COLORADO
Department of Health Care Policy & Financing

FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Northeast Health Partners*

Line of Business: *RAE*

Contract Number: *19-107508*

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—Final Copy—

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the fiscal year (FY) 2019-20 Network Adequacy Crosswalk Definitions (December 4, 2019 version).

The practitioners, practice sites, and entities included in the quarterly NA report will include ordering, referring, and servicing contractors that provide care through a Colorado Medicaid or CHP+ MCE. To ensure consistent data collection across MCEs, each MCE must use this HCPF-approved report template (MS Word and MS Excel templates) to present the MCE's quarterly NA report and data for the corresponding practitioners, practice sites, and entities. Report due dates will align with those outlined in the MCE's contract, unless otherwise stated.

Fiscal Year Quarter Reported	Months Included in the Report
FY 2019-20 Q2	October, November, December
FY 2019-20 Q3	January, February, March
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September

Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_0320* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_0320* document.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.
- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service, excluding single case agreement (SCA) practitioners.

- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business.

This report template contains a comprehensive list of NA requirements for the CHP+ MCO, Medicaid MCO, and RAE lines of business. Each table in this MS Word document contains a header row which confirms the applicable line(s) of business for each response. The table below shows expected network categories by MCE type. The accompanying MS Excel spreadsheet contains tabs in which network data can be imported (e.g., member counts, ratio results, time/distance calculation results).

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (Entities) (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X	
Prenatal Care and Women's Health Services	X	X	X
Primary Care Providers (PCPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

- Contact the MCE's Department contract manager or specialist for data submission instructions and assistance with questions or access to HCPF's FTP site.

2. Network Adequacy

Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of practitioners/practice sites to assure that all covered services to members will be accessible without unreasonable delay. The MCE shall demonstrate that it has the capacity to serve the expected enrollment in that service area.

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
- To count practitioners:
  - Include each unique practitioner contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

Define unique practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

Table 1A-Establishing and Maintaining the MCE Network: Primary Care/PCMP Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	78,469	N/A	75,786	N/A
Total primary care practitioners/PCMP practitioners	299	N/A	319	N/A
Primary care practitioners/PCMP practitioners accepting new members	268	89.63%	296	92.79%
Primary care practitioners/PCMP practitioners offering after-hours appointments	105	35.12%	109	34.17%
New primary care practitioners/PCMP practitioners contracted during the quarter	1	0%	28	8.78%
Primary care practitioners/PCMP practitioners that closed or left the MCE's network during the quarter	0	0%	8	0.25%

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Table 1B-Establishing and Maintaining the MCE Network: Primary Care/PCMP Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners/PCMP practice sites to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
Overall, NHP has a network for physical health that meets the needs of the membership. NHP continues to implement strategies to recruit and maintain providers to strengthen the existing network. During the reporting period, NHP finalized contracts with Keene Clinic, located within Weld County, and Wayne E. Hoppe, a solo practitioner in Burlington, which is located in Kit Carson County. We continue to work with Boulder Community Clinic, which opened two locations in Erie, which is located in Weld County, to finalize a contract. Colorado Plains terminated three (3) of their locations due to either closing the sites or the location no longer offered primary care. NHP is working with HCPF to transition the attributed members to Plan de Salud Health Center to ensure access and quality of care. There is a continued need across the region for Gynecology and OB/GYN providers of all levels, including physicians and physician assistants. NHP's barrier will be identifying the available providers in the region with this expertise and recruiting them to serve Medicaid Members. During the reporting period, Provider Relations outreached to practices to update the practitioners within their practices. As a result, we were able to capture 28 new practitioners within the network providers, including practitioners that are part of the newly contracted PCP locations. The majority of the new providers are Family Practitioners. However, there is one (1) provider who is an OB/GYN physician and one (1) Nurse Midwife. NHP uses alternative methods to serve Members of all ages and genders within the access to care standard requirements. For example, partner FQHCs, *Sunrise Community Health Center* and *Plan de Salud Health Center*, as well as independent primary care providers, offer women's health services through their Family Medicine practitioners. Provider Relations continues to review the Enrollment Summary Report with data of non-contracted providers to identify PCMP practices in the Region that are offering services to Medicaid Members, but not currently part of the network. During the last reporting period, Provider Relations identified an OB/GYN practice, Obstetrix Medical Group of Colorado, located in Sterling, which is located in Logan County. Outreach to this practice during the reporting period had limited response. We will continue to pursue this practice for recruitment. NHP is working to address access to care with network providers to ensure covered services are available to Members within the access to care standards. The previous report identified a high number of providers with appointment availability that met the standards through the access to care audit. As a result, the focus was primarily on notifying the providers about the results of their access to care audit. Providers will be re-audited to monitor their compliance and track the effectiveness of the outreach. NHP will be updating the outreach strategy based on provider feedback, level of compliance, and best practices to improve access within the network.

