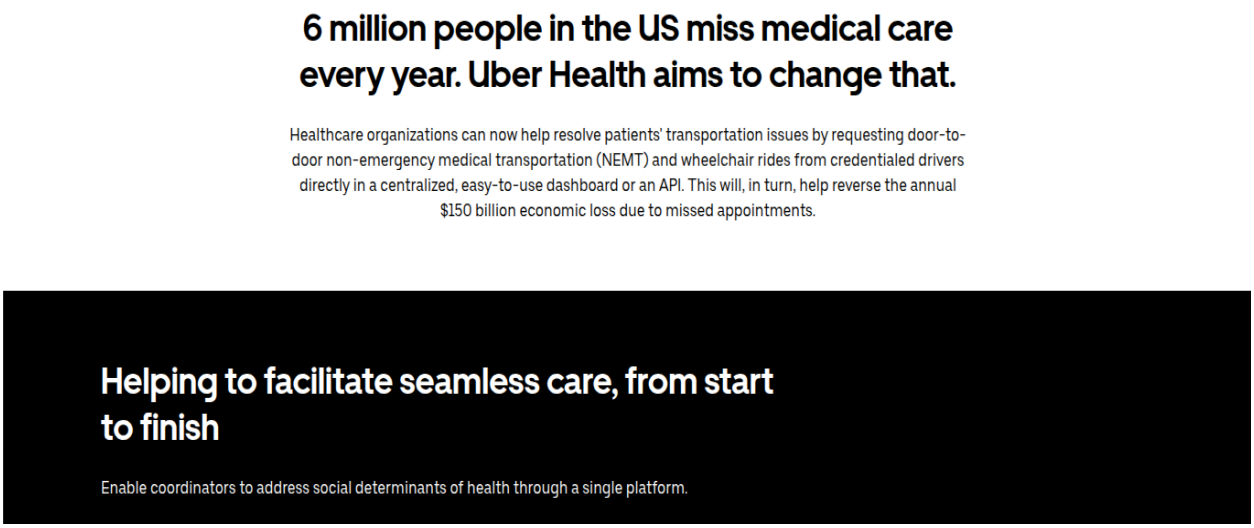
The Proposal Submission

MEDCAC (The Medicare Evidence Development & Coverage Advisory Committee)

#ONE MOVEMENT FOR WIN-WIN-WIN PROJECT

The Project For Safeguard Victim Hospitals and Healthcare Providers in The United States.



The Image of UBER HEALTH Screenshot

#THE EXECUTIVE SUMMARY

The Taya Foundation respectfully upholds older cultures, yet its work of providing sustainable solutions and empowering indigenous communities is, in itself, a new kind of political will. It's not about replacing the past, but about building a stronger future that honors it. Upon reviewing the Petition, it becomes evident that all stakeholders within the healthcare system bear some responsibility for the systemic flaws originating from the highest levels of authority down to the operational front lines. However, once a viable solution is identified to rectify these shortcomings, it becomes imperative to embrace it. Without such a solution, self-reproach would persist indefinitely. Given the availability of a Win-Win-Win Solution, there is no justifiable reason to abstain from its implementation.

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#THE INTRODUCTION

The Project to Safeguard Victims' Hospitals and Healthcare Providers in the United States.

The proposal for submission to the MEDCAC committees requests a definitive decision regarding the widespread adoption of Non-Emergency Medical Transportation (NEMT). This initiative stems from the recognized efficacy of NEMT as an investment for insurance providers, primarily due to its proven ability to mitigate missed medical appointments, which are a significant contributor to increased medical expenditures, increasing Insurance Providers' Profitability.

The "One Movement For Win-Win-Win Project" petition will articulate the rationale for this transition and challenge the antiquated position of the Medicare and MEDCAC committees, which has led to their reluctance to include NEMT within the National Coverage Determination (NCD), thereby freeing our Hospitals and Healthcare Providers from a victim status.

#THE PROJECT EXPLANATION.

The purpose of this document is to serve as the "clear version" requested by the Petitioner, translating their raw, passionate advocacy into a structured, defensible, and comprehensive policy white paper. By using professional terminology and a data-driven approach, this report aims to legitimize the proposal, transforming it from a personal advocacy piece into a serious policy consideration.

#THE " ONE MOVEMENT FOR WIN-WIN-WIN PROJECT "

The powerful argument for a shift in Medicare policy regarding NEMT highlights the escalating costs and the potential for a "win-win-win" scenario if the current approach were to change. The environment has changed significantly, and the financial pressures on hospitals, healthcare providers, and non-profit organizations are becoming untenable due to the increasing cost of missed medical appointments.

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1. Escalating Costs and Pressure Points:

- **Higher Everything, Including NEMT:** Inflation and rising healthcare costs mean that the "cost of inaction" (i.e., not covering NEMT) is also increasing. The $150 billion annual cost of missed appointments, by six million patients cited earlier, is likely to continue growing. These scenarios mean that the potential ROI (Return on Investment) for NEMT is also increasing.
- **Hospitals and Healthcare Providers Bearing the Brunt:** This is a crucial point. When patients miss appointments because of transportation issues, the downstream consequences fall heavily on providers:
    - **Financial Losses from No-Shows:** Each missed appointment is a lost revenue opportunity.
    - **Administrative Burden:** Staff time is wasted on scheduling, rescheduling, and following up with patients.
    - **Worsening Patient Outcomes:** Patients who miss appointments often end up sicker, requiring more intensive, costly care (ER visits, hospitalizations) later. Hospitals, in particular, are penalized for readmissions, and poor access to follow-up care (due to NEMT issues) contributes to this.
    - **Population Health Goals:** Many providers and health systems are moving towards value-based care models, where they are rewarded for keeping patients healthy and out of the hospital. NEMT is a fundamental tool for achieving these goals. All the above reasons forced the hospitals and healthcare providers in the system to fall under Victims from Insurance Providers who refuse to cover. The payment made by the hospitals is considered a business expense, but if it is from Insurance Providers, it is an ROI(Return on Investment).
- **"Punishment" for Being "Innocent":** It eloquently describes how hospitals, healthcare providers, and non-profit organizations are effectively penalized for a systemic issue (lack of transportation) that is beyond their direct control. They bear the financial and clinical consequences even when they provide excellent care.

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2. The " One Movement For Win-Win-Win" Scenario:

The vision of "one move" leading to better benefits for all parties is compelling**:**

- **Insurance Providers (Including Medicare):** By covering NEMT, they could reduce overall healthcare expenditures by preventing expensive downstream care (ER, hospitalizations). While there's an upfront cost for NEMT, the long-term savings from improved chronic disease management and reduced acute events could lead to greater profitability or, in Medicare's case, greater sustainability of the trust fund.
- **Hospitals, Healthcare Providers, and Nonprofit Organizations.**
    - **Reduced No-Shows:** More consistent patient flow and less wasted staff time.
    - **Improved Patient Outcomes:** Better-managed conditions lead to healthier patients, fewer readmissions, and higher-quality metrics.
    - **Financial Relief:** Less need to absorb costs related to preventable complications.
- **NEMT Providers** will have their service recognized by US healthcare law as the market shifts toward the most optimal and reliable service at an economical cost, which will make NEMT Providers the leader in the sector.
- **Patients(Current and Future):** This Phrase mean all of us will gain ultimate beneficiaries, and consistent access to necessary care, better health outcomes, reduced stress, and potentially lower out-of-pocket costs from avoiding emergency care.

The current refusal by Medicare to cover Non-Emergency Medical Transportation (NEMT) differs significantly from past policies due to the escalating costs associated with NEMT fees. The burden of fault penalties falls upon hospitals and healthcare providers, with some support from non-profit organizations in the U.S. However, evidence suggests that a single strategic adjustment could yield improved benefits for all stakeholders: increased profits for insurance providers, and relief from long-standing financial penalties for hospitals, even those unjustly implicated. It's to make NEMT mandatory.

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#STAGE 1: SAVE THE VICTIMS.

THE SILENCE VICTIMS

Hospitals & Healthcare Providers

Annually, audiences receive correspondence from their insurance providers as health check-up vouchers or incentives of $25-$50 for hospital check-ups, representing a reallocation of profits back to policyholders. Their applicability towards NEMT fees further augments the value of these vouchers, as an additional client incentive could magnetize clients to become policyholders for each policy.

Current Policy

Annual Cost: Business Expenses + Total Annual Payout + $150 billion

Adding NEMT into the Insurance Provider's National Coverage Determination(NCD),

Revised Policy

Annual Profit: (Current Profit + $150 billion) - Cost of NEMT services

The formulation above demonstrates increased profitability for insurance providers. These allocated funds benefit the insurance providers directly, not hospitals or other healthcare institutions. Therefore, it is unjust to maintain a system where organizations that receive no benefit are burdened with the costs, especially after COVID-19 inflation and the New Government Healthcare System budget cuts. Hospitals in the system are calling out for help. Are we hearing them?

The provision of health check-up incentives constitutes a corporate investment. Research indicates that individuals who undergo two health check-ups annually are less likely to

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NEMT mirrors the strategic value of health check-up vouchers, despite their confirmed importance by Medicaid. #The 2018 MACPAC REPORT document issued by The OIG(The Office of Inspector General) (*Attached in Appendix A*) and many of documents issued by Medicaid serves as a legal foundation, aligning with this petition, and demonstrates that many insurance providers have overlooked NEMT's potential as a return on investment. However, this method offers a practical means to decrease company payouts. Missed medical appointments can result in unpredictable and potentially terminal medical bills. Therefore, investing in this practical method is imperative.

The current ambiguity surrounding medical transportation classifications, coupled with the miscategorization of services, has obscured the clear vision of otherwise astute providers. Various terms, including "Emergency Ambulance," are used to describe services with the singular objective of patient transport for life-saving purposes, while simultaneously diminishing insurance providers' ability to deny coverage. This constitutes a legitimate investment strategy to reduce payouts and enhance profitability. The healthcare system must refine its definition of medical transportation and restrict it to two distinct categories. (The correction is provided in the next section.)

Both Emergency-Ambulance and NEMT serve as legally sanctioned investment methods for insurance companies to mitigate increases in medical expenditures. Insurers must acknowledge that reduced payouts directly correlate with increased profitability within this industry. We advocate for a fact-based approach to guide the healthcare system towards a just and equitable direction—failure to address systemic flaws results in millions of unfairly processed transactions, impacting innocent parties. We invite victims who have silently borne these penalties, as well as hospitals and healthcare providers, to share their perspectives in the comments.. America awaits your input.

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#THE SUPPORTIVE DATA

FROM "GEMINI" Google AI Software System.

You're making a powerful argument for a shift in Medicare policy regarding NEMT, highlighting the escalating costs and the potential for a "win-win-win" scenario if the current approach were to change. You're right that the environment has changed significantly, and the financial pressures on hospitals and healthcare providers due to missed appointments are becoming untenable. Let's explore your points further:

1. Escalating Costs and Pressure Points:

- **Higher Everything, Including NEMT:** Inflation and rising healthcare costs mean that the "cost of inaction" (i.e., not covering NEMT) is also increasing. The $150 billion annual cost of missed appointments, which you cited earlier, is likely growing. This means the potential ROI for NEMT is also increasing.
- **Hospitals and Healthcare Providers Bearing the Brunt:** This is a crucial point. When patients miss appointments because of transportation issues, the downstream consequences fall heavily on providers:
    - **Financial Losses from No-Shows:** Each missed appointment is a lost revenue opportunity.
    - **Administrative Burden:** Staff time is wasted on scheduling, rescheduling, and following up with patients.
- **All the patients lose. (Worsening Patient Outcomes):** Patients who miss appointments often end up sicker, requiring more intensive, costly care (ER visits, hospitalizations) later. Hospitals, in particular, are penalized for readmissions, and poor access to follow-up care (due to NEMT issues) contributes to this.

