Memorandum of Agreement (MOA) FAQs

May 2019

MOA Process

Where can I find the MOA form?

The MOA form will be available for electronic submission at www.keproqio.com/MOA on June 8, 2019.

What is the process to submit an MOA?

Visit www.keproqio.com/MOA for a link to the electronic submission form. Open the form, fill out the fields, sign the form, and electronically submit it to KEPRO. Once completed, KEPRO will review, sign, and email the completed agreement back to you.

Will my organization need to submit a new MOA if one was completed any date prior to June 8, 2019?

Yes. A new MOA will be required if it is submitted prior to June 8, 2019.

Who can I contact with questions about the MOA?

Please contact the MOA Coordinator via email at MOA.kepro@hcqis.org.

Once the MOA is submitted, how long will it take to receive a copy from KEPRO?

A provider should receive a signed and completed agreement in approximately 5 days from submission.

Can the MOA be submitted by fax or mail?

No. The form must be submitted electronically.

Who signs the MOA?

The MOA must be signed by representatives of the QIO and appropriate provider representatives.

What happens if the provider refuses to sign the MOA?

If a provider refuses to sign the MOA, the QIO is required to inform the CMS Contracting Officer Representative (COR) of this matter. If the provider continues to act outside the provisions of the MOA, the COR may 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.

Can the language on the MOA be altered?

No alterations can be made to the MOA.

Can the QIO develop one MOA with a home health agency that has different branch locations?

The QIO may develop one MOA with a parent home health agency as long as it is billing its branches using the parent company's CCN number.

If there are multiple hospitals in a healthcare system, does each hospital need an individual MOA?

If the hospital has its own Medicare number, it needs an individual MOA.

Is an MOA necessary for the Medicare Administrative Contractor (MAC)?

No. MACs responsible for processing Medicare Part A and B claims must cooperate with the QIO for data exchange requirements necessary for the QIO to fulfill its case review requirements specified in the contract. Regulations at 42 CFR 476.80 require that each MAC have an agreement with the QIO and that terms of the Joint Operating Agreement (JOA) reflect mutually agreeable conditions necessary for data exchange requirements in recognition of the unique capabilities and requirements of each party. QIOs performing case reviews must maintain agreements with each MAC processing claims in the QIO services area(s) designated in the QIO contract.

Are QIOs required to have an MOA with State Agencies responsible for licensing/certification of providers/practitioners?

The QIO should 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 the QIO and the licensing/certification agencies. Then the QIO should develop MOAs with licensing/certification agencies to exchange agreed-upon information/data.

What happens if there is a dispute between the QIO and the provider regarding the MOA?

The parties shall attempt to resolve those differences in good faith. If a good faith dispute resolution should fail, the QIO shall notify CMS, and CMS shall advise the parties concerning the matter in dispute.

Will the MOA need to be renewed at any time after the June 8, 2019, submission?

The MOA will need to be renewed if the BFCC-QIO contractor changes or if the ownership of the provider changes.

MOA General Information

What is an MOA?

An MOA is a written document that outlines the Quality Improvement Organization's (QIO) administrative and review responsibilities and the responsibilities of providers necessary to accomplish certain review requirements under the QIO's contract. The responsibilities of both parties should be clearly outlined in the MOA.

Which entities are required to have an MOA?

QIOs are required to develop, implement, and revise MOAs, acceptable to CMS, with certain providers of health services, including hospitals (short-term, long-term, and critical access), skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and hospices who wish to participate or continue to participate in the Medicare program, as specified in the contract with the Secretary.

Are individual practitioners required to have an MOA?

QIOs are not required to develop MOAs with individual practitioners.

Are Federally Qualified Health Centers required to have an MOA?

QIOs are not required to develop MOAs with Federally Qualified Health Centers.

Are ESRD/dialysis facilities required to have an MOA?

QIOs are not required to develop MOAs with ESRD/dialysis facilities.

Where is the statutory requirement for the MOA found?

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

- Section 1154(a)(1) of the Act gives QIOs the authority to review services furnished by physicians, other healthcare practitioners, and institutional and non-institutional providers of healthcare services for which payment may be made under Medicare, as specified in the QIO's contract with the Secretary.
- Section 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.
- Section 1154(a)(7)(C) of the Act requires QIOs to examine the pertinent records of any practitioner or provider of healthcare services that the QIOs have responsibility for reviewing.
- Section 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.
- Section 1852(e)(3)(A) of the Act requires each MAO to maintain a written agreement with a QIO or some other independent quality review and improvement organization to review MAO services for purposes of, among other things, quality review and beneficiary complaints.
- Section 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.
  Section 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.
- Section 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).
- Section 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.

Publication No. A234-754-5/2019. This material was prepared by KEPRO, a Medicare Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.