



DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA MEDICAID

COVID-19 PUBLIC HEALTH EMERGENCY

OPERATIONAL UNWINDING PLAN

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## Background and Overview

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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 Financing 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 beneficiaries 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 beneficiaries.

The U.S. Department of Health and Human Services (HHS) has extended the PHE through October 13, 2022. HHS has remained committed to providing states at least a 60-day notice prior to the official end date. The deadline for HHS to notify states the national PHE would be ending on October 13, 2022, was August 14, 2022. In the absence of such notice, states can assume the PHE will be extended on October 13, 2022, for an additional 90 days, until January 11, 2023. 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 beneficiaries, 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 continuity of coverage for Nevada beneficiaries throughout the unwinding of the FFCRA continuous coverage requirement. The resumption of normal eligibility operations is described in greater detail later in the plan..

The following sections are intended to provide a comprehensive view of Nevada Medicaid's plan to unwind the flexibilities implemented during the PHE. The Nevada Medicaid Global Unwinding Approach outlines the guidelines set forth by CMS. Nevada intends to adhere to CMS requirements and adopt strategies to promote 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 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 conditions end and outlines the approach and strategies to complete renewals. Furthermore, CMS is offering many flexibilities and strategies states may pursue as they resume renewals, and this section will also address new flexibilities requested by Nevada.

## Nevada Medicaid Global Unwinding Approach

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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 three State Health Official (SHO) Letters specifically on unwinding federal flexibilities authorized during the PHE—[SHO# 20-004](#), [SHO# 21-002](#), and [SHO# 22-001](#) – and provided tool kits, presentation slide decks, and other materials. CMS hosts numerous all-state webinars and make available 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 B of SHO# 20-004 describes the specific circumstances in which the expiration of an 1135 flexibility requires advanced notice to affected beneficiaries. Nevada Medicaid plans to notify beneficiaries of flexibilities that are expiring. This is particularly relevant for the COVID-19 Uninsured Group; page 25 provides details on how this will be handled. The flexibilities that are expiring mainly impact Medicaid providers. The state has already notified providers of these changes through web announcements and other provider communications.

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 beneficiaries, MCOs, providers, and stakeholders all understand the applicable Nevada Medicaid policies and procedures. Nevada Medicaid will utilize 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 processes.

## Part I: Unwinding Programmatic Flexibilities

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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 take action 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 expire at the end of the PHE.

[Appendix A: DHCFP Flexibilities Requested due to COVID-10 PHE](#) lists 30 flexibilities DHCFP obtained federal 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. Flexibility



Item #10 related to Provider Enrollment terminated September 2022. DHCFP will move forward with extending Flexibility Items #16: Public Notice & Tribal Consultations via another 1135 flexibility waiver that will be 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. 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 plans to maintain SPA submission requirements, public notice requirements, and tribal consultation 1135 waiver flexibilities through the ARPA COVID-19 SPA submission process. The public hearing was held on June 28, 2022, and DHCFP submitted SPA #22-0013 to CMS on June 29, 2022.

- **Submission Deadlines:** 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:** 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:** Section 1135 (b)(5) of the Act allows modification of the required Tribal consultation timelines specified in the Medicaid state plan under 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 changing federal 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.

The public hearing was held on May 31, 2022, and DHCFP submitted SPA #22-0012 to CMS on June 1, 2022 for review and approval.

### **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 submitted an ARPA COVID-19 SPA attesting 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 beneficiaries 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. 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.

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 beneficiaries.

### Part II: Resumption of Normal Eligibility Operations

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Under the continuous coverage requirement in the FFCRA, states are required to maintain enrollment of nearly all Nevada enrollees through the end of the month in which the PHE ends. When the continuous coverage requirements expire, states will need to conduct a full renewal for all beneficiaries 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 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 beneficiaries 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 PHE, 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 beneficiaries to ensure those who can remain eligible. 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 PHE 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 [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 beneficiary 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. CMS also clarified that states may use information gathered during a renewal initiated up to two months prior to the end of the PHE to take final action in the month after the month in which the PHE ends. In summary, the PHE unwinding period would be 12-months, with an additional two months, totaling 14 months, to complete all outstanding eligibility and enrollment actions from the PHE. The “PHE Unwinding Period,” is defined throughout this document as 12 months.