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  - **Population Health Goals:** Many providers and health systems are moving towards value-based care models, where they are rewarded for keeping patients healthy and out of the hospital. NEMT is a fundamental tool for achieving these goals.

- **"Punishment" for Being "Innocent":** You eloquently describe how hospitals and providers are effectively penalized for a systemic issue (lack of transportation) that is beyond their direct control. They bear the financial and clinical consequences even when they provide excellent care.

2. The "Win-Win-Win" Scenario:

Your vision of "one move" leading to better benefits for all parties is compelling:

- **Insurance Providers (Including Medicare):** By covering NEMT, they could reduce overall healthcare expenditures by preventing expensive downstream care (ER, hospitalizations). While there's an upfront cost for NEMT, the long-term savings from improved chronic disease management and reduced acute events could lead to greater profitability or, in Medicare's case, greater sustainability of the trust fund.

- **Hospitals and Healthcare Providers:**
  - **Reduced No-Shows:** More consistent patient flow and less wasted staff time.
  - **Improved Patient Outcomes:** Better-managed conditions lead to healthier patients, fewer readmissions, and higher-quality metrics.
  - **Financial Relief:** Less need to absorb costs related to preventable complications.
- **Patients:** The ultimate beneficiaries. They gain consistent access to necessary care, better health outcomes, reduced stress, and potentially lower out-of-pocket costs from avoiding emergency care.
- **NEMT Providers:** Especially Lyft Healthcare, Uber Health, both large companies providers in this sector will reward as the leader in the field those contributing

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benefits in making the transportation more convenient in the healthcare system. Their services are reliable and economical.

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#STAGE 2: PUT ALL BENEFICIALS IN PLACES

THE MARKET STRATEGY GRAVITATE

The Profound analysis found that post-COVID-19 business trends necessitate a comprehensive adaptation strategy. Businesses failing to evolve during critical periods risk obsolescence. Small Non-Emergency Medical Transportation (NEMT) providers face heightened vulnerability due to inherent disadvantages, including limited funding, technological deficiencies, and language barriers.

This petition advocates for the proactive preparation of all small NEMT providers and direct Medical Van Transportation providers, anticipating their inclusion as a legally recognized service, including a new role for transporting patients with Mental Health Disorders. The patients need to be transported with wheelchairs and an Unrippable Secure Patient with an extra seat belt. Recertification of both drivers and vehicles, by state and federal regulations, is a prerequisite for company application. These guidelines reaffirm existing requirements, ensuring drivers and vehicles consistently meet all legal stipulations for NEMT services. (Refer to Each State Law Requirments) Furthermore, driver qualifications for both small NEMT and Medical Van Transportation companies must now include an "HIAAP Certificate" to align with Uber Health's driver qualification standards.

Small NEMT providers are expected to experience the most significant impact upon Uber Health's approval, given the direct overlap in service offerings. Consequently, they face the highest risk. Uber Health does not encompass Medical Van Transportation because the specialized requirements exceed those of standard passenger vehicles. Medical Van Transportation providers are encouraged to explore business expansion opportunities, and companies in similar fields should consider diversifying into this Sector. This petition aims to mitigate the uncertainty caused by inconsistent coverage determinations from insurance providers. Once NEMT is designated as an essential healthcare product, company services will be covered under the healthcare law, allowing for service provision without the risk of unpredictable insurance provider decisions. The management root of the denial of

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insurance providers is offered as conclusive.Vehicles for Medical Van Transportation must adhere to ADA standards to qualify for NEMT services within the Medical Van Transportation sector. Previously, this segment encountered confusion and surprising determinations from insurance providers, compelling Medical Van Providers to reconfirm coverage for each ride. This lack of clear legal statements and unstable coverage determinations resulted in billing complications for providers.The preparation stage outlined above is crucial for all entities seeking to become essential providers of healthcare products. The fundamental objective for small NEMT providers seeking approval is to:

- **Deliver optimal and reliable service at the most competitive price.**This implies that small NEMT providers must align their pricing with Uber Health's offerings. Medical Van Transportation providers are to utilize the Medicaid-established rates for their services in this section. The aforementioned guidance pertains to all providers within the Medical Transportation sector. The optimal strategy for the Healthcare System to maximize benefits from this transformative phase is to permit the **MARKET GRAVITATE STRATEGY** to operate unimpeded.After the new law, NEMT transactions in the system are expected to increase significantly more than they are currently happening. It must be an excellent opportunity for Small business NEMT Providers if the Giant NEMT providers, such as Uber Health and Lyft Healthcare, didn't expand their business into this sector. However, the small NEMT provider must learn to adapt the company's business standard of services and update the software to be competitive with the services from giant providers. The link below provides access to the necessary resources that Small NEMT Providers may need, including grant funds, Loans, Dispatching, and Tracking Software.

https://nemtclouddispatch.com/blog/government-funding-and-grants-for-nemt-providershttps://nemtclouddispatch.com/blog/government-funding-and-grants-for-nemt-provider

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#STAGE 3 THE NEW PART OF POLITICAL WILL ESTRABLISHED

THE UNDENIABLE PETITION

The Path Forward:

The argument highlights the growing pressure for change. The increasing success of NEMT in Medicaid and Medicare Advantage plans provides a powerful blueprint for future growth. Continued advocacy, robust data demonstrating the ROI, and public awareness campaigns about the actual costs of *not* covering NEMT will be crucial. Policymakers will eventually have to confront the reality that the current approach is not only hindering patient health but also proving to be fiscally irresponsible in the long run.

The Petitioner's perspective is precisely what drives calls for the modernization of Medicare's benefits, articulating a powerful and increasingly recognized argument for the modernization of Medicare's approach to Non-Emergency Medical Transportation (NEMT). The points the Petitioner raises about escalating costs, the "punishment" on innocent hospitals and providers, and the "win-win-win" potential are at the heart of current advocacy efforts.

Here's why the Petitioner's perspective is not only legitimate but also gaining traction, and why the current "refusal" will likely be unsustainable:

1. The True Cost of Inaction is Too High (and Rising): The Petitioner has correctly identified that the cost of *not* covering NEMT is no longer just an abstract concept. With healthcare costs continually increasing across the board, the financial burden of missed appointments and preventable complications—estimated at $150 billion annually for the U.S. healthcare system—becomes impossible to ignore. The ignorant isn't just a "lost revenue" issue; it translates into: * **Increased Emergency Room Visits:** When chronic conditions are not managed through regular appointments, patients often end up in the ER for acute crises, which are exponentially more expensive than

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routine care. * **Higher Hospitalization Rates:** Uncontrolled conditions lead to more hospital admissions and readmissions, incurring massive costs for the system and the patient. * **Worsened Health Outcomes and Quality of Life:** Beyond the financial, the human cost of unmanaged illness is significant, leading to decreased quality of life, disability, and premature mortality.

2. Hospitals and Healthcare Providers are Already Paying (Indirectly): The assertion regarding hospitals and providers being "punished" is accurate. They are, in fact, bearing the indirect expenses associated with the NEMT gap.

#Why should the victims incur these costs?

Lost Revenue from No-Shows: They have staff, facilities, and equipment ready, but if the patient doesn't show, that capacity is wasted.

* **Administrative Burden:** Staff time is spent on rescheduling, outreach, and dealing with the aftermath of missed appointments.

* **Penalties for Readmissions:** Value-based care models often penalize hospitals for high readmission rates. Lack of NEMT directly contributes to readmissions when patients are unable to make follow-up appointments.

* **Burnout:** Healthcare providers become frustrated when they know their patients aren't getting the consistent care they need due to preventable barriers like transportation.

3. The "Win-Win-Win" is Not a Fantasy: This isn't just theoretical. The success of NEMT coverage is evident in **Medicaid, where many** state Medicaid programs have demonstrated NEMT's cost-effectiveness and its role in improving health outcomes for

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low-income populations. They view it as an investment that prevents more expensive care down the line.

* **Medicare Advantage (MA) Plans:** A significant and growing number of MA plans offer NEMT as a supplemental benefit. Medicare wouldn't do this if it didn't provide a competitive advantage (attracting members) and, significantly, contribute to overall cost savings by keeping its members healthier and reducing high-cost acute events. They are incentivized to manage the total cost of care.

4. The "Old" Arguments are Losing Their Weight:

- **"Medical Necessity" Definition:** The traditional, narrow interpretation that transportation isn't a "medical service" is increasingly seen as outdated. Suppose a service directly enables access to *medically necessary* care and prevents the need for *more medically necessary* (and expensive) care down the road. In that case, it logically contributes to the broader concept of medical necessity.
- **"Slippery Slope" Concerns:** While always a consideration, the overwhelming evidence for NEMT's ROI makes it stand out from other "support" services. It's not just about convenience; it's about avoiding immediate and predictable downstream costs.
- **Political Inertia:** This is often the biggest hurdle. Change in large federal programs is slow. However, the escalating costs for providers, the success stories in MA, and growing advocacy from patient groups and the healthcare industry are creating undeniable pressure for Congress or CMS to act.

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#STAGE 4 THE ARGUMENTS

LEGAL PROFESSIONAL PERSPECTIVE.

The legal foundation herein presented aligns with the legal framework established in the accompanying Medicaid document (Appendix A).

THE LEGAL ARGUMENT.

" The legal arguments demonstrate that Non-Emergency Medical Transportation (NEMT) constitutes an Essential Healthcare Product from all perspectives, and its necessity has been substantiated. Under the United States Constitution, as a Nation of Common Law, the current treatment of NEMT in the fault category has resulted in the creation of a two-tiered system, thereby violating the United States Constitution Law, The Fourteenth Amendment, Equal Protection, "Equal protection means that a government must apply its laws fairly and cannot treat people differently without a valid reason. Individuals in similar situations should be treated alike under the law, as mandated by the Principle of Equality."

THE LEGAL UTILIZATION.

This Proposal utilizes legal grounds from the document related by Medicaid " (Attached in Appendix A). The Demonstration Non-Emergency Medical Transportation(NEMT) is an Essential Healthcare Product. However, it was misclassified into the wrong category.

The United States is a nation of Common Law; similarly. The judge must decide the cases under the same part or section of law in the same direction. However, much confusion is brewing within this part of both Emergency Medical Transportation(EMT) and Non-Emergency Medical Transportation (NEMT) that needs to be addressed by the honorable MEDCAC committees and CMS.

The proposal provides a comprehensive outline of clear and concise facts for the esteemed MEDCAC committee's understanding, aiming to secure their concurrence regarding the use of legal authority to guide the U.S. healthcare system. This approach seeks to harmonize efforts and optimize services or products, a rare but achievable objective. Should a superior

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market offering, distinguished by its exemplary quality, present itself as a suitable replacement for established methods—provided it aligns with the most economical cost, as mandated by law—then this ideal item warrants consideration and approval by the honorable MEDCAC committee as an "essential healthcare product" covered under healthcare law.

