APPLICATION FOR MODIFICATION OF LICENSURE SERVICE AREA EXPANSION

North Carolina Department of Insurance
Life and Health Division
1201 Mail Service Center
Raleigh, NC 27699-1201
(919) 733-5060

ABOUT THE MODIFICATION TO HMO CERTIFICATE OF AUTHORITY PROCESS

The North Carolina Department of Insurance (Department) is the only agency in North Carolina responsible for the regulation of Health Maintenance Organizations. Many separate Divisions within the Department play a role in the ongoing regulation. In some instances, more than one Division will be involved in a particular regulatory issue, but in other instances, you may deal with only one Division.

Life and Health Division: (919) 733-5060
This division is responsible for coordinating the review of Certificate of Authority modification applications and making the final recommendation as to whether or not the Commissioner should grant requested modifications.

Actuarial Services Division: (919) 733- 3284
This division is responsible for reviewing premium rate setting methodologies and rating assumptions. Review will also rely upon financial condition and Financial Feasibility Plan.

Financial Division: (919) 733-5631
This division is responsible for reviewing the financial solvency issues, including the Financial Feasibility Plan, Insolvency Protection Plan and Financial Statements. Also responsible for determining levels of working capital and reserves appropriate to the application submitted.

Pre-Application Meeting

If the applicant has not scheduled and/or already participated in a pre-application meeting with the NCDOI you must contact the Life and Health Division to schedule an informational meeting to review the service area expansion process and requirements. This meeting is essential for the successful completion of the application. This meeting is most productive when scheduled once you have begun to complete the application, but well prior to submission, in order that you may have prepared specific and informed questions. The application may be impacted by the answers received during the meeting.

If the HMO has current issues open with the Department, they may impact the review of this application.

The issues to be discussed at this meeting include but are not limited to:

- What information must be included in the application
- Additional information that may be included in the application
- Financial requirements
- Accessibility and availability requirements
- Requesting the service area
- Regulatory changes which may effect the application

INSTRUCTIONS FOR FILING A SERVICE AREA EXPANSION

In an effort to reduce the processing tim e for the approval of an expansion of service area request, the North Carolina Departm ent of Insu rance (NCDOI) has prepared these guidelines which m ay be used to assist the applicant in com pletion of a Service Area Expansion Application.

The application references North Carolina statut es and regulations, which m ust be m et by the applicant in order to receive approval to m odify the HMO certificate of authority. Please be advised this list is not all-inclusive and it r ecommended the applicant contact the publisher for a complete reference of applicable statutes and regulations.

General Statutes of North Carolina - Insurance, Chapters 58 and 58A - The Michie Company
(800) 446-3410
North Carolina Regulations - National Insurance Law Service
(800) 423-5910

GENERAL FILING REQUIREMENTS

The North Carolina Department of Insurance (NCDOI) has prepared this guideline and checklist to help HMOs prepare their applications in a manner that promotes prompt and thorough review by the NCDOI. **This guideline is not all-inclusive.** Each Exhibit or sections submitted to the NCDOI must be accompanied by the appropriate supporting documentation, in the order requested. The NCDOI will not accept an incomplete application. The application cannot be amended once submitted, except for specific changes requested by the NCDOI.

The application and all of its contents will become public information immediately upon submission. The NCDOI is authorized to protect only legitimate trade secrets from public view. The NCDOI approves trade secret, confidential information on a section by section basis, rather than entire documents. Therefore, written information must be submitted that identifies the specific areas requested to be classified as confidential. In order to have material classified as trade secret and thereby confidentially maintained by the Department, an applicant must:

1. Indicate clearly the specific information to be treated as a trade secret;
2. Submit a written memorandum to the Life and Health Division explaining why this information qualifies as a trade secret pursuant to North Carolina General Statute (NCGS) Chapter 24, Article 66, Section 152 and Article 132 Section 1.2. This information must include specific explanations as to how and why the area meets the definition of trade secret and not a restatement of the definition itself (e.g. how economic value could be obtained)

The explanation and the indicated materials will be reviewed by the Life and Health Division and legal counsel to determine if it meets the criteria as outlined in NCGS 24-66-152 and 132-1.2. The applicant will be notified of the decision rendered. Historically, little information included in the application has been determined to qualify as a trade secret.
In accordance with 11 NCAC 11C .0311, applications for expansion of service area must demonstrate at least a minimum of one year of net operational gains by the applicant in the current approved service area.

