ADVOCACY IN ACTION
Arkansas Ambulance Association
PO Box 11330
El Dorado, AR 71730
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This Medicaid Supplemental Payment Program Support Agreement ("**Agreement**") is entered into on the dates indicated below each signature and effective on the last of those dates ("**Effective Date**") by and between the Arkansas Ambulance Association ("**ArAA**") and the undersigned person or entity ("**Participant**"), individually and on behalf of one or more EMS providers as hereinafter provided ("**Participating Providers**").

WHEREAS, ArAA is an Arkansas not-for-profit corporation, the mission of which includes promoting excellence in Emergency Medical Services ("**EMS**") and mobile health care transportation, and working with its Participants and their Participating Providers collaboratively to find better ways to serve others; and

WHEREAS, the current level of Medicaid payments to EMS providers in Arkansas is substantially below the costs incurred by Arkansas EMS providers in rendering those services; and

WHEREAS, this inadequate Medicaid reimbursement threatens the quality of EMS available to all citizens of Arkansas; and

WHEREAS, ArAA is engaged in a project with the Arkansas Department of Human Services ("**DHS**") to develop and implement a medical transportation assessment fee program ("**Assessment Fee Program**") to fund and make supplemental Medicaid payments to certain EMS providers in Arkansas; and

WHEREAS, the Assessment Fee Program will include both the payment by certain EMS providers (other than those owned by governmental entities or volunteer fire departments) of assessments and the receipt by those EMS providers of supplemental Medicaid payments; and

WHEREAS, in some cases, the supplemental Medicaid payments received by some EMS providers will be less than the assessment fee paid by them; and

WHEREAS, in order to insure that all EMS providers benefit from the Assessment Fee Program, EMS providers will enter into this Agreement; and

WHEREAS, ArAA has and will continue to incur substantial expense in the development and implementation of the Assessment Fee Program; and

WHEREAS, it is essential to the implementation and continued success of the Assessment Fee Program that the Eligible EMS Providers that benefit from that program support the related expenses; and

WHEREAS, this Agreement is required to insure that all Eligible EMS Providers benefit from the Assessment Fee Program and that the expenses thereof are properly funded; and

WHEREAS, the undersigned Participant owns, or otherwise has the right to enter into this Agreement on behalf of, certain Eligible EMS Providers listed on Exhibit I.9 ("**Participating Providers**"), all of which are parties to this Agreement.

NOW, THEREFORE, for and in consideration of the mutual promises and conditions contained herein, the parties mutually agree as follows:

I. Definitions

1. "**Assessment Fee"** – The fee charged by the State of Arkansas on Eligible EMS Providers, including Participating Providers, as part of the Assessment Fee Program.

2. "**Assessment Fee Program**" – The program implemented by DHS under which an Assessment Fee is charged to and paid by Eligible EMS Providers and used to fund Supplemental Medicaid Payments to Eligible EMS Providers, including Participating Providers.

3. "**Assessment Fee Services**" – Those medical transportation and other related services, whether emergency or non-emergency, which are subject to the Assessment Fee.

4. "**Base Payments**" – Any and all payments currently made by DHS to Eligible EMS Providers, including Participating Providers, for Assessment Fee Services provided by such Eligible EMS Providers to Arkansas Medicaid beneficiaries, which does not include any Medicaid supplemental payments.

5. "**Eligible EMS Providers**" – Those providers of emergency medical services in Arkansas that are subject to the Assessment Fee.

6. "**Medicaid supplemental payments**" – Those payments, over and above the Base Payments, made by DHS as part of the Assessment Fee Program.

7. "**Participant**" – The entity which owns, or otherwise is authorized to execute this Agreement on behalf of, itself and those Participating Providers listed on Schedule I.9. Participant may also be a Participating Provider.

8. "**Participating Provider Contribution**" – The amount, calculated as provided herein, which each Participating Providers agrees to pay to ArAA upon implementation of the Assessment Fee Program.

