Alaska Medicaid
Supplemental Emergency Medical Transportation (SEMT) Program

SEMT Provider Participation Agreement

Name of Provider: _____

Provider NPI Number: _____ Alaska Medicaid Provider Numbers _____

Service period begin date: _____ Service period end date: _____

Statement of Intent

The purpose of this agreement is to allow participation in the Supplemental Emergency Medical Transportation Program (SEMT 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.

SEMT Provider Responsibilities

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

A. Provider agrees to comply with each of the following, as periodically amended:
   - Titles 42 and 45 of the Code of Federal Regulations (CFR)
   - Alaska Medicaid State Plan
   - State issued policy directives, including the Alaska Administrative Code and Alaska Medicaid Billing Manuals
   - Title 2 of the Code of Federal Regulations Part 200

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
   1. Submit annually the participation agreement and cost report form.

   2. 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.

   3. 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 recipient of adequate documentation supporting a disallowed or questionable expense, supplemental payment reimbursement may resume.

D. Within five months of the provider's fiscal year end: Provider agrees to submit, electronically via email, the Excel version of the cost report accompanied by a signed PDF copy of the annual SEMT participation agreements and cost report for the prior fiscal year to: AKSEMT@alaska.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 State of Alaska is not responsible for the compliance costs of the SEMT providers.

G. Provider agrees to reimburse the Alaska Department of Health and Social Services an administrative fee for all costs associated with the implementation and administration of the SEMT Program. The fee is a flat per cost report submission fee to cover the state fund costs of administering the program based on cost reports submitted during the state fiscal year, is due on or before June 30 each year, and cannot be included as a reported expense on the provider's annual cost report.

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 the State of Alaska is relying on the truthfulness and accuracy of the information presented.

_____ _____

Provider Authorized Representative's Signature Street Address, City, State, and Zip

_____ _____

Print Name Date

_____

Title