
CMS Manual System

Pub. 100-10 Medicare Quality Improvement Organizations

**Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)**

Transmittal 5

Date: AUGUST 1, 2003

| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
|-----------------|-------------------------|---------------------|-------------------------|
| 3 | | Table of Contents | |
| 3 | | 3000 - 3210 | |
| 3 - Exhibit | | Exhibits 3-1 - 3-3 | |

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 1, 2003

Throughout Chapter 3, all references to Health Care Financing Administration (HCFA) are changed to Centers for Medicare & Medicaid Services (CMS), and all references to Peer Review Organization (PRO) are changed to Quality Improvement Organization (QIO). All references to Payment Error Prevention Program (PEPP) are changed to Hospital Payment Monitoring Program (HPMP), and all references to 42 CFR 466 are changed to 42 CFR 476.

Section 3110 - Intermediary/Carrier Memorandum of Agreement (MOA) Specifications instructs the QIO that MOAs must include language to notify a physician of the need for prior authorization for services when the QIO receives a claim from the intermediary made by a physician who failed to have a service authorized prior to furnishing services.

Section 3200 - Introduction defines a MOA and instructs the QIO that the responsibilities of both parties should be clearly outlined in the document.

Section 3210 - Memorandum of Agreement (MOA) With State Agencies Responsible for Licensing\Certification of Providers\Practitioners advises the QIO that each party must sign the agreement. If a modification has been made to the document, each party must agree to its contents and sign the agreement.

Workload and Costs: These instructions do not represent an increase in workloads or costs.

NOTE: Normally red, italic font identifies new material. However, because this release is a new manual, normal text font is used for the initial release.

Quality Improvement Organization Manual

Chapter 3 - Agreements

TABLE OF CONTENTS (Rev. 5, 08-01-03)

MEMORANDUM OF AGREEMENT (MOA) WITH PROVIDERS OF HEALTH CARE SERVICES

- 3000 - Background
- 3005 - Statutory Authority for Memorandums of Agreement (MOAs)
- 3010 - Scope
- 3015 - Provider Memorandum of Agreement (MOA) Specifications
- 3020 - Memorandums of Agreement (MOAs) With Specific Providers

MEMORANDUM OF AGREEMENT (MOA) WITH PAYERS OF HEALTH CARE SERVICES

- 3100 - Introduction
- 3105 - Scope
- 3110 - Intermediary/Carrier Memorandum of Agreement (MOA) Specifications

AGREEMENTS WITH OTHER ORGANIZATIONS

- 3200 - Introduction
- 3210 - Memorandum of Agreement (MOA) With State Agencies Responsible for Licensing\Certification of Providers\Practitioners

EXHIBITS

- Exhibit 3-1 - Model Memorandum of Agreement (MOA) Cover Letter for Providers
- Exhibit 3-2 - Model Memorandum of Agreement (MOA) for Providers
- Exhibit 3-3 - Model Memorandum of Agreement (MOA) for State Licensing\Certification Agency

3000 – Background

(Rev. 5, 08-01-03)

The Memorandum of Agreement (MOA) is a written document that outlines your administrative and review responsibilities and the responsibilities of providers necessary to accomplish certain review requirements under your contract (See §3005 for statutory authority applicable to MOAs). The responsibilities of both parties should be clearly outlined in the MOA.

Quality Improvement Organizations (QIOs) are required to develop, implement, and revise MOAs, acceptable to CMS, with certain providers of health services (i.e., Hospitals, Critical Access Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Medicare + Choice Organizations) who wish to participate or continue to participate in the Medicare program, as specified in the contract with the Secretary. It is the provider's responsibility to sign and return the MOA. In all instances, both the QIO and the provider are expected to honor the terms of the agreement. QIOs are not required to develop MOAs with individual practitioners.

NOTE: QIOs are not required to develop MOAs with individual physicians pertaining to physician services rendered in freestanding physician offices or physician offices related to Medicare + Choice Organization (M+CO) reviews.

3005 - Statutory Authority for Memorandums of Agreement (MOAs)

(Rev. 5, 08-01-03)

The Social Security Act (the Act) contains statutory provisions applicable to MOAs:

- §1154(a)(1) of the Act gives QIOs the authority to review services furnished by physicians, other health care practitioners, and institutional and non-institutional providers of health care services for which payment may be made under Medicare, as specified in the QIO's contract with the Secretary.
- §1154(a)(4)(A) of the Act requires QIOs to provide that a reasonable proportion of the QIOs' activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.
- §1154(a)(7)(C) of the Act requires QIOs to examine the pertinent records of any practitioner or provider of health care services that the QIOs have responsibility for reviewing.
- §1154(a)(14) of the Act requires QIOs to conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

- §1852(e)(3)(A) of the Act requires each M+CO to maintain a written agreement with a QIO or some other independent quality review and improvement organization to review M+CO services for purposes of, among other things, quality review and beneficiary complaints.
- §1866(a)(1)(E) of the Act requires providers of services to have an agreement with QIOs to release data related to patients when a QIO requests it.
- §1866(a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the Prospective Payment System (PPS) to maintain an agreement with QIOs to review the validity of diagnostic information provided by such hospitals, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought.
- §1866(a)(1)(F)(ii) of the Act requires hospitals, Critical Access Hospitals (CAHs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) to maintain an agreement with the QIO to perform certain functions listed in §1866(a)(3)(A).
- §1866(a)(3)(A) of the Act requires QIOs, under MOAs with SNFs, HHAs, CAHs and hospitals, to perform functions described under the third sentence in §1154(a)(4)(A) related to quality and under §1154(a)(14) related to beneficiary complaints.