Filing Instructions are available on-line at the following link:
http://www.ncdoi.com/lh/lh_filings_instructions.asp

- The $500.00 filing fee may be mailed to the Department if filing electronically
- The application must be labeled properly with the applicant's name
- A cover letter must be submitted with the application
- Label and identify the separate exhibits describing the contents of the application
- Identical items should be cross-referenced, rather than duplicated throughout the document
- Signed documents may include electronic signature

APPLICATION REVIEW PROCESS

Access to the application will be shared with each of the above listed Divisions. The application will be available for public review. Once received by each Division, the application will be assigned to a particular analyst in each Division. The applicant will be notified in writing within five business days of the name of each contact person.

Within the Life and Health Division, the application will become a work unit identified by a LH Tracking Number and assigned to an Analyst, who will then become the primary point of contact for routine matters relating to the review.

The Life and Health Division and the Actuarial Services Division will concurrently review applications. The applicant will receive correspondence from each Division and at this point responses should be addressed directly to the particular Division regarding its questions and concerns. The Financial Evaluation Division conducts a preliminary review of the application, however this review cannot be completed until rating methodologies and projections are secured and finalized by the Actuarial Services Division. The applicant does not typically develop new member forms with an expansion request however, the Life and Health Division will receive any new member materials under a separate filing.

Applicants are required to respond within 90 days of receiving correspondence from any Division. All applicable Divisions should be copied on the response. If the response is not received within this time frame, the application will be closed.

The entire application will be approved at one time. Approval for use of all submitted items is granted through a letter from the Life and Health Division, which lists the additional counties granted. This letter should be attached to your Certificate of Authority as a new Certificate of Authority will not be issued. Applicants may not expand into additional counties until approval is granted.

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1201 Mail Service Center

Raleigh, NC 27699-1201

Assigned to (internal use only):	Date Received:
Returned:	
Qualified and accepted:	Application Fee Received:
	Date Distributed to Divisions:

APPLICANT INFORMATION

Applicant's Name**:** _____

Applicant's Address:_____

_____

Counsel Name, Address, Phone Number:_____

_____

Name of Contact Person Responsible for Application ,Address, Phone Number:

_____

_____

Proposed Date of Expansion : _____

(Date)

EXHIBITS

The following exhibits are required pursuant to North Carolina General Statutes (NCGS) Chapter 58, Article 67, Section 10 (d)(1) and Title 11 of the North Carolina Administrative Code (NCAC) Chapter 20, Section 0600. The exhibits should be clearly labeled as Exhibit 1, 2, 3 etc. Any attachments to the Exhibit should be labeled 1a, 1b, 1c etc., and referenced accordingly.

EXHIBIT 1: BASIC ORGANIZATIONAL DOCUMENT

- This exhibit should contain any amendments to the basic organizational documents including the articles of incorporation or associations, partnership agreement, or other applicable documents and articles of amendments from the Secretary of State, which will result from modifying the existing service area.

- **If there is no change to existing documents on file, please so indicate.**

EXHIBIT 2: BYLAWS, RULES, REGULATIONS, ETC.

This exhibit typically includes amended bylaws or rules and regulations or similar documents regulating the conduct of the internal affairs of the applicant which have been made as a result of this expansion request. The documents should be certified copies.

If there is no change to existing documents, please so indicate.

EXHIBIT 3: NAMES, ADDRESSES AND POSITIONS OF OFFICERS AND BOARD

- This exhibit should list the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association **if not already on file**. **Label Exhibit 3a**

- A biographical affidavit has been supplied with this exhibit. Application Forms must be completed and signed for each of the officers and directors **not already on file** with the Department. All questions must be answered and if the question is not applicable, or the answer is none, please so indicate. **Label Exhibit 3b**

- The list of Officers and Board members should be consistent with the Company's current bylaws, including number of board members and number and title of officers.