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Table 2A-Establishing and Maintaining the MCE Network: Behavioral Health Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	78,469	N/A	75,786	N/A
Total behavioral health practitioners	1,968	N/A	2,069	N/A
Behavioral health practitioners accepting new members	1,968	100%	2,069	100%
Behavioral health practitioners offering after-hours appointments	445	22.61%	473	22.91%

Table 2B-Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
The NHP region primarily comprises rural and frontier communities with limited availability of behavioral health providers within its boundaries. Overall, NHP has a robust state-wide network for behavioral health to meet the needs of the membership. Most members access services through Community Mental Health Centers (CMHCs) and independent behavioral health providers bordering the region like Larimer County. This is due in part by the traffic and work patterns of the communities NHP serves, in addition to, member choice. As a result, NHP continues to recruit providers to strengthen the network within the region and its bordering counties using the following strategies: 1- Utilizing current listings of Health First Colorado (Medicaid) participating providers and Department of Regulatory Agency (DORA) Registry to identify providers within the region. Provider Relations outreached providers identified through the listings of Health First Colorado participating providers and the Department of Regulatory Agency (DORA) Registry. The majority of the providers with service locations in the rural and frontier counties identified through these listings are associated with the local CMHC. Additionally, the research on DORA yielded SUD licensed providers not associated with a CMHC for recruitment in the following counties: Lincoln (1), Logan (7), Morgan (4), Washington (1) and Weld (92). These providers are not Health First Colorado enrolled providers based on the available information. The outreach has had barriers as these providers are currently not serving Medicaid Members and have limited incentive to join the network. Providers identified through this process have not been successfully recruited to join the network. Provider Relations will continue to outreach these providers for recruitment and learn more effective approaches to recruit providers to serve Medicaid Members.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE

2- Tracking utilization, Single Case Agreement (SCA) data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) Members.

Provider Relations has had high success in focusing recruitment efforts on providers that are actively serving NHP-assigned Members through SCAs. As part of the on-going monitoring of the SCA data, Provider Relations is actively outreaching providers that have received more than one (1) SCA in the previous six months. The efforts and feedback from providers are reviewed monthly to track progress for the recruitment. This process helps identify and address potential barriers to recruit specific provider (e.g., rates). This is also an opportunity to better understand the gaps in specialty services within the network (e.g., psychiatrists) and prioritize their recruitment. Each provider who was outreached through this strategy was successfully recruited and has initiated the process to join the network.

3- Working with county DHS departments to identify CORE providers and work with these providers in becoming credentialed within the system.

As part of the on-going engagement with county DHS departments to connect with CORE providers, NHP participated in an open forum with CORE Providers hosted by DHS Weld. During this forum, NHP provided information about the levels of service, medical necessity, and addressed provider questions. Additionally, Provider Relations outreached individual providers who are not part of the NHP network to recruit and assist them with the credentialing process.

4- Offering telemedicine services to Members in rural and frontier areas who have psychiatry and other specialty needs.

NHP has been working on furthering telemedicine in the region. As a result of the COVID-19 crisis, telemedicine has become a stronger focus to ensure behavioral health access during the state of emergency, which began at the end of the third quarter. NHP is working closely with providers to educate them on telehealth requirements, billing, and documentation. This has been driven through Provider Alerts, dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. We expect that Member and provider exposure to telemedicine during this crisis will increase their comfort level with the technology. This may help expand Member requests for telemedicine and providers' willingness to offer these services moving forward, which may increase utilization overall. NHP will continue to monitor the changing environment of telemedicine to support providers as they build capacity and sustainability.

5- Improving operational processes to successfully recruit providers to join the network.

As part of the changes in the operational process, NHP has increased the number of providers by 186 from the last report through facility roster updates or credentialing. We continue to monitor providers in the credentialing process to communicate with them on the status of their application and assist with any required documentation. These improvements will assist with recruitment by addressing provider concerns by providing transparency on the status of their application.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
Furthermore, Provider Relations has increased education and outreach to facilities (a.k.a. Entities), FQHCs, and CMHCs to submit data of the staff providers that have joined and left their facilities (a.k.a. Entities) on a monthly basis. Receiving the facility data on an increased frequency allows for increase auditing of their staff providers for future reports. A large percentage of the behavioral health services rendered to NHP Members are provided through NHP's partner CMHCs, *North Range Behavioral Health* and *Centennial Mental Health*. Provider Relations worked with the CMHCs to update their licensed and unlicensed staff providers in the system. Although unlicensed staff providers are not applied to the ratios and time/distance analysis, it shows, the receipt of this data has allowed to more accurately assess the capacity of the CMHCs.

