Jennifer Krupp, MPH, MBA, PHP, Administrator
Division of Consumer Health Services

Stacie Weeks, JD, MPH, Director
Nevada Health Authority

Workshop Wednesday Q&A

July 29, 2026

Q: Can you send the list in the DMI list/book of business summary?
A: Nevada Health Link no longer has the ability to provide brokers with a report of consumers who have open Data Matching Inquiries (DMIs). Brokers are responsible for monitoring and tracking DMIs for their own clients using the Broker Portal.

Q: Can we still filter our client list to only see those with open DMIs?
A: Yes. In the Broker Portal, navigate to Active Individuals, select See All, then choose Applicant Verifications. From there, you can filter clients by DMI status, including 15-day, 30-day, 60-day, and 90-day notices, as well as Pending, Past Due, and Unresolved.

Q: Does Nevada Health Link notify brokers when clients have a Data Matching Inquiry (DMI)?
A: Brokers are responsible for monitoring their clients' DMIs. The Applicant Verifications filter in the Active Individuals section of the Broker Portal can be used to identify consumers with open DMIs.

Q: Can you clarify the rule on commissions for BBSP? Are carriers required to provide competitive rates?
A: Questions regarding commission rates or whether they are considered competitive should be directed to the individual carrier or the Nevada Division of Insurance.

Q: Was NVHA's directive simply "You must pay commissions," or were additional requirements communicated to carriers?
A: The Nevada Health Authority, through Nevada Health Link, is requiring that all QHP issuers include commission in their QHP products to be certified for sale on the Exchange. This directive was included in the 2027 Letter to Issuers (Plan Year 2027 Plan Certification Letter to Issuers) in Chapter 2, Section 11 on pages 19 and 20.

Q: Will you send the PowerPoint so we can review what we missed?
A: The presentation will be available on the Nevada Health Link website under "Information for Nevada's Broker & Navigator Partners." https://nevadahealthlink.com/information-for-brokers-and-navigators/

Q: Will not meeting Medicaid work requirements be listed as the reason someone no longer qualifies?
A: Yes. If an individual loses Medicaid eligibility due to not meeting the Community Engagement (Work) Requirements, the denial reason will indicate this. Individuals denied for this reason are not eligible for Marketplace financial assistance (APTC/CSR). Visit: New Requirements for more information.

Q: When do Medicaid recipients need to renew their applications?
A: Beginning January 1, 2027, Medicaid recipients will be required to renew their eligibility every six months following their initial enrollment. Visit: New Requirements for more information.

Q: What are the Work & Community Engagement requirements?
A: Information is available at: https://www.nevadamedicaid.nv.gov/WorkRequirements/
Materials from the 7/14/26 Medicaid Stakeholder Workshop are available online: Informational Materials

Q: What if someone is unable to meet work requirements due to disability?
A: Individuals who meet certain criteria, including qualifying disabilities, may be exempt. Additional information is available on the Nevada Medicaid Work Requirements webpage.
https://www.nevadamedicaid.nv.gov/WorkRequirements/

Q: Will clients with Employment Authorization Cards (work cards) be eligible for APTC in 2026?
A: Yes. Lawfully present noncitizens with Employment Authorization Documents (EADs) remain eligible for APTC through December 31, 2026, if they otherwise qualify. Effective January 1, 2027, individuals whose lawful presence is based solely on a work permit will no longer be eligible for APTC unless they are:

- Lawful Permanent Residents (Green Card holders),
- Cuban/Haitian Entrants, or
- Citizens of Compact of Free Association (COFA) nations.

Q: Are our clients notified if they are no longer eligible for APTC next year due to immigration status?
A: Yes. Consumers impacted by this change will receive a notification through their Nevada Health Link secure inbox during the annual renewal process.

Q: If someone reconciles taxes under 100% FPL and was denied Medicaid due to presence time frame, will they have to pay back subsidies?
A: Tax situations vary by individual. Consumers should consult a qualified tax professional or refer to IRS guidance regarding Premium Tax Credit reconciliation.

For more information visit: Questions and answers on the Premium Tax Credit | Internal Revenue Service

Q: Does IRS require consumers under 100% FPL to repay all APTC?

A: Consumers generally are not required to pay back APTC in this scenario.

If a consumer was enrolled in Marketplace coverage with APTC for one month or more based on estimating their household income to be at least 100% of the federal poverty level (FPL), and the consumer did not intentionally or recklessly misrepresent their household income when enrolling in the coverage, IRS rules state that this consumer may still qualify for and claim the premium tax credit on their tax return even when the household income as reported on their tax return is below 100% of the FPL. Click here for more info.

(See Q31. What are repayment caps?: Questions and answers on the Premium Tax Credit | Internal Revenue Service)

Q: Does updating income always trigger a QLE and require documentation upload?
A: No. Updating income does not automatically trigger a Qualifying Life Event. Documentation may be requested if the income change affects eligibility for Cost-Sharing Reductions (CSR) or requires verification.

Q: If someone's income goes down due to job loss, can they submit documentation to receive more APTC?
A: Consumers who are already receiving APTC will generally continue receiving financial assistance while Medicaid completes its eligibility determination. New applicants are not eligible for APTC until Medicaid issues a denial, if applicable.

Q: If a client updates to a lower income while being assessed by Medicaid, do they keep their subsidy? What if Medicaid denies them?
A: If the client was already receiving APTC, they keep it while Medicaid evaluates.
New applicants will not receive APTC until Medicaid issues a denial.

Q: What happens if someone has low income but too many assets to qualify for Medicaid?
A: If Medicaid denies an individual based on non-financial eligibility factors, such as excess assets, they may still qualify for financial assistance through Nevada Health Link. A valid Medicaid denial is required, and the household's projected annual income must otherwise meet Marketplace eligibility requirements.

Q: **Why isn't NVHL accepting the Notice of Denial (NOD)?**
A: Nevada Health Link can accept a Medicaid Notice of Denial when it is accompanied by the appropriate Medicaid eligibility file needed to complete the eligibility determination.

Q: How do Medicaid recipients receive communications?
A: Medicaid communications are generally sent by the Division of Social Services (DSS) via postal mail.

Q: Files from Medicaid to NVHL take weeks. Is this expected?
A: Processing times can vary. Delays commonly occur when Medicaid is waiting for additional information from the consumer or when duplicate applications have been submitted.

Q: What is Medicaid Express?
A: Nevada Medicaid Express is a new pathway for Nevadans to apply for Medicaid coverage through Nevada Health Link. Individuals who are under 65 and meet income-based Medicaid eligibility requirements may receive a real time Medicaid determination. Additional information will be included in the Plan Year 2027 training modules.

Q: What is the Medicaid phone number?
A: Contact information for Nevada Medicaid is available at:
https://www.nevadamedicaid.nv.gov/contact-us/

Q: How can clients get their Medicaid denial faster?

A: When new consumers are assessed as potentially Medicaid eligible, their accounts are transferred to Medicaid, and a valid Medicaid denial is needed in order to grant APTC eligibility. Delays in Medicaid responses being sent to the Exchange often occur when Medicaid is waiting for additional documentation from consumers. Also, duplicate applications submitted before a response is received can sometimes cause Medicaid processing delays.

Please note, it is possible to obtain a live determination from Medicaid by talking to a DSS caseworker. However, at this time, an account transfer denial file may still be needed before accurate exchange eligibility can be processed.