- Throughout the process, provide the Department with updates, including applicable biographical affidavits, as officers and board members change or are added.

- **If there is no change to existing documents, please so indicate.**

EXHIBIT 4: PROVIDER CONTRACTS / ADMINISTRATIVE CONTRACTS

This exhibit must contain a copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in Exhibit 3, **which will result from submission of this expansion request**. **All contracts must be submitted to the Department for review and approval.**

Any management or administrative agreements entered into pursuant to NCGS-58-67-30 and/or NCGS 58-19 must be submitted for review and approval prior to use, **which will result from submission of this expansion request**. Such contracts should clearly outline the obligations of both parties including the services to be provided to the HMO and the fee to be paid by the HMO. Services to be provided to the HMO should be outlined in terms of operational areas, support staff, etc.

- Review the regulations provided with this exhibit which outline the provisions which must be included in all provider contracts
- Review the regulations provided with this exhibit which outline the provisions which must be included in all intermediary contracts
- Provider contracts must be secured prior to the Department granting approval of a service area expansion request.

If there is no change to existing documents, please so indicate.

PROVIDER CONTRACT PROVISIONS

. The following provisions should be included in provider agreements:

- Definitions of all technical insurance and managed care terms used in the contract such as:
    - all terms with specific insurance or managed care meanings
    - clinical peer, if used in the contract
    - covered person, if used in the contract
    - emergency medical condition, if used in the contract
    - emergency services, if used in the contract
    - grievance, if used in the contract
    - medical necessity, if used in the contract
    - stabilize, if used in the contract
    - urgent care, if used in the contract
    - terms with member payment implications (deductible, coinsurance, copayment, covered services, etc.)
    - terms with provider payment implications (capitation, withhold, etc.)
- General Provisions, including:
    - Term of contract
    - Requirements for written notice of termination and each party's grounds for termination
    - Provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations should address:

    - transition of administrative duties and records
    - continuation of care, when inpatient care is on going.

    - Contract and specified amendments, exhibits, attachments or addendums constitute the entire contract between the parties
    - Contract not assignable by provider, or not assignable by provider without written consent of the HMO
    - Nondiscrimination provision
    - North Carolina governing law
- Provider Representations and Warranties:
    - Current unrestricted license
    - Requirement to notify the HMO of changes in the status of license
    - Unrestricted hospital privileges, at a minimum of one HMO contracted hospital, if applicable
    - Requirement to notify the HMO of changes in the status of hospital privileges, if applicable
    - Professional liability insurance coverage of specified per occurrence and per annum amounts
    - Requirement to notify the HMO of changes in the status of professional liability insurance
    - Current unrestricted DEA Registration Certificate, if applicable
    - Requirement to notify the HMO of changes in the status of narcotic prescribing privileges, if applicable
    - Facility accredited by the Joint Commission on Accreditation of Healthcare Organizations, if applicable

- Requirement to notify the HMO of revocation or suspension of JCAHO accreditation, if applicable
- Certified to participate in the Medicare/Medicaid program, if applicable
- Requirement to notify the HMO of any sanctions imposed by the Medicare Program, if applicable

- Provider Obligations:
  - Provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials
  - Provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of such.
  - Provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles (prepaid basis only)
  - Provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services
  - Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility
  - to participate in the Medicare/Medicaid program, if applicable
  - Requirement to notify the HMO of any sanctions imposed by the Medicare Program, if applicable
  - For capitated programs, provision or attachment describing the specific health care services to be provided
  - Member hold harmless provision
  - Requirement to practice in accordance with professionally recognized standards of care
  - Emergency service/admission notification requirements, if applicable
  - Provider required to participate in and cooperate with the HMO's:
    - utilization review program
    - quality assurance program
    - credentialing program
    - sanctions program, if separate from utilization review, quality assurance and/or credentialing program
    - member grievance program
    - practice site visits
    - coordination of benefits program
    - claims submission requirements
    - procedures and requirements for referrals
  - Maintain medical records of members in accordance with industry standards or specific standards developed or adopted by the HMO
  - Make medical records available for review by the HMO
  - Maintain the confidentiality of member medical records and other personal information
  - Provide 24 hour per day, seven day per week call coverage, if applicable
  - Continuing obligation after termination of contract