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Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members		N/A		N/A
Total specialty care practitioners		N/A		N/A
Specialty care practitioners accepting new members				
Specialty care practitioners offering after-hours appointments				
New specialty care practitioners contracted during the quarter				
Specialty care practitioners that closed or left the MCE's network during the quarter				

Table 3B-Establishing and Maintaining the MCE Network: Specialty Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO
N/A

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Categories Included in Network

Supporting contract reference: The MCE shall ensure that its contracted networks are capable of serving all members, including contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

Table 4A-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
NHP has only one (1) urban county, three (3) rural counties, and six (6) frontier counties. The availability of behavioral health and primary care providers in rural and frontier counties is limited, especially those with capacity to serve all Members, including those who offer specialized training and expertise across all ages, levels of abilities, gender identities, and cultural identities. Overall, NHP has a robust network for physical and behavioral health to meet the needs of the membership. There is a need across the region for OB/GYN providers of all levels, including physicians and physician assistants. The limited number of OB/GYN providers lowers the ability to serve Members without delays. NHP's efforts during the reporting period to identify providers within the existing family practices assisted in reporting additional providers with capacity to provide women's health services. However, due to the HSAG categorization, only one (1) of these providers in Morgan County met the HSAG criteria as an OB/GYN. The other six (6) providers are captured as a Family Practitioner in the data. For behavioral health services, NHP has a need for providers with a license to prescribe in all areas. The majority of the providers seeking SCAs are psychiatrists. Efforts are underway to have these providers join the network to increase the capacity of prescribers. However, many of them are providers outside NHP's ten (10) counties. There are limited available providers licensed to prescribe within the region. NHP monitors the network through periodic network adequacy reviews regarding the availability of providers who meet or exceed the cultural needs of Medicaid Members by: • Using updated and accurate lists in assessing the number of providers with expertise in key culturally based populations and gender, specifically women for gynecology care; • Determining the number of Members, by county, through the enrollment file, within the key population groups; and • Determining any existing gaps by comparing the availability of providers, as well as reviewing findings in Member and Family Affairs surveys available on the NHP website named "Your Opinion Matters" or through contacts/surveys with advocacy organization of key populations. For behavioral health providers, Beacon Health Options (Beacon) engaged specialty provider groups and facilities based on the identified need through the network monitoring. This engagement included providers who have:

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE

- A unique specialty or clinical expertise;
- A license to prescribe in all areas: APRN/APN, NP, PA, MD/DO (Board Certified Child and Adult Psychiatrists);
- Capability to treat in a foreign language, ASL, and/or have specific cultural experience;
- Capability of billing both Medicare and Medicaid;
- A practice located in NHP's service area that is considered rural or frontier where there are fewer providers;
- Telehealth, especially for prescriber services;
- Alignment with primary care and co-located in an integrated model;
- Capability to serve unique populations and disorders;
- Specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries, or other groups that provide behavioral health services in addition to their non-covered specialty. Also, providers with experience in specialty care, long-term services and supports (LTSS), managed service organizations and their networks of substance use disorder providers, dental and other ancillary providers; and
- Behavioral health providers that span inpatient, outpatient, and all other covered mental health and substance use disorder services.

Medicaid Members in RAE Region 2 rely on NHP partner CMHCs: *North Range Behavioral Health* and *Centennial Mental Health Center*, and partner FQHCs: *Sunrise Community Health Center* and *Plan de Salud Health Center* as primary sources for specialized behavioral health and primary care services, respectively. As a result, our partner providers take steps to ensure they have accessible and expertise to serve Members across all ages, levels of abilities, gender identities, and cultural identities.

Our partner CMHCs utilize specialty programs to address the culture and language needs of the community. For example, *North Range Behavioral Health Center* employs numerous Americorps workers who speak multiple languages to assist families in accessing services and addressing healthcare needs. The average number of languages spoken by the Americorps workers is between five (5) and eight (8) languages.

Within Morgan County, it is estimated that between 27 and 40 languages are spoken. Local law enforcement has been nominated to work on a national grant to ensure the availability of culturally appropriate services and interventions. Our goal is to partner within the community to ensure we are providing individualized, culturally aware services. Navigation of systems, with the language spoken by the individual, is also available through the Global Refugee Center of Northern Colorado.

Within the Primary Care Provider Network, our partner FQHC recruits providers and support staff that speak the language and are part of the culture in the community they serve. *Sunrise Community Health Center* utilizes Stratus Video to assist with the interpretation needs of the members at the point of receiving medical care. Status Video is a unique onsite interpretation solution, which connects the Clinic directly with local interpreters, improving scheduling visibility. The interpretation units are touch screen so staff may select the language they need and connect to the live interpreter.