The following section of the PHE 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, beneficiary communications and outreach, system readiness, and data reporting. This PHE 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**

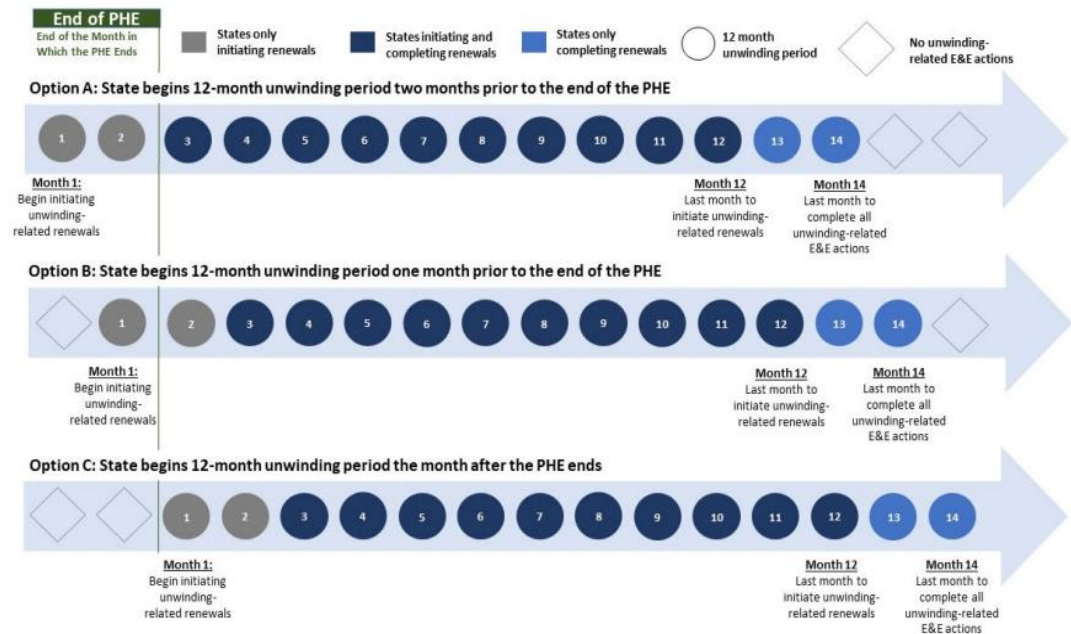
Two primary factors influenced Nevada Medicaid caseloads during the PHE: the continuous coverage requirement and a volatile labor market. The federal FFCRA requirement implemented a continuous coverage requirement, under which Nevada Medicaid beneficiaries may be disenrolled only under very limited circumstances. 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 coverage requirements and beneficiary 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 PHE Unwinding Period. A key goal is to keep the PHE unwinding process **as simple as possible**. When the continuous coverage requirement 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 PHE ends (option C), these recommendations and graph were issued by CMS.

Furthermore, Nevada is working on enhancing the automation of ex-parte renewals scheduled to be implemented the beginning of the fourth quarter of 2022. The automation of ex-parte renewals will ensure eligible individuals retain coverage and minimize 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 will conduct a full renewal at the next scheduled renewal month following the end of the PHE.

This approach achieves the following:

- 1) Least disruptive to workloads on both an initial and ongoing basis
- 2) Aligns, to the greatest extent possible, on 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 coverage requirements.

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

The COVID-19 PHE is currently tentatively set to expire October 13, 2022. Assuming the end of PHE remains in October, Nevada will begin initiating unwinding related renewals the month after PHE ends, this means that renewals will be initiated November 1, 2022, for individuals with a December 31, 2022 renewal date for January eligibility.

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

- **November 2022** - Ex-parte approval notices and renewal packets are mailed out beginning November 1<sup>st</sup>. Note: Ex-parte is conducted 15 days prior to the renewal packets being sent out. Unsuccessful ex-parte renewals will go through the manual renewal process.
- **December 2022** - Renewal packets mailed November 1<sup>st</sup>, including unsuccessful ex-parte, are due



December 31<sup>st</sup>. A Notice of Decision (NOD) is sent 10 days prior to adverse action if the annual renewal remains incomplete or the beneficiary is no longer eligible for Nevada Medicaid. January 31, 2023 is the final day of Nevada Medicaid eligibility for discontinued beneficiaries.

- **January 2023** - If the recipient failed to return the renewal packet and is determined ineligible, they will have 90 days to submit the renewal packet to be re-evaluated.