    - Collect applicable member deductibles, copayment, coinsurance and fees for noncovered services

- HMO Obligations:
    - Detailed description of payment methodology and risk arrangements, if any
    - Provide information on benefit plans, administrative and utilization management requirements and timely notification of changes in such requirements (i.e., practice administrative manual)
    - Provide member identification cards and a mechanism for verifying member coverage
    - Provider dispute resolution mechanism
    - Provide performance feedback reports/information if fees are related to efficiency criteria
    - List provider in Provider Directory (when authorized by provider) and make the directory available to members

Please also note the following:

- Mandatory, binding arbitration for members is prohibited by NCGS 58-3-35. Therefore, binding arbitration for members should not be referenced in provider contracts.
- Because the Department strongly discourages HMOs from practicing subrogation, provider contracts should not reference it either.
- HMOs are discouraged from filing for bankruptcy under federal code in North Carolina, pursuant to NCGS 58-67-5 (f) which defines an HMO as a domestic insurance company for purposes of USC 11, the federal bankruptcy code. This statute places HMOs under the jurisdiction of the Commissioner of Insurance. In addition, NCGS 58-67-145 outlines provisions for rehabilitation, liquidation or conservation of HMOs. Therefore, provider contracts should reference the more general term "insolvency," rather than bankruptcy.
- Contracts should be in the true, legal name of the Company, as provided by NCGS 58-3-50.
- No language that has the potential to be interpreted as limiting physician actions or communications with members that is consistent with their professional or ethical responsibilities will be permitted. In addition, program requirements for credentialing, utilization management, etc. may not contain such provisions.
- If provider administrative manuals or provider handbooks are referenced within and made a part of the provider contracts, these documents must be submitted for review.
- All exhibits and addendums referenced in the contracts should be submitted for review.

EXHIBIT 5: DESCRIPTION OF HMO OPERATIONS

This exhibit should contain a detailed description of how this significant modification will change existing HMO operations. The description should include, but is not limited to the following information:

- A description of proposed operational changes including claims processing and payment, utilization management, quality management, enrollment and billing, customer service, provider relations, etc.
- The city and state where each operation will be performed (i.e. claims will be paid in Jacksonville, Fl)
- Changes to any affiliates and/or intermediary relationships who will perform operations on behalf of the applicant if known
- Additional Management Information Systems to be employed and location of these systems

ORGANIZATIONAL CHARTS

- Include in this exhibit separate corporate organizational charts which clearly identify the relationships between the applicant and any affiliates.

- Include a chart(s) showing the internal organizational structure of the applicant's management [Officers] and administrative staff [Day-to-Day CEO, Medical Director, CFO, VPs, Secretary, etc..].

EXHIBIT 6: FINANCIAL STATEMENTS

This exhibit should include current financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statements may satisfy this requirement unless the Financial Evaluation Division directs that additional or more recent financial information is required. Please be advised of the following:

- The financial statements and projections filed must be on a statutory accounting basis based upon North Carolina law.

- In accordance with 11 NCAC 11C .0311, applications for expansion of service area must demonstrate at least a minimum of one year of net operational gains by the applicant in the current approved service area.

- The aforementioned requirement may be waived by the Commissioner if additional capital as determined by the Commissioner is placed in the HMO, or if a guaranty agreement approved in writing by the Commissioner, to pay for any loss to enrollees claiming reimbursement due to insolvency of the HMO is made. In order to qualify, the guaranteeing organization must:
  - submit to the jurisdiction of this State for actions arising under the guarantee;
  - submit certified, audited annual financial statements to the Commissioner; and
  - appoint the Commissioner to receive service of process in this State.

EXHIBIT 7: FINANCIAL FEASIBILITY PLAN/FORECASTS

This exhibit should include a financial feasibility plan, which includes a comparison of the actual financial results, including total membership revenues, and expenses to the projected financial results for at least the most recent 12-month period.