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Access for Special Populations

Supporting contract reference: The MCE shall have the ability to meet the needs of members in special populations. When establishing and maintaining its networks, MCEs shall take the following into consideration: members access to transportation and whether the location provides physical access and accessible equipment for members with disabilities. The MCE shall have the ability to meet the needs of members with limited English proficiency.

Table 5-Access for Special Populations: Discussion

Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
Beacon, on behalf of NHP, monitors if there are sufficient providers in the network with the ability for physical access, reasonable accommodations, and accessible equipment for Members with physical or other disabilities. Provider data in Beacon's system is used to identify provider locations as accessible in the provider directory and to count the number of providers that meet the requirements in the network adequacy analysis. Provider Relations has trainings available on the RAE 2 website to educate providers on how they can directly update their demographic information through Beacon's Provider Portal and CAQH, which includes reporting the physical access and/or accessible equipment information for each of their practice locations. Additionally, Beacon integrates data from CAQH to maintain accurate records for network providers in Beacon's system, which in turn, populates the Provider Directory and network adequacy analysis. Finally, Provider Relations conducts on-going phone outreaches to providers that do not have a CAQH profile to validate the information on the Provider Directory. Providers that want to learn more about physical access and/or accessible equipment for practice locations may request Provider Relations staff to conduct an assessment of their facilities for Members with physical and other disabilities. There were no requests for these assessments during the reporting period and the assessments will continue to be promoted at provider support calls. This is an opportunity to engage with the practices and increase accessible facilities in the network.

3. Network Changes and Deficiencies

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

Table 6-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
NHP, the RAE for Region 2, did not experience a change in its network in regards to quality of care, competence, or professional conduct. As such, no notification to the Department was required during the reporting period.

Table 7-CHP+ MCO Network Volume Changes and Notification: Discussion

If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions: **Did the MCE notify the Department, in writing, within ten (10) business days of the change?** **Was the change due to a practitioner/practice site/entity's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation?** **Was the change due to a practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
N/A

interChange Policies

Supporting contract reference: The MCE shall employ measures to help ensure that the MCE and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating practitioner/practice site/entity.

- Retroactively enrolled or practitioners/practice sites/entities with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 8-CHP+ MCO *interChange* Policies: Discussion

1. Does the MCE employ measures to help ensure all contracted, ordering, or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating practitioner/practice site/entity? **2. Did the MCE have a health care practitioner/practice site/entity that was no longer identified as a participating practitioner/practice site/entity in the *interChange*?** **If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care practitioner/practice site/entity contracts for provision of services to members with contracted practitioner/practice site/entity?**
CHP+ MCO
N/A

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Inadequate Network Policies

Supporting contract reference: If the MCE fails to maintain an adequate network that provides Members with access to PCPs within a county in the MCE's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible Members by providing the MCE a thirty (30) calendar day written notice.

Table 9-CHP+ MCO Inadequate Access to PCPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?
CHP+ MCO
N/A

Table 10-CHP+ MCO Discontinue Services to an Entire County: Discussion

Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area? If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?
CHP+ MCO
N/A

Table 11-CHP+ MCO Provider Network Changes: Discussion

Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network? If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?
CHP+ MCO
N/A

Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

Table 12-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Primary care providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against Members (e.g., hours of operation may be no less than those for commercially insured or publicly insured, fee-for-service individuals), and that services are available 24 hours a day, seven days a week when medically necessary. Access to care standards, set by the state of Colorado, require all participating primary care medical providers (PCMPs) to have availability for Members within seven (7) days of request, and that urgent access is available within 24 hours from the initial identification of need. Provider Relations conducted a six-month outbound phone call initiative to survey access to care within the PCP practice locations in December 2019. Provider Relations sent notices to surveyed physical health providers on the results and information on the standards. Providers are scheduled for re-audit to monitor access to care compliance. For providers that continue to not meet the requirement, they will receive a request to submit a correction action plan. The results of the re-audit will be reported in the fourth quarter report.

Table 13-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Behavioral health providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against Members (e.g., hours of operation may be no less than those for commercially insured or publicly insured, fee-for-service individuals), and that services are available 24 hours a day, seven days a week when medically necessary. Access to care standards, set by the state of

Colorado, require all participating behavioral health providers to have availability for Members within seven (7) days of request, and that urgent access is available within 24 hours from the initial identification of need.

Provider Relations continued to conduct outbound phone calls to survey access to care. A total of 18 provider locations were audited during the reporting period. Of those contacted, only one provider location met all the standards. Most of the providers did not meet the requirement to offer an appointment within seven (7) days of request.

