



National Indian Health Board NATIONAL TRIBAL COVID-19 RESPONSE

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Section 1135 Medicaid Waiver Authority – Nevada

Background

When the President of the United States declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the HHS Secretary is authorized to use Section 1135 of the Social Security Act to modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements in order to allow states to respond to the emergency.

On April 7, 2020, the Centers for Medicare & Medicaid Services (CMS) approved Nevada's Section 1135 waiver, accessible [here](#).

On December 18, 2020, CMS approved Nevada's 2nd 1135 waiver, accessible [here](#).

This one-pager is meant to be a general guide and is not an exhaustive description of the waiver.

What does Nevada's Section 1135 waiver look like?

The waiver makes several changes to Nevada's Medicaid program, as outlined below:

Provider Enrollment

CMS authorized Nevada to expedite the enrollment of out of state providers who are not currently enrolled in the state's Medicaid program. Nevada may continue to use existing procedures to enroll out of state providers who are already in the state's Medicaid program (with one small exception, CMS is waiving the limit on claims within a 180 day period).

CMS has also authorized providers not currently enrolled in Medicare or another state's Medicaid agency to temporarily enroll in Nevada's programs. To make this possible, Nevada will be allowed to waive application fee requirements, criminal background checks, site visits, and state licensure requirements. However, the program provider must maintain an out of state license. To these temporarily authorized providers, Nevada must cease payment within six months of the emergency declaration being lifted, unless the providers submit an application for full participation in the program and are approved.

Pre-Admission Screening and Annual Resident Review

Level 1 and 2 assessments can be waived for 30 days and all new admissions may be treated like exempt hospital discharges. While CMS is not setting a time frame for the completion of Resident Reviews, reviews should be



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completed on new admissions having a mental illness or intellectual disability diagnosis as soon as resources are available.

Pre-Approval Requirements

Nevada is also authorized to temporarily waive or modify pre-approval requirements for Medicaid procedures through its fee for service program.

Allowing services in alternative settings

Pursuant to the waiver, Nevada may allow services to be provided in unlicensed settings, such as temporary shelters, when a provider's facility is not available. The state has to make a reasonable assessment that the facility meets minimum standards to ensure the health, safety, and comfort of beneficiaries and staff. The placing facility is responsible for determining reimbursements for the temporary setting.

State fair hearing requests and appeal deadlines

Nevada is approved to modify the timeline under which managed care enrollees can request an appeal of a denial of services. Enrollees may request a state fair hearing immediately, bypassing the requirement to exhaust all appeals with their managed care organization. Further, Nevada is authorized to waive the 120 day deadline for enrollees to file an appeal with the state, provided the 120 day deadline would have occurred during the period of the public health emergency. Managed care recipients in that situation will receive an additional 120 days to file their appeal for a state fair hearing.

Nevada also has the flexibility to allow recipients to have "more than 90 days" to request a state fair hearing for eligibility or fee for service issues.

Modification of 42 C.F.R. §438.420(a)(i) timeframe to continue or reinstate benefits

Nevada is approved to modify of the timeframe under 42 C.F.R. §438.420(a)(i) to allow the Medicaid managed care plan to continue benefits if requested within the current 10-day time frame or reinstate benefits for the enrollee when the individual requests continuation of benefits between 11 and 30 days if the managed care plan has not yet made a decision on the appeal and the State fair hearing is pending. The managed care plan will not seek reimbursement or payment for the additional days of services furnished during this period (aside from otherwise applicable cost sharing if any) from the enrollee.

Modification of 42 C.F.R. §431.231(a) timeframe for reinstatement of benefits related to fair hearing

Nevada is approved to extend this timeframe so that it may reinstate services and benefits for beneficiaries who request a fair hearing more than 10 days after the date of action, but not to exceed the time permitted (under either the state plan or under an approved section 1135 waiver) for beneficiaries to request a fair hearing. The state should reinstate the individual's services and benefits as quickly as practicable.



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SPA Flexibilities: Tribal Consultation

Nevada has also been approved to modify the Tribal consultation period associated with any emergency SPA that they file to address COVID-19. This applies only to emergency provisions that will sunset at the end of the emergency. No guidance is given as to how much this period may be shortened.

How does this affect Tribes?

If a state seeks a Section 1135 waiver, Tribes are impacted by its provisions. Nevada has 19 federally recognized Tribes.



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Medicaid Disaster State Plan Amendment – Nevada

Background

The Medicaid State Plan is the foundational document for a state's Medicaid program; it sets the rules for eligibility, benefits, and payments. Before a state can participate in the Medicaid program, it must file a state plan with the Centers for Medicare & Medicaid Services (CMS). There are certain requirements that a state plan must adhere to and if a state wishes to deviate from these statutory requirements, they must seek a waiver (such as a Section 1115 or Section 1915 waiver) of the usual Medicaid rules. When a state wants to amend their State Plan, they have to file what is called a "State Plan Amendment" (SPA).

On June 18, 2020, Nevada was approved for an Emergency State Plan Amendment in order to respond to COVID-19. You can find it [here](#).

All approvals are for the duration of the public health emergency unless otherwise stated.

State Residency

Nevada is amending its State Plan in order to consider those who have evacuated from the state or left for reasons related to the COVID-19 emergency and who are intending to return to continue being residents for purposes of receiving Medicaid.

COVID-19 Testing

Nevada is amending their State Plan in order to cover testing for the optional testing group.

Billing

Nevada is amending their State Plan in order to allow for 100 percent Medicaid reimbursement in accordance with Medicare reimbursement for COVID-19 laboratory testing procedure codes.

Questions?

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