**General:**

**INSTRUCTIONS**

(MA State Certification Form)

This form is required to be submitted with all MA applications. The MA applicant is required to complete the items above the line (items 1 - 4), then forward the document to the appropriate State Agency Official who should complete those items below the line (items 5-8). After completion, the State Agency Official should return this document to the applicant organization for submission to CMS as part of its application for a MA contract.

The questions provided must be answered completely. The completed form must be current and must include the requested service area. Forms submitted for prior years’ applications will not be accepted. If additional space is needed to respond to the questions, please add pages as necessary. Provide additional information whenever you believe further explai1ation will clarify the response.

The MA State Certification Form demonstrates to CMS that the MA contract being sought by the applicant organization is within the scope of the license granted by the appropriate State regulatory agency, that the organization meets state solvency requirements and that it is authorized to bear risk. A determination on the organization's MA application will be based upon the organization's entire application that was submitted to CMS, including documentation of appropriate licensure.

# Items 1 - 4 (to be completed by the applicant):

* + 1. List the name, d/b/a (if applicable) and complete address of the organization that is seeking to enter into the MA contract with CMS.
		2. Indicate the type of license (if any) the applicant organization currently holds in the State where the applicant organization is applying to offer an MA contract.
		3. Specify the type of MA contract the applicant organization is seeking to enter into with CMS.
		4. Enter the National Association of Insurance Commissioners (NAIC) number if there is one.

New Federal Preemption Authority-The Medicare Modernization Act amended section 1856(b)(3) of the SSA to significantly broaden the scope of Federal preemption of State laws governing plans serving Medicare beneficiaries. Current law provides that the provisions of Title XVIII of the SSA supersede State laws or regulations, other than laws relating to licensure or plan solvency, with respect to MA plans.

# Items 5 - 8 (to be completed by State Official):

* + 1. List the reviewer's pertinent information in the event CMS needs to communicate with the individual conducting the review at the State level.
		2. List the requested information regarding other State departments/agencies required to review requests for licensure.
		3. A. Circle where appropriate to indicate whether the applicant meets State financial solvency requirements. ·· ··
			1. Indicate State Agency or Division, including contact name and complete address, that is responsible for assessing whether the applicant meets State financial solvency requirements.
		4. A. Circle where appropriate to indicate whether the applicant meets State licensure requirements.
			1. Indicate State Agency or Division, including contact name and complete address, that is responsible for assessing whether the applicant meets State licensing requirements.

# MEDICARE ADVANTAGE (MA) STATE CERTIFICATION REQUEST

MA applicants should complete items 1-4.

1. MA applicant Information (Organization that has applied for MA contract(s)): Name

D/B/A (if applicable)

Address

City/State/Zip

1. Type of State license or Certificate of Authority currently held by referenced applicant: (Circle more than one if entity holds multiple licenses)
	* HMO • PSO • PPO • Indemnity • Other----

Comments:

1. Type of MA application filed by the applicant with the Centers for Medicare

& Medicaid Services (CMS): (Circle all that are appropriate)

* + HMO • PPO • MSA • PFFS • Religious/Fraternal Requested Service Area:
1. National Association of Insurance Commissioners (NAIC) number:

I certify that ’s application to CMS is for the type of MA plan(s) and the service area(s) indicated above in questions 1-3.

MAO

Date

CEO/CFO Signature

Title

**(An appropriate State official must complete items 5-8)**

**Please note that under section 1856(b)(3) of the SSA and 42 CFR 422.402, other than laws related to State licensure or solvency requirements, the provisions of title XVIII of the SSA preempt State laws with respect to MA plans.**

1. State official reviewing MA State Certification Request: Reviewer's Name

State Oversight/Compliance Officer Agency Name

Address Address City/State Telephone

-

E-Mail Address

1. Name of other State agencies (if any) whose approval is required for licensure:

Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Financial Solvency:

Does the applicant organization named in item 1 above meet State financial solvency requirements? (Please circle the correct response)

•Yes• No

Please indicate which State Agency or Division is responsible for assessing whether the named applicant organization meets State financial solvency requirements.

1. State Licensure:

Does the applicant organization named in item 1 above meet State Licensure requirements? (Please circle the correct response)

•Yes• No

Please indicate which State Agency or Division is responsible for assessing whether this organization meets State licensure requirements.

**State Certification**

I hereby certify to the Centers for Medicare & Medicaid Services (CMS) that the above organization (doing business as (d/b/a) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) is:

(Check one)

 licensed in the State of as a risk bearing entity, or

 authorized to operate as a risk bearing entity in the State of

And

(Check one)

 is in compliance with State solvency requirements, or

 State solvency requirement not applicable [please explain below].

By signing the certification, the State of is certifying that the organization is licensed and/or that the organization is authorized to bear the risk associated with the MA product circled in item 3 above. The State is not being asked to verify plan eligibility for the Medicare managed care products(s) or CMS contract type(s) requested by the organization, but merely to certify to the requested information based on the representation by the organization named above.

Agency

Date

Signature

Title