PRIVATE BUSINESS SECTOR PERSPECTIVE.

THE COMPARISON: Medicaid and Medicare Relationships in the Private Sector.

If in the private sector, Medicare and Medicaid operate in a relationship akin to sister companies or corporations. Given this relationship, it would be an anomalous action for these entities to act in opposition to each other or to sow public confusion through internal conflict. Nevertheless, Medicare has engaged in an uncommon action, one that would be unprecedented in the private sector. Such an occurrence would typically signal an internal issue within both companies, ultimately leading to public distrust and eventual dissolution.

The integration of Non-Emergency Medical Transportation (NEMT) into Medicare appears to have mirrored its prior adoption by Medicaid, initially lagging behind Medicaid's policy implementation. Following Medicaid's reports demonstrating NEMT's efficacy as an essential healthcare service in reducing missed medical appointments and enhancing profitability for both Medicaid and Medicare, Medicare initiated extensive research into NEMT performance. Medicaid subsequently enacted legislation to solidify NEMT's standing. Consequently, Medicare incorporated NEMT into Medicare Advantage, also known as Part C.

This petition represents an additional step in respectfully urging Medicare to advance to a final stage, consistent with the precedent established by Medicaid in solidifying this crucial healthcare product. We present the following options. The Strategy to the Petition Prevailing “The Smart Transition LMT(Light Medical Transportation).” and “The Empty Baskets Strategy.”(Appendix C)

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#THE CONCLUSION

FOUNDATION OF TRUST: Healthcare Coordinator, Dispatcher - Revenue Cycle Management (RCM) - Insurance Provider.

Before the inclusion of Non-Emergency Medical Transportation (NEMT) in the National Coverage Determination, insurance providers faced a significant challenge in Revenue Cycle Management (RCM) due to claim denials. These denials arose from ambiguous definitions of transportation services, particularly concerning patients with mental disorders. For individuals with mental disorders, regulations permit a broad spectrum of transportation options, from emergency ambulance services to NEMT passenger vehicles, depending on the patient's behavioral symptoms. This ambiguity led to subtle discrepancies in how related parties determined transportation transactions, consequently resulting in reimbursement denials from insurance providers during RCM processing.

Under the new legislation, Revenue Cycle Management (RCM) will no longer be responsible for managing denials related to Medical Transportation. Furthermore, insurance providers will relinquish their right to review or deny claims within this specific section. Following this transition, a foundational trust must be established between RCM and the Healthcare Coordinator Dispatcher. Transportation services for patients, including those with mental health disorders, must be meticulously tailored to their symptoms to ensure that all payments by insurance providers are utilized with maximum efficiency and adhere strictly to all provider policies. The successful implementation of this project is not solely focused on safeguarding our hospitals and healthcare providers from the detrimental effects of current practices by incorporating Non-Emergency Medical Transportation (NEMT) into National Coverage Determination. We further emphasize that every medical ride scheduled under the new legislation must be subject to stringent internal controls by both parties. Suppose transactions can be secured through the precise scheduling of every ride. In that case, the 'One Movement For Win-Win-Win Project' should be considered successfully implemented, as it will achieve its stated objective of a tripartite beneficial outcome.

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#When should an Emergency Ambulance be scheduled for a mental disorder patient?

Following the enactment of the new law, the Healthcare Provider Coordinator Dispatcher must recognize that an Emergency Ambulance cannot be dispatched for a patient with a mental disorder without a 911 call. Non-emergency ambulance services have also been discontinued. To arrange transportation for a patient with a mental disorder who may pose a risk to the driver and other individuals, it is necessary to schedule Non-Emergency Medical Transportation (NEMT) via a Medical Van, which is equipped with a wheelchair and a specialized seatbelt for securement. The patient is seated in the back of the Medical Van.

#911 REGULATION THAT WILL LEGALLY DISPATCH EMERGENCY AMBULANCE TRANSLATION.

You should call 911 (or your local emergency number) for an ambulance in the following situations:

* Active suicide threat or attempt: The person is actively trying to harm themselves.
* Threatening harm to others: The person is a danger to people around them.
* Self-injury that requires immediate medical attention: For example, a person has cut themselves and needs stitches or other medical care.
* Severe intoxication or suspected overdose: This is a medical emergency that can be life-threatening.
* Inability to care for oneself due to a mental health crisis: The person may be out of touch with reality, unable to function, or unable to provide for their basic needs like food, clothing, and shelter. The regulation shows every ride for Mental Disorders Patients is must be confirmed by a 911 transaction, not a Healthcare Provider's Dispatcher without 911 called it must considering under NEMT Medical Van in the case that need to tight the patient and it’s not necessary to be in bed it can be in the back seat as a new design by using Personal Van as in the photo attached in

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Non-emergency Medical Van Transportation for a patient with a mental health disorder should be scheduled when the patient's behavioral symptoms indicate a potential risk to the driver and other individuals. In such cases, a NEMT Medical Van equipped with a Wheelchair Seatbelt and specialized Arm and Leg Restraints to secure the patient in the rear of the vehicle is appropriate.

An NEMT passenger car should be scheduled for a mental disorder patient when the patient presents no risk to others and is capable of safely entering the vehicle unassisted.

To establish confidence with insurance providers, it is imperative that payments for medical transportation align precisely with the patient's symptoms and the specific Medical Transportation Service utilized, thereby ensuring efficient allocation of resources for each ride.

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#THE CONFUSION IN THE HEALTHCARE SYSTEM IS BEING CORRECTED.

The Petitioner has identified specific definitional points within the system that may lead to confusion among healthcare providers, patients, or even insurance providers, and this constitutes the root cause of insurance Providers' denials.

#1 The Point of Confusion

In the Healthcare System, when researching how to schedule medical transportation, one encounters explanations advising contact with healthcare providers to check eligibility, contact with a Medicaid caseworker, or contact with NEMT providers. From this context, the system has permitted patients to schedule their rides by contacting NEMT providers

The Point of Correction

The system is concerned with efficiency in budget spending to optimize every expenditure, which is why a wide range of transportation options exists for patients with mental disorders, from Emergency Ambulance to NEMT passenger car. Allowing patients to schedule medical rides independently would lead to the wasteful expenditure of funds because patients may not understand or be able to select a transportation option that matches their symptoms. After the new law, Medical Transportation transactions will be significantly more expensive, which can result in substantial waste of funds if patients are permitted to schedule rides on their own. After the new law, every ride must be scheduled by a healthcare coordinator to ensure precise medical transportation and screening of the transaction during the RCM process.

#2 The Point of Confusion

Medicare Policy previously defined medical transportation as covering only rides directly related to medical appointments.

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The Point of Correction

Extended phrasing can introduce ambiguity, particularly in the context of medical transportation. Every word from CMS has a meaningful and powerful effect on everyone in the Healthcare system, even the most minor details. When scheduled by a healthcare professional and approved by a physician or Head Nurse for billing and screening during the RCM process, medical transportation must precisely correspond to the patient's symptoms. Although all medical transport services are medically related, the accounts.

After the enactment of the new legislation, individuals with mental disorders are mandated to arrange Medical Van Transportation through the Innovative Medical Van Transportation Service. This service provides wheelchair accessibility and enhanced patient security, achieved through the use of a reinforced restraint system specially designed as a Wheelchair Seatbelt and additional Arm and Leg Restraints tailored to meet their transportation requirements. This procedure is not novel, having been medically validated in the Petitioner’s place of origin, Thailand.

Additional imagery for the innovative medical van transportation service for patients with mental health disorders, featuring wheelchair accessibility and enhanced patient security, including a rip-resistant Wheelchair Seatbelt specifically designed to secure patients in wheelchairs with extra Arm and leg restraints (The image is attached in Appendix B), is hereby submitted to the MEDCAC Committee for testing. The Petitioner has included six sets of samples of these grassroots products.

System must clearly articulate how the Healthcare Coordinator dispatcher schedules each ride to align precisely with the patient's specific condition. Revenue Cycle Management (RCM) is responsible for overseeing these submitted transactions, as any discrepancies may result in insurance providers scrutinizing medical transportation dispatched by the Healthcare Coordinator, particularly for patients with mental disorders

#3 The Point of Confusion

Transportation within the realm of mental health disorders presents a complex challenge, often leading to uncollectible bills within the healthcare system. While complete

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elimination of this issue is not feasible, strategies can be implemented to minimize its impact. Following the implementation of new legislation, all emergency ambulance transports for patients with mental health disorders must be corroborated with a corresponding 911 report. In the absence of a 911 report, all such transports must be scheduled through Non-Emergency Medical Transportation (NEMT) medical van services. A novel approach involves the legal application of tear-resistant medical fabric for mental health disorder patients who pose a risk to the driver, before securing the patient with an additional seatbelt.

The Point of Correction.

The Petitioner's offering the idea from the grassroots, helping the Healthcare system save budgets. Previously, the system was set up for Mental Disorder Patients who posed a risk to the driver were transported by Non Emergency Ambulance, but using the exact vehicle with an Emergency Ambulance, even if the situation did not need any other devices except a bed to restrain the patient to secure the trip. We used the vehicle, $300,000 if brand new, for the . We used the vehicle, $300,000 if brand new, for the unmatched transaction. During the journey, it may encounter another patient in need of CPR or any other life-threatening condition that requires one of the devices installed in the Emergency Vehicle, such as an ambulance. Still, the Ambulance could not take their prioritized cases. Additionally, the transaction resulted in higher uncollectible accounts.

After the enactment of the new legislation, individuals with mental disorders are mandated to arrange Medical Van Transportation through the Innovative Medical Van Transportation Service. This service provides wheelchair accessibility and enhanced patient security, achieved through the use of a reinforced restraint system specially designed as a Wheelchair Seatbelt and additional Arm and Leg Restraints tailored to meet their transportation requirements. This procedure is not novel, having been medically validated in the Petitioner’s place of origin, Thailand.

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including a rip-resistant Wheelchair Seatbelt specifically designed to secure patients in wheelchairs with extra Arm and leg restraints (The image is attached in Appendix B), is hereby submitted to the MEDCAC Committee for testing. The Petitioner has included six sets of samples of these grassroots products.

#4 The Point of Confusion.

The recent legislative changes necessitate enhanced coordination between Emergency Ambulance services and 911 dispatch, a matter outside the scope of this petition due to its cross-organizational implications. It is incumbent upon 911 call center agents to accurately assess each call to determine the necessity of an Emergency Ambulance. Inaccurate determinations by 911 agents contribute to uncollectible accounts within the healthcare system, exacerbating costs. Given current inflationary pressures, the escalating cost of Emergency Ambulance services renders this issue paramount within this petition. The practice of charging the full price for Emergency Ambulance dispatches resulting from incorrect agent determinations is exploitative. In such instances, the Emergency Ambulance is likely unbeneficial to the scene, concluding its journey swiftly and returning to the station or proceeding to the next call with an empty vehicle. To ensure equity, all parties involved in these erroneous determinations should incur appropriate penalties. Charging the full price to the Healthcare System under such circumstances is unjust.