A completed financial projection worksheet, available on diskette, and provided by the Actuarial Services Division must contain a three-year financial projection that details total membership, revenues, and expenses and that includes a statement of cash flow, a balance sheet, and a statement of working capital and net worth for both the existing service area and the proposed area of expansion.

A hard copy of the financial projections must also be provided. For the purposes of the Financial Evaluation Division's review, the projections must be on a monthly basis and include year-end totals. If filing electronically the financial projection diskette may be mailed to the Life and Health Division. Please identify the diskette with the assigned LH Tracking Number for proper handling.

RATE COMPLIANCE

In accordance with 11 NCAC 16.0603, the expansion application must include detailed rate development for all proposed benefit packages to be used with the expansion. All rate filings shall include the following data:

- Identification and a brief description of the HMO model type;
- Identification of the enrollee issue basis, whether individual or group;
- Identification and a brief description of the type of rating methodology, such as community rating, community rating by class, adjusted community rating, or other;
- Identification and listing of all rate classification factors, such as age, gender, geographic area, industry, group size, or effective date;
- A brief summary description and numerical demonstration of the development of the capitated rate, including a listing of sources used;
- A brief summary description and numerical demonstration of the development of any portion of the premium rate developed for fee-for-service claims, including listing of sources used;
- A brief, summary description of the claim reserving methodology and the incorporation of claim reserves into the premium rate;
- A brief, summary description of the procedure and assumptions used to convert the total per member per month cost to the proposed premium rates; including assumptions for the distribution of community rated contracts by contract type, the ratios by tier to the single rate and the average number of members in each contract type;
- The projected monthly incurred loss ratios by tier to the single rate, and the average number of members in each contract type;
- The projected monthly incurred loss ratios for the period of time equal to the number of months for which the rates will be in effect, plus the number of months the rates will be guaranteed;
- The percentage of the per member per month premium for administrative expenses and for surplus.

Please review the rate bulletins, provided with this exhibit to ensure continued compliance with North Carolina General Statutes and Regulations with respect to rating practices.

EXHIBIT 8: POWER OF ATTORNEY (HMO/POA/LGL)

This exhibit must contain the power of attorney form provided with the application if it has been amended with respect to this expansion request.

If there is no change to existing documents, please so indicate.

EXHIBIT 9: SERVICE AREA

This exhibit should include a com pleted service ar ea form which is provided with this exhibit, indicating by way of a check or x, each county the applicant is proposing to serve. Additionally, a North Carolina Map should be provided which cl early indicates by way of shading or coloring the existing service area and the proposed service area. Please be advised:

- HMOs are licensed in North Carolina by county. Please clearly indicate which counties are being requested. Changes in the requested service area after the application has been received will necessitate a new filing.

- A provider network must support each county requested. Signed provider contracts must be submitted to the Department during the review process.

- Failure to demonstrate an adequate network in a given county will result in that county being excluded from the service area. The deletion of counties from the service area is likely to result in a requirement for a revised financial feasibility plan.

- Phased-in service areas are not permitted.

- Service area expansions requests cannot be made within the first 12 months of operation.

EXHIBIT 10: INSOLVENCY PROTECTION PROVISIONS

This exhibit must provide the HMO's provisions for protection against insolvency pursuant to NCGS 58-67-110, 115 and 120 if the HMO is proposing a change from its current protection.

If a reinsurance agreement is to be used to satisfy the provisions of Article 67 (detailed below), a draft of that agreement must be filed with the application. The reinsurance agreement must be with an insurance company licensed to do business in North Carolina. The applicant must indicate that the reinsurance agreement is filed pursuant to which, if any of the following:

- NCGS 58-67-110(e) - Protection Against Insolvency.
- NCGS 58-67-11(B)(1)(b) - Hold Harmless Agreements or Special Deposit.
- NCGS 58-67-120 - Continuance of Benefits.

Reinsurance agreements require the prior approval of the Department before execution. An executed copy of the agreement must be received prior to issuance of the applicant's license.