9. "**Participating Providers**" - Those EMS providers represented by Participant, which are bound by the terms of this Agreement, and which are listed on Schedule I.9. Participating Provider may also be the Participant.

II. Obligations of Participant

1. Each Participating Provider agrees to pay to ArAA a Participant Contribution, if any, calculated for each calendar quarter as follows:

   A. The amount of Medicaid supplemental payments paid to Participating Provider in each quarter shall be determined by ArAA based on reported payment data from DHS.

   B. The amount of the Assessment Fee paid by such Participating Provider in that same quarter shall be determined by ArAA based on reported assessment data from DHS.

   C. The "**Participating Provider Contribution Threshold**" shall be determined by multiplying the Participant's Assessment Fee (II.1.B, above) by 1.05.

   D. The "**Participating Provider Contribution Balance**" shall be determined by subtracting the Participating Provider Contribution Threshold (II.1.C, above) from the Participating Provider's Medicaid supplemental payments (II.1.A, above).

   E. If the Participating Provider Contribution Balance is negative, the ArAA will remit to Participating Provider, as hereinafter provided, from funds collected from Participating Providers with positive balances, an amount equal to such Participating Provider's Participant Contribution Balance.

   F. If the Participating Provider Contribution Balance is positive, the Participant will remit to the ArAA, as hereinafter provided, a Participating Provider Contribution in an amount equal to thirty-five percent (35%) of such Participant's Participant Contribution Balance.

2. Examples – The following, provided solely for clarification, reflect examples of the calculation in II.1, above.

(continued on next page)

A. Alpha Ambulance Service –

Assessment Fee	$1,000	
Supplemental Payments	$3,000	
Participating Provider Contribution Threshold	$1,050	(1.05 X Assessment Fee)
Participating Provider Contribution Balance	$1,950	(supplemental payment – Participating Provider Contribution Threshold)
Participating Provider Contribution to ArAA	$683	Participating Provider Contribution Balance X 35%
ArAA payment to Participating Provider	$0	
Net Participating Provider return	$1,267	Supplemental payment – (Assessment Fee + Participating Provider Contribution)

B. Beta Ambulance Service

Assessment Fee	$1,000	
Supplemental Payments	$800	
Participating Provider Contribution Threshold	$1,050	(1.05 X Assessment Fee)
Participating Provider Contribution Balance	-$250	(supplemental payment – Participating Provider Contribution Threshold)
Participating Provider Contribution to ArAA	$0	Participating Provider Contribution Balance X 35%
ArAA payment to Participating Provider	$250	
Net Participating Provider return	$50	Supplemental payment + ArAA payment - Assessment Fee

3. Any Participating Provider Contribution due from Participating Provider to ArAA under II.1.F, above, will be paid to ArAA as provided in Exhibit II.3, attached hereto and made a part hereof, no later than ten (10) days of receipt of notice from ArAA of the amount due. Exhibit II.3 may be updated from time to time by the mutual consent of the parties. If any Participating Provider Contribution is not paid within ten (10) days, Participating Provider shall additionally owe to ArAA a late payment penalty of five percent (5%) of the amount due and owing.

4. In the event that it is determined, following such payment of the Participating Provider Contribution, that a greater Participating Provider Contribution is due, Participating Provider shall remit the unpaid balance within ten (10) days of notice thereof.

5. Should it become necessary for ArAA to engage the services of an attorney to collect the Participating Provider Contribution, ArAA shall be reimbursed by Participating Provider, in addition to the Participating Provider Contribution and any late payment penalties due, reasonable attorneys fees incurred by ArAA in such collection.

III. Obligations of ArAA

1. Participating Provider Contribution Management. With respect to each calendar quarter following implementation of Medicaid supplemental payments (or portion thereof):

   A. ArAA will work with DHS to determine all Assessments Fees paid by Participating Providers and Medicaid supplemental payments paid to Participating Providers.

   B. Within ten (10) days of receipt of the above information, ArAA will notify all Participating Provider of any Participating Provider Contributions due under II.1.E, above.