3010 - Scope

(Rev. 5, 08-01-03)

MOAs specify your administrative and review responsibilities and the providers' administrative and review responsibilities necessary to accomplish certain review requirements under your contract. MOAs are intended to be informational in order to facilitate the review process and to avoid any misunderstandings between you and the provider.

Your MOA with hospitals, HHAs, SNFs, M+COs, and CAHs should reflect your specific review responsibilities referenced in §1866(a)(3)(A), §1154(a)(4)(A), and §1154(a)(14) of the Act concerning these providers.

In addition, your MOA should reflect the specific responsibilities of you and the provider regarding Scope of Work (SOW) activities that fulfill the responsibilities in the MOA (See §3020, MOAs with Specific Providers). Expectations regarding activities under the current SOW applicable to each provider type should be outlined in your MOA such as:

A. Mandatory Case Review -- You are responsible for reviewing specific types of cases, including beneficiary complaints, hospital and M+CO notices of non-coverage (e.g., Hospital-Issued Notice of Non-coverage (HINN) and Notice of Discharge and Medicare Appeal Rights (NODMAR)), assistants at cataract surgery, Diagnosis Related Group (DRG) changes, anti-dumping cases, CAH and/or utilization (payment) determinations by evaluating quality of care, the appropriateness of admission/discharge, Medicare coverage issues, accuracy of coding, or appropriateness of medical services. This is accomplished by the review procedures specified in Chapters 4 and 5. The provider must provide you with the medical record in order for you to conduct these reviews. The results of these reviews may include denial of payment for admission, DRG changes, or confirmed quality of care concerns.

B. Health Care Quality Improvement -- Health Care Quality Improvement Projects are collaborative efforts with entities and individuals such as health care providers, Centers for Medicare & Medicaid Services (CMS), practitioners, M+COs, advocacy groups, specialty societies, and beneficiaries, which promote measurable improvement of processes and outcomes of care for Medicare beneficiaries. The goal is to make measurable improvements in Medicare beneficiary health status or satisfaction. You are required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers and others to improve the processes of care by further reducing the variations and enhancing the results. You use information abstracted from medical records to accomplish this work. The provider is expected to provide all pertinent materials from the medical record for these efforts (See Chapter 4).

3015 - Provider Memorandum of Agreement (MOA) Specifications

(Rev. 5, 08-01-03)

Hospitals, CAHs, SNFs, HHAs, and M+COs providers are required to maintain an agreement with you if they wish to continue to participate in the Medicare program. Examine all agreements currently in use in your review area and modify them to incorporate activities mentioned in the statute and current SOW.

Forward the MOA/modified MOA to the provider for signature and include a return due date in your correspondence to the provider (See Exhibit 3-1). Forward the MOA using certified mail or an equivalent delivery service. Provide an informational copy of the agreement to each provider that signed a MOA.

A. Provisions of Agreement -- MOAs with providers should address certain required activities referenced in the Statute (i.e., §1154(a)(4)(A), §1154(a)(14), §1866(a)(F)(i), and §1866(a)(3)(A) of the Act), as well as those activities in the SOW. At a minimum, include your responsibilities and the responsibilities of the provider regarding the following, if applicable:

- Health Care Quality Improvement Project Activities -- Conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers to improve the processes of care by further developing the variations and enhancing the results.
- Medical Review -- Review of medical services to determine whether the services were reasonable and medically necessary, were furnished in the appropriate setting, and were of a quality that meets professionally recognized standards of care.

NOTE: In hospitals and M+CO MOAs, include review requirements regarding notices of non-coverage (See Chapter 7). In hospital MOAs, include the preadmission and pre-procedure review requirements (e.g., assistants at cataract surgery). For additional information concerning assistants at cataract surgery see §3110A.3 and §3110A.4.

- Data Analysis -- Review of individual patient care data furnished by providers to ensure the validity of all diagnostic and procedural information. Identify requirements that the provider agrees to comply with in providing necessary data and information.
- Claims Analysis -- Review of payment data to determine whether payment may be made for services furnished (as appropriate).
- Complaint Analysis -- Review of cases in response to written beneficiary complaints about the quality of services.
- Confidentiality and Disclosure -- Include confidentiality and disclosure requirements in accordance with §1160 of the Act and 42 CFR Part 480.
- Beneficiary Rights Outreach & Education Activities -- Conduct programs to inform Medicare enrollees about QIO review programs, the role of the QIO, and grievance and complaint procedures.
- Timing of Review -- Conduct review within the timeframes specified in the contract.
- Location of Review -- Specify all locations where QIO review of cases may take place (e.g., at the QIO or facility).
- Work Space for Review Activities -- Address provisions of space for staff to conduct onsite review.
- Corrective Action -- Develop, implement, and complete corrective action plans to address confirmed quality concerns or patterns of quality problems.

