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Medicaid Express Demo Follow-up Questions and Answers (Q&A)

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Q: If a broker is helping a consumer enroll and is assigned to the consumer's account, does the broker need to complete the new Authorized Representative form?

A: If the broker is assigned to the consumer's account, then authorized consent has already been provided by the consumer. Consumers can appoint an authorized representative by submitting the form, or by providing their authorization through their online application or by calling the Nevada Health Link call center.

Q: Is there a separate Authorized Representative form for Medicaid?

A: A broker should not identify themselves as an Authorized Representative unless the consumer has formally designated them to fulfill the responsibilities of an AR.

If a consumer designates a broker or navigator as an Authorized Representative, the broker or navigator can assist with submission of an application. The consumer should review and approve the designation as part of the existing application process.

The online Authorized Representative designation through Nevada Health Link is treated the same as an online designation through Access Nevada.

If the application is transferred to the Division of Supportive Services (DSS) through the Account Transfer process, the Authorized Representative designation will be included with the application. DSS can contact the designated Authorized Representative if additional information is needed.

Q: Which specific categories of Cuban/Haitian entrants will qualify for Medicaid and Marketplace financial assistance?

Answer: For Medicaid, beginning October 1, 2026, certain Cuban and Haitian entrants may continue to qualify for full Medicaid coverage if they meet all other Medicaid eligibility requirements.

A Cuban/Haitian entrant generally includes a national of Cuba or Haiti who meets certain immigration conditions, such as:

- Being granted Cuban/Haitian Entrant status or another qualifying special status for Cuban or Haitian nationals;
- Being paroled into the United States and meeting the applicable requirements;
- Being in removal proceedings; or
- Having a pending application for asylum.

The individual must meet the federal definition of a Cuban/Haitian entrant under Section 501(e) of the Refugee Education Assistance Act of 1980. Eligibility will depend on the individual's specific immigration circumstances and verification.

For the Marketplace, beginning January 1, 2027, the following immigrants will qualify as “eligible noncitizens” in order to receive Marketplace financial assistance.

- Lawful permanent residents
- Cuban and Haitian entrants
- Compact of Free Association (COFA) migrants

Examples of documents that may be requested include:

- Permanent Resident Card (“Green Card”)
- Employment Authorization Document
- Passport or immigration documents
- Other records issued by U.S. Citizenship and Immigration Services (USCIS) or the Department of Homeland Security.

For information regarding new federal rules impacting Medicaid eligibility beginning October 1, 2026, visit: <https://www.nevadamedicaid.nv.gov/WorkRequirements/non-citizen-eligibility/>

Q: If an application cannot receive an immediate Medicaid determination and is sent to DSS, will Nevada Health Link automatically update the application when DSS makes the final determination?

A: If an application cannot receive an immediate Medicaid determination, then the application will be sent to DSS as an assessment and follow the associated account transfer process and associated timelines. Following DSS review, Nevada Health Link will receive the final determination from DSS and update the consumer's eligibility information.

Brokers and Navigators should not need to wait for the consumer to receive a paper denial letter or manually upload it before the application can move forward.

Q: If a consumer is later reassessed by DSS and found ineligible for Medicaid, will Nevada Health Link automatically update the application?

A: The system will update once Nevada Health Link receives the updated eligibility information from DSS.

Q: How quickly will a Medicaid denial come back to Nevada Health Link so the consumer can move to Marketplace coverage?

A: If a consumer is potentially Medicaid eligible, the Exchange will send the eligibility assessment to DSS and await an account transfer (AT) response to verify Medicaid eligibility. The existing process for Medicaid assessments remains the same and DSS has up to 45 days to make a determination when additional information is needed. Medicaid Express is intended to help free up DSS resources and, when possible, help speed up the process.

If the Nevada Health Link system determines a consumer as Medicaid eligible (meaning all Medicaid eligibility is met and all verifications are met) then they will be sent as a determination, and the Exchange will not receive a response from DSS.

Q: If DSS returns a Medicaid denial, will the consumer still have to provide proof of the denial before moving to Marketplace coverage?

A: If the DSS Medicaid AT file indicates Medicaid denial for excess income or citizenship, there should be no need for consumer to provide denial letter. The AT file should reflect the consumer's correct APTC eligibility on the Medicaid AT file so no additional proof would be required. If the consumer is reporting a Qualifying Life Event (QLE), like loss of Medicaid they would still need to provide this proof when applying for Marketplace coverage.