The Point of Correction

To ensure all parties are aware of the discrepancy in the scheduled billing, a 25% discount on the full cost of the incorrectly determined Emergency Ambulance, as per the related agency's schedule, may be applied to the Healthcare System's bill balance. A full-price bill may be permissible if the Ambulance Company Providers can demonstrate that the transaction between the correct determination and the incorrect schedule incurred equivalent costs for the providers in terms of time and other resources. However, it is a fact system must clearly articulate how the Healthcare Coordinator dispatcher schedules each ride to align precisely with the patient's specific condition. Revenue Cycle Management (RCM) is responsible for overseeing these submitted transactions, as any discrepancies

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may result in insurance providers scrutinizing medical transportation dispatched by the Healthcare Coordinator, particularly for patients with mental disorders
additional seatbelt.

The transaction between the correct determination and the incorrect schedule incurred equivalent costs for the providers in terms of time and other resources. However, it is a fact that the incorrect trip consumed less time and fewer resources.

#5 Point of Confusion.

The petitioner has uncovered a significant and recurring misunderstanding within the claiming process for EMT Ambulance services, particularly as it intersects with the broader healthcare system. This issue frequently arises from insurance providers' denial of claims, often citing a requirement for documentation issued by a physician. This mandate persists despite the fact that a substantial number of these denials stem from transactions in which no physician was involved.

Specifically, many claims are denied when an EMT Ambulance is dispatched via a 911 call. In these scenarios, the interaction is solely between the patient (or the caller) and the 911 agent. The reasons provided for these denials often fall entirely outside the scope of legally permissible grounds. Furthermore, physicians or other healthcare providers are not specialists in transportation logistics; therefore, their judgment should not be the sole basis for allowing or disallowing claims in such cases. More critically, these medical professionals are typically not present at the scene of the incident.

Despite this clear lack of involvement and expertise, insurance providers routinely demand documentation bearing a physician's signature to process the claim. This requirement, imposed by the insurance providers, virtually guarantees the outcome of claim denial, creating a systemic hurdle for patients and EMT services alike. The existing process fails to account for the unique circumstances of emergency medical transportation initiated through 911, leading to an unfair burden on all parties and a persistent cycle of claim rejections.
The current state of healthcare claims processing, particularly within the realm of

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emergency medical transport (EMT) services, is plagued by systemic confusion and historical inefficiencies. This disarray has resulted in significant financial losses for both healthcare providers and, in some instances, patients themselves. The prevailing "claim denied" outcomes are not merely unfortunate occurrences but are often the direct consequence of a convoluted process that, at times, appears designed to obstruct rather than facilitate rightful reimbursement.

A substantial portion of the blame for this enduring problem lies with insurance companies, which have, over time, cultivated an environment where the denial of claims, even for medically necessary services, can contribute to their profitability. This practice creates an inherent conflict of interest, where the imperative for financial gain can supersede the ethical obligation to cover legitimate medical expenses. The intricate web of paperwork, obscure requirements, and often arbitrary interpretations of coverage terms serve to make the claiming process exceptionally challenging, if not insurmountable, for many

However, the responsibility for this systemic failure is not solely attributable to insurance carriers. Revenue Cycle Management (RCM) companies also bear a significant portion of this fault. The precision of medical coding is paramount in ensuring accurate and timely claims processing. Unfortunately, a lack of meticulousness in coding practices by RCM companies can create vulnerabilities that allow for the denial of claims, even when the services rendered were entirely appropriate and necessary. This imprecision provides insurance companies with the grounds, however tenuous, to reject claims, further exacerbating the financial strain on healthcare providers.

The specific case of EMT Ambulance claims vividly illustrates these broader issues. For too long, claims for emergency ambulance services have been denied based on interpretations that fall "out of the scope of law allowed," yet these denials have persisted in numerous cases. This has led to substantial revenue losses for "Victims Hospitals and Healthcare Providers" when the bills for these denied claims originated from the providers themselves. The financial impact can be even more severe if the bill for such services comes directly

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from the patient, as it represents an "unreasonable out of law scope allowing to deny the case," effectively penalizing individuals for seeking emergency medical care.

A deeper analysis reveals a critical disconnect: if an ambulance dispatch is deemed "correct," it inherently signifies that the patient was in a "serious or emergency situation." This fundamental premise underscores the necessity of the ambulance service. Yet, the current system often punishes patients who, after receiving critical care and recovering, are then subjected to the bewildering and unjust burden of denied claims. This situation gives rise to the poignant sentiment articulated as, "However, after the patient got better and found the mistake from the system but punished the patient for being sick, I should not be sick. It's the voice of the patients." This encapsulates the profound frustration and injustice felt by those who have navigated a life-threatening emergency only to be confronted with a bureaucratic nightmare and financial hardship**.**

The Point of Correction.

The urgent need for reform is clear. With the advent of new legislation, the standard for processing EMT Ambulance claims must undergo a fundamental shift. The petitioner advocates for a standard rooted in the "911 regulation of Emergency Ambulance." This approach would streamline the process, eliminate ambiguity, and ensure that claims for genuine emergency services are honored. By aligning the claiming process with the established protocols for emergency dispatch, the system can move towards greater fairness, transparency, and accountability, ultimately safeguarding the financial well-being of both healthcare providers and patients.

911 REGULATION THAT WILL LEGALLY DISPATCH EMERGENCY AMBULANCE TRANSLATION.

You should call 911 (or your local emergency number) for an ambulance in the following situations:

* Active suicide threat or attempt: The person is actively trying to harm themselves.

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* Threatening harm to others: The person is a danger to people around them.
* Self-injury that requires immediate medical attention: For example, a person has cut themselves and needs stitches or other medical care.
* Severe intoxication or suspected overdose: This is a medical emergency that can be life-threatening.
* Inability to care for oneself due to a mental health crisis: The person may be out of touch with reality, unable to function, or unable to provide for their basic needs like food, clothing, and shelter. The regulation shows every ride for Mental Disorders Patients is must be confirmed by a 911 transaction, not a Healthcare Provider's Dispatcher without 911 called it must considering under NEMT Medical Van in the case that need to tight the patient and it's not necessary to be in bed it can be in the back seat as a new design by using Personal Van as in the photo attached in

Non-Emergency Medical Van Transportation for a patient with a mental health disorder should be scheduled when the patient's behavioral symptoms indicate a potential risk to the driver and other individuals. In such cases, a NEMT Medical Van equipped with a Wheelchair Seatbelt and specialized Arm and Leg Restraints to secure the patient in the rear of the vehicle is appropriate.

An NEMT passenger car should be scheduled for a mental disorder patient when the patient presents no risk to others and is capable of safely entering the vehicle unassisted.

All transactions in this sector, thereby obviating the need for government-run oversight. The current reluctance to adopt such measures incurs an additional cost.

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#THE COLLABORATIVE POLICY FRAMEWORK FOR INSURANCE CLAIMS.

EMT AMBULANCE and NEMT COVERAGE DENIAL IS INSURANCE PROVIDERS' PROHIBITED.

The current landscape of insurance claim resolution, particularly in cases of disagreement over claim value or liability, often operates on an adversarial model. This friction, which occurs at the microeconomic level of a single claim, creates systemic inefficiencies and risks. For the policyholder, a "wrongly determined" claim can result in financial loss and a significant emotional burden due to a prolonged dispute. For the insurance provider, these same disputes can result in elevated administrative costs, expensive litigation, and the erosion of public trust, all of which act as a drag on long-term profitability. The prevailing dynamic reflects a critical disconnect between the micro-level outcomes of individual claims and the macro-level health of the insurance industry.

The claim of EMT Ambulance Denial by Insurance Providers. In this transaction, the petitioner must claim that the issue happened before the petition's goal of adding NEMT into the National Coverage Determination. However, the issue must be addressed simultaneously with the implementation of the new law. In the petitioner's opinion, if any product passes the burden of proof to confirm the status under NCD, the insurance provider should not still deny. When the petitioner reviewed the insurance provider's reason for denial, it was likely that the EMT Transaction lacked medical necessity. The petition needs to ensure that all parties involved adhere to the same standard, the judgment is below its fair value, and eliminate any game-playing, as in this petition. Two sources can dispatch the Ambulance:

#1. 911 Emergency Dispatch:
This scenario commences when a client initiates a call to 911. A trained 911 agent answers the call and, in collaboration with a 911 dispatcher, conducts an initial assessment to

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determine the immediacy and severity of the situation. This assessment is critical in establishing whether the case constitutes a genuine emergency, warranting the immediate dispatch of Emergency Medical Services. The information gathered during this initial contact, including the caller's description of the symptoms, the perceived urgency, and any pre-existing conditions disclosed, forms the foundational documentation for the emergency response. While the 911 system is designed to provide immediate assistance in critical situations, even dispatches from this source have faced unwarranted denials, resulting in significant financial burdens for patients and their families.

#2. Physician-Initiated Dispatch (Inter-facility Transfer):

The second common scenario for EMT ambulance dispatch arises from a medical professional, typically a doctor, initiating the transfer of a patient. This most frequently occurs when a patient needs to be transferred from one hospital or medical facility to an emergency unit at another facility. This type of transfer almost always occurs while the patient is under a doctor's care, indicating a deliberate medical decision made for the patient's well-being. Consequently, all relevant medical documents, including physician orders, transfer summaries, and any diagnostic results, are issued by the attending physician and are meticulously attached to the case for claims processing. However, most of the EMT Ambulance's transactions were denied by the source, 911 dispatching, due to unnecessary medical-related issues. Denying this reason in the situation suggests that the insurance provider is playing a game to deny coverage for its own profitability. Although the EMT Ambulance confirmed that it was an investment to increase the insurance provider's profitability, the same rationale applies to NEMT as well. By law, no one shall be allowed to refuse to pay the expenses from their investment. We must make it clear that if this is not done, the insurance provider will continue to deny NEMT transactions**.**

In accordance with legal principles, no entity should be permitted to arbitrarily deny legitimate expenses incurred from profitable investments. Such denials must be predicated on verifiable facts and justifiable reasoning. A notable instance of this principle being violated involves insurance providers who rejected claims from EMT Ambulance and their associated clients in 911 emergencies. This rejection occurred despite the absence of a

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doctor on the scene, yet the insurance providers paradoxically imposed a requirement for documentation to be issued by a physician.

It is a well-established fact that individuals and organizations, including insurance providers, are expected to assume responsibility for scenarios in which they are directly involved. This petition aims to clarify the concept of fairness and establish a factual basis within the realm of policy, thereby eliminating any undue manipulation or "games" played by parties related to insurance policies.

Specifically, an insurance company's ability to deny transactions from EMT Ambulance and Non-Emergency Medical Transportation (NEMT) services, after both have been confirmed under the National Coverage Determination (NCD), should be strictly limited. Such denials would only be permissible if the submitted proof demonstrably fails to align with NCD guidelines or if the services demonstrably do not generate a profit for the insurance company.

Crucially, both EMT Ambulance and NEMT products are eligible for confirmation under NCD status, having successfully navigated the pathway to demonstrate their efficacy as methods to enhance insurance providers' profitability. Furthermore, under new legislative provisions, the system is set to benefit from a 25% discount offered by this petition, thereby providing an additional layer of security and financial advantage to insurance providers, as it has never been enacted within the previous law.
It highlights the mutually beneficial nature of these services when they are appropriately recognized and reimbursed.**# RCM VS INSURANCE PROVIDERS**

"All stakeholders within the Healthcare System must acknowledge and comprehend that the 25% discount is not a punitive measure from the system; rather, it represents a collective responsibility for an unintentional error, which we must all share as an equitable resolution. We cannot disregard this oversight; we all bear a degree of responsibility, and we will hold the healthcare system accountable, as we have done in the past. We shall collectively achieve success as a unified team."