Provider Relations sent notices to behavioral health providers on the results and information on the standards. Providers are scheduled for re-audited within 90 days of receiving the results regarding access to care compliance. For providers that continue to not meet the requirement, they will receive a request to submit a correction action plan.

5. Time and Distance Standards

Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the practitioners/practice sites/entities in the MCE's Region.

Enter detailed time and distance results in the MS Excel template. Use Tables 13, 14, and 15 for additional relevant information regarding the MCE's compliance with time and distance requirements. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MS Excel template tabs; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under the Family Practitioner category.

Table 14-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate practitioner/practice site/entity counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. If your MCE does not use driving distances when calculating time and distance results, describe the method used.
CHP+ MCO, Medicaid MCO, RAE
Beacon uses the latest Quest Analytics, an industry-standard application, to conduct a geographic access (GeoAccess) mapping analysis for time and distance starting from the Member's residence and driving to the closest available provider based on the county classification. This application is also used to calculate the provider-to-member ratios at the regional and county level by provider type.

The provider data that was used in this report was pulled directly from the physical health and behavioral health databases hosted by Beacon, on behalf of NHP. The data was pulled directly out of the database using the SQL editor, Toad. The requested data elements for the Individual PH Practitioner and Individual BH Practitioner tabs are available in the databases and were pulled directly. This is also the case for the Practice Sites and the Entity Locations tabs. The Members by County tab was a simple calculation of enrolled Members by their county of residence broken out per the Members by County Instructions. The Provider Locations by County tab was calculated by summing the number of locations by their county name per the instructions of the Provider Locations by County Instructions.

For the HCPF Network Categories, we began by conducting a quality check of provider National Provider Identifiers (NPIs) and taxonomy codes using several different methods. For the NPI quality check, we compared all NPIs in our provider data against the list of NPIs in the monthly ATN report to confirm those providers had valid NPIs. Additionally, there was a review of provider taxonomy codes against the National Plan & Provider Enumeration System (NPPESS) NPI Registry to ensure correct taxonomy codes. Once the quality checks were completed, we used the HSAG technical specification document (*FY2019-20 Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; December 4, 2019 Version*) to define provider groupings. This was done using the provider's taxonomy code and the provider's degree or credentials. This allowed us to roll-up our provider counts by provider group code.

Beacon has been working to refine the reporting logic for behavioral health after the first submission of the Quarter 2 Network Adequacy Report. We shifted the analysis of behavioral health provider data to the local reporting team to align with how it is being done for the primary care side. The benefit of having the data reporting locally is that the team is more familiar with the network providers and Colorado requirements. We streamlined the process for validation and adjustments to the logic to enhance the quality of the reporting. As a result of these changes, we conducted an in-depth review of the logic that identified the need to adjust the report logic, as well as incorporated HCPF's feedback from the first submission of the Quarter 2 Report. Overall, changes to the logic included:

- Data cleaned to remove duplicate providers due to name spelling and other data entry errors
- Data cleaned to validate Medicaid IDs and exclude providers missing Medicaid IDs
- Distinguish licensure levels (LPC and LCSW)
- Reviewed and updated the categories to capture additional applicable licensure levels
- Reviewed and updated the logic to better capture unlicensed staff in the CMHCs

The changes outlined above, in addition to the recruitment and facility staff provider's data collection efforts (see Table 2B), resulted in a net increase of 101 individual behavioral health providers from the previous report to the current quarter report. NHP has stronger confidence in the data reported in the second submission. We are continuing to enhance the data collection and reporting methodology. We will address new findings through our internal process and guidance from the Department.

In the process of reviewing the Network Adequacy Report, NHP identified on the BH Entities tab there were entities listed with "mental hospital" and "psychiatric residential treatment facility" that did not appear consistent with the facility. After reviewing this further, we identified that the logic pulled some of the entities as "mental hospital" or "psychiatric residential facility" due to the combination of the facility's licensure, taxonomy, and specialty. We verified the logic to pull the correct licensure, taxonomy, and specialty combination that aligns with the appropriate HCPF Category Code. As a result, NHP updated the report for the

identified entity locations and updated the BH Location by County, BH Ratios and Time/Distance tabs, accordingly. For the fourth quarter report, NHP is continuing to validate the logic to ensure individual practitioners, practice sites, and entities are categorized with the most appropriate HCPF Category Code based on the most updated HSAG Crosswalk.

