Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

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Frequently Asked Questions

COVID-19 PHE Unwinding for Managed Care Organizations & Dental Benefits Administrator

Background

The Centers for Medicare and Medicaid Services (CMS) has granted state Medicaid programs an "unwind" period of up to 12 months to return to normal eligibility and coverage policies and operations upon the expiration of the federal Public Health Emergency (PHE). This includes initiating eligibility renewals for all enrollees. The U.S. Department of Health, and Human Services (HHS) is committed to providing advance 60-day notice prior to the end of the PHE. Because the notice was not release on August 14, 2022, states can safely assume the PHE will be extended another 90 days, slated for January 11, 2023. Nevada Medicaid continues to move forward with its efforts to plan and prepare for the end of PHE and unwinding activities accordingly. This document is intended to help address questions related to these activities with respect to the Nevada Medicaid managed care organizations and dental benefits administrator.

New*:* States have up to 14 months to complete all outstanding redeterminations (all must be initiated within first 12 months). How much time has Nevada said it will use to complete redeterminations?

Nevada Medicaid will use 14 months to initiate and complete redeterminations.

New: States have the option to begin redeterminations (i.e., checking enrollee eligibility and identifying those no longer eligible) up to 60 days prior to the PHE ending. Or States can wait until the PHE ends to begin these activities. When is the state expected to begin its process?

Nevada Medicaid has elected to start redeterminations the month after the end of PHE, see the below visual. Nevada selected option C:

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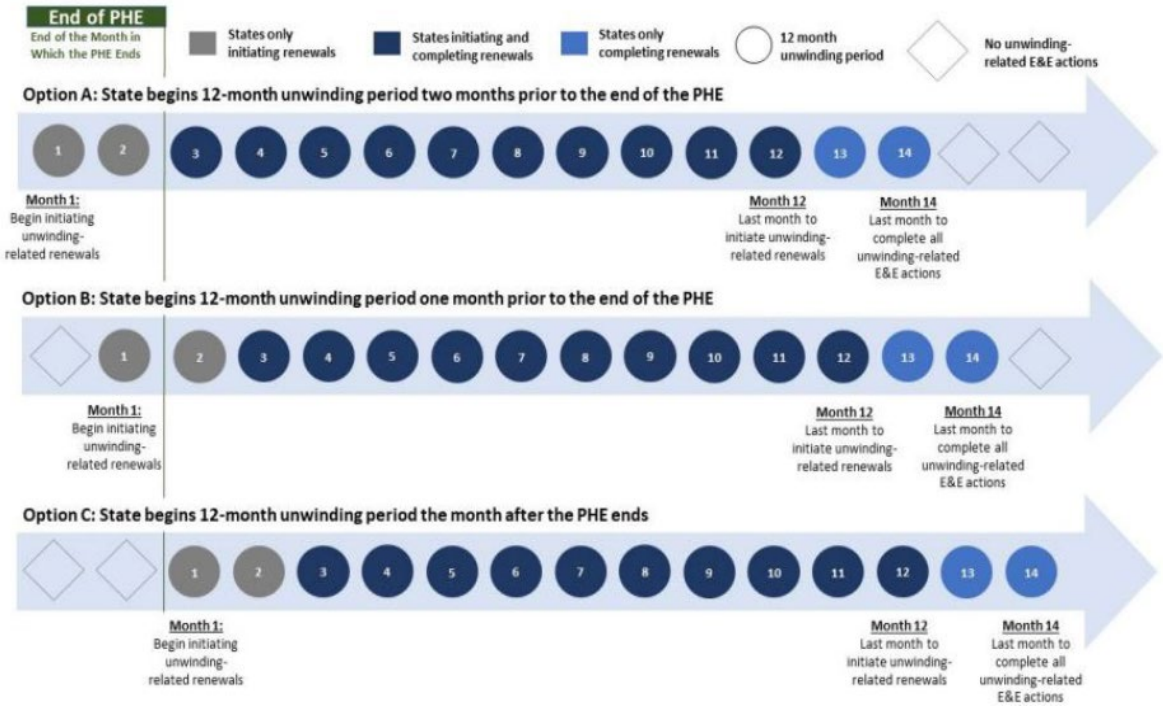

New: States can choose their approach to prioritizing groupings of their total caseload to be redetermined over the timeframe they choose. States are expected to use a risk-based approach by population or time/age of outstanding redeterminations. State can also use a hybrid or state-specific approach. What approach does Nevada intend to use? Which populations or other grouping/factors will be prioritized or deprioritized (e.g., children, dual eligible, etc.)?