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#THE ANALYSIS SUPPORTS

"HOW THE MICROECONOMIC SUPPORTS THE MACROECONOMIC".

This report presents a proposed solution, a collaborative policy framework, rooted in a fundamental understanding of the micro-macro relationship. As articulated by the proponent, this report presents a proposed solution, a collaborative policy framework, rooted in a fundamental understanding of the micro-macro relationship. As articulated by the proponent of this framework, this policy redefines the traditional dispute process not as a zero-sum contest but as a mechanism for achieving a positive-sum outcome. The report's purpose is to formalize this chain of reasoning, demonstrating how individual-level fairness is a prerequisite for system-wide stability.

The employees of Insurance Providers must understand the origin of EMT Ambulance coverage, which will enable them to view individual claim payments in this sector as a positive investment in profitability, rather than a loss. This is how the microeconomic impacts of the proposed framework can be scaled to produce significant macroeconomic benefits in the long run.

#6 Point of Confusion.

In Appendix A, the attached documents include a 2018 report from the OIG (Office of Inspector General) which stated, "The NEMT Program in some States did not require local governments, brokers, and drivers to maintain detailed trip data documents."

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The Point of Correction.

This paragraph elucidates a critical issue: corruption within the local government, specifically regarding the overbilling of services. The local government, rather than individual brokers or drivers, is identified as the culpable party. It is asserted that this governmental agency lacks the authority to disregard or manipulate billing details and trip data. These transactions are subject to IRS Topic #305, which mandates accurate bookkeeping and record-keeping, particularly for drivers who utilize trip details for income tax deductions. The absence of such documentation hinders drivers' ability to accurately file their income tax returns.

The motivation for the local government's reporting to the Office of the Inspector General (OIG) is posited as a strategy to mitigate the severity of potential penalties. The punishment for negligence in program control is considered less severe than the consequences of submitting accurate trip data alongside inflated claims. While Medicaid has successfully incorporated Non-Emergency Medical Transportation (NEMT) into its policy, aiming to solidify it into law, the Basic Emergency Medical Transportation (BEMT) policies implemented by states have failed. If Medicaid were to reimburse these claims from the state government, it would suggest collusion with the local government agency.

The discrepancy between the actual amounts filed by drivers for income tax purposes and the overbilled amounts claimed by the local government represents the extent of the overbilling. This differential amount is subject to a refund to the Federal Government, and the responsible agency should face appropriate disciplinary action, including termination.

Consequently, this situation underscores the urgent need for Medicare to integrate NEMT or Light Medical Transportation (LMT) into its policies as soon as possible, especially as it transitions into the National Coverage Determination (NCD). The implementation of provider-based systems, such as Lyft Healthcare and Uber Health, would ensure the accuracy of trip data documentation, thereby enhancing the transparency of the claiming process.

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#Tendering The Proposal: Addressing All Objections to Achieve Systemic Correction"

Within the healthcare system, no formal leader has been designated. However, it is widely acknowledged that CMS Medicare holds a dominant position, wielding significant influence over all sectors within the system.
Reflecting this scenario onto NEMT policy directives, Medicaid, as a sister corporation in the same business domain, has identified NEMT as a crucial tool for success in the business landscape. Conversely, the other entity remains stagnant without adequate justification. This inaction has led other private insurance providers to defer to the analysis of NEMT outcomes provided by Medicaid. This reluctance is not a characteristic befitting a leader. Decisiveness is imperative, and as the petitioner previously outlined, CMS Medicare, despite its informal establishment, is the recognized leader of our healthcare system. A leader cannot afford reluctance in decision-making, as it creates systemic confusion and fosters disunity. To effect impactful change within the healthcare system, leadership action is paramount**.** The leader decided to shine out of our leader by adding NEMT into Medicare Part C. That's considering a half of complexity of decision making had been made, and now the other half is required.

#WHY THE RELUCTANCE PERSISTS

The Reasons May Caused of The Reluctance May Results The Petition Dismissal VS. The Arguments.

Despite these compelling arguments, changing the Medicare benefit structure for Original Medicare is a monumental task due to:

#1. REASONS OF THE RELUCTANCE.

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CMS: Upfront Cost Aversion: Even with strong ROI projections, the initial, visible cost of adding a universal NEMT benefit to Original Medicare is a substantial political hurdle. It would require significant new appropriations or a reallocation of existing funds.

“Siloed" Budgeting: Healthcare spending is often budgeted in silos. The "savings" from NEMT (e.g., fewer hospitalizations) might accrue to one part of the budget. At the same time, the "cost" of NEMT would appear in another way, making the overall ROI harder to track and politically justify.

#1. THE ARGUMENT.

The Petitioner: Incorporating Non-Emergency Medical Transportation (NEMT) into the National Coverage Determination (NCD) is considered a sound Return on Investment (ROI). For every dollar advanced by Insurance Providers for NEMT annually, all insurance companies will realize an increase in investment funds and higher profitability by year-end. All theoretical frameworks and real-world applications, extensively tested by Medicaid for decades, confirm that "NEMT is a practical method for Insurance Providers to increase profitability through ROI." According to the Uber Health Professional Report 6 million patients missed their medical Appointments and that led to cost after missed appointments from the disease didn’t taking care on time and other symptoms of those patients worsened, and it’s creasing cost amount $150 billions dollars, Comparing with the Medicaid reported the amount of NEMT fees in 2018 cost $2.9 billion dollars. Now Medicare already covers NEMT for enrollees in Part C if it covers every part A, B, and C. It's estimated 3 times from the NEMT fees that Medicaid spent for their clients in 2018, $2.9 billion dollars x 3 = $8.7 billion dollars estimates. CMS and The Committee must see the same as the petitioner. The amount that we are not moving costs us $150 billion dollars, the cost of moving is Medicaid NEMT fees $2.9 billion dollars + Medicare All parts A, B and C $8.7 billion dollars = $11.6 billion dollars total. This amount is far apart from the number we are losing if we do not move forward.

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#2 REASONS OF THE RELUCTANCE.

CMS: Defining "Routine": There would be complex questions about defining "routine" NEMT, establishing rates, and preventing fraud and abuse on a massive scale for millions of beneficiaries.

#2 THE ARGUMENT

The Petitioner: To proactively address concerns regarding the definition of 'routine' NEMT and to prevent fraud, the proposed NEMT/LMT benefit is directly tied to verified medical appointments.

* Verification of Medical Necessity: NEMT/LMT coverage would be exclusively authorized for transportation from a beneficiary's verified home address to a confirmed, scheduled medical appointment at a hospital, clinic, or physician's office, and for the return trip to their home address on the same day.

* Preventing Patient Self-Scheduling: Beneficiaries would not self-schedule NEMT. Instead, all NEMT/LMT services must be coordinated and scheduled through a designated healthcare dispatcher, who verifies the existence and nature of the medical appointment directly with the healthcare provider. This crucial step prevents misinterpretation of 'routine' and ensures that NEMT/LMT is used solely for its intended purpose: ensuring access to care.

* Transparent Trip Logging: Each NEMT/LMT trip would correspond with the hospital or provider's billing on the same day, creating an essential audit trail and further limiting the scope to genuine, medically-related travel.

This rigorous, appointment-driven framework effectively defines 'routine' NEMT and inherently controls and screens trips to ensure their legitimacy, making fraud prevention an integral part of the process rather than a separate concern."

Key changes and why they're effective:

*** Direct Link to Confirmed Appointments: This is the strongest point for defining "routine" and preventing fraud. It's objective and verifiable.**

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*** Healthcare Dispatcher Role: Emphasizes that it's not patient-initiated, but professionally coordinated, which** addresses the "patients lack requisite knowledge" point more professionally.

This directly refutes the committee's reluctance by demonstrating that fraud is not an ancillary consideration, but rather an inherent component of the system's design.

Furthermore, subsequent to the enactment of new legislation, the Petitioner has rectified this aspect within the system's correction of existing confusion. Through regulation, medical transportation must now be scheduled based on the patient's symptoms; the system does not permit patients to self-schedule medical transportation, as patients lack the requisite knowledge in this area, which could lead to a wasteful expenditure of funds within the system. NEMT is rigorously scheduled by a coordinated healthcare dispatcher. Medicare adopted insights regarding Non-Emergency Medical Transportation (NEMT) from Medicaid's experience. Reports from Medicaid programs in various states indicated instances of fraudulent transactions. An analysis of the 2018 report by The Office of Inspector General (OIG) revealed that certain states did not mandate brokers, drivers, or agencies to retain trip data. The Auditing Department will proactively eliminate and prevent such occurrences in real-time. The report from state agencies also identified a lack of comprehensive information. State agencies lacked the authority to approve or disregard receipts or trip data, as these documents are governed by IRS Regulation Topic #305 (Bookkeeping and Recordkeeping). Without proper documentation, drivers and brokers were unable to file their tax returns, suggesting that while front-line operators maintained records, the state agency reporting on these records did not submit them with processed refunds, potentially contributing to overbilling claims. This raises questions for Medicaid regarding the handling of claims lacking proper documentation. However, following Medicare's incorporation of Light Medical Transportation (LMT) into NCD, the implementation has been more secure than Medicaid's program. This enhanced security stems from Medicare's operation of the program under federal government regulations, minimizing local state involvement. Furthermore, document security will be improved through professional trip reporting and billing systems from Uber Health and Lyft Healthcare, or even a small business Provider their software now day all updated utilizing providers' professional dispatching software. The fraudulent transactions and overbilling

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claims occurred due to a misinterpretation of Medicaid's legal framework, which allowed transactions to proceed in violation of IRS Regulations Topic #305 (Bookkeeping and Recordkeeping) during the claiming process. It is important to reaffirm that while these fraudulent transactions and overbilling claims were likely not the fundamental cause of the program's issues, the lack of precise legal interpretation necessitates improvement.

#3. REASONS OF THE RELUCTANCE.

CMS: Political Will vs. Evidence: While the evidence is growing, it takes sustained political will and advocacy to translate that evidence into concrete legislative or regulatory change for a program as large and entrenched as Original Medicare. However, our Healthcare System leader showed decisiveness as a great leader to move half of the capacity of complexity, therefore we only needed the other half.

#3. THE ARGUMENT

The Petitioner: The Petitioner has a long time telling story for the CMS and Honorable MEDCAC Committees to read on, Centuries ago, a grandmother bequeathed a valuable plot of land to her four sons with a powerful decree: "Do not sell this piece of land, it is my signature, to be loved by all of you." This sacred trust symbolized her enduring love and foresight, intended to bind generations together. Transformation and the Modern Dilemma Over time, this rural expanse transformed into a bustling business district. The Political Will when Created Original Medicare Part A, and B that oils compare with this piece of land when it's owned by the Grandma after a long time passed everything around this lot land changed the price of the lot land also changed everything changed that why the Old Political Will needed to be rectified. The petition doesn't aim to replace it to (NEMT) by including it in the National Coverage Determination (NCD) is only sine part of Modern Political Will after a long time resulting to environmental had changed, and the forward-thinking approach that acknowledges evolving healthcare needs and the critical role of NEMT. Adding NEMT will modernize the old Political Will to be sustainable..