Managing the provider data for completeness and accuracy is a continuous process. We have various mechanisms in place to capture and correct data discrepancies and audit the provider information entered into the system. We anticipate a minimal margin of error in the data accuracy each quarter and we are continuing to enhance the data collection and reporting methodology to reduce the margin error. There are two areas with behavioral health data that we are continuing to improve for the next reporting period. First, reduce the practitioners that appear with multiple records for similar service locations or similar names. We identified on this report 49 of the 2,069 unique behavioral health providers on the report that have similar service locations and names which may potentially be duplicate records. While this represents less than 3% of the total records, we still want to improve the data wherever possible. These records are in the process of review and validation with the provider to update, as appropriate, for the following quarter. Second, improve the Medicaid ID data for individual providers, specifically facilities' staff providers. Historically, facility staff providers were not included in the network adequacy report. As a result of the new reporting requirement, we identified that the collection of the data for facility staff providers was not complete. This report has providers with multiple Medicaid IDs or sharing the same Medicaid ID with other providers, which is not in accordance with the HSAG guidelines. NHP has put in place a process to request the data from facilities and audit the facility staff Medicaid ID provided. Any inconsistencies found will be reviewed with the facility to correct and resubmit. We anticipate this process will increase accuracy for future quarterly reports. NHP will address new findings through our internal process and guidance from the Department.

The technical tools used to complete this reporting requirement included Toad and Microsoft Excel. Toad was used to pull the data from Beacon's databases and, where appropriate, conduct the data aggregation calculations. The results of this aggregation were manually entered into the designated Network Adequacy template, which is in an Excel file format.

Table 15–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
NHP has one urban county, Weld, in which nearly all adult and pediatric membership have access to providers for each provider type within the time and distance requirement for both behavioral health and primary care. The exception is access to Pediatric Primary Care Mid-level and primary and mid-level OB/GYN providers as there are zero (0) providers for this provider type in the network.

During the reporting period, NHP worked with network PCP practices to update the providers in their practice locations to identify any new practitioners. There was no improvement in recruiting Pediatric Primary Care Mid-level into practices. We were successful in identifying existing and new physician assistants that provide OB/GYN services. Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category.

Table 16–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Logan, Morgan, and Phillips counties are qualified as rural counties. The majority of the members have access to providers within the required distance of 45 minutes or 45 miles for PCPs, and 60 minutes or 60 miles for behavioral health providers. For physical health, NHP worked with network PCP practices to update the providers in their practice locations to identify any new practitioners. There were limited opportunities to recruit these providers into their practices. NHP recruited new PCP practices and increased the number of rendering providers for the entire region, including adding new Family Practitioners within the rural counties. Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category. This impacted the number of sufficient OB/GYN at all levels (MD, DO, NP) across the three (3) rural counties. Another area of need is Pediatric Primary Care (Mid-Level) in Phillips, Morgan, and Logan counties. For behavioral health, the rural counties did not meet access for Psychiatric Residential Treatment Facilities within the required distance. In large part, access for this level of services is a challenge due to the sparse provider/facility availability within rural and frontier regions. This will require work with the Department and community partners to address.

Table 17–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
The majority of the RAE Region 2 counties qualify as frontier. The majority of the Members have access to providers within the required distance for all provider types within the required distance of 60 minutes or 60 miles for PCPs, and 90 minutes or 90 miles for behavioral health. For physical health, NHP worked with network PCP practices to update the providers in their practice locations to identify any new practitioners. There were limited opportunities to recruit these providers into their practices. NHP recruited a new PCP practice in the frontier county of Kit Carson and increased the number of rendering providers within the frontier counties. There are sufficient number of Primary Practitioner Level providers (MD, DO, NP) that serve the pediatric population within the time/distance standards of the frontier counties. Although this mitigates the lack of mid-level providers serving pediatric population, NHP will continue to see opportunities to recruit additional pediatric mid-level providers in Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma counties. Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category. This impacted the number of sufficient OB/GYN at all levels (MD, DO, NP) across the frontier counties. For behavioral health, Cheyenne and Sedgwick counties did not meet access for Psychiatric Residential Treatment Facilities within the required distance. In large part, access for this level of services is a challenge due to the sparse provider/facility availability in rural and frontier regions. This will require work with the Department and community partners to address.

Network Directory

Supporting contract reference: For each of the following practitioner/practice site/entity types covered under this contract the MCE must make the following information on the MCE's network practitioners/practice sites/entities available to the enrollee in paper form upon request and electronic form:

- Practitioner/practice site/entity's name as an individual or entity, as well as any group affiliations,
- Business street address,
- Telephone number,
- Electronic mail address,
- Website URLs, as appropriate,
- Specialties, as appropriate,
- Whether network practitioners/practice sites/entities will accept new enrollees,
- The cultural and linguistic capabilities of network practitioners/practice sites/entities, including languages (including ASL) offered by the practitioner/practice site/entity or a skilled medical interpreter at the practitioner's office, practice site, or entity location, and whether the practitioner/practice site/entity has completed cultural competence training,
- Whether network practitioner's offices, practice sites, or entity locations have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Table 18-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE practitioner/practice site/entity network information updated at least monthly?** **Did the MCE make the network practitioners'/practice sites'/entities' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
NHP lists the Provider Directory on the following URL https://www.northeasthealthpartners.org/members/find-a-provider/. A Member can contact Member Services to request the provider directory in paper form and electronic form by calling 1-888-502-4189. The provider directory data is updated when providers report a change through Beacon's provider portal or by calling Provider Relations. When NHP identifies a change, the provider is contacted to verify the information and submit any appropriate changes. The Provider Directory on the NHP website is updated at least once a month.