The Division of Welfare and Supportive Services (DWSS) will maintain the beneficiaries' current renewal month in their case records and will conduct a full renewal at the next scheduled renewal month following the month of the end of the PHE.

New: Does Nevada Medicaid allow MCO's to text members to engage them in redeterminations? If so, can MCO's text only if the obtain new "opt-in" consent, or can MCOs simply text and provide an opt-out option.

Yes, MCO's and the state's DBA may engage with members via text as long as an "opt-in" consent to text is obtained prior to texting members.

New: Can the Qualified Health Plan (QHP) outreach to members via text with the intent to educate and offer the option for enrollment in a Commercial plan, using either "opt-in" consent or by providing an opt-out option?

Yes, please note that, per CMS, federal regulation only prohibits insurance policies (qualified health plans) that would be sold "in conjunction with" enrollment in the Medicaid managed care plan. Section 438.104 alone does not prohibit a Medicaid managed care plan from providing information about a QHP to potential enrollees who could enroll in such a plan as an alternative to the Medicaid managed care plan due to a loss of Medicaid eligibility or to potential enrollees who may consider the benefits of selecting a Medicaid managed care plan that has a related QHP in the event a future eligibility changes.

New: Does Nevada Medicaid allow MCO's to contact members who recently disenrolled in order to engage them on coverage options? If so, for how long after disenrollment can MCOs contract these members (e.g., for 30, 60, 90 days)?

For purposes of the unwind related to the PHE, we will allow MCOs to contract members up to 90 days after disenrollment in order to engage them on coverage options.

New: Can the QHP proactively make outreach to at risk/disenrolled Medicaid members (as indicated on the 834) educating and offering them the option for enrollment in a Commercial plan?

Yes, please note, per CMS, federal regulation only prohibits insurance policies that would be sold "in conjunction with" enrollment in the Medicaid managed care plan. Section 438.104 alone does not prohibit a Medicaid managed care plan due to a loss of Medicaid eligibility or to potential enrollees who may consider the benefits of selecting a Medicaid managed care plan that has a related QHP in the event of future eligibility changes.

New: If yes to the previous question, which of the listed modalities are approved for outreach: mail (letter), email, outbound calling both landlines & cell phones, SMS text, and in-market flyer (to be shared at/with grassroots events, providers, community groups, etc.)

All modalities listed are permissible in accordance with CMS guidance and any applicable state laws regarding outreach and marketing for private health insurance plans in Nevada. Please see

response above about consent for text messages pursuant to existing state and federal requirements regarding consent for texting members.

New: Can MCO representatives discuss both Medicaid renewal as well as an MCO commercial plan options with consumers, especially if the consumer is indicating that they are being disenrolled from Medicaid because they no longer qualify? And/or can an MCO representative and an QHP representative share a table or booth to act as a carrier resource to reach impacted consumers with help on both Medicaid renewal and commercial plan options?

Yes, as long as it complies with CMS guidance below:

Q1. Regulations at 42 CFR 438.104(b) (1) (IV) prohibit Medicaid managed care plans from seeking to influence enrollment in their plan in conjunction with the sale or offering of "private insurance." Does this prohibit a carrier that offers both a qualified health plan (QHP) and a Medicaid managed care plan from marketing both products?

A1. The regulation only prohibits insurance policies that would be sold "in conjunction with" enrollment in the Medicaid managed care plan. Section 438.104 alone does not prohibit a Medicaid managed care plan from providing information about a Qualified Health Plans (QHP) to potential enrollees who could enroll in such a plan as an alternative to the Medicaid managed care plan due to a loss of Medicaid eligibility or to potential enrollees who may consider the benefits of selecting a Medicaid managed care plan that has a related QHP in the event of future eligibility changes. However, Medicaid managed care plans should consult their contracts and the State Medicaid agency to ascertain if other provisions exist that may prohibit or limit such activity.