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

### 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 and the 12-month PHE Unwinding Period that could lead to a negative action are paused, in accordance with the continuous coverage requirement. Negative actions can resume when the beneficiary's annual renewal is initiated at the end of the PHE, as determined by their renewal date on their Nevada Medicaid case record. Once a beneficiary's annual renewal is completed post-PHE (the 12- Month PHE Unwinding Period plus two additional months), DWSS will process reported changes 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 PHE expires in October 2022, and a beneficiary has a renewal month of February 2023—In November 2022, the beneficiary reports new employment that could potentially lead to losing Nevada Medicaid coverage. Although the PHE concluded in October 2022, the change in circumstance will not be processed until the beneficiary's annual renewal in February 2023, when a full renewal using current information can be completed.
- **Example 2:** The PHE expires in October 2022, and a beneficiary has a renewal month of March, and the annual renewal is completed in March 2023—In May 2023, the beneficiary reports new employment. DWSS





would process the change in circumstance using existing case processing rules because a full post-PHE 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. Social 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.

### 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. Under [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 April 22, 2022 CMS issued a [proposed rule](#) to reduce barriers to coverage that would establish five new exceptional conditions special enrollment periods (SEPs) under Medicare Parts A and B. These include an SEP that would allow individuals to enroll after termination of Medicaid coverage following the end of the federal public health emergency (PHE), without being subject to a late enrollment penalty. The proposed rule would establish a Medicare SEP that would allow the eligible individual to enroll in coverage that would begin the following month. This rule, if finalized, would become effective January 1, 2023. This SEP would align with the end of the PHE and would be effective as of the date the individual receives notice of the termination of their Medicaid enrollment. DHCFP administers the Medicare enrollment (buy-in) program and will monitor the status of the proposed rule. DHCFP will take the appropriate action to 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 PHE 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 nearly 900,000 members, an approximate 35% increase in total enrollment since March 2020, largely due to the continuous coverage 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 PHE ends and the continuous coverage requirement expires 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. Currently, the returned mail rate is approximately 25% or higher.

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 PHE 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.

The 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

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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.
- Assume \$0 income when information is not available through data sources at renewal, and there is a \$0 income attestation in the case file verified within the 12 months.
- 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 flexibility requests to CMS. These requests will assist with managing the significant volume of disenrollment related actions that were paused due to the continuous coverage requirements and will help mitigate coverage losses to the greatest extent possible. Below are three additional flexibilities



Nevada 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.” Under this waiver authority, CMS lays out five potential targeted enrollment strategies that can be used to facilitate renewals that lead to fewer disenrollments during the 12-month unwinding period. DWSS requested and received approval for two out of five of these targeted enrollment strategies, which temporarily permit the following:

- 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.

### Evergreen Disaster Relief

SPA #22-0018 was submitted to CMS on July 22, 2022 for review and approval to implement 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. 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 Disenrollment 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.

If approved under this SPA, Nevada will continue with the flexibility of waiving premiums for 365 days post current 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.

Key strategies include:

- Requiring DWSS to request updated contact information at all points of contact
- Creating a dedicated unit to process contact information changes
- 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
- 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)



## Program Operations: Nevada Medicaid/CHIP Program Policies during PHE Unwind

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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 PHE Unwinding Period. Notably, 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.

### Modified Adjusted Gross Income (MAGI)

The 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. Beneficiaries 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 beneficiary's next post-PHE 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-Modified Adjusted Gross Income (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 beneficiary's next post-PHE 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.

### Transition to [Nevada Health Link](#)

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[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 costs.



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, which offers 126 plan options across seven major insurance carriers.

SSHIX is collaborating with its vendor GetInsured (GI) to ensure 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)

## PHE Unwind Communication and Outreach Campaign

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The end of the PHE and the Nevada Medicaid continuous coverage requirements necessitate a coordinated, phased communication campaign. This campaign will reach beneficiaries with messages across multiple channels using trusted community partners. As Nevada plans to resume normal Nevada Medicaid eligibility operations, beneficiaries will need to know what to expect and what they need to do to keep their health coverage. Most beneficiaries 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, is 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 beneficiaries to provide DWSS with any updated contact information such as: name, address, phone number, and email so DWSS can contact beneficiaries with important information about keeping their Nevada Medicaid. This phase is underway.
- **Phase 2** – This phase is designed to encourage beneficiaries to continue to update contact information with DWSS, to report any change in circumstances, as well as check for upcoming renewal packets for beneficiaries whose cases have not auto-renewed. Phase 2 will begin 60 days prior to the end of the PHE. A Phase 2 Communication and Messages for outreach toolkit will be released in the future.