COLORADO
Department of Health Care Policy & Financing

Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-A and A-B below to list individual practitioners with SCAs and describe the MCE's use for SCAs.

Table A-A-Practitioners with SCAs: Data

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Primary Care*
CHP+ MCO, Medicaid MCO, RAE				
ABBATE, LAUREN	50800086	Logan	BV100	Psychiatrists
ANGELIDIS, MATTHEW	26788217	El Paso	BV100	Psychiatrists
ARGUELLES, CARLOS	90371861	Larimer	BV100	Psychiatrists
AST, AARON	48658375	Larimer		Uncategorized Practitioner
AUGUST, COLLEEN	22871853	Weld		Uncategorized Practitioner
AUSTIN, EVERETT	35130253	Larimer	BV100	Psychiatrists
BELLOWS, JASON	85201871	Jefferson	BV100	Psychiatrists
BORCHERS, LYNN	9000155095	Larimer		Uncategorized Practitioner
BRADLEY, JOHN	92970311	Boulder	BV100	Psychiatrists
BROWN, TRAVIS	38456541	Larimer	BV100	Psychiatrists
BYE WOLFE, VALERIE	61453731	Adams	BV132	Licensed Professional Counselors (LPCs)
CAMPAIN, JIM	1326974	Weld	BV100	Psychiatrists
CARNAHAN, ERIN	77854560	Weld		Uncategorized Practitioner

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
CLARK, CHRISTOPHER	68900066	Weld	BV100	Psychiatrists
CLEVELAND, SHARON	49205030	Weld	BV132	Licensed Professional Counselors (LPCs)
COOK, JOHN	9000148652	Larimer	BV100	Psychiatrists
CROSWAITE BRINDLE, KHARA	57150257	Denver	BV132	Licensed Professional Counselors (LPCs)
CUPRISIN, CAREY	83132261	Adams	BV100	Psychiatrists
DAVIDSON, PAUL	1312404	Denver	BV100	Psychiatrists
DAY, LUKE	96770058	Larimer	BV100	Psychiatrists
DEBORD, SARAH	68917503	Weld	BV100	Psychiatrists
DELLOTA, KRISS	27607861	Larimer	BV100	Psychiatrists
DEVRIES, ERIC	9000174584	Adams	BV100	Psychiatrists
DILLE, RENEE	60300078	Boulder	BV100	Psychiatrists
DOYLE, ROBERT	66009057	Larimer	BV100	Psychiatrists
FARMER, BRANDON	9000150810	Larimer	BV100	Psychiatrists
FLYNN, R. KEVIN	58186824	Jefferson	BV100	Psychiatrists
FRALICH, THOMAS	66456762	Larimer	BV100	Psychiatrists
FROST, HELEN	38812541	Weld	BV130	Licensed Clinical Social Workers (LCSWs)
GITLER, CYNTHIA	9000151692	Weld	BV100	Psychiatrists
GREEN, GABRIEL	98279246	Larimer	BV100	Psychiatrists
HACKMAN, SCOTT	9000147125	Adams	BV100	Psychiatrists

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
HAMEL, JOSEPH	31738761	Larimer		Uncategorized Practitioner
HARROD, CANDACE	80856276	Adams	BV100	Psychiatrists
HILLIS, GENEVIEVE	9000148976	Logan	BV100	Psychiatrists
HOBBS, PAIGE	21028575	Larimer		Uncategorized Practitioner
INGOLDBY, CHLOE	9000150860	Boulder	BV100	Psychiatrists
JONES, ERIC	9000174890	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)
KAMENSKI, JEFFREY	37824384	Larimer		Uncategorized Practitioner
KAN, JUSTIN	9000144516	Weld	BV100	Psychiatrists
KAO, AMANDA	87927772	Boulder	BV100	Psychiatrists
KARBER, NATHAN	86374273	Jefferson	BV100	Psychiatrists
KLEMT, RYAN	58220089	Adams	BV100	Psychiatrists
KRAMER, JANELLE	9000165514	Jefferson	BV132	Licensed Professional Counselors (LPCs)
LANDSGAARD, HENRY	95937072	Larimer	BV100	Psychiatrists
LANGENFELD, STASIA	9000144302	Larimer		Uncategorized Practitioner
LARIMORE, KATHERYN	9000163696	Adams	BV100	Psychiatrists
LAWS, ELIZABETH	9000174550	Weld	BV100	Psychiatrists
LEINS, DARLENA	93222262	Larimer	BV100	Psychiatrists
LEO, COREY	22285270	Larimer		Uncategorized Practitioner
LUND, DEBORAH	7650779	Boulder	BV100	Psychiatrists

