboratory diagnostic and serology testing reimbursement rates approved <p>How this works, page 17</p> <ul style="list-style-type: none"> ▪ Example revised with new dates <p>Acting on Changes in Circumstance, pages 18 and 19</p> <ul style="list-style-type: none"> ▪ Examples 1 & 2 revised ▪ Appendix B: Nevada Renewal Periods revised <p>Medicare Enrollment Period, page 20</p> <ul style="list-style-type: none"> ▪ Medicare enrollment and eligibility final rule information inserted, previously documented the proposed rule <p>Federal Eligibility-Related Flexibilities & Strategies, page 23</p> <ul style="list-style-type: none"> ▪ Removed 2nd bullet regarding \$0 income, moved to page 24 <p>Section 1902€(14)(A) Flexibilities/Strategies – pages 24 and 25</p> <ul style="list-style-type: none"> ▪ Added three waivers <ul style="list-style-type: none"> ○ Ex parte \$0 Income (1st bullet) ○ NCOA-USPS (2nd bullet) ○ Streamlined Asset Verification (5th bullet) <p>Evergreen Disaster Relief, page 25</p> <ul style="list-style-type: none"> ▪ Status update <p>Table: 12-month view of renewals</p>



		<ul style="list-style-type: none"> ▪ Nov. 2023 through Oct. 2023 data provided
<p>February 8, 2023</p>	<p>v.1.2</p>	<ul style="list-style-type: none"> ▪ Background and Overview, pages 4 – 9 <ul style="list-style-type: none"> ▪ The White House announces the End of the COVID-19 Public Health Emergency. ▪ Consolidated Appropriation Act, 2023 (CAA) overview inserted. ▪ 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(...) ▪ Nevada Medicaid Global Unwinding Approach, pages 9 - 11 <ul style="list-style-type: none"> ▪ Added link to SHO #23-002 ▪ Outlines requirements under CAA, 2023 provisions as described in SHO #23-002 ▪ Extending Flexibilities, page 13 <ul style="list-style-type: none"> ▪ Status update for COVID ARPA SPA #22-0013 ▪ Part II: Resumption of Normal eligibility Operations, pages 16 – 18 <ul style="list-style-type: none"> ▪ Inserted first paragraph: CAA, 2023 is the key driver of Part II of this plan ▪ Added link to SHO #23-002 ▪ Added link to Key Dates Related to the Medicaid continuous enrollment Provision in the Consolidated Appropriations Act, 2023 ▪ Guiding Principle: Maximizing Continuity of Coverage for Nevada Beneficiaries, pages 19 <ul style="list-style-type: none"> ▪ Screen shot revised to reflect End of continuous enrollment condition three (3) options for 12-month unwinding period ▪ New ex parte information added ▪ How this works, pages 20 and 21 <ul style="list-style-type: none"> ▪ Added end of the COVID-19 PHE end date ▪ CAA, 2023 provisions added ▪ Revised monthly process within the unwinding period to reflect Nevada’s initiating renewal timeline (the month after the end of the continuous enrollment condition) ▪ Appendix B revised ▪ Acting on Changes in Circumstances, page 22 <ul style="list-style-type: none"> ▪ Example 1 & 2 revised



