

Whereupon, Council member Weland motioned that the following Resolution be approved.

**RESOLUTION 2025-21**

**A RESOLUTION AUTHORIZING A PROVIDER PARTICIPATION AGREEMENT  
WITH IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES**


**WHEREAS**, the City Council of the City of Eagle Grove feel that it is in the best interest of the City and its residents to pursue a participation agreement, and

**NOW THEREFORE BE IT RESOLVED** that the City Council of Eagle Grove, Iowa hereby approve and authorize the Mayor to execute this PROVIDER PARTICIPATION AGREEMENT FOR UNCOMPENSATED COST PROSPECTIVE PAYMENT PROGRAM AGREEMENT BETWEEN THE CITY OF EAGLE GROVE AND THE IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES on this 18<sup>TH</sup> day of February, 2025.

The motion was seconded by Council member Limerick and after due consideration thereof, the roll was called and the following Council members voted:

AYES: Vandewater, Arstell, Lorenzen, Limerick, Weland  
NAYS:

Whereupon, the Mayor declared said Resolution duly passed and approved on this 18<sup>th</sup> day of February, 2025.

  
\_\_\_\_\_  
Michael Boyd  
Mayor

ATTEST:

  
\_\_\_\_\_  
Bryce Davis  
City Administrator/Clerk



## PROVIDER PARTICIPATION AGREEMENT

### IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) UNCOMPENSATED COST PROSPECTIVE PAYMENT PROGRAM

Provider Name:

City of Eagle Grove Ambulance Service

Provider NPI Number:

1093889644

#### Statement of Intent

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

#### 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:
  1. Title XIX of the Social Security Act
  2. Titles 42 and 45 of the Code of Federal Regulations (CFR)
  3. Iowa Medicaid State Plan
  4. State issued policy directives, including the Iowa Medicaid Ambulance Provider Manual
  5. Terms of the Provider's Iowa Medicaid Provider Enrollment Agreement
  
- 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 reconciled cost reimbursement under this Agreement shall be sufficient cause for the state to deny or recoup payment to the Provider as well as terminate this Agreement.
  
- C. Provider agrees to comply with the following allowable expenses and fiscal documentation requirements:
  1. Submit annually the GEMT Program cost report to Iowa Medicaid
  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 state and CMS, pursuant to this agreement to permit a determination of expenses allowed.
  3. If the allowance of an expense 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 generally accepted accounting principles or practices, all questionable costs may be disallowed and payment may be withheld by the State.

- D. Provider agrees to submit within the timeframes determined by the State, transfer of the non- federal share of the GEMT uncompensated cost reimbursement according to the Intergovernmental Transfer of Public Funds Agreement prior to the uncompensated cost prospective payments from HHS.
- E. Provider agrees to accept as payment in full the reimbursement received for services subject to reconciled cost reimbursement pursuant to this Agreement. Under no circumstance will the total amount of reimbursement received exceed one hundred percent (100%) of actual care costs. As such, if the Provider does not have any uncompensated care costs, the Provider will not receive a 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 (thirty) calendar days.

### **Limitations of State Liability**

- A. Notwithstanding any other provision of this Agreement, the HHS shall be held harmless from any federal audit disallowance and interest resulting from payments made by the federal Medicaid program as reimbursement for costs of providing services.
- B. To the extent that a federal audit disallowance and interest results from costs for which the Provider has received reimbursement, the HHS shall recoup from the Provider, upon written notice, amounts equal to the amount of the disallowance and interest in that fiscal year for the disallowed costs. All subsequent costs submitted to the HHS applicable to any previously disallowed cost, may be held in abeyance with no payment made until the federal disallowance issue is resolved.
- C. Notwithstanding paragraphs A and B above, to the extent that a federal audit disallowance and interest results from costs which the Provider has received reimbursement for services provided by a nongovernmental entity under contract with, and on behalf of the Provider, the HHS shall be held harmless by the Provider for one-hundred percent (100%) of the amount of any such federal audit disallowance and interest.

**TERMS OF THIS AGREEMENT**

The period of this Cooperative Agreement shall begin July 1, 2025. This Agreement may be canceled or amended at any time upon agreement by both parties or by either party after giving thirty (30) days prior notice in writing to the other party provided, however, that reimbursement shall be made for the period when the contract is in full force and effect.

*Boyce Davis*

GEMT Provider Signature

*2/18/2025*

Date

*City of Eagle Grove  
Emergency Medical Services*

GEMT Provider Printed Name