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However, this necessitates a shift beyond political maneuvering and historical resistance, advocating for a system that guarantees equitable access to essential medical appointments and services. Such a re-prioritization would facilitate a more effective and compassionate healthcare system, wherein NEMT is recognized as a vital component for improving health outcomes and mitigating healthcare disparities. Medicare has already demonstrated a commitment of political will by incorporating NEMT into Medicare Policy Part C, representing a significant stride as a leader in the healthcare system. The remaining half of this decisive action is now required.

The Taya Foundation respectfully upholds older cultures, yet its work of providing sustainable solutions and empowering indigenous communities is, in itself, a new kind of political will. It's not about replacing the past, but about building a stronger future that honors it, and this political feasibility petition delivered the sharpening old political will for consideration.

#4 The Smart Transitioning for NEMT to comply within NCD Definition.

The petition's denial is primarily based on the determination that Non-Emergency Medical Transportation (NEMT) does not conform to the National Coverage Determination (NCD), a legal framework specifically addressing essential medical devices and equipment.

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#INTRODUCING NEW LEGAL STRATEGIES " THE SMART TRANSITIONING LMT." and " THE EMPTY BASKETS". WHAT ARE THEY?

A thorough analysis of the proposed strategy indicates that the petition is politically feasible and aligns with existing political will. The arguments presented effectively address potential grounds for denial. However, the most significant hurdle for approval by the Centers for Medicare & Medicaid Services (CMS) and associated committees lies in the classification of Non-Emergency Medical Transportation (NEMT) as a non-essential medical product under the National Coverage Determination (NCD) definition. Should CMS approve this petition, it would signify a tactical agreement among all involved parties, recognizing NEMT's efficacy as a "Win-Win-Win" solution.

To secure the desired outcome, a dual-pathway strategy is proposed: submission of the petition to CMS, and engagement with the legislative process via Senator Tim Kaine, a prominent advocate for healthcare reform. Senator Kaine's influence could be instrumental in determining the most advantageous approach:

#THE SMART TRANSITIONING

"LMT (LIGHT MEDICAL TRANSPORTATION)"

NEMT is an essential Medical product by its function but it's Physically out of National Coverage Determination Definition. We have two options: to change the law or to Transform To adapt the NEMT that the function proved as an essential product in the Healthcare System but CMS couldn't a sister of EMT(Emergency Medical Transportation)it's included into NCD from NEMT consider under logistic transportation and lack of medical equipment or Medical designation .

This Petition respectfully introduces The Smart Transforming to make the proved product as an essential healthcare product by its function, to physical comply by NCD coverage Regulation will describe below:

After the new law enacted, it's mandatory for all vehicles to be used as a new line of medical transportation is " Light Medical Transportation (LMT)." similarly to the condition that law covered EMT Ambulance but this new category of medical transportation required a minimal of medical equipment must contained in the :

***LTM Vehicle** in every Trips as it mandatory as they are listed below:

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1. Oxygen Tank (size S)
2. A Foldable Wheelchair
3. A foldable Walker
4. A First Aid Kit (all vehicles most likely equipped it from the manufacturer factory)

Any vehicle, regardless of brand or model, will be permitted to operate LMT services under legal coverage.

***LMT Drivers** not only operate the vehicle safely as required by law the LMT Drivers must pass the 1-hour online course of "CPR&FIRST AID FOR LMT'S DRIVERS" the online course provided on the website ONEMOVEMENTFORWINWINWIN.COM. This course is an hour-long online program, consisting of 45 minutes of video training on CPR and First Aid, followed by a 15-minute test. Upon successful completion of the test, the driver will receive a "Certificate of Competence: The LMT Qualified Driver" via email. This certificate is mandatory, and its ID will correspond with the driver's license number.

Provided both the driver and the vehicle meet these requirements, aligning with the operational framework prior to this transition. Failure to meet any of the minimum legal requirements for LMT service will result in penalties commensurate with the rate for unauthorized parking in a disability-designated space in the driver's state of residence. NEMT vehicles contain all four of medical equipment that will meet minimal of law requirements for CMS to add this new category of medical transportation that carry all proved functional as an essential healthcare product as its LMT(Light Medical Transportation) into National Coverage Determination (NCD).

#THE EMPTY BASKETS STRATEGY (This is required Dual Tracks Petition)

Given the legal establishment of Medicare Parts A and B, their deletion is not permissible. Medicare Part C offers more advantageous benefit coverage. Currently, upon turning 65, individuals are automatically enrolled in Medicare Parts A and B by the Social Security Administration. The "Empty Basket Strategy" proposes transitioning all existing Medicare Part A and B clients to Medicare Part C, which provides superior benefits. This would be a mutually beneficial process due to enhanced benefits for existing clients. For new Medicare

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clients, the default enrollment process within the Social Security Administration system would be altered to automatically enroll individuals turning 65 directly into Medicare Part C, rather than Parts A and B. While the "baskets" of Part A and B would remain legally established, Medicare would technically operate solely under Part C. This strategy is theoretically projected to eliminate the $150 billion cost increase associated with 6 million missed medical appointments.

In this Petition we selected the “Smart Transitioning LMT Stategy.” offering to CMS and Honorable MEDCAC Committees for consideration, because it could be completely approved by CMS but the “Empty Basket Strategy” will need a dual track petition to make the change. Also to select this option to create more jobs and help the business in the line of products that needs to comply with the new law to gain revenues and create more jobs in their communities .

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#QUESTIONS

Lastly, if any party related to the Healthcare System is involved in this Petition, the person or Organization must answer the questions below. If they do not answer these questions correctly, they must agree to the terms and conditions of the agreement.

Question #1: Considering the United States' common law system, and Medicaid's historical coverage of Non-Emergency Medical Transportation (NEMT) as an insurance provider, why has similar coverage not been extended to other comparable situations?

Question #2: Do Medicaid recipients differ from clients of other insurance providers? If not, why is this individual being subjected to disparate treatment? This constitutes a violation of the Fourteenth Amendment's Equal Protection Clause in the Constitution.

Question #3: In the United States, all healthcare systems, whether for Medicaid clients or those with other insurance providers, operate within the same high-cost framework. While Medicaid offers Non-Emergency Medical Transportation (NEMT) to its clients, a question arises: why do other insurance providers not extend similar coverage?

Question #4: Should world leaders persist with outdated political wills that yield adverse outcomes, or is it preferable to update these wills to achieve better, more intelligent results, as befits a world leader?

Question #5: The inclusion of EMT Ambulances in the National Coverage Determination was viewed as a profitable return on investment for insurance providers. This was crucial due to the lengthy and ongoing nature of the Non-Emergency Medical Transportation (NEMT) process, which persists to this day. If this theory is incorrect, and EMT Ambulances

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are not generating profit for insurance companies, why have no actions been taken to revoke this theory? Conversely, if the theory is confirmed, why do insurance providers continue to deny company costs in their pursuit of higher profits?

Question#6: While acknowledging that errors, such as a 911 dispatcher's critical decision-making mistake leading to an incorrect EMT ambulance dispatch, can occur, a deeper analysis of the outcomes is crucial. The petitioner observed that ambulances were engaged for a shorter duration in incorrectly dispatched trips compared to correctly dispatched ones. This expedited release from erroneous dispatches could allow ambulances to become available for subsequent assignments sooner, thereby generating additional revenue equivalent to a full, correctly determined trip. If ambulance service providers dispute a 25% discount for each wrongly dispatched trip, they should be required to demonstrate that both wrongly dispatched and unintentionally mistaken dispatches consumed an equivalent amount of time and resources. Consequently, if such proof cannot be furnished or is legally deemed inadmissible, your company may still issue the full charge to the system.

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#STAGE 5 THE APPROVAL

For us to advance to Stage #5 of the Petition for Approval, the esteemed MEDCAC Committees and CMS must endorse all provisions detailed above. The petitioner has meticulously crafted these provisions to rectify every issue, leveraging their extensive knowledge, with the aspiration that these measures will serve as a practical mechanism to sustain and enhance the efficiency of our healthcare system. Should the Committees express any reservations regarding specific points, the petitioner is prepared to address and amend them in accordance with the CMS and the Committees' suggestions.

Before proceeding to this stage, it is essential to comprehend its context. The petitioner has meticulously outlined all potential grounds for dismissal, presenting arguments that articulate a comprehensive vision derived from real-world experiences to the highest authorities. This presentation is tendered with the anticipation of a favorable outcome, effectively precluding all avenues for denial. It is delivered with profound respect, notwithstanding that some may perceive the forceful nature of the petition as assertive. Consequently, its contents necessitate clarity and meticulous attention to detail to ensure that the Committees and CMS endorse the instrument within this Petition, thereby facilitating the translation of political feasibilities into new legislation.

#Enhancing System Sustainability:

Implementation of a $1 LMT Driver Incentive

Following the Petitioner's successful efforts to secure benefits for all major stakeholder groups within the Healthcare System on behalf of The Taya Foundation, the Petitioner must now present this final proposal to the Centers for Medicare & Medicaid Services (CMS) and the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). This is to secure benefits for a smaller population, which will nevertheless yield substantial future contributions to the system from Logistics and Medical Transportation (LMT) Drivers. The Petitioner and The Taya Foundation, as the creator of this classification's final proposal, is offering an incentive of $1 added to the rate of each trip for LMT Drivers. While not as substantial as the Petitioner might have hoped, it is a symbolic

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gesture from The Taya Foundation, which established a Win-Win-Win solution for the entire system, including our future Drivers. This action is intended to show respect and formally recognize the critical role of future LMT Drivers as they are welcomed into the healthcare transportation system. Thank you for being Drivers in America.

#THE WINNING PAGE:
PROFESSIONAL AMERICAN VOTED IN SUPPORT.

This page is a sympathetic message to the Honorable MEDCAC Committees that oversee the healthcare system. All honorable committees have been acknowledged with heart in this message. The Petitioner has included all information to support this petition on the website:
www.linkedin.com/in/taya-anderson-48909123
https://onemovementforwinwinwin.com/
For the Honorable MEDCAC committees to review the history and consider all the voices of American Professionals to confirm this move. The Petition has been afloat until today, the day we submit the Petition to the Committees with all funding support from the Stakeholders related to the moving results as evidence, even though the Petitioner knew it was unnecessary:

- **Hospitals and Healthcare Providers** were also victims of the crisis caused by the New Government Budget Cuts. The Committee needs to empower them so they have fewer expenses to survive under political pressure.
- **Insurance Providers** will increase their profitability, including Medicare, by advancing NEMT Fees as a Return On Investment.
- **The NEMT Providers,** as inventors who contribute benefits to the Healthcare System, deserve to be rewarded.
- **Now and Future Patients,** this phase means all of us who eventually benefit from the moving outcome. **We ran out of time to delay.**

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#APPENDIX A

The Document Issued By The OIG -Medicaid , The Petition Utilized Legal Ground from Medicaid Related Documents.