   C. ArAA will use commercially reasonable efforts to promptly collect from Participating Providers the Participating Provider Contributions required under II.1.E, above.

   D. No later than ten (10) days following receipt of Participating Provider Contributions sufficient to make all payments to all Participating Providers due under II.1.E, above, ArAA shall remit such payments, notwithstanding that other Participating Provider Contributions remain unpaid. Prior to receipt of sufficient Participating Provider Contributions to make all payments required by this paragraph, ArAA may, at its sole discretion, make a partial payment to Participating Providers entitled to such payments, provided that all Participating Providers receive the identical proportion of the amount due.

   E. ArAA shall make any payment due to Participating Providers under Section II.1.E of this Agreement according to the instructions in **Exhibit III.1.E**, attached hereto, which may be updated from time to time by the mutual consent of the parties.

2. Program Obligations.

   A. Upon final approval by the Centers for Medicare & Medicaid Services (CMS) of the Assessment Fee Program, ArAA will monitor and work with DHS to implement and maximize the benefits of the new Assessment Fee Program to Participating Provider.

B. ArAA shall provide education specific to data submission requirements for Assessment Fees and assistance with compliance.

C. ArAA will continue to work with DHS to identify and implement additional opportunities that will enhance reimbursement for services provided by Participating Provider.

D. ArAA will be solely responsible for all costs associated with the development and implementation of the Assessment Fee Program, including engaging professionals such as attorneys, certified public accountants, policy experts, and others as necessary to accomplish the objectives described herein.

E. ArAA shall provide for an independent third party review of compliance with the terms of this Agreement. The report shall be made available to Participating Providers.

IV. Term and Termination

1. This Agreement is effective on the Effective Date stated above, and shall continue for an initial term of three (3) years from September 1, 2017. Notwithstanding the foregoing, the three (3) year term of this Agreement shall automatically renew for successive three (3) year terms, unless either party provides written notice to the other party of its intention not to extend this Agreement beyond the end of the then current three-year term at least thirty (30) days prior to the expiration of such current term.

2. This Agreement may be terminated as follows:

   A. By either party immediately upon written notice to the other in the event that the Assessment Fee Program is not approved, or is materially modified by CMS, or is permanently discontinued by DHS.

   B. By either party, in the event of a change in any applicable law or regulation, or in the controlling interpretation of any applicable law or regulation, which renders any material obligation of either party invalid, unenforceable or illegal, upon thirty (30) days written notice to the other, provided that the parties agree during the thirty (30) day period to negotiate in good faith on an amendment to cure the issue which is the basis of the notice.

   C. In the event of a material default by either party, upon thirty (30) days written notice by the non-defaulting party to the defaulting party, unless the defaulting party has

cured the default to the satisfaction of the other party prior to the expiration of the thirty day notice period

V. Miscellaneous

1. Authority. Participant represents and warrants that it has the authority to enter into this Agreement and to bind hereunder and hereto the Participating Provider(s) listed on Schedule I.9. Participant further represents and warrants that entering into this Agreement, and that Participating Provider(s) entering into this Agreement, is not prohibited by and does not violate any applicable obligation, whether legal, contractual or otherwise, of Participant or any of the Participating Providers.

2. Confidentiality. This Agreement and the attachments are confidential documents provided, however, that Participant, Participating Providers, and ArAA may share these documents with any of their owners, directors, employees or agents. Both parties agree to hold these documents confidential and will not disclose paper or electronic copies to any outside parties without express written permission from the other party. ArAA agrees not to share the specific amounts being received or being paid by the Participating Provider under this Agreement with any third party (except for any Participant and Participating Provider participating in the Assessment Fee Program and all Participants and Participating Providers will be treated equally and receive the same information) without the prior written consent of the Participant. In addition, ArAA agrees not to use any information about the Participating Providers and their participation in the Assessment Fee Program for any purpose other than the implementation of such methodology.

3. Publicity. No party to this Agreement shall originate any publicity, news release or other public announcement, about, related to, or arising out of this Agreement, without the prior written consent of the other party.

