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Relief for Nevada Providers: Medicaid Exclusion Requirement Waived Through 2026

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On February 19, 2026, the Nevada Health Authority (NHA) waived the requirement that healthcare providers contract with at least one Public Option health plan as a condition of participation in Nevada Medicaid (Medicaid). This requirement had applied to providers enrolled in Medicaid, contracted with a Nevada Medicaid Managed Care Organization (MCO), or contracted with the Nevada Public Employees' Benefits Program (PEBP), collectively, the "Government Payors." NRS 422.2372(8) (requiring the Medicaid administrator to "exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of NRS 695K.230). The NHA's February 19, 2026 waiver (Waiver) retroactively applies beginning January 1, 2026, and extends through December 31, 2026. During this period, failing to participate in a Public Option plan will not require automatic exclusion from Medicaid.

Background

In 2021, Nevada passed legislation creating a Public Option to offer at least two health plans administered by MCOs contracted by the state to administer its Medicaid program. The laws creating and governing the Public Option within NRS Chapter 695K were enacted with a five-year phase-in process and took effect on January 1, 2026. The Public Option plans, referred to as "Battle Born State Plans," are offered on Nevada's Affordable Care Act health insurance exchange at the gold and silver plan rating levels. *See* NRS 695K.200(2), (3), and (6). By law, each plan's pricing was set with a target of at least 5% lower than the reference premium for the area where the plan is offered, and annual increases to the plan's premiums are capped. NRS 695K.200(4).

NRS 695K.230(1) imposes certain duties on Nevada's healthcare providers, including both licensed providers and facilities such as hospitals, surgery centers, and skilled nursing facilities. *See* NRS 695K.080; NRS 695G.070. Providers enrolled with Governmental Payors, or who provide services paid for by workers' compensation or occupational disease insurers (Occupational Insurers), are required to enroll in at least one Public Option plan and accept new patients enrolled in Public Option plans just as they would any other new patient, regardless of payor identity. NRS 695K.230(1).

The 2021 adoption of the Public Option also included an amendment to Nevada's Medicaid laws, specifically NRS 422.2372. Although enacted in 2021, this amendment took effect on January 1, 2026, and required the

Medicaid administrator to exclude from the Medicaid program (including Medicaid benefits administered through MCOs), all healthcare providers who fail to enroll with at least one Public Option plan. NRS 422.2372(8). Whether through conscious choice, ignorance, or difficulties in contracting or obtaining an appointment to a Public Option plan's provider panel, healthcare providers may find themselves excluded from Medicaid. To address concerns of provider disenrollment or exclusion, NRS 695K.230(2) allows the Medicaid Director and PEBP Executive Director to waive the requirements of NRS 695K.230(1).

The Waiver

The Waiver issued under the authority of NRS 695K.230(2) is granted "to ensure sufficient access to covered services during the first year of the new [Public Option] program," when NHA's Director, Stacie Weeks, determines "it is necessary to waive this requirement." No further information is provided about "necessity" means. During this waiver period, the NHA's Waiver "encourages eligible providers to work with the state's three Battle Born State Plan carriers to ensure compliance with subsection 1 of NRS 695K.230 no later than January 1, 2027."

Considerations for Providers

Importantly, the text of the Waiver limits its application only to Governmental Payors; it is silent to the Occupational Insurers, and it currently is not clear whether failure to participate in a Public Option plan requires Occupational Insurers to terminate their payor agreements with providers. Providers enrolled with Occupational Insurers should consult their payor agreements to determine if they are required to enroll in a Public Option plan to maintain their enrollment. Similarly, providers enrolled in PEBP are advised to consult their payor agreements to determine whether non-participation in a Public Option plan may result in PEBP's termination of that agreement.