- Miscellaneous -- Identify additional review activities and procedures as prescribed by CMS.

B. Signatures -- MOAs must be signed by representatives of your organization and appropriate provider representatives. If a provider refuses to sign the MOA, inform the CMS Project Officer (PO) of this matter.

C. Modifying MOAs -- Modify MOAs when changes in the requirements of the SOW necessitate additional understandings between you and the provider. Representatives of your organization and a representative of the provider organization must sign the revised MOA.

D. Failure to Return, Sign, or Honor the Terms of a MOA -- If a provider fails to return the MOA by the requested due date, or refuses to sign the MOA, or fails to honor the provisions of the MOA, document your efforts and refer the circumstances to your PO for resolution. It is the provider's responsibility to return the signed MOA by the requested due date.

If the provider continues to act outside the provisions of the MOA, the PO should contact the staff in the Regional Division of Medicaid and State Operations (DMSO), Survey and Certification Branch. DMSO will initiate action to terminate the provider agreement based on failure to comply with 42 CFR 489.53(a)(1). If the institution is dissatisfied with a determination that its provider agreement is proposed to be terminated, it is entitled to a hearing and judicial review of that hearing under 42 CFR 498.

3020 - Memorandums of Agreement (MOAs) With Specific Providers

(Rev. 5, 08-01-03)

Your MOA with hospitals, HHAs, SNFs, M+COs, and CAHs should reflect your specific review responsibilities referenced in §1866(a)(3)(A), §1154(a)(4)(A), and §1154(a)(14) of the Act as well as the responsibilities of the provider regarding SOW activities. Your MOA with the providers listed below should include the following specific activities.

A. Hospitals -- Hospitals that provide inpatient hospital services paid under the Prospective Payment System (PPS) are required to maintain an agreement with you to review the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided with respect to services for which payment may be made under Part A of Medicare.

The MOA must stipulate that a reasonable proportion of your activities are involved in reviewing, under §1154(a)(1)(B) of the Act, the quality of services and that a reasonable allocation of these activities be made among different settings. In addition, §1154(a)(14) of the Act requires that you conduct an appropriate review of written complaints from

beneficiaries about the quality of services not meeting professionally recognized standards of care.

B. Home Health Agencies (HHAs) and Skilled Nursing Facilities (SNFs) -- Your MOA with HHAs and SNFs must stipulate that a reasonable proportion of your activities are involved in reviewing, under §1154(a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

Also, include language in your MOA that specifies that you conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care (§1154(a)(14)). Review beneficiary complaints utilizing the review procedures specified in Chapter 5 of the QIO Manual. The provider must provide you with the medical record in order for you to conduct these reviews. The results of the review may include a denial of payment for admission, DRG changes, or confirmed quality of care concerns. Utilize the review procedures specified in Chapter 4 of the QIO Manual when reviewing beneficiary complaints. The provider must provide you with the medical record in order for you to conduct these reviews. The results of the review may include a denial of payment for admission, DRG changes, or confirmed quality of care concerns.

You may also want to include language to address Fiscal Intermediary (FI), Carrier, Clinical Data Abstraction Center (CDAC), CMS, Office of the Inspector General (OIG), and State Agency referrals in your MOA.

Also, include language to address Health Care Quality Improvement Projects. Health Care Quality Improvement Projects are collaborative efforts with health care providers and/or beneficiaries, which promote measurable improvement of processes and outcomes of care for Medicare beneficiaries. The goal is to make measurable improvements in Medicare beneficiary health status or satisfaction. You are required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers to improve the processes of care by further developing the variations and enhancing the results. QIO quality improvement projects typically focus on specific preventative services and care processes known to improve patient outcomes. Quality interventions are measures of how often these critical processes or services are performed or how often desired outcomes are achieved. You use information abstracted from medical records to accomplish this work. The provider is expected to provide all pertinent materials from the medical record for these efforts (See Chapter 4).

Include appropriate specifications in §3015 and refer to the model agreement (See Exhibit 3-1) when preparing the MOA.

NOTE: You may develop one MOA with a parent HHA operating in a state that has branches located in the same state as the parent agency. Ensure that the name and address of all branch office locations are listed in the MOA with the parent agency. Separate MOAs with the respective State QIO are required for subunits of a parent HHA

that serves patients in geographic areas different from that of the parent HHA because these subunits have their own agreement number. HHA subunits are considered to be semi-autonomous organizations and must independently meet the conditions of participation for HHAs (See 42 CFR 484.2).