- If a guaranty is to be used to meet the provisions of Article 67 (detailed below) a draft of the Agreement, which is in substantial com pliance with the Departm ent's m odel guaranty agreement (available upon request), m ust be filed with this exhibit. The current financial statements of the guarantor m ust be filed with the Agreem ent. The applicant m ust indicate that the guaranty agreement is filed pursuant to either, or both of the following:

  - NCGS 58-67-110 - Protection Against Insolvency.
  - NCGS 58-67-115(B)(1)(b) - Hold Harmless Agreements or Special Deposit.

Guaranty Agreements require the prior approval of the Department prior to execution. An executed copy of the agreement must be received prior to the issuance of the applicant's license.

If there is no change to existing provisions, please so indicate

EXHIBIT 11: DESCRIPTION OF GRIEVANCE PROCEDURES

A member grievance procedure should be submitted which describes the internal grievance procedures to be utilized for the investigation and resolution of member complaints and grievances as provided for in NCGS 58-50-62 if it will be amended as a result of this service area expansion request.

If there is no change to existing procedures, please so indicate.

EXHIBIT 12: CLAIMS ADMINISTRATION

A description of the claims administration system should be submitted which clearly demonstrates any changes to the HMOs current compliance with provisions of NCGS 58-3-172, 58-63-15 and 11 NCAC 4.0319.

If there is no change to the existing systems, please so indicate.

EXHIBIT 13: PROVIDER CREDENTIALING PLAN

This exhibit should contain all program documents which have been developed in accordance with 11 NCAC 20.0400 which will change as a result of this service area expansion request. This may include but not be limited to: provider credentialing plan, credentialing policies, procedures and/or criteria provider/facility credentialing application, tools used to assess provider capabilities such as office assessments, provider profiles etc.

If there is no change to existing documents, please so indicate.

EXHIBIT 14: QUALITY MANAGEMENT PROGRAM

This exhibit should include all program documents which assure quality of care and health care services managed and provided through the health care plan in accordance with 11 NCAC 20.0500 which will change as a result of this service area expansion request.

If there is no change to existing documents, please so indicate .

EXHIBIT 15: UTILIZATION MANAGEMENT PROGRAM

A utilization review program document should be submitted which clearly demonstrates compliance with each provision of NCGS 58-50-61 and 58-50-62 if it will change as a result of this service area expansion request.

If there is no change to existing documents, please so indicate

EXHIBIT 16: PROVIDER AVAILABILITY STANDARDS

This exhibit should include the provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees in the proposed service area which meets all the requirements of 11 NCAC 20.0301 and 20.0304

Provider availability standards must be submitted and should address the following:

- Each network plan carrier must establish a methodology to determine the size and adequacy of the provider network necessary to serve its members. The methodology must provide for the development of performance targets that address the following:
  1. The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier;
  2. A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier; and
  3. A method for arranging or providing health care services outside of the service area when providers are not available in the service area

EXHIBIT 17: ACCESSIBILITY STANDARDS

This exhibit should include the applicant's provi der network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees in the proposed service area. This exhibit m ust pr ovide all docum entation, which dem onstrates compliance with 11 NCAC 20.0302, 20.0303 and 20.0304

Provider accessibility standards must be submitted and should address the following:

- Each network plan carrier must establish performance targets for member accessibility to primary and specialty care physician services, hospital-based services, and health care services provided by non-physician providers. Written policies and performance targets must address the following:
  1. Proximity of network providers as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care and hospital services, taking into account local variations in the supply of providers and geographic considerations;
  2. The availability to provide emergency services on a 24-hour, seven day per week basis;
  3. Emergency provisions within and outside of the service area; and
  4. The average or expected waiting time for urgent, routine and specialist appointments.

- HMOs must demonstrate that the services provided will be accessible in each expansion county requested. In order to demonstrate the accessibility of the network, please submit the following:
  - Accessibility standards (i.e., ratio of physicians to members, drive time, distance to providers in terms of mileage, etc.)
  - A chart illustrating provider interest in all requested counties, broken down by county and provider specialty including mental health and ancillary. Hospital interest should also be included.

Please be advised, if the HMO is unable to meet its availability and accessibility standards in all counties and/or there is no interest in counties where physicians are available, those counties may not be approved for expansion.