	<p>Loss of Contact and Procedural Discontinuances, page 25</p> <ul style="list-style-type: none"> ▪ Medicaid population revised <p>Section 1902(e)(14)(A) Flexibilities/Strategies, pages 26 and 27</p> <ul style="list-style-type: none"> ▪ Added SHO #23-002 guidance <p>Evergreen Disaster Relief, pages 29 and 30</p> <ul style="list-style-type: none"> ▪ Section revised <p>Returned Mail, pages 30 and 31</p> <ul style="list-style-type: none"> ▪ Section revised to include CAA, 2023 requirements plan <p>Program Operations: Nevada Medicaid/CHIP Program Policies during the Unwinding, pages 31 and 32</p> <ul style="list-style-type: none"> ▪ Section revised to include CAA, 2023 requirements approach <p>COVID-19 Uninsured Group, page 33 and 34</p> <ul style="list-style-type: none"> ▪ Included population volume and termination effective date <p>Transition to Nevada Health Link, pages 34 - 37</p> <ul style="list-style-type: none"> ▪ Added CMS Information and Insurance Oversight Temporary Special Enrollment Period (SEP) FAQs <p>Unwinding Communication and Outreach Campaign, page 37</p> <ul style="list-style-type: none"> ▪ Phase 2 revised <p>Managed Care Organization (MCO) Role, page 40</p> <ul style="list-style-type: none"> ▪ Revised CMS guidance link, updated January 2023 <p>Unwinding Renewal Workload, page 41 and 42</p> <ul style="list-style-type: none"> ▪ Section Revised to reflect latest workload report <p>Tracking Nevada Medicaid/CHIP Coverage Trends During the Unwinding Period and Beyond, page 44</p> <ul style="list-style-type: none"> ▪ Medicaid population revised <p>Medicaid Unwind Dashboard, page 44</p> <ul style="list-style-type: none"> ▪ Dashboard specific publish date added <p>Unwinding and Beyond Federal Monitoring, pages 44 – 46</p> <ul style="list-style-type: none"> ▪ Section revised to include CAA, 2023 requirements
--	---



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, provides 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 on 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 is offering many flexibilities and/or strategies to resume renewals. This section will also address new flexibilities requested for the purposes of E&E.

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 begins 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 ending 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.

