



Stacie Weeks, JD, MPH, Director



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Date: October 14, 2026

To: Nevada Medicaid including Managed Care Organizations, the Public Employees' Benefit Program and Department of Business & Industry-Division of Industrial Relations

From: Jennifer Krupp, NVHA Division of Consumer Health Services Administrator

RE: Guidance on Subsection 1 of NRS 695K.230

Effective January 1, 2026, Subsection 1 of Nevada Revised Statute (NRS) 695K.230 requires providers who are enrolled or contracted with Nevada Medicaid, a Nevada Medicaid Managed Care Organization, the Public Employees' Benefits Program (PEBP), or a participant in the industrial insurance system to also enroll as a contracted provider with at least one (1) Battle Born State Plan (BBSP). Under previously issued guidance by the Director of the NVHA ([link](#)) enforcement was postponed under Subsection 2 of NRS 695K.230 until January 1, 2027, to ensure sufficient access to covered services during the first year of the new Battle Born State Program.

This memo serves as guidance for affected State agencies on how the Division of Consumer Health Services (DCHS) plans to proceed with tracking and enforcement of the statute.

Beginning January 1, 2027, a provider may be removed from eligibility to participate in the Medicaid fee-for-service program, a Nevada Medicaid Managed Care Organization (MCO), PEBP, or the Nevada industrial insurance program for failure to comply with the provisions of NRS 695K.230.

NVHA is outlining the following procedure to be undertaken before removing any provider's eligibility:

- NVHA is identifying non-compliant providers by cross-referencing network lists for BBSPs, Nevada Medicaid Managed Care, Nevada Medicaid fee-for-service, PEBP, and the industrial insurance program.
- NVHA may request assistance from our MCO and Division of Industrial Relations (DIR) partners to contact providers, inform them of their status and afford them an opportunity to enroll in at least one BBSP network.
- Providers will have 60 days to come into compliance or request an exemption.
- A provider that fails to come into compliance or request an exemption within the allotted 60 days may be eligible for removal from the listed programs.
- **NEVADA MEDICAID, INCLUDING MANAGED CARE ORGANIZATIONS, PEBP, AND DIR SHOULD NOT TAKE ANY ACTION TO REMOVE A PROVIDER FROM A NETWORK OR PARTICIPATION LIST PURSUANT TO NRS 695K.230 UNLESS DIRECTED TO DO SO BY THE DIVISION OF CONSUMER HEALTH SERVICES.** DCHS has a procedure in place to receive, review and adjudicate exemption requests or otherwise

attempt to bring providers into compliance with the statute. Only after those processes have been exhausted will DCHS recommend a noncompliant provider's eligibility be removed.

- If DCHS determines that removal or a provider's eligibility is appropriate DCHS will transmit that determination to Nevada Medicaid, PEBP and DIR. Upon receipt of the determination from DCHS the agencies should begin the process of removing the affected providers from networks and eligibility lists, *including following any other relevant statutes*. (e.g., required notice periods for change in network, etc.)
- A provider that is removed for failure to comply will be removed from all Medicaid MCO and fee-for-service networks, PEBP networks, and industrial insurance lists that the provider may have been a part of.
- Such providers may petition the Director of NVHA to have their eligibility to participate restored upon furnishing proof of participation in at least one BBSP network.

A provider may, at any time, request an exemption from the provisions of NRS 695K.230(1). Any such exemption request must be submitted to the NVHA using a form prescribed by the Director.

Examples of exemption requests include, but are not limited to:

- The provider only offers services that are covered by the Medicaid program, the PEBP program, or industrial insurance and are not covered services under any of the BBSP offerings;
- The provider made a good-faith effort to comply with NRS 695K.230 and was denied by all BBSP issuers; or
- The provider's participation in a BBSP offering causes serious financial hardship which would result in the provider's closure, affecting access issues within the state.

Exemption requests must be accompanied by supporting documentation to substantiate the need for an exemption. (e.g., denials from all BBSP issuers, proof of financial hardship, etc.)

All exemption requests will be approved or denied by the Director of NVHA.

All exemption requests will be valid for a period of one year. Any provider with an approved exemption will need to show continuing need for an exemption to be reissued or must substantiate a new need.

The Director of NVHA reserves the right to issue blanket exemptions when necessary. Such instances may include, but are not limited to, when known provider types or services have no overlap between the Medicaid program and BBSP offerings, or compliance is otherwise known to be impossible.



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Providers are encouraged to visit our site, <https://www.nvha.nv.gov/our-programs/DCHS/BBSP/providers/> for additional information. Inquiries concerning this bulletin should be directed to our dedicated mailbox for providers, BBSPproviders@nvha.nv.gov.