C. Medicare + Choice Organizations (M+COs) -- For purposes of NODMARs immediate review, you are not required to have an agreement (to perform this review) with the M+CO(s) in another state or in your state if you do not have the Medicare contract with the M+CO. Your MOAs with the hospitals in your review area will suffice. The QIO that has an agreement with the hospital treating the beneficiary will review the beneficiary's immediate review request.

D. Assistants at Cataract Surgery -- In accordance with 42 CFR 476.78(a), hospitals in the state are required to maintain MOAs with you. The MOA must provide for review of assistants at cataract surgery prior to service and for monitoring of the services billed on a post-payment basis (See §3110A.3 and §3110A.4).

3100 – Introduction

(Rev. 5, 08-01-03)

An intermediary is a private insurance company that has entered into a contract with CMS to process Medicare bills (claims) for Part A services performed by institutional providers. Carriers are private insurance companies that have contracted with CMS to process beneficiary bills (claims) for Part B services provided by non-institutional providers. Carriers also handle claims for services by physicians. For purposes of this section, the terms “payers” refers to intermediaries and carriers (See Glossary).

MOAs are written documents that specify your administrative and review procedures necessary to accomplish all of your review requirements in your contract. Regulations at 42 CFR 476.80 require that each MOA be a negotiated agreement between you and the intermediary/carrier, and reflect mutually agreeable conditions necessary for data exchange requirements in recognition of the unique capabilities/requirements of each party (See §3110).

3105 – Scope

(Rev. 5, 08-01-03)

You are required to develop, implement, and revise MOAs, acceptable to CMS, with all appropriate intermediaries and carriers for Part A and Part B services (See 42 CFR 476.80(a)). You and the intermediary or carrier should identify the specific claims information you will communicate, the methods you will use to communicate that information, and specify the role and responsibility of each party in communicating this information. Both you and the intermediary or carrier are expected to honor the terms of

the agreement. Roles and responsibilities regarding how payment adjustment and payment errors should be processed must be clearly defined in accordance with the SOW.

3110 - Intermediary/Carrier Memorandum of Agreement (MOA) Specifications

(Rev. 5, 08-01-03)

Examine all agreements currently in place and modify them to reflect current activities. Provide an informational copy of each agreement to all intermediaries and carriers in your review jurisdiction. You are expected to establish a separate MOA for intermediaries or carriers that service facilities in each state.

A. Elements of MOAs -- At a minimum, the MOAs with intermediaries/carriers should include the applicable requirements mentioned in §3015 and the following elements below:

- Claims Review -- Determine whether a provider or group of providers is furnishing non-covered or medically unnecessary services. Specify how you will receive any records subject to your review that are not provided directly by CMS. The MOA must distinguish between hard copy and electronic submissions and reference the format for any electronic submission.
- Data Review and Exchange -- Specify how you will receive records subject to your review that are not provided directly by CMS. Provide for full compliance with CMS requirements for the exchange of CMS-approved adjustment records and reconciliation of pending adjustment totals. Specify any physician or facility identifiers used by the intermediary other than the Medicare provider number and the intermediary code or Unique Physician Identification Number (UPIN).
- Coordination -- Communicate confidentiality concerns or issues related to QIO activities. Ensure that the intermediary/carrier will provide you with as much advance notice as possible of significant fluctuations in the volume of processed claims. You must provide all appropriate internal contacts and procedures for resolving problems and exchanging any needed information or negotiating changes timely.

In reviewing Part A and B claims, you may determine that a surgical procedure was not necessary and that the physician portion of that service (Part B payment) may not be payable. Communicate this information to the intermediary and the carrier.

NOTE: QIO/Carrier MOAs -- In accordance with 42 CFR 476.80, maintain MOAs with each carrier processing cases you review. Include in the MOA a provision that payment will not be made for the use of an assistant at cataract surgery without prior approval (See §1862(a)(15)(A) of the Act). Include provisions to establish a system to authorize payment and any other matters that are necessary for the coordination of the function.

- Prepayment/Pre-procedure Review -- Your request to intermediaries and carriers to implement pre-procedure (e.g., assistant at cataract surgery) and prepayment review of a procedure, diagnosis, provider, or practitioner must conform to the negotiated MOAs between you and the payers outlining the conditions for necessary data exchange requirements. MOAs must require that a QIO notify a physician of the need for prior authorization when the QIO receives a claim from the intermediary made by a physician who failed to have a service authorized prior to furnishing the service.
- Notification of Denial and Reconsideration Determinations -- Provide for transmission of your denial letters to servicing payers and, when necessary for medical review, copies of the medical records used. Include a negotiated processing timeframe for your notification to the payers of denials, reconsideration reversals, or modifications.
- Information Exchange -- Include details for implementing the following activities:
 - Exchange of medical review policies;
 - Quarterly meetings (which may be conference calls); and
 - QIO review and comment on new carrier/intermediary policies for new technology.

B. Required Signatures -- MOAs must be signed by representatives of your organization and appropriate intermediary/carrier representatives.

C. Modifying a MOA -- Modify MOAs when changes in the requirements of the SOW necessitate additional understanding between you and the intermediary/carrier. The revised MOA must be signed by the appropriate parties.