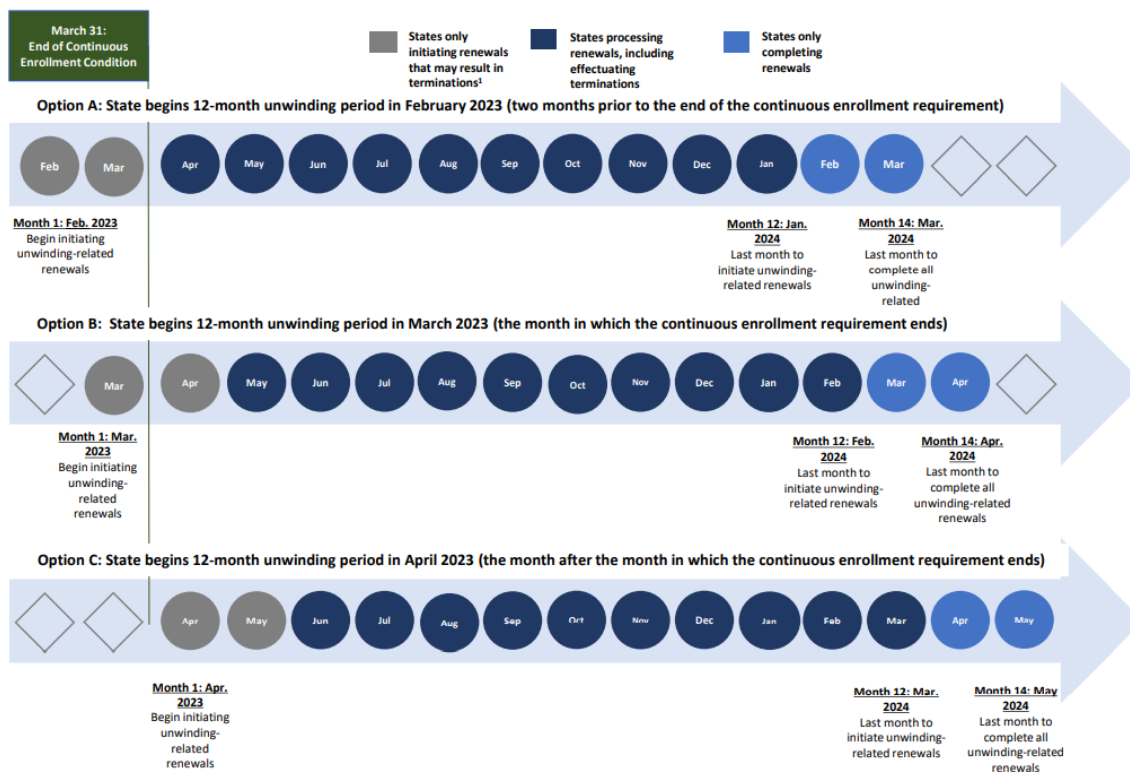
COVID-19 Impacts to Enrollment

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 expires, CMS guidance provides that states will generally have up to 14 months to return to normal eligibility and enrollment operations. This means Nevada has a total of 14 months to initiate and complete renewals for nearly all of Nevada's beneficiaries. Nevada has opted to begin the 12-month unwinding period the month after the CAA, 2023 continuous enrollment condition ends (option C). These recommendations and graph were issued by CMS.



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.



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](#).

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, prior to the PHE. This familiarity is critical as we roll out the communication and outreach campaign discussed 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.

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

The COVID-19 PHE is currently set to expire May 11, 2023. However, the new provision under [CAA, 2023](#) has carved out the continuous enrollment condition effective March 31, 2023. As described above Nevada will begin initiating unwinding related renewals the month after the CAA, 2023 continuous enrollment condition ends. This means that renewals will be initiated April 1, 2023, for individuals with a May 31, 2023, renewal date for June (renewal month) eligibility.

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

- **March 2023** – Around March 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 and marked for auto-completion beginning April 1, 2023.
- **April 2023** – Ex parte will approve the June eligibility renewals for all identified cases and generate the



notice of decision informing the household of their continued eligibility. All remaining renewals will have a paper renewal packet mailed out on April 1, 2023, with a submission due date of May 31, 2023.

- **May 2023** - If the paper renewal packet is not received by May 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: May 31, 2023, is the final day of Nevada Medicaid eligibility for unresponsive beneficiaries. Any renewal packet received by May 31, 2023, is processed, and evaluated for eligibility. A notice of decision is sent to these beneficiaries advising of the eligibility determination.
- **June 2023** - If the beneficiary failed to return the renewal packet and is determined ineligible for Medicaid starting June 1, 2023, they will have 90 days after June 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 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 one modality for any individual who is determined ineligible based on returned mail prior to disenrolling that person.



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 lead to a negative action are paused, in accordance with the continuous enrollment condition. Negative actions can resume when the continuous enrollment condition unwinding period begins 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 PHE, changes that result in a positive change will be processed upon receipt of the change.

- **Example 1:** The continuous enrollment condition expires March 31, 2023, and a beneficiary has a renewal month of April 2023—In January 2023, the beneficiary reports new employment that could potentially lead to losing Nevada Medicaid coverage. The change in circumstance will be processed and any changes in eligibility noted in the case record as no negative actions can be taken until April 1, 2023. Once the end of the continuous enrollment condition ends, DWSS will begin processing changes. If no changes are reported/processed before the beneficiary's annual renewal in April 2023, after the continuous enrollment coverage has ended, a full renewal will be conducted in June 2023 using current information, and eligibility will be re-evaluated allowing the case to be processed and eligibility determined appropriately.
- **Example 2:** The continuous enrollment coverage expires on March 31, 2023, and a beneficiary has a renewal month of June, and the annual renewal is completed in June 2023—In August 2023, 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.



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](https://www.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 rule, 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, 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.

Federal Eligibility-Related Flexibilities & Strategies

CMS is offering 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 program 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 t



allow states to implement modified effective dates, without needing to submit a revised request to CMS. Nevada Medicaid requested and received approval for five out of nine of these 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 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.
- 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.
- 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.
- 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.

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 organization 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 faith 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 to process all renewals aside from the implementation of 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 request only information needed to determine eligibility when eligibility cannot be renewed on an ex parte basis. 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 will be 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 Statutes 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 cost.

