



February 28, 2019

The Honorable Alex Azar  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 120 F  
Washington, DC 20201

Re: **Request for Meeting to Discuss the Value of Inpatient Hospital Rehabilitation and Coverage of Seat Elevation and Standing Feature Power Wheelchairs for Medicare Beneficiaries**

Dear Secretary Azar:

We recently became aware of an interview you gave at an Axios forum in mid-December where you discussed the Trump Administration's efforts to reduce health care costs and the direction those efforts would take in 2019. In the course of answering a question about payment for value and outcomes rather than payment for procedures, you cited an example of an individual who leaves an inpatient rehabilitation hospital in a wheelchair rather than walking. Specifically, you stated the following:

“So, I've got a relative who was just in a rehab hospital....Instead [of regulating staffing ratios at the rehabilitation hospital] what we ought to be saying is, if my relative walks out of the [rehabilitation] hospital, you get paid this much [signaling greater reimbursement], if my relative's in a wheelchair, you get paid this much [signaling lower reimbursement]. You've done your job; you haven't done your job, and we're not going to really micromanage how you do that.”

As leaders of two consumer-driven coalitions that advocate to preserve access to rehabilitation services (“CPR Coalition”) and assistive devices and technologies (“ITEM Coalition”), we wish to meet with you to discuss this important set of issues. Taken at face value, these statements are not accurate and do not reflect the reality of the types of individuals treated in inpatient rehabilitation hospitals and units (“IRFs”) across the country. As you know, numerous individuals leave IRFs every day in wheelchairs despite receiving excellent rehabilitative care.

We understand the need for efficient language in conveying illustrative examples in the context of a real-time interview and do not intend to overreact to something you likely did not mean to convey. Therefore, we would like to meet with you to discuss two major concepts implicated by your example that are of great importance to our coalitions.

## **1. Patient Access to and Outcomes in Inpatient Rehabilitation Hospitals and Units**

Medicare patient access to inpatient rehabilitation hospitals is under pressure in both traditional Medicare and the Medicare Advantage (“MA”) program. This is alarming to beneficiary organizations whose members need access to this setting of comprehensive and intensive rehabilitation. The statement you made at the Axios event, however, addressed the issue of patient outcomes at the time of discharge from a rehabilitation hospital, rather than access to that setting of care.

As you know, the fact is that many individuals are non-ambulatory at the time of discharge from IRFs due to the diagnosis and severity of their condition, particularly as lengths of stay in IRFs have decreased consistently over the past few decades. Individuals with paralysis, severe stroke, brain injury, limb loss, significant neurological disorders, and many other conditions routinely leave IRFs without the ability to ambulate at the time of discharge. Some of these individuals will develop the ability to walk again over the course of recovery, often with the help of outpatient therapy and other services and assistive devices. Others may never be able to ambulate again.

The goal of an IRF stay is to provide medical management while the patient undergoes a relatively intense, coordinated, multi-disciplinary rehabilitation program designed to enhance recovery and improve functional capacity. Ambulation is always the goal, but some conditions do not allow achievement of this objective at discharge regardless of the quality of the rehabilitation program.

We wish to meet with you to discuss the importance of access to and outcomes in IRFs, especially as the Centers for Medicare and Medicaid Services (“CMS”), the Medicare Payment Advisory Commission (“MedPAC”), and Congress consider moving to a unified post-acute care payment system which has major implications on Medicare beneficiaries in need of rehabilitation services to maximize health, function, independent living, and quality of life.

## **2. The Need to Revisit Medicare Coverage of Seat Elevation and Standing Feature in Power Wheelchairs**

Your Axios example about wheelchair use after an IRF stay triggered concern, whether intended or not, that the Medicare program (and perhaps other payers) may view long-term wheelchair use as a failed outcome, when in fact, numerous conditions necessitate permanent wheelchair use as the primary means of mobility. The goal of rehabilitation is for patients to achieve their maximum level of function and quality of life, regardless of the assistive devices and technologies available to help them achieve that goal. However, current Medicare coverage policy creates unnecessary barriers to successful outcomes for long-term wheelchair users.

Currently, CMS does not consider two important functions of power wheelchairs to be covered services under Medicare: seat elevation and the standing feature. Both of these features are integral to certain covered power wheelchairs and assist particular Medicare beneficiaries to perform Mobility Related Activities of Daily Living (“MRADLs”). Performance of MRADLs is

the basis for coverage under the National Coverage Determination for Mobility Assistance Equipment (“NCD” for “MAE”).

In fact, these two features are not even considered “primarily medical in nature” which is a required element of the definition of durable medical equipment (“DME”). Non-coverage of seat elevation and standing feature in power wheelchairs is an antiquated policy that prevents non-ambulatory beneficiaries from maximizing their potential function, ability to perform MRADLs, the ability to live independently, and their quality of life.

Members of our coalitions met with Kate Goodrich, M.D., CMS’ Chief Medical Officer and Director for the Center on Clinical Standards and Quality, on October 3, 2018, to request that CMS revisit coverage of seat elevation and standing feature power wheelchairs. We participated in a follow-up conference call on February 1, 2019, with Demetrios Kouzoukas, Principal Deputy CMS Administrator and Director of Medicare. We would now like to brief you on this important issue for the disability community as CMS considers our request for coverage of these features.

Thank you for your consideration of our views, and we sincerely hope you are willing and able to meet with us personally to discuss these important issues. Peter Thomas, coordinator of both the CPR and ITEM Coalitions, will contact your scheduler to arrange such a meeting. He can be reached at [peter.thomas@powerslaw.com](mailto:peter.thomas@powerslaw.com) or 202-872-6730.

Sincerely,

**CPR and ITEM Coalition Steering Committee Members**

Paralyzed Veterans of America

United Spinal Association

Center for Medicare Advocacy

Falling Forward Foundation

National Multiple Sclerosis Society

Brain Injury Association of America

Amputee Coalition

Christopher and Dana Reeve Foundation