Section 438.104(b)(1)(iv) implements a provision in section 1932(d)(2)(C) of the Social Security Act, titled "Prohibition of Tie-Ins." In promulgating regulations implementing this provision, CMS clarified that we interpreted it to preclude tying enrollment in the Medicaid managed care plan with purchasing (or the provision of) other types of private insurance. We do not intend the statutory prohibition of tie-ins to apply to a discussion of a possible alternative to the Medicaid managed care plan, which a QHP could be if the consumer is determined to be not Medicaid eligible or loses Medicaid eligibility.

New: Is Nevada Medicaid using a federal waiver flexibility to accept MCO member contact information updates to the record on file directly

confirming the information with the enrollees?

Yes, CMS has approved this flexibility for Nevada and will go through the unwinding period (through the 14 months of renewals).

How will the Division of Welfare & Supportive Services (DWSS) & Division of Health Care Financing (DHCFP) respond to end of the PHE?

CMS will notify Nevada Medicaid (DHCFP) when HHS announces the end of the PHE and any information on when to begin the redeterminations and will provide a timeline with parameters.

- Medicaid agencies nationwide will gradually return to normal operations through a strategic unwind of PHE provisions.
- States have had the option to keep most clients continuously enrolled in Medicaid since March 2020 to receive extra federal Medicaid dollars.
- Nevada Medicaid enrollment has grown by an estimated 900,000 individuals since the pandemic began in March 2020.
- DWSS eligibility caseworkers expect to process an unprecedented number of redeterminations in the 12 months after the PHE ends.

- DWSS & DHCFP have agreed that redeterminations will be initiated the month after
  the end of PHE.

As the end of the PHE approaches, DWSS in collaboration with DHCFP has been working on a robust outreach and communication strategy to ensure critical messaging reaches impacted individuals.

What can MCOs/DBA do now to prepare?

- Use all the recommended messaging provided on the Member Outreach web page: MemberOutreach (nv.gov)
- Create a plan to regularly adjust and recycle messages for members and providers
- Reach out to community partners and share messaging and explain importance of ensuring members do not experience a gap in coverage.
- Direct members to https://dhcfp.nv.gov/UpdateMyAddress/

How will DWSS & DHCFP return to normal operations?

- Phasing out extra federal Medicaid dollars that states have been receiving since

March 2020.
- Ending some policies that allowed continuous coverage for current enrollees.
- Determining eligibility for current Nevada Medicaid clients based on normal renewal cycles.

How will DWSS & DHCFP handle coverage transitions?

Seamless transition of coverage is critical to our health equity efforts. Some clients will no longer qualify for Nevada Medicaid but may be eligible for other health insurance coverage:

Qualified Health Plans (QHP) through Nevada Health Link also known as Silver State Health Insurance Exchange: Silver State Health Insurance Exchange - Nevada Health Link - Official Website

Where do the MCOs/DBA find the DHCFP member outreach campaign for updating contact information?

Go to: MemberOutreach (nv.gov). Further details on the public communication plan can be found within the 'COVID-19 Unwind Public Communication Plan' emailed to the MCOs and DBA on June 16, 2022.

Additionally, DHCFP is in the process of creating an operational plan which outlines all activities associated with the federal PHE unwind. The operational plan will be posted on DHCFP web page, the MCOs & DBA will be notified by DHCFP when this plan has been posted.

The MCOs and DBA can conduct outreach to update member contact information now

- DHCFP-approved messaging and guidance will be used for outreach to members.
- The MCOs and DBA should direct members to the best method based on their individual needs.

How should plans encourage clients to update their current contact information?

Members may request to update their address through https://dhcfp.nv.gov./UpdateMyAddress/.

The MCOs & DBA may also follow the current process for encouraging clients to update their profiles through Access Nevada: Access Nevada (nv.gov) or by calling 1-800-992-0900.