D. Failure to Honor the Terms of a MOA -- The MOAs are written documents that specify your administrative and review procedures necessary to accomplish all of your review requirements. Both parties to a MOA (you and the Medicare payer) are expected to honor these agreements.

Notify your Project Officer (PO) immediately if:

- You are unable to reach an agreement with any payer;
- A payer fails to comply with the terms of an existing MOA; or
- You are unable to comply with the terms of an existing MOA.

If a payer fails to comply, CMS reserves the right to determine if you made reasonable efforts to resolve the issue. If the intermediary/carrier continues to act outside the provisions of the MOA, the PO should contact staff in the Medicare contractor operations component of CMS' Center for Beneficiary Choices (CBC). CBC will investigate the infringement to determine if it violates the provisions of certification for Medicare payment.

If you fail to honor the provisions of the MOA, CMS reserves the right to determine if this is a breach of your review responsibilities stipulated in your contract.

3200 – Introduction

(Rev. 5, 08-01-03)

You are required to have a MOA with State Agencies responsible for licensing/certification of providers/practitioners. The MOA is a written document that outlines your administrative and review responsibilities and the responsibilities of the State agencies responsible for licensing/certification of providers/practitioners, necessary to accomplish certain review requirements under your contract. MOAs are intended to be informational in order to facilitate the review process and to avoid any misunderstanding between you and the other organization. The responsibilities of both parties should be clearly outlined in the MOA.

3210 - Memorandum of Agreement (MOA) With State Agencies Responsible for Licensing\Certification of Providers\Practitioners

(Rev. 5, 08-01-03)

Meet with the State agencies responsible for licensing/certification of Medicare providers/practitioners subject to QIO review to discuss the types of information/data exchange that would be useful to both you and the licensing/certification agencies.

Develop MOAs with licensing/certification agencies to exchange agreed-upon information/data. The information/data exchange is to be in accordance with the dates and timeframes specified in the MOA and the confidentiality requirements of Chapter 10 of this manual. Use CMS' model MOA (See Exhibit 3-3).

Implement a process for the ongoing, routine exchange of agreed-upon information/data that conforms to the confidentiality and disclosure requirements set forth in §1160(b)(1)(c) and §1154(a)(9)(B) of the Act and CMS regulations and instructions.

A. Required Signatures -- MOAs must be signed by representatives of your organization and appropriate State agency representatives.

B. Modifying MOAs -- Modify MOAs when changes in the requirements of the SOW necessitate additional understanding between you and the State agency. The revised MOA must be signed by the appropriate parties.

C. Failure to Return, Sign, or Honor the Terms of a MOA -- If a State agency responsible for licensing/certification fails to return the MOA by the requested due date, or refuses to sign the MOA, or fails to honor the provisions of a MOA, document your efforts and refer the circumstances to your PO for resolution. It is the State agency's responsibility to return the signed MOA by the requested due date.

D. Both parties to a MOA are Expected to Honor These Agreements -- Notify your PO immediately if:

- You are unable to reach an agreement with any State agency;
- A State agency fails to comply with the terms of an existing MOA; or
- You are unable to comply with the terms of an existing MOA.

If you fail to honor the provisions of the MOA, CMS reserves the right to determine if this is a breach of your review responsibilities.

Exhibit 3-1 - Model Memorandum of Agreement (MOA) Cover Letter for Providers

(Rev. 5, 08-01-03)

Your Letterhead

Dear (Name of Provider):

The (QIO Name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare beneficiaries in the state of _____. As you may already know, we review medical records to determine whether services delivered to these beneficiaries meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. In addition, we review written complaints from Medicare beneficiaries about the quality of Medicare services they have received and conduct quality improvement projects to make measurable improvements in beneficiary health status or satisfaction.

In order to participate in the Medicare program, hospitals, critical access hospitals, skilled nursing facilities, and home health agencies are required to have a Memorandum of Agreement (MOA) with a QIO under Federal law. Medicare + Choice Organizations (M+COs) must have a MOA with a QIO or an independent quality review organization. MOAs are intended to facilitate the review process by outlining the QIO's administrative and review responsibilities and the provider's responsibility in assisting us in

accomplishing our review requirements. MOAs are also intended to be informational. (QIO Name) wants to inform (Name of State) hospitals, critical access hospitals, M+COs, skilled nursing facilities, and home health agencies of (a) (QIO Name) procedures with respect to certain contract obligations, (b) review and appeal rights which providers have with respect to these obligations, and (c) opportunities providers have to partner with (QIO Name) in local and national quality improvement projects.

NOTE: §1866(a)(1)(E) of the Act requires providers of services to have an agreement with a QIO to release data related to patients.

NOTE: §1866(a)(1)(F)(I) of the Act requires hospitals which provide inpatient hospital services paid under the Prospective Payment System (PPS) to maintain an agreement with a QIO to review the validity of diagnostic information provided by such hospital, the completeness, adequacy and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided.