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
MARTIN, MATTHEW	18513522	Larimer	BV100	Psychiatrists
MCLEAN, JAMES	64102351	Larimer		Uncategorized Practitioner
MCNAB, KEITH	9000162574	Weld	BV100	Psychiatrists
MCNALLY, THOMAS	8431345	Larimer		Uncategorized Practitioner
MCNITT, WILLIAM	9000149446	Adams	BV100	Psychiatrists
MENEFEE, JULIE	18525539	Larimer		Uncategorized Practitioner
MIANZO, DANIELLE	16433734	Weld	BV100	Psychiatrists
MONTOYA, BARBRA	94773301	Larimer	BV132	Licensed Professional Counselors (LPCs)
MOORE, MAUREEN	833843	Weld	BV102	Psychiatric NPs
MORTENSEN, D KILEY	90002075	Boulder	BV100	Psychiatrists
NEVRIVY, MARY	9000147853	Weld	BV100	Psychiatrists
O'MARA, ADAM	9000157787	Weld	BV100	Psychiatrists
PEROTTI, KEVIN	91782058	Larimer		Uncategorized Practitioner
PERRIN, LINDA	9000149095	Larimer	BV102	Psychiatric NPs
PHILBECK, GEORGE	20302843	Larimer	BV100	Psychiatrists
PITTS, HANNAH	9000159661	Arapahoe	BV130	Licensed Clinical Social Workers (LCSWs)
REICHERT, BROCK	9000151754	Larimer		Uncategorized Practitioner
REINERSMAN, EUGENE	21378045	Larimer	BV100	Psychiatrists
RICHTER, EMILY	9000142905	Larimer	BV120	Psychologists (PhD, PsyD) - General

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
RICKETT, DEVIN	9000146967	Larimer	BV100	Psychiatrists
ROWH, MARTA	9000170641	Weld	BV100	Psychiatrists
ROY, CAROLINE	9000144936	Boulder	BV130	Licensed Clinical Social Workers (LCSWs)
SALSBERG, JEREMY	9000150144	Weld	BV100	Psychiatrists
SCOTT, CHRISTOPHER	43507786	Larimer		Uncategorized Practitioner
STADIE, DEREK	55220061	Larimer	BV100	Psychiatrists
STAFFORD, AARON	14279835	Adams	BV100	Psychiatrists
STEPHENS, NATHANIEL	9000157631	Larimer	BV100	Psychiatrists
STUEVEN, JEREMY	72639563	Larimer	BV100	Psychiatrists
SULLIVAN, PAUL	1373075	Boulder	BV100	Psychiatrists
THEILER, ALEXANDER	37280058	Larimer		Uncategorized Practitioner
TIGCHELAAR, MATTHEW	91528364	Adams	BV100	Psychiatrists
TREMBLAY, DARREN	82806861	Weld	BV100	Psychiatrists
VAUGHN, TYLER	9000169932	Larimer	BV100	Psychiatrists
VINCENT, EVAN	9000174190	Larimer	BV100	Psychiatrists
WEDEL, CYNTHIA	17687047	Weld	BV130	Licensed Clinical Social Workers (LCSWs)
WHITE, HILARY	75481774	Larimer		Uncategorized Practitioner
WIERCINSKI, ADAM	9000174204	Jefferson	BV100	Psychiatrists
WILL, TONI	3359018	Weld		Uncategorized Practitioner

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
WILLIS, WINSTON	14770067	Weld	BV100	Psychiatrists
WOLF, RYAN	31505244	Larimer		Uncategorized Practitioner

Table A-B-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. **Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.**
CHP+ MCO, Medicaid MCO, RAE
Out-of-network providers are able to request SCAs to render service for NHP Members for the purpose of continuity of care or specialty services that are not available through the current network (e.g., psychiatrists). Additionally, providers who are undergoing the credentialing process may request SCAs to start working with NHP Members. The majority of the providers who rendered services through a SCA during the reporting period have initiated the credentialing process. Provider Relations monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process. Providers in the credentialing process and are using SCAs to render services are monitored to ensure they complete credentialing and formally join the network.

Appendix B. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

Appendix C. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.