4. Notices. (a) Any notice shall be deemed to have been received on the date which is: (i) 3 business days after the date of proper posting, if sent by certified U.S. mail or by Express U.S. mail or the date delivery is acknowledged by a recognized overnight courier; or (ii) the date on which sent, if sent by facsimile transmission, with confirmation and with the original to be sent by certified U.S. mail or recognized overnight courier, addressed as provided on **Exhibit V.3**, attached hereto. Any party hereto may change its address specified for notices herein by designating a new address by notice to the other party.

5. Assignment. This Agreement shall not be assignable by any of the parties hereto without the written consent of the other party.

6. Entire Agreement. The parties hereto acknowledge that this Agreement, including the Appendices and documents incorporated by reference, sets forth the entire agreement and understanding of the parties hereto as to the subject matter hereof, and shall not be subject to any change of modification except by the execution of a written instrument subscribed to by the parties hereto. This Agreement shall supersede all previous communications, representations or understandings, either oral or written, between the parties relating to the subject matter hereof.

7. No Third Party Beneficiary. Nothing in this Agreement, express or implied, is intended to confer on any person other than the parties hereto, or their respective successors, assigns and legal representatives any rights, remedies, obligations or liabilities under or by reason of this Agreement.

8. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

[Signatures on following pages]

THUS DONE AND SIGNED, Arkansas Ambulance Association has executed this Medicaid Supplemental Payment Program Support Agreement effective as the Effective Date stated above.

ArAA:

ARKANSAS AMBULANCE ASSOCIATION

By: _____
Name: _____
Title: _____
Date: _____

THUS DONE AND SIGNED, Participant has executed this Medicaid Supplemental Payment Program Support Agreement effective as the Effective Date stated above.

PARTICIPANT:

_____

By: _____
Name: _____
Title: _____
Date: _____

Schedule I.9
EMS Providers that are Parties to this Agreement ("Participating Providers")

Participating Provider	Medicaid Provider Number

Exhibit II.3
Instructions for Participating Provider Contribution Payments
(complete one for each Participating Provider listed on Schedule I.9)

I. Bank Account Information:

Participating Provider's Name: _____

Account Name: _____

Bank: _____

Account Number: _____

Routing Number: _____

II. Initial one of the following:

____ Arkansas Medicaid payments to the Participating Provider named above are made to this account and not swept or otherwise transferred into another account.

____ Arkansas Medicaid payments to the Participating Provider named above are made to another account but swept or otherwise transferred into this account.

III. Disclosures: Describe any lien or other restriction or agreement that would prevent the Arkansas Ambulance Association from drafting this account as provided in the Medicaid Supplemental Payment Program Support Agreement:

IV. Agreement: The above named Participating Provider hereby authorizes the Arkansas Ambulance Association to draft this account according to the terms of the Medicaid Supplemental Payment Program Support Agreement entered into between the Participant, Participating Provider and the Arkansas Ambulance Association on _____, 2017, and the terms of the agreement relating to such drafting attached hereto.

(signature on following page)

PARTICIPATING PROVIDER: _____

BY: _____

Name: _____

Title: _____

Date: _____

Exhibit III.1.E
Participating Provider Instructions for Payments from ArAA
(complete one section, below)
(complete one for each Participating Provider listed on Schedule I.9)

____ EFT to the following bank account:

Participating Provider's Name: _____

Account Name: _____

Bank: _____

Account Number: _____

Routing Number: _____

____ Check delivered to the following address:

Participating Provider's Name: _____

Address: _____

_____

_____

Exhibit V.3
Notice Information
(complete one for each Participating Provider listed on Schedule I.9)

If to ArAA:	Arkansas Ambulance Association Attn: President P.O. BO 11330 El Dorado, AR 71730
With a copy to:	Healthcare Solutions Group, LLC Attn: Donna Newchurch 5010 Hwy 1 Napoleonville, LA 70390
If to Participating Provider:	_____ _____ _____ _____
With a copy to:	_____ _____ _____ _____