NOTE: §1866(a)(1)(F)(ii) of the Act requires hospitals, critical access hospitals, skilled nursing facilities, and home health agencies to maintain an agreement with a QIO to perform certain functions.

NOTE: §1852(a)(3)(A) of the Act requires that each Medicare + Choice Organization (M+CO), for each M+C plan it operates, have an agreement with an independent quality review and improvement organization to perform functions of the type described in §§1154(a)(4)(A) and 1154(a)(14).

Please review and sign the enclosed MOA and return it to the office listed below by the due date indicated.

(Address of QIO)

If you have questions, please contact us at:

(QIO Contact Person)
(QIO Telephone Number)

Sincerely yours,

Enclosure: (See Exhibit 3-2)

Exhibit 3-2 - Model Memorandum of Agreement (MOA) for Providers

(Rev. 5, 08-01-03)

Memorandum of Agreement Between (Name of QIO) and (Name of Provider)

I. Agreement

A. Parties

The parties to this agreement are the (Name of QIO) hereinafter referred to as _____ and (Name of Provider) hereinafter referred to as hospital, critical access hospital, skilled nursing facility, home health agency, or Medicare + Choice Organization (M+CO).

B. Statutory Specifications

§1154(a)(1) of the Social Security Act (the Act) requires QIOs to review services furnished to Medicare beneficiaries by physicians, other health care professionals, providers and suppliers as specified in the contract with the Secretary.

§1154(a)(4)(A) of the Act requires that a reasonable proportion of the QIOs activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

§1154(a)(14) of the Act requires that a QIO conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

§1852(e)(3)(A) of the Act requires that each Medicare + Choice Organization, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization to perform functions of the type described in §§1154(a)(4)(B) and 1154(a)(14).

§1866(a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the Prospective Payment System (PPS) to maintain an agreement with a QIO to review the validity of diagnostic information provided by such hospital, the completeness, adequacy and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which the hospital is seeking additional payments.

§1866(a)(1)(F)(ii) of the Act requires hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), and home health agencies (HHAs) to maintain an agreement with the QIO to perform certain functions listed in §1866(a)(3)(A).

§1866(a)(3)(A) of the Act requires QIOs, under the MOA, to perform functions described under the third sentence in §1154(a)(4)(A) related to quality of services and under §1154(a)(14) related to beneficiary complaints.

II. QIO Program

In 1982, Congress established Utilization and Quality Control Peer Review Organizations (PROs) (now known as QIOs) to perform two broad functions: (a) promote quality

health care services for Medicare beneficiaries, and (b) determine whether services rendered are medically necessary, appropriate, and meet professionally recognized standards of care. CMS also contracts with QIOs to validate provider-coding assignments, which affect reimbursement. The goal of the QIO program is to improve the processes and outcomes of care for Medicare beneficiaries. The QIO is to achieve this goal through performance of various directives promulgated by CMS in the QIO Contract, as discussed below.

III. Purpose of Agreement

The purpose of this Agreement is to define the administrative relationship that will exist between parties in the exchange of data and information. This Memorandum of Agreement is required by the Medicare statute and regulations as well as the QIO Manual and certain QIO contract directives. It is also intended to be informational. (Name of QIO) wants to inform (Name of state) hospitals, M+COs, SNFs, and HHAs of (a) (Name of QIO) procedures with respect to certain contract obligations, (b) review and appeal rights which providers have with respect to these obligations, and (c) opportunities providers have to collaborate with (Name of QIO) in local and national quality improvement projects.

IV. Effective Date

This Agreement shall be effective upon execution and shall remain in effect so long as (Name of QIO) is the Quality Improvement Organization, under contract with CMS, for the area in which the provider is located, or is terminated in accordance with Section VIII of this Agreement, or the provider withdraws or is terminated from the Medicare program.

V. Responsibilities of Parties

MOAs with hospitals, HHAs, SNFs, M+COs, and CAHs reflect the specific QIO review responsibilities referenced in §1866(a)(3)(A), §1154(a)(4)(A), and §1154(a)(14) of the Act as well as the responsibilities of each provider regarding SOW activities (See §§3015 and 3020 of the QIO Manual).

At a minimum, the MOA stipulates that a reasonable proportion of QIO activities are involved in reviewing, under §1154(a)(1)(B) of the Act, the quality of services and that a reasonable allocation of these activities be made among different settings. In addition, §1154(a)(14) of the Act requires that QIOs conduct an appropriate review of written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

In addition, (Name of QIO) agrees that it will assume responsibility for performing the following activities mentioned in the SOW for Medicare:

A. QIO Responsibilities

The list of QIO Responsibilities in the areas below is not all-inclusive. Many of the QIO's activities are provided in the SOW, which change with each three-year QIO/CMS contract period.

