Provider Participation Agreement

Washington State Health Care Authority

Washington Apple Health (Medicaid) Ground Emergency Medical Transportation (GEMT) Program

Name of provider | Provider NPI number

Statement of Intent

The purpose of this agreement is to allow participation in the Ground Emergency Medical Transportation Supplemental Reimbursement Program (GEMT Program) by the governmentally owned or operated provider, named above, subject to the provider's compliance with the requirements and responsibilities set forth in this agreement.

GEMT Provider Responsibilities

By entering into this agreement, the provider agrees to the following:

a. Provider agrees to comply with each the following, as periodically amended:
   - Title XIX of the Social Security Act
   - Titles 42 and 45 of the Code of Federal Regulations (CFR)
   - Washington State Medicaid State Plan
   - State issued policy directives, including the Revised Code of Washington, the Washington Administrative Code, Washington Apple Health Billing Guides
   - Terms of the provider's Medicaid Core Provider Agreement
   - Federal Office of Management and Budget (OMB) Circular A-87

b. Provider agrees to ensure all applicable state and federal requirements, as identified in paragraph A, above, are met in rendering services under this agreement. The provider understands and agrees that their failure to meet all applicable state and federal requirements in rendering services subject to supplemental reimbursement under this agreement shall be sufficient cause for the state to deny or recoup payments to the provider as well as terminate this agreement.

c. Provider agrees to comply with the following expense allowability and fiscal documentation requirements:
   - Submit the participation agreement and cost report form.
   - Maintain for review and audit and supply to the state, upon request, auditable documentation of all amounts claimed, and any other records required by the federal Centers for Medicare and Medicaid Services (CMS), pursuant to this agreement to permit a determination of expense allowability (RCW 41.05.730).
   - If the allowability or appropriateness of an expense cannot be determined by the state because fiscal records or other documentation is not present or is inadequate, according to state and/or federal accounting principles and practices, all questionable costs may be disallowed and payment may be based solely on the current Medicaid fee schedule. Upon receipt of adequate documentation supporting a disallowed or questionable expense, supplemental payment reimbursement may resume.

d. By November 30 of each year: Provider agrees to submit, electronically via email, the Excel version of the cost report and cost report for the prior fiscal year ending June 30, to: **HCAGEMTAdmin@hca.wa.gov**.

e. Provider agrees to accept as payment in full the reimbursement received for services subject to supplemental reimbursement pursuant to this agreement. Under no circumstances will the total amount of reimbursement received exceed one hundred percent of actual care costs. As such, if the provider does not have any uncompensated care costs, the provider will not receive a supplemental payment under this program.

f. Provider agrees that when it is determined that they received federal funds in excess of their determined cost per transport, the state shall recover the excess in accordance with state and federal regulations within 30 calendar days. The Washington State Health Care Authority (HCA) is not responsible for the compliance costs of the GEMT providers.

g. Provider agrees to reimburse HCA an administrative fee for all costs associated with the implementation

and administration of the GEMT Program. The fee is based on the number of transports provided during the service period (July 1 through June 30) and cannot be included as a reported expense on the provider's annual cost report.

h. Provider agrees that this agreement shall continue in force unless the state terminates this agreement as specified in this agreement or the provider submits notification to **HCAGEMTAdmin@hca.wa.gov** to conclude participation in the program.

The undersigned hereby warrants that:

They have the requisite authority to enter into this agreement on behalf of

(provider) and thereby bind the above named provider to the terms and conditions of the same, and

The information provided in support of this agreement is true and correct and that the undersigned understands that HCA is relying on the truthfulness and accuracy of the information presented.

Provider Authorized Representative's Signature Date

Print Name Title

Street Address

City State Zip