The MCO's & DBA may also send an email to DWSS at: Welfare@dwss.nv.gov to report an address change for their members.

DHCFP has requested the MCOs & DBA to track and report address changes from January 1, 2022 through the end of the unwinding activities (tentatively December 2023).

Can plans outreach to members who lost coverage?

Current outreach is focused on updating contact information. Outreach for renewals and coverage loss will begin upon the end of PHE announcement (60 days in advanced).

General marketing rules apply 90 days after member's MCO enrollment ends. Outreach to terminated members is permitted through standard messaging DHCFP has provided and will continue to provide. MCO's and DBA may submit outreach proposals to

ManagedCare@dhcfp.nv.gov for an expedited review for materials outside of DHCFP standard messaging. Submissions will follow an expedited review process.

Review and approval of MCO & DBA PHE renewal outreach materials can be submitted now.

Standard messaging can be found on the DHCFP web page: MemberOutreach (nv.gov)

Will DWSS provide the MCOs and DBA a list of clients who are due for a renewal for the purposes of targeted outreach?

No, not at this time. DWSS sends out redetermination (renewals) 60 days in advanced of the renewal month. The 834 currently contains an eligibility date (12-month eligibility: February 1, 2022 – January 31, 2023). The MCOs and DBA have been given directions to query the 834.

For example: renewals for February 2023 will be sent out December 1, 2022 (60 days in advance). Outreach for clients with renewals in February 2023 can being December 1, 2022.

DHCFP is taking the following steps to support outreach:

- The 834 file is being modified to include termination reason codes, the client's email address, and potentially the recertification date. This effort is scheduled to be implemented tentatively at the end of 2022 (December 2022).
- The operational plan provides a 12-month forecast of renewals. An update of the renewal forecast will be shared during the COVID-19 Unwind Status Meeting.
- The MCOs and DBA will be able to conduct Renewal Outreach according to

DHCFP guidelines. At a high-level, outreach should consist of the following:

- If a client needs help in renewing, the MCO should provide the client with access to the most appropriate resource.
- If a client confirms they are ineligible, an MCO may provide additional information to the client to support an informed choice and to promote continuity of care.

Additional guidance will be communicated as we approach this activity.

What are the timelines for Renewal outreach?

The MCOs may conduct outreach to terminated clients for up to 90 days after they have lost eligibility.

Can plans share Qualified Health Plans (QHP) information with interested members?

Yes, MCOs may conduct outreach to individuals who were enrolled with their health plan before or after a loss of Medicaid coverage to assist with the renewal process and discuss their QHP product offerings, if available, with individuals who have lost

their Nevada Medicaid eligibility.

Federal regulations do not prohibit a MCO that offers a QHP from providing information on that QHP to members who could potentially enroll in a QHP due to a loss of eligibility, or to potential enrollees who may consider the benefits of selecting a MCO that has a related QHP in the event of future eligibility changes for health insurance (42 CFR 438.104; See 81 FR 27502 for more information).

Therefore, MCOs and DBA may reach out to individuals before they lose Medicaid coverage to allow them to apply for Exchange (QHP) coverage in advance and thereby avoid a gap in coverage.

MCOs and DBA that provide information about a QHP (whether before or after the loss of Medicaid eligibility) – including providing information on enrollment in the QHP – is not considered marketing when it is about the QHP offered by that plan.

If states permit the plans to provide the QHP information, it is not limited to terminated enrollees. MCOs and DBA in Nevada may contact members prior to a loss of eligibility to promote continued access to health care as a result of the PHE unwind.

Refer individuals who are interested in enrolling in a QHP to Silver State Health Insurance Exchange - Nevada Health Link - Official Website for assistance.

Resources

Online:

- **DHCFP:** MemberOutreach (nv.gov)
- **Update My Address:** https://dhcfp.nv.gov/UpdateMyAddress/
- **DWSS (Access Nevada):** Access Nevada (nv.gov)
- **SSHIX:** Silver State Health Insurance Exchange - Nevada Health Link - Official Website

Email:

- **DHCFP** - ManagedCare@dhcfp.nv.gov
- **DWSS -** Welfare@dwss.nv.gov