MEDICARE ADVANTAGE (MA)
STATE CERTIFICATION REQUEST

MA applicant should complete items 1-3.

1. MA Applicant Information~~-~~ ~~:~~(Organization that has applied for MA contract(s)):

   Name_____

   D/B/A (if applicable~~)~~ ~~-~~ ~~)~~ _____

   Address_____

   City/State/Zip_____

2. Type of State license or Certificate of Authority currently held by referenced applicant: (Check more than one if entity holds multiple licenses)

   ❒ HMO ❒ PSO ❒ PPO ❒ Indemnity ❒ Other_____

   Comments:

3. Type of MA application referenced applicant has filed with the Centers for Medicare & Medicaid Services (CMS): (Check all that are appropriate)

   ❒ HMO ❒ PPO ❒ MSA ❒ PFFS ❒ Religious Fraternal

   Requested Service Area: _____

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

_____
MA Organization

_____ _____
Date CEO/CFO Signature

_____
Title

(An appropriate State official must complete items 4-7.)

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

4 State official reviewing MA State Certification Request:

Reviewer's Name_____

State Oversight/Compliance Officer _____

Agency Name_____

Address_____

City/State_____

Telephone_____

E-Mail Address _____

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

Agency_____

Contact Person_____

Address_____

City/State_____

Telephone_____

E-Mail Address _____

6. Financial Solvency:

Does the applicant organization named in item 1 above meet State financial solvency requirements?

❒ Yes ❒ No

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

7. State Licensure:

Does the applicant organization named in item 1 above meet State Licensure requirements?

❒ 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 _____) 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 checked 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.~~herein~~.

~~that the aforementioned organization is authorized to bear the risk associated with the type of Medicare Advantage contract(s) indicated above.~~

_____
Agency

_____ _____
Date Signature

_____
Title

INSTRUCTIONS

(MA State Certification Form)

General:

This form is required to be submitted with all Medicare Advantage (MA) applications. The MA applicant organization is required to complete the items above the line (items 1 - 3), then forward the document to the appropriate State Agency Official who should complete those items below the line (items 4-7). 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. Applicants should place this document in the Organizational and Contractual section of the application in the Legal Entity subsection.

The questions provided must be fully completed. If additional space is needed to respond to the questions, please add pages as necessary. Provide additional information whenever you believe further explanation will clarify the question.

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 as submitted to CMS, including documentation of appropriate licensure.

Items 1 - 3 (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) applicant organization currently holds in the State where applicant organization is applying to offer an MA contract.
3. Specify the type of MA contract applicant organization is seeking to enter into with CMS.

New Federal Preemption Authority – The Medicare Modernization Act amended section 1856(b)(3) of the Social Security Act 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 Social Security Act supersede State laws or regulations with respect to MA plans other than laws relating to licensure or plan solvency.

Items 4 - 7 (to be completed by State Official):

4. List the reviewer's pertinent information in case CMS needs to communicate with the individual conducting the review at the State level.
5. List the requested information regarding other State departments/agencies required to review requests for licensure.
6. a. Check the appropriate box to indicate whether the applicant meets State financial solvency requirements.
   b. Indicate State Agency or Division, including contact name and complete address, which is responsible for assessing whether the applicant meets State financial solvency requirements.
7. a. Check the appropriate box to indicate whether the applicant meets State licensure requirements.
   b. Indicate State Agency or Division, including contact name and complete address, which is responsible for assessing whether the applicant meets State licensing requirements.