### DHCFP PHE Unwind 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 coverage requirement. The tool kit can be accessed [here](#).

Trusted community partner messengers and Medicaid beneficiaries can download the updated Nevada continuous coverage resources (including language translations) from the website to educate beneficiaries 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](#). Furthermore, 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 PHE Unwinding Communications & Messages

All communications to households are being 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 beneficiaries about maintaining Nevada Medicaid coverage after the PHE ends. Trusted community partner messengers consist 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

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MCOs are a trusted source that will communicate important outreach messages to beneficiaries. To underscore the importance of MCOs during the PHE Unwind, CMS released guidance in [December 2021](#), and updated in [March 2022](#) ("[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 PHE. DHCFP has been working with the MCOs on several strategic approaches. Key strategies include:

1. Obtaining and updating beneficiary contact information and ensuring it is forwarded and/or captured by DWSS
2. Conducting outreach and providing support to individuals enrolled in Nevada Medicaid during their renewal period
3. Assisting 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 of the PHE. The Health Navigators will focus on proactively engaging beneficiaries 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 beneficiaries with Health Navigators for assistance with completing annual renewal packets and responding to DWSS requests to maintain coverage.

## DWSS Readiness

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This section outlines DWSS' readiness for initiating and completing renewals when the continuous coverage requirement 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).

### PHE Renewals Workload

DWSS plays a significant role in the PHE 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 PHE ends. DWSS continued conducting renewals while the continuous coverage requirement 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 of 53,000 renewals out of the 636,000 medical cases. The average of 53,000 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 PHE continuous coverage methodology, the renewal count has remained normal over the last two years with heavier renewals numbers in the fall/winter month (Sep – Feb). 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 11-month view of renewals from September 2022 to July 2023\**

Program	22-Sep	22-Oct	22-Nov	22-Dec	23-Jan	23-Feb	23-Mar	23-Apr	23-May	23-Jun	23-Jul
<b>Medicaid/CHIP</b>	45708	44806	52598	61081	54678	60363	27520	29350	24880	20143	7581
<b>MAABD</b>	10059	10479	13804	16387	11947	14948	10016	9926	7870	7380	3330
<b>Total</b>	55767	55285	66402	77468	66625	75311	37536	39276	32750	27523	10911

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

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### Policy Guidance

During the PHE, DWSS issued guidance and instructions on maintaining continuous coverage for beneficiaries. DWSS will issue written policy guidance updates as needed to assist with completing renewals after the PHE ends. The updated written policy guidance related to the unwinding of the PHE 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 PHE ends 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 beneficiaries 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. 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 working on implementing as soon as possible for this reason.

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

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

### Medicaid Unwind Dashboard

An Unwinding Eligibility Data Dashboard will be released publicly on the DHCFP webpage the month of the end of PHE. 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 (NevadaHealthLink) throughout the 12-month PHE Unwinding Period. The Dashboard will be updated monthly.



## PHE Unwind 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).

For states that are out of compliance, CMS may require the submission of a corrective action plan that details strategies and timelines 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](mailto:dhcfp@dhcfp.nv.gov) with the subject: COVID19 Operational Unwinding Plan.

# Appendices

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- Appendix A: DHCFP Flexibilities Requested due to COVID-10 PHE
- Appendix B: Nevada Renewal Periods





## Resources & References

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### Resources

SHO 20-004	December 22, 2020	<a href="#">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</a>
All State Call Presentation	June 16, 2020	<a href="#">Additional information on federal requirements for retaining Medicaid state plan flexibilities</a>
<a href="#">CIB</a>	December 4, 2020	<a href="#">Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements</a>
All State Call Presentation	January 7, 2021	<a href="#">Overview of December 2020 State Health Official Letter</a>
All State Call Presentation	January 19, 2021	<a href="#">Overview of eligibility and enrollment provisions in December 2020 State Health Official Letter</a>
<a href="#">Presentation</a>	July 29, 2021	<a href="#">Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 1</a>
<a href="#">Presentation</a>	August 3, 2021	<a href="#">Ensuring Continuity of Coverage and Preventing Inappropriate Terminations – Part 2</a>
<a href="#">SHO 21-002</a>	August 13, 2021	<a href="#">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</a>