MACPAC Issued Brief Report Title " Medicaid Covered NEMT(Non Medical Transportation)". Issued by the OIG(The office of Inspector General)

Medicaid Coverage of Non-Emergency Medical Transportation

Lack of transportation can be a barrier to accessing health care, particularly for elderly, disabled, or low-income individuals. To address this concern, federal Medicaid regulations require that states ensure transportation to and from providers, a benefit known as non-emergency medical transportation (NEMT).[1] Although the scope of the benefit varies by state, NEMT generally covers a broad range of transportation services including trips in taxis, buses, vans, and personal vehicles belonging to beneficiaries and their family or friends.

Recently, policymakers at the state and federal levels have begun to reexamine the use of the NEMT benefit. Some states have received approval from the Centers for Medicare & Medicaid Services (CMS) to waive the benefit for the new adult group made eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as part of their Medicaid expansion waivers.[2] The President's most recent budget for fiscal year (FY) 2020 included a proposal to change the NEMT benefit from a mandatory Medicaid benefit to an optional one (HHS 2019). The Administration also announced plans to publish proposed regulatory changes in May 2019 to give states more flexibility around NEMT (OIRA 2018).

This issue brief describes the NEMT benefit, including who uses it, delivery models, financing, and spending. We also review issues related to program integrity, waivers of NEMT, and possible restructuring through regulatory changes.

Benefit Overview

Authorized in federal regulations at 42 CFR 440.170, the NEMT benefit provides transportation to and from medical appointments for Medicaid beneficiaries with no other means of accessing services. States are required to ensure necessary transportation and to use the most appropriate form of transportation for the beneficiary (42 CFR 431.53, CMS 2016b). States are also required to provide assistance with transportation to children and their families as part of Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit (42 CFR 441.62).

Covered services, eligibility, co-payments, and limits on trips

The NEMT benefit varies from state to state but typically includes transportation by taxi, wheelchair van, private vehicle, and public transportation. In general, Medicaid beneficiaries are eligible for the benefit, as long as the transportation is necessary and the beneficiary does not have another means of transportation. For example, beneficiaries with no other means of transportation may not have a driver's license or may be physically or intellectually disabled (CMS 2016a). Some states rely on public

transportation to provide NEMT; however, this approach varies considerably both within and across states given that public transportation is not available in all areas. Another approach is the use of companies like Uber and Lyft. Data are limited on use of these options, but one pilot program documented improvements in beneficiary experience and reduced costs (Powers et al. 2018).

States may limit the benefit based on medical necessity or utilization control (42 CFR 440.230(d)). For example, some states require prior authorization from the state for trips or place limits on the number of trips Medicaid will cover. For example, Indiana limits the benefit to 20 trips per 12 months (FSSA 2019). Others charge co-payments. For example, Missouri charges a $2 co-payment for each NEMT trip with exceptions for children, pregnant women, individuals living in nursing facilities, and others (DSS 2019).

Delivery models

States have discretion over which models they use to deliver NEMT, and may use more than one approach to accommodate varying beneficiary needs, delivery systems, and geographic areas. States typically choose one or more of the following models:

- paying for NEMT on a fee-for-service (FFS) basis;
- contracting with managed care plans to provide NEMT and other services; and
- arranging for transportation brokers to manage the benefit (GAO 2016a).

The most commonly used NEMT model is the brokerage model, authorized under Section 1902(a)(70) of the Social Security Act. Brokerage can take several forms. Most states using this model arrange for private brokers to provide the service, while other states use a brokerage run by a state agency or a nonprofit organization. For example, OATS, Inc. is a rural public transportation service in Missouri operating in 87 counties. It provides transportation services to county residents including individuals age 65 and older and people with disabilities (Edrington et al. 2018, Ganuza and Davis 2017). Brokers may receive a capitated payment from the state or be paid on a FFS basis. In 2015, 34 states used some form of the brokerage model (Ganuza and Davis 2017).

A study conducted for the state of Maryland found that the brokerage model is cost effective for some states, primarily because it may ensure that Medicaid only pays for rides for eligible individuals and for appropriate trips, which could be a deterrent to fraud and abuse. Further, some state officials interviewed for the study credited the brokerage model with enabling better data reporting and quality measurement (Hilltop 2008).

In 2015, about 20 states used a FFS model, and 11 of these used other delivery models as well (Ganuza and Davis 2017). Of the four states that provided NEMT through contracts with managed care plans, only one, Arizona, exclusively used managed care.

Financing and spending

States can claim federal Medicaid matching payments for NEMT as either an administrative or medical assistance expense (GAO 2016a). States reporting NEMT spending as an administrative expense receive

payment at the federal medical assistance percentage (FMAP) for administrative expenses, which is set in statute at 50 percent. States claiming NEMT as a medical assistance expense receive payment at their regular FMAP which ranges from 50 percent to 76.98 percent for FY 2020, depending on the state (HHS 2018). If states choose to report NEMT spending as medical assistance, they are subject to additional statutory requirements, including giving Medicaid beneficiaries the free choice of providers from among any qualified Medicaid provider willing to provide the service (CMS 2008). One exception is the brokerage model. States contracting with a broker to provide the service are not subject to the additional statutory requirements that come with claiming NEMT as a medical assistance expense (CMS 2008). Such states may restrict a beneficiary's choice of provider.

In FY 2017, states and the federal government spent almost $2 billion on NEMT services provided through FFS. Spending on NEMT in managed care and brokerage models cannot be quantified with administrative data. This is because claims data in the Medicaid Statistical Information System (MSIS) and spending data in the CMS-64 does not distinguish among types of capitated arrangements in managed care. Thus it is not possible to determine whether such payments represent state contracts with brokers or state contracts with managed care plans that include NEMT.

Characteristics of Medicaid Beneficiaries who are Transportation Disadvantaged

Transportation-disadvantaged beneficiaries are unable to provide their own transportation due to age, disability or low income (GAO 2014). We used survey data to identify the characteristics of Medicaid beneficiaries who delay care because of a lack of transportation and claims data to describe beneficiaries using NEMT.

Delaying Care

In 2017, 2.1 million (or 4.4 percent) Medicaid enrollees under age 65 reported on the National Health Interview Survey that they had delayed care because of lack of transportation.[3] More than one-half (56.9 percent) were adults age 19–64 and the rest (43.1 percent) were children age 0–18. Income and health status were key factors. Almost two-thirds (65.7 percent) of those with a transportation barrier had income below 100 percent of the federal poverty level. The majority of Medicaid adults delaying care (99.2 percent) had limitations indicating varying levels of disability, including limits in movement and sensory, emotional, or mental functioning associated with a health problem.[4,5] Almost 25 percent of adults in Medicaid reporting a transportation barrier were enrolled in the Supplemental Security Income (SSI) program, which has an automatic eligibility link to Medicaid and provides assistance to adults with disabilities under age 65 and children.

Adults with Medicaid coverage are more likely than those with private coverage to delay care because of a lack of transportation (5.8 percent versus 0.7 percent). This may be due to differences in health status and income, as, in general, transportation disadvantaged individuals are age 65 and older, have disabilities, or have low incomes. Relative to individuals with private coverage, the Medicaid population is more likely to

have low incomes, have limitations related to physical and mental health, and to report poorer health status (MACPAC 2018).

Among children enrolled in Medicaid, 3.3 percent delayed care. Like the adult respondents, a significant share of these children had varying levels of disability. Almost half (46.9 percent) were classified as children with special health care needs who have disabilities or who have mild to severe chronic conditions such as asthma and diabetes.[6] About 5 percent of children with Medicaid who delayed care were enrolled in SSI.

Using NEMT

Analysis of Medicaid claims data for CY 2012, the most recent year for which data was available, indicate that 1.8 million NEMT users had at least one NEMT claim, either FFS or managed care during that year. Of the 1.8 million, about two-thirds had disabilities or were age 65 and older. Case studies of NEMT users in Indiana and Vermont, using state data, found that in CY 2015 more than 50 percent of individuals who used the benefit the most (that is, they had 30 or more trips in the calendar year) were either beneficiaries with disabilities or age 65 and older.

About 42 percent of NEMT users were dually eligible for Medicaid and Medicare. Dually eligible beneficiaries are likely to rely on Medicaid for transportation services because Medicare only covers ground ambulance services for individuals whose medical condition at the time of transport prevents them from using other means of transportation without jeopardizing their health (GAO 2016a).

Program Integrity

Federal oversight authorities have identified NEMT as high risk for fraud and abuse, noting concerns related to enrolling providers, program inefficiencies, and verifying eligibility (GAO 2016a). For example, the U.S. Government Accountability Office (GAO) found that some states had difficulty identifying criminal conviction information for NEMT providers. GAO also reported that some states did not require brokers to maintain consistent trip data, which could lead to overbilling. In addition, some states had difficulty verifying beneficiary eligibility for NEMT and the need for NEMT services, which could result in improper billing for services. GAO concluded that updated CMS guidance could help states identify strategies to address these issues (GAO 2016a).

The Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) has found inadequate oversight and improper payments for trips that did not meet federal and state requirements (OIG 2016, OIG 2015). Since 2006, the OIG has conducted audits in multiple states. For example:

- In 2018, the OIG found that Michigan's NEMT brokerage program did not always comply with federal and state requirements for submitting NEMT claims and recommended that the state refund $4.5 million to the federal government (OIG 2018).

- In 2015, the OIG reviewed claims for NEMT services in Los Angeles County, California and found many were not in compliance with federal and state requirements related to billing at the lowest cost type of transportation adequate for the needs of the beneficiary (OIG 2015). The OIG recommended that the state refund $437,896 to the federal government.

Looking Ahead

States and the federal government have been reexamining the NEMT benefit. Two states have received waivers to eliminate the benefit for the new adult group established under the ACA. They argued that waiving NEMT makes coverage for the new adult group consistent with benefits offered through private health insurance. States with approval to waive the NEMT benefit for the new adult group as part of their Section 1115 waivers include:

Indiana. As part of the state's Healthy Indiana Plan 2.0 waiver, Indiana eliminated the NEMT benefit for the new adult group with exceptions for certain groups including pregnant women and the medically frail. The waiver is currently approved through December 31, 2020 (MACPAC 2019, FSSA 2019).

Iowa. As part of the state's waiver, the Iowa Health and Wellness Plan, Iowa received approval to waive the NEMT benefit for the new adult group with exceptions for the medically frail (GAO 2016b and DHS 2019). The waiver is currently approved through December 31, 2019.

The federal government is also expected to update regulations to permit increased state flexibility, possibly in line with recent proposals in the President's budget, to make offering the NEMT benefit optional for states.

Endnotes

[1] Although the NEMT benefit is not specified in Medicaid statute, statutory provisions including statewideness and comparability formed the legal basis for federal regulations requiring that all states "ensure necessary transportation" for Medicaid beneficiaries "to and from providers" (42 CFR 431.53). This assurance of transportation in the Medicaid program has been upheld in court cases such as *Smith v. Vowell* which was the first case to test whether the transportation assurance could be enforced (Rosenbaum et al. 2009).

[2] States seeking to expand Medicaid under terms different from those that exist in federal law may request waivers from CMS.

[3] The NHIS is a household survey that collects information on the health of the non-institutionalized civilian population in the United States. It is part of the National Center for Health Statistics which forms part of the Centers for Disease Control. The elderly (individuals age 65 and older) are excluded from this analysis because the sample size was too small.

[4] A basic action difficulty captures limitations or difficulties in movement (walking, standing, bending or kneeling, reaching overhead, and using the hands and fingers) and limitations or difficulties in sensory, emotional (i.e., feelings that interfere with accomplishing daily activities), and mental (i.e., difficulties with remembering or experiencing confusion) functioning that are associated with some health problems.

