Proposed Recommendations	**Criteria**	**Rationale**
1) Maintain Standards as is.	(6)	We haven't seen how these work. 2017.
2) Add pediatrics to primary care category.	SA not county (9)	Was a data request by SA; it doesn't change adequacy; Oversight in original NA plan, but we have little data.
3) Maintain service area vs. using county	(9)	
4) Add other provider types: Home Health; pulmonary; Gastro; CVD;	(1)	Was a data request by SA; it doesn't change adequacy; Doesn't change network adequacy based on state level; Need to look at 4 SA and by carrier. Need to know for each carrier their defined service area + the impact of proposals.
5) Increase the #/% of contracted ECP in network – may result in losing providers who don't meet credentialing requirement	Data: Is there a problem in NV contracting with ECPs (2)	We have 40% racial/ethnic minority; work in 200% at below poverty; traditionally see low income underserved area because of concern for right to contract.
6) Just clarification: Facilities: Gen Acute Care, Critical Care- ICUs A health plan has beh health benefits they should have a contract with a facility that effects these (Don't see the latter part in the print outs).	No voting just clarification	It's critical to concept of "access", there's a body of research validating "secret shopper" methodology. [Health Affairs]
7) Have adequacy requirements based on wait time.	(6) (for future)	It is critical to concept of "access"; there is a body of research validating "secret" shopping methodology (Health Affairs)
8) Carriers have the ability to restrict # of enrollees to meet network adequacy	(3) (for future) Linked to number 7	Accuracy – adequacy of data is questionable and is a challenge for considering new recommendation; may need to look at what we learn from 2017 and we

		improve data / methods. Time frame is restrictive to absorb all the data; give thoughtful considerations and be able to make sound decision
9) Consumer language needs to be accommodated through a language translation line (HP insures access to translation services)	Add “language” to provider credentialing Regulations for hearing impaired FQHC / Medicaid/ Hospitals On provider vs carrier; how does fee get covered (7)	Translation services. Provider language can be listed – language of providers not part of credentialing application. Hospitals are read based on proportion of consumers/”__” Medicaid.