(Name of QIO) shall assume the federally-mandated responsibility for performing the following activities for Title XVII (Medicare):

- Mandatory Case Review that involves non-physician screening and physician review of medical records, which require review under the SOW. Mandatory case review categories include certain anti-dumping violations, assistant surgeon at cataract surgery, beneficiary complaints, hospital notices of non-coverage, notice of discharge and Medicare appeal rights, hospital-requested higher-weighted DRG adjustments, potential concerns identified during project data collections, and referrals made by the OIG, FI, and CMS.
- Health Care Quality Improvement Projects that are collaborative efforts with health care providers and other groups, which result in measurable improvement of processes and outcomes related to health care.
- Communication Activities that result in providing information for education of health care providers, beneficiaries, and others to improve quality of care and to promote early detection and prevention of disease.

B. Provider Responsibilities

The list of Provider Responsibilities in the areas below is not all-inclusive. Many of the provider activities in the SOW change with each three-year QIO/CMS contract period.

The (provider type) shall submit medical records and other information to the QIO which are needed for conducting of offsite review and cooperative project activities.

The (provider type) shall allocate adequate space to QIO staff for conducting onsite review and cooperative project activities, and shall provide medical records and other related information at the time of the QIO's visit.

The (provider type) will adhere to applicable Federal laws, regulations, and guidelines that protect the confidentiality of medical review information as well as applicable State laws and regulations.

The (provider type) may, as part of participating in health care quality improvement projects, request technical assistance from the QIO or accept technical assistance offered by the QIO.

VI. Confidentiality of Records and Other Data

(Name of QIO) will abide by the applicable Federal confidentiality laws and regulations in §1160 of the Act and 42 CFR Part 480. (Name of QIO) recognizes the inherent right of the individual to privacy and at the same time acknowledges the medical profession's need for adequate information in order to carry out its activities under this Agreement. To protect the confidentiality of data acquired by (Name of QIO) in carrying out its responsibilities under this contract, (Name of QIO) shall be bound by §1160 of the Act and applicable regulations. (Name of QIO) shall ensure the confidentiality and security of the (provider type) medical records and data from the time the medical records/data are acquired by (Name of QIO) until their destruction in accordance with the statute and regulations.

The (provider type) shall adhere to the applicable State and Federal laws that protect the confidentiality of medical review information.

VII. Modification of Agreement

This Agreement may be amended by (Name of QIO) at any time as necessary to conform with any changes or modifications to relevant State or Federal laws or applicable regulations, CMS transmittals, program directives, or instructions issued pursuant to applicable laws and regulations. In the event of such an amendment, (Name of QIO) shall provide the (provider type) with notice of any such new or revised laws, regulations, CMS transmittals, program directives, or instructions, etc.

VIII. Termination of Agreement

This agreement may be terminated, upon advance written notice by one party to the other, as follows:

- A. By the (provider type) without cause with 60-day prior written notice to (name of QIO) if the (provider type) determines that it is no longer required to be a party to this agreement as a condition of participation in the Medicare program.
- B. In the event that the (Name of QIO) status as a QIO and/or the (provider type) status, as an institution qualified and eligible to receive reimbursement for services and items provided under the Medicare program, is terminated by CMS.
- C. In the event that CMS terminates this agreement, (Name of QIO) shall notify (provider type) of termination.
- D. In the event that the QIO and the provider cannot agree to a modification to the Agreement.

IX. Miscellaneous Provisions

- A. Severability:

Should any clause, portion, or section of this Agreement be unenforceable or invalid, this shall not affect the enforceability or validity of the remainder of this Agreement. Should any particular provision(s) of this Agreement be held unreasonable or unenforceable for any reason, the provisions shall be given effect and enforced to whatever extent would be reasonable and enforceable.

B. Governing Law:

To the extent procedures for resolving any dispute under this Agreement are not available through the Department of Health & Human Services, this Agreement and any disputes arising under it shall be governed by laws of the State of (Name of State of QIO).

C. Resolution of Disputes:

If problems in the parties' relationship present themselves, or in the event a dispute arises between the parties, the parties shall attempt to resolve those differences in good faith. If a good faith dispute resolution should fail, (Name of QIO) shall notify CMS, and CMS shall advise the parties concerning the matter in dispute.

D. Notices:

Notice from (Name of QIO) concerning this Agreement shall be directed to the party specified on the signature page below. Other notices from (Name of QIO) which are issued as a result of activities required by this Agreement shall be directed to an individual designated by the (provider type). (Name of Provider) is responsible for notifying (Name of QIO) about any change in the person designated to receive such communications.

Notices from the (provider type) in response to (Name of QIO) notices shall be directed to the individual or department specified in (Name of QIO) communications.

E. Change of Ownership:

In the event of a change of ownership, the new owners will assume all obligations in the current MOA.

Agreement To Terms

The undersigned acknowledge that this Agreement is made pursuant to §1866(a)(1)(F)(i), §1866(a)(1)(F)(ii), and §1852(e)(3)(A) of the Act, 42 CFR Part 476, the QIO Manual and certain QIO contract directives, and agree to abide by the terms and conditions set forth.