All State Call Presentation	August 19, 2021	<a href="#">Overview of August 2021 State Health Official Letter</a>
<a href="#">Issue Brief</a>	November 24, 2021	<a href="#">Connecting Kids to Coverage: State Outreach, Enrollment and Retention Strategies issue brief</a>
<a href="#">Issue Brief</a>	November 24, 2021	<a href="#">Strategies States and U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as they Return to Normal Operations</a>
All State Call Presentation	November 30, 2021	<a href="#">Strategies for retaining eligible individuals and engaging managed care plans</a>
<a href="#">Presentation</a>	December 8, 2021 Updated -March 3, 2022	<a href="#">Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations</a>
<a href="#">All State Call Presentation</a>	February 15, 2022	<a href="#">Sunsetting Medicaid and CHIP disaster relief SPAs and section 1135 waivers and options for disaster relief SPA provisions</a>
<a href="#">All State Call Presentation</a>	February 22, 2022	CMS Office of Communications consumer research on preventing churn during unwinding
<a href="#">SHO 22-001</a>	March 3, 2022	<a href="#">Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and</a>



<a href="#">All State Call Presentation Proposed Rule</a>	March 8, 2022	<a href="#">Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency CMS Unwinding Resources</a>
<a href="#">Unwinding and Returning to Regular Operations after COVID-19 Medicare.gov</a>	April 22, 2022	<a href="#">Implementing Certain Provisions of the Consolidated Appropriates Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199 – P) Unwinding and Returning to Regular Operations after COVID-19   Medicaid</a>
<a href="#">Centers for Medicare &amp; Medicaid Services (CMS)</a>	December 2022	<a href="#">When can I sign up for Medicare?</a>
<a href="#">DHCFP Website</a>		<a href="#">CMS.gov</a>
<a href="#">DCHFP Website Members</a>		<a href="#">DHCFP Flexibilities – Nevada’s Approved COVID-19 Waiver Request</a>
<a href="#">Access Nevada</a>		<a href="#">Member Outreach Page</a>
<a href="#">DHCFP Provider Web Portal</a>		<a href="#">Access Nevada – Get Access to All The Benefits Provided by the State of Nevada</a>
		<a href="#">DHCFP Web Portal</a>





[DWSS Website](#)

[Update My Address Webpage](#)

[NevadaHealthLink](#)

[DWSS Website](#)

<http://dhcfp.nv.gov/UpdateMyAddress/>

[Silver State Health Insurance Exchange](#)

### References

Nevada's approved flexibility letter from CMS	April 7, 2020	<a href="https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/1135Approval.pdf">https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/1135Approval.pdf</a>
Nevada's approved Appendix K letters from CMS	April 15, 2020 Updated August 18, 2020	<a href="https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/Appendix-K-Approval.pdf">https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/Appendix-K-Approval.pdf</a> <a href="https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/2nd%20Approval%20Letter%20Appendix%20K.pdf">https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/2nd%20Approval%20Letter%20Appendix%20K.pdf</a>
Disaster SPA #20-0009	June 18, 2020	<a href="https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/NV%20SPA%2020-0009%20Approval%20Package%20(ADA)%2006-23-20.pdf">https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/NV%20SPA%2020-0009%20Approval%20Package%20(ADA)%2006-23-20.pdf</a>
Disaster SPA #21-0003	March 25, 2021	<a href="https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/NV21-0003ApprovalPackagesigned03252021.pdf">https://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/COVID-19/NV21-0003ApprovalPackagesigned03252021.pdf</a>
COVID-19 FAQ for State Medicaid and CHIP	April 2020	<a href="#">COVID-19 FAQs for State Medicaid and CHIP Agencies</a>



## Agencies

Kaiser Family Foundation Report	May 10, 2022	<a href="#">Unwinding the PHE: What We Can Learn From Pre-Pandemic Enrollment Patterns</a>
Urban Institute	September 2021	<a href="#">What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?</a>
Nevada Health Link	July 28, 2022	HIX PR Inflation Reduction Act Statement FINAL 7-28-22
SSHIX SBM Change Request	September 2021	The GetInsured State-Base Marketplace (SBM) Platform
Regulations Sites		<a href="#">FFCRA</a> <a href="#">ARPA</a> <a href="#">eCFR</a> <a href="#">Social Security</a>
Nevada Health Response		<a href="#">Governor Directives and Declarations</a>
DHCFP Medicaid Operations Manual		<a href="#">Medicaid Operations Manual</a>
Guidance for the end of the declaration of emergency	May 20, 2022	<a href="#">End of the COVID-19 Declaration of Emergency</a>



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 \(CMS-4199-P\)](#)