Q: If a consumer reports that their income increased and they are no longer Medicaid eligible, will they have to provide pay stubs, bank statements or other documentation?

A: It depends on whether the reported income can be verified through trusted data sources.

If the consumer updates their income through Nevada Health Link and the system can verify the reported income through trusted data sources, no additional documentation would be required.

If the information cannot be verified, the consumer may be asked to provide additional documentation or an explanation to DSS.

Q: How will this work for self-employed consumers and independent contractors whose income cannot be verified through traditional third-party sources?

A: Nevada Health Link will verify income through trusted data sources whenever possible. If a consumer's attested income cannot be verified electronically, the current process will apply.

- If the attested income is below the Medicaid threshold, the application will be sent to DSS for an assessment, just as it is today.
- If the attested income is above the Medicaid threshold, the consumer may receive conditional APTC, as they do under the current process.

Additional documentation may be required if income cannot be verified.

Q: Will Medicaid Express use the same income methodology that DSS currently uses, or will it use the Marketplace MAGI methodology?

A: Medicaid Express will apply the applicable Medicaid eligibility rules when determining Medicaid eligibility. The system will use current monthly income information and check trusted data sources when available.

Brokers and Navigators should continue to enter the consumer's estimated annual income for the coverage year on the application, as they do today.

If the application indicates the consumer may be eligible for Medicaid, Medicaid Express will check available trusted data sources for recent income information. If the income cannot be verified electronically, additional information or documentation may be requested by DSS

Q: Will newborns who currently show as "potentially eligible" for CHIP receive an immediate eligibility determination through Medicaid Express?

A: Newborns may be assessed or determined eligible for Medicaid or CHIP (Nevada Check Up) depending on their financial and non-financial factors and whether the information can be verified electronically.

If the newborn has not yet been issued a SSN but otherwise meets non-financial requirements and has a calculated household income under the Medicaid limit, they will be sent as an assessment to DSS.

Q: If a household includes children who already have Medicaid or CHIP and are not seeking new coverage, should they still be included on the Nevada Health Link application?

A: The child's applicant status has an impact on parents' evaluation for Medicaid under Parent/Caretaker.

The child should still be included and should be marked as seeking coverage. When asked about whether the child has other health coverage, they can indicate that the child has Medicaid.

Q: When the system displays options to select both Medicaid and Marketplace coverage, is that only when members of the household have different eligibility results?

A: Yes. The example shown was a mixed household, for example, parents eligible for Marketplace coverage while children are eligible for Medicaid or CHIP.

If everyone in the household is eligible for Medicaid, the consumer will only see the Medicaid coverage selection. If everyone is eligible for Marketplace coverage, they will only see the Marketplace plan options.

Q: If someone is determined eligible for Medicaid, can they choose a Marketplace plan instead?

A: A consumer can choose to purchase a Marketplace plan instead of enrolling in Medicaid. However, if they are eligible for Medicaid, they will not qualify for Marketplace financial assistance and would have to pay the full premium.

Q: If a consumer wants to see a particular hospital or provider, will Medicaid Express tell the consumer which MCO covers that provider?

A: Not at initial implementation. Medicaid Express will provide information about the available MCOs and their benefits, but it will not include a provider search during initial implementation.

Similar to the existing process for QHPs, consumers can check each MCO's provider directory on the MCO's website to see whether a specific hospital or provider is in network.

Q: Where should consumers go with questions about their MCO's benefits or plan?

A: Consumers will receive contact information for Nevada Medicaid and their selected MCO. Once an MCO is selected, the system provides the MCO's contact information.

Consumers should contact their MCO directly with questions about their plan, benefits, or additional services.

For general Medicaid questions, consumers can visit [Nevada Medicaid Member Information](#).

Q: After a consumer selects an MCO, what should brokers tell them to expect next?

A: Because MCO selection is only offered to consumers who receive a Medicaid determination, the application does not go through the standard DSS review process. The determination packet is automatically sent to DSS through the Account Transfer process.

Consumers should expect the following:

1. DSS sends an eligibility notice.
DSS will send the consumer an eligibility notice by mail.
2. If additional information is needed, DSS will contact the consumer.
DSS will send a request for any required information through the mail.