Provider name: _____

Address: _____

Signature: _____

Date: _____

Name, address, and title of individual (QIO) executing Agreement:

Signature: _____

Date: _____

Exhibit 3-3 - Model Memorandum of Agreement (MOA) for State Licensing/Certification Agency

(Rev. 5, 08-01-03)

Memorandum of Agreement Between (QIO Name) and (State Licensing Agency/Certification Body Name)

I. Agreement

A. Parties to the Agreement:

The parties to this Memorandum of Agreement are the (State Licensing Agency/Certification Body Name and Address), hereinafter referred to as the (_____), and the (QIO Name).

B. Statutory/State Law Specifications:

Quality Improvement Organizations (QIOs) are authorized to perform Medicare peer review as defined in titles XI and XVIII of the Social Security Act (hereinafter referred to as the Act). This authorization is made effective through the QIO's contract with the Centers for Medicare & Medicaid Services (CMS). Section 1160(b)(1)(C) of the Act specifically authorizes QIOs to assist appropriate State agencies, recognized by the Secretary as having responsibility for licensing/certification, by providing data and information (at the request of such agency) insofar as such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law. State licensing agencies/certification bodies may provide data/information to QIOs in accordance with applicable State law.

C. Purpose of Agreement:

The purpose of this Agreement is to define the administrative relationship that will exist between the parties in the exchange of data and information that relates to promoting appropriate and professionally recognized standards of care to Medicare beneficiaries.

D. Acknowledgements:

The (QIO Name) and (State Licensing Agency/Certification Body Name) share a mutual interest in exchanging data and information that may be used to improve health care outcomes. Participants to this Agreement are expected to provide data/information as specified herein.

E. Term of Agreement:

This Agreement is effective on and after _____, 20____ and until such time as a new Agreement is deemed necessary by the parties.

F. Provisions of Agreement:

- Applicable Law -- This agreement shall, to the extent applicable, be governed by and construed in accordance with the provisions of titles XI and XVIII of the Act, and applicable Federal regulations.
- Severability -- If any provision of this Agreement is determined to be inconsistent with any Federal or State law or regulation, the Federal or State law or regulation shall control (In cases where Federal and State law conflict, the Federal law shall prevail). However, the remainder of this agreement shall remain valid.
- Medicare Liability -- This Agreement shall not be construed to increase either party's financial liability beyond that required by Medicare (i.e., the release or sharing of QIO data will be performed within the QIO's current operating budget).

II. QIO Responsibilities

The (QIO Name) has the responsibility to provide (in accordance with the dates and timeframes set forth in this section) to the (State Licensing Agency/Certification Body Name) the data/information listed in this section.

(Enter Responsibilities)

III. Licensing Agency/Certification Body Responsibilities

The (State Licensing Agency/Certification Body Name) has the responsibility to provide (in accordance with the dates and timeframes set forth in this section) to the (QIO Name) the data/information listed in this section.

(Enter Responsibilities)

IV. Confidentiality and Disclosure

The parties agree to comply with confidentiality requirements of §1160 of the Act and regulations at 42 CFR Part 480 as well as confidentiality requirements under all other applicable Federal statutes, Federal regulations, and any applicable State law. None of the confidential information or any data derived from the information will be released by the recipient to any other organization or individual in confidential form without prior CMS approval. Appropriate administrative, technical, procedural, and physical safeguards shall be established by the recipient to protect the confidentiality of the data and to prevent unauthorized access to it. The safeguards shall provide a level of security that is at least comparable to the level of security described in Office of Management and Budget (OMB) Circular No. A-130, Appendix III -- Security of Federal Automated Systems, which sets forth guidelines for security plans for automated information systems in Federal agencies. The (State Licensing Agency/Certification Body Name) will not re-disclose QIO data to other parties within the limitations set forth in 42 CFR Part 480 unless otherwise approved by CMS. Data release agreements will be entered into by such other parties and CMS.

V. Channels of Communication -- QIO and State Licensing Agency/Certification Body Contacts

QIO and licensing agency/certification body contact persons for oral or written communication regarding this data/information exchange process shall be:

QIO:

(Name)
(Phone Number)

Re: Memorandum of Agreement

(Name)
(Phone Number)

State Licensing Agency/Certification Body:

(Name)
(Phone Number)

Re: Memorandum of Agreement

(Name)
(Phone Number)

VI. Amendment of Agreement

This Agreement may be amended in writing by mutual agreement of the parties when required by (1) the Department of Health & Human Services (DHHS) changes to the QIO contract; (2) QIO changes to operational requirements mandated by Federal law and CMS directives; (3) DHHS changes in instructions or regulations; or (4) mutual agreement by all parties.

VII. Termination of Agreement

A. This agreement may be terminated for any reason, upon mutual written consent of the parties with 90 days written notice by either party to the other, subject to applicable law and regulation. Both parties must provide written notice to CMS of either party's decision to terminate the agreement.

B. This agreement shall be assigned automatically to the succeeding QIO for any state if, for any reason, the current QIO ceases to exercise QIO review authority.

IN WITNESS WHEREOF, The parties hereby execute this agreement:

QIO: _____

TITLE: _____ DATE: _____

STATE LICENSING AGENCY/
CERTIFICATION BODY: _____

TITLE: _____ DATE: _____