SSHIX has been safeguarding health care coverage in Nevada, exhibited during the most recent Open Enrollment Period (OEP) where they experienced record-breaking 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 is also evaluating to incorporate the 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 off Medicaid or CHIP coverage and into a Marketplace qualified health plan (QHP) takes place.

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 is currently rolling out in two phases to prioritize and sequence strategies, tactics, and messages across the state to prepare for the resumption of normal eligibility operations.

- **Phase 1** – This phase is 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 auto-renewed. Phase 2 has begun, Nevada has 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.

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 through Access Nevada.

All Notices of Decision (NOD) are being 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 and is expected to redetermine the full Nevada Medicaid population during the 14-month period after the end of the continuous enrollment condition. 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 have been spread out over the entire calendar year based on the case renewal due date. Renewals where there has been no contact have been dispersed among a 12-month period with a monthly average per the latest 12-month workload as described below of 45,000 renewals out of the 536,000 medical cases. The average of 45,000 renewals per month meets the 1/9 per month threshold requirement. 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 12-month period after the end of the PHE 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 Feb 2023 to Jan 2024

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

Program	23-Feb	23-Mar	23-Apr	23-May	23-Jun	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan
Medicaid/CHIP	44115	43550	46760	47290	48189	56209	19486	19652	22184	25714	26847	20788
MAABD	8732	11245	10941	10467	9503	11366	6776	7170	8928	9863	10749	9113
Total	52847	54795	57701	57757	57692	67575	26262	26822	31122	35577	37596	29901

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. 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 begins 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 14-month allotted time 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/change reasons codes for Medicaid and CHIP eligibility which will be reported to CMS through T-MSIS data. Although this effort is not required until 6 months post PHE, DWSS and DHCFP are planning to implement sooner. DHCFP realized the stop/change reason codes can help with targeted outreach to Nevada Medicaid members by sharing this information with the MCOs and DBA and is implementing as soon as possible for this reason.



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 utmost importance.

Medicaid Unwind Dashboard

An Unwinding Eligibility Data Dashboard will be released publicly on the DHCFP webpage by April 1, 2023. Dashboard metrics will include enrollment by week; call efficiencies and state workload level with total applications; pending applications; account transfers; annual renewals due; and account transfer (Nevada Health Link) throughout the 12-month 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 has revised and updated due date 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.

[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 procedural reasons	Unwinding Data Report, Monthly Metric
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	Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations
	Updated -March 3, 2022	
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)
All State Call Presentation Proposed Rule	March 8, 2022	Upon Conclusion of the COVID-19 Public Health Emergency CMS Unwinding Resources
Unwinding and Returning to Regular Operations after COVID-19 Medicare.gov	April 22, 2022	Implementing Certain Provisions of the Consolidated Appropriates Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199 – P)
DHCFP Website	December 2022	Unwinding and Returning to Regular Operations after COVID-19 Medicaid
DCHFP Website Members		When can I sign up for Medicare?
Access Nevada		DHCFP Flexibilities – Nevada’s Approved COVID-19 Waiver Request
DHCFP Provider Web Portal		Member Outreach Page
DWSS Website		Access Nevada – Get Access to All The Benefits Provided by the State of Nevada
Update My Address Webpage		DHCFP Web Portal
		DWSS Website
		http://dhcfnv.gov/UpdateMyAddress/



References

Nevada's approved flexibility letter from CMS	April 7, 2020	https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/1135Approval.pdf
Nevada's approved Appendix K letters from CMS	April 15, 2020 Updated August 18, 2020	https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/Appendix-K-Approval.pdf https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/2nd%20Approval%20Letter%20Appendix%20K.pdf
Disaster SPA #20-0009	June 18, 2020	https://dhcfnv.gov/uploadedFiles/dhcfpnavgov/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://dhcfnv.gov/uploadedFiles/dhcfpnavgov/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 ARPA eCFR 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](#)