3. If approved, the consumer will receive enrollment information.

Medicaid will mail the consumer their enrollment information, including their Medicaid ID card and MCO assignment.

Important: The MCO selected through Medicaid Express is a preference and does not guarantee the consumer will be assigned to that MCO.

Q: Can a consumer change their MCO after making a selection?

A: A consumer can change their MCO preference until the information is sent to DSS. This typically means they can change their selection on the same day they apply.

Once the Account Transfer occurs, the consumer will need to contact Nevada Medicaid with questions or requests to change their MCO; Call **(866) 569-1746 (TTY: 7-1-1)**, or email medicaid@nvha.nv.gov. New online form is available for members to use when requesting a health plan change. The form can be accessed here: [Here is the form!](#) You can only use it within 90 days of signing up for Nevada Medicaid, for Good Cause Disenrollment, or during Medicaid's Open Enrollment from November 1 – December 15.

Q: Does everyone in a household have to select the same MCO?

A: Yes, everyone in the household who is determined Medicaid eligible must be enrolled with the same managed care organization.

Q: Once Medicaid denies someone, does the consumer automatically move to Marketplace eligibility?

A: Yes. Once Nevada Health Link receives the Medicaid determination, the consumer's application will be updated, and they can continue through the same application to be evaluated for Marketplace coverage and financial assistance.

However, not all Medicaid denials qualify for Marketplace financial assistance. The denial must be based on a reason such as excess income or the immigration/5-year bar. Administrative or non-cooperation denials do not qualify for Marketplace financial assistance.

Q: Will brokers have access to a test or sandbox environment before Open Enrollment so they can practice the Medicaid Express process?

A: No, there will not be a separate sandbox or test environment.

The application process itself is largely unchanged. Medicaid Express primarily changes what happens after Nevada Health Link evaluates a consumer for Medicaid eligibility by adding real-time verification and determination, faster transfer to DSS, and MCO selection.

Brokers and Navigators should continue using the existing application process, with the new Medicaid Express features incorporated into that process.

Q: What is the broker's role when helping a consumer apply through Medicaid Express?

A: The broker's role remains the same: **help the consumer complete the application and understand their coverage options.**

If the consumer is determined eligible for Medicaid, the broker's role ends once the Medicaid application is completed and submitted. The consumer will then work directly with Nevada Medicaid regarding their Medicaid enrollment and MCO.

Q: Does Medicaid Express handle Medicaid renewals?

A: No. At this time, Medicaid renewals will continue to be handled by DSS. Medicaid Express is a new pathway for new MAGI-eligible Medicaid applicants.

Q: What happens to people who are not MAGI-eligible for Medicaid?

A: Medicaid Express is focused on MAGI Medicaid eligibility. Individuals who may qualify for Medicaid based on disability, age, or other non-MAGI circumstances will continue through the existing DSS process.

If a non-MAGI applicant applies through Nevada Health Link, the application will be referred to DSS through the existing Account Transfer (AT) process, and the current rules and procedures will apply.

The NVHL application asks a few lead questions to identify individuals who may be eligible for Medicaid on bases other than income (i.e. Non-MAGI Medicaid). If an applicant does not appear to be eligible for Medicaid based on income but has one of those non-MAGI factors (disability, ADL assistance, receiving SSI, or aged 65+), they will be referred to DSS for Non-MAGI evaluation while, in parallel, they can shop for and enroll in Marketplace coverage.

Q: Will consumers have to complete separate applications for Medicaid and Marketplace coverage?

A: **Nevada Health Link's** Medicaid Express functionality allows consumers to apply for Marketplace and MAGI Medicaid through a single streamlined application. Individuals who may qualify for Medicaid based on disability, age, or other non-MAGI circumstances will continue through the existing DSS process.

The Nevada Health Link application includes questions to identify consumers who may qualify for Medicaid through a non-MAGI pathway. If a consumer does not appear eligible for Medicaid based on income but has a potential non-MAGI factor—such as a disability, need for assistance with activities of daily living, receiving SSI, or being age 65 or older—the application will be referred to DSS for a non-MAGI evaluation through the existing Account Transfer (AT) process.

At the same time, the consumer can shop for and enroll in Marketplace coverage while DSS evaluates their potential non-MAGI Medicaid eligibility.