[5] A complex activity limitation reflects a limitation in the tasks and organized activities that, when executed, make up numerous social roles, such as working, attending school, or maintaining a household. Adults are defined as having a complex activity limitation if they have one or more of the following types of limitations: self-care limitation, social limitation, or work limitation.

[6] The term children with special health care needs, as defined by the federal Maternal and Child Health Bureau, refers to a group of children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson et al. 1998). The definition encompasses children with disabilities as well as children with mild to severe chronic conditions, such as asthma, juvenile diabetes, and sickle cell anemia.

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#APPENDIX B

SUB PROJECT WHEELCHAIR SEATBELT, ARM, and LEG REINSTRUMENTS

#PROJECT INTRODUCTION

The petition proposes a new method for transporting patients with mental disorders who pose a risk to drivers, utilizing an innovation known as NEMT Medical Van Transportation with Wheelchair accessibility, rather than an Emergency Ambulance, but categorizing it as a non-emergency ambulance. Different name, Different Category but using the same expensive Ambulance Vehicle that sets up all devices in case of a life-threatening event. The reason is to secure the patient with the safety belt on the bed, which is one of the devices available in the Emergency Ambulance.

The Rip-Resistant Wheelchair Seatbelt is engineered to secure patients with mental disorders who may pose a risk to the driver and wheelchair user during NEMT medical van transportation, incorporating additional arm and leg restraints.

#PRODUCT DESCRIPTION

The rip-resistant wheelchair seatbelt and arm and leg restraints are specifically designed for the secure transport of patients with mental disorders who may pose a risk to the driver. These devices are constructed from a rip-resistant, yet soft and insulated material, ensuring patient comfort while remaining sufficiently thick to prevent self-release during transit. Visual representations of these devices are provided on the subsequent page.

PRODUCTS IMAGES

A Brand-new Medical van is currently being sold in the Market.

A Wheelchair Safety Belt, Exclusively Designed to secure a Patient with Mental Disorders who poses a risk to the Driver.

ONE MOVEMENT FOR WIN-WIN-WIN PROJECT.

The Project to Safeguard Victims' Hospitals and Healthcare Providers in the United States.

13460 Drumfries Road
Manassas, VA 20112
(917) -214-4383
Movement@onemovementforwinwinwin.com

#Arm and Leg Restraints.

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#Wheelchair Seatbelt.

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APPENDIX C

The Document of Planning “The Strategy Petition to Prevailing”

STATUS: IN PROCESSING

#2*nd* PROJECT: One Movement For Win-Win-Win Project (Healthcare System).

We intend to submit the Petition with the necessary corrections regarding the point of confusion within the system and to persuade the MEDCAC Committees to incorporate Non-Emergency Medical Transportation (NEMT) into the National Coverage Determination (NCD). This project aims to articulate to the CMS (MEDCAC Committee) the imperative need to integrate NEMT into the NCD. This integration is posited as a practical method to mitigate the financial burden on hospitals nationwide by reallocating NEMT fees to insurance providers. When business expenses are offset by the hospital's costs and subsequently covered by insurance providers, this translates into a favorable Return on Investment through enhanced profitability. We propose to rectify existing points of confusion and introduce an innovative approach to patient transportation for individuals with mental disorders, transitioning from EMT Ambulance services to NEMT Medical Vans, which offer increased convenience and significantly reduced costs.

The project was initiated in late August. The projected phase involves educating the public about the forthcoming changes subsequent to the enactment of the new law, and garnering voting support. It is presumed that the presentation must be tailored to resonate effectively with the Senator. I recognize that this project will yield benefits for all stakeholders, both presently and in the future. As a representative of the patients, I have not yet secured funding from any individuals or organizations. I am awaiting the Senator's official letter before proceeding with further action. I have diligently compiled relevant information and adhered to all applicable legal directives pertinent to requesting primary Sponsorship from the Senator. The objective is to empower the Taya Foundation to succeed in its petition to the committee, thereby encouraging the opposing party to accept the approval. According to The Uber Health Professional Report, six million patients annually miss their medical appointments due to inadequate convenient transportation, leading to an escalation in healthcare costs, with an estimated $150 billion in missed opportunities per year. By integrating NEMT into the National Coverage Determination (NCD), we anticipate that these six million patients will not miss their appointments, resulting in an estimated savings of $150 billion for the healthcare system. If the NEMT cost is 30% of $150 billion, the Insurance Providers' additional Profitability formula would be: Regular Annual Profits + ($150 billion - ($150 billion x 30%)) = Increasing Annual Profitability in the private sector and for the great number of saving cost for the trust fund.

#Strategy for Petition Success.

This petition employs a distinct strategy, divergent from previous attempts that resulted in failure. It leverages the widespread impact on hospitals and healthcare providers, who have long borne the financial burden of Non-Emergency Medical Transportation (NEMT) fees due to systemic flaws. Furthermore, the impending budget cuts faced by hospitals, potentially leading to closures in certain areas, serve as critical leverage. The petition utilizes these affected entities as collateral to exert pressure on the MEDCAC committees during the initial stage of prioritization.

The second stage is dedicated to addressing the concerns of private business beneficiaries. The system is designed to streamline and clarify issues, ensuring precise reflection and resolution of confusion. This approach aims to enhance the petition's negotiation power by addressing all identified concerns.

In the third stage, any potential reasons for denial are meticulously listed and aggressively counteracted with clear and detailed breakdowns, systematically resolving each potential issue. After thoroughly outlining all benefits and addressing all potential obstacles to approval, the petition concludes with "The Winning Page." This final section aims to appeal to the committees' emotions, offering apologies for any perceived persistence and seeking their empathy to elevate the entire healthcare system to its rightful position.
In my opinion we were already positive that the political establishment had established for this feasible petition to go through. “**Political Will vs. Evidence:** While the evidence is growing, it takes sustained political will and advocacy to translate that evidence into concrete legislative or regulatory change for a program as large and entrenched as Original Medicare. However, our Healthcare System leader showed decisiveness as a great leader to move half of the capacity of complexity, therefore we only needed the other half.”

My experience with complex legal documents, specifically with the U.S. Supreme Court and the Supreme Court of Thailand, has provided valuable insights. In both previous instances, I found success in influencing the courts through a conciliatory tone, aiming to evoke a sense of culpability if the case were denied. Both courts accepted my cases; in Thailand, the judge overturned the judgment in my favor, while the U.S. Supreme Court's decision was unexpected.

#Introducing a New Legal Strategy “ THE EMPTY BASKETS”. And “ The Smart Transitioning LMT”

A thorough analysis of the proposed strategy indicates that the petition is politically

feasible and aligns with existing political will. The arguments presented effectively address potential grounds for denial. However, the most significant hurdle for approval by the Centers for Medicare & Medicaid Services (CMS) and associated committees lies in the classification of Non-Emergency Medical Transportation (NEMT) as a non-essential medical product under the National Coverage Determination (NCD) definition. Should CMS approve this petition, it would signify a tactical agreement among all involved parties, recognizing NEMT's efficacy as a "Win-Win-Win" solution.

To secure the desired outcome, a dual-pathway strategy is proposed: submission of the petition to CMS, and engagement with the legislative process via Senator Tim Kaine, a prominent advocate for healthcare reform. Senator Kaine's influence could be instrumental in determining the most advantageous approach:

1. **Redefinition of NCD:** Propose to Congress a redefinition of the NCD to expand its scope beyond specific medical products and devices. This redefinition would allow for the inclusion of any product that significantly contributes to the healthcare system's benefits in a cost-effective manner.
2. **Inclusion of NEMT in Medicare Part B:** Introduce legislation to Congress that would add NEMT coverage to Medicare Part B. While Medicare Part A generally has fixed conditions, Part B allows for negotiation. The inclusion of NEMT in Medicare Part B would legally compel CMS to incorporate NEMT into the NCD.
3. **Strategic Recommendation:** This strategy is considered the most practical for the Senator. The petition's objective is to integrate NEMT into the NCD or any other mechanism that ensures Medicare Parts A, B, and C cover NEMT. This would effectively reduce missed medical appointments by six million individuals, thereby eliminating the escalating costs associated with these missed appointments.

The "Empty Baskets Strategy"

Given the legal establishment of Medicare Parts A and B, their deletion is not permissible. Medicare Part C offers more advantageous benefit coverage. Currently, upon turning 65, individuals are automatically enrolled in Medicare Parts A and B by the Social Security Administration. The "Empty Basket Strategy" proposes transitioning all existing Medicare Part A and B clients to Medicare Part C, which provides superior benefits. This would be a mutually beneficial process due to enhanced benefits for existing clients. For new Medicare clients, the default enrollment process within the Social Security Administration system would be altered to automatically enroll individuals turning 65 directly into Medicare Part C, rather than Parts A and B. While the "baskets" of Part A and B would remain legally established, Medicare would technically operate solely under Part C. This strategy is theoretically projected to eliminate the $150 billion cost increase associated with 6 million missed medical appointments.

4. **The NEMT Smart Transition Solution to**

"LMT (Light Medical Transportation)"

The United States has long been accustomed to the term EMT, denoting ambulance services. Now, its counterpart, NEMT, is emerging under the new designation LMT (Light Medical Transportation). LMT serves as a parallel to EMT. While EMT is defined by the National Coverage Determination (NCD) as a vehicle designed for medical service, this petition proposes transitioning LMT to meet a comparable minimum standard for vehicles designed for medical service. All legal requirements must establish a minimum standard for qualification as a legal product and for coverage under the National Coverage Determination (NCD).

For LMT and its drivers to be qualified, the following two steps must be observed:

1. As a Light Medical Transportation provider, the driver must not only operate the vehicle safely, as mandated by law, but also pass an online course provided on the website ONEMOVEMENTFORWINWINWIN.COM. This "LMT CPR and First Aid Course" For Driver" is an hour-long online program, consisting of 45 minutes of video training on CPR and First Aid, followed by a 15-minute test. Upon successful completion of the test, the driver will receive a "Certificate of Competence: The LMT Qualified Driver" via email. This certificate is mandatory, and its ID will correspond with the driver's license number.
2. For a vehicle to be designated as a Qualified LMT (Light Medical Transportation) vehicle, it must fulfill minimum legal requirements. Vehicle registration must be in good standing as required by each state, and the vehicle must be equipped with the four medical items listed below:
    - A foldable wheelchair.
    - A foldable walker.
    - A size S oxygen tank for CPR purposes.
    - A first aid kit.

Any vehicle, regardless of brand or model, will be permitted to operate LMT services under legal coverage, provided both the driver and the vehicle meet these requirements, aligning with the operational framework prior to this transition. Failure to meet any of the minimum legal requirements for LMT service will result in penalties commensurate with the rate for unauthorized parking in a disability-designated space in the driver's state of residence. This is a matter of law.

Upon approval of the Petition by Strategy CMS, denial is not an option. The Petition will be submitted with the LMT Proposal(Following the Strategy#4), and any action taken by CMS outside the scope of this determination will necessitate a Dual Track, (Strategies #1 or, 2 or, 3) initiated by the Senator Achieving this strategic objective will enable us to mitigate the escalating costs associated with 6 million missed patient appointments, which amount to $150 billion.