U.S. House Committee on Energy & Commerce

Subcommittee on Health

Hearing: April 16, 2015

Statement of Samuel Hammerman, M.D.

Chief Medical Officer, Long Term Acute Care Hospitals

Select Medical Corporation

Good morning. Thank you, Chairman Pitts and Ranking Member Green for holding today's hearing on the future of American post-acute care. My name is Dr. Samuel Hammerman and I am the Chief Medical Officer of Select Medical's Long Term Acute Care ("LTAC") Hospital division. I oversee more than one hundred LTAC hospitals in thirty states.

Before joining Select Medical several years ago, I was director of pulmonary and critical care medicine for the northeast division of Geisinger Health System. Most of my twenty-plus years of practicing medicine have been in post-acute care.

In terms of Medicare policy, "post-acute" means inpatient rehabilitation hospitals, LTAC hospitals, home health and nursing homes. But, for me, personally as a physician, "post-acute" simply means how do we treat patients that are not well enough to go home immediately after a hospital stay.

I will try to offer some insights today based on my experiences and based on the experiences of the company I am proud to serve as a Chief Medical Officer for, Select Medical.

Select Medical is based outside Harrisburg, Pennsylvania and is one of the largest providers of post-acute care in the country. Besides the one hundred-plus LTAC hospitals, Select Medical also operates about twenty inpatient rehabilitation hospitals and a thousand outpatient therapy clinics. Altogether, Select Medical employs over 30,000 Americans in more than thirty states.

Before beginning with specifics, I want to note that Select Medical is proud to be a member of the American Hospital Association ("AHA"). I know the AHA has issued a statement as part of today's hearing and Select Medical agrees with the positions put forward by the AHA. I would refer you to the AHA and its policy statements for important insights into this debate.

Let me begin by saying that Select Medical does not oppose a bundled post-acute care payment system. With this in mind, my observations on our post-acute care system are as follows:

POINT #1: Congress passed the IMPACT Act to address post-acute bundling.

I want to stress that Congress has already enacted extensive legislation laying the foundation for bundled payments for post-acute services. Just last fall, Congress passed the "IMPACT" Act of 2014. This law will enable Congress to develop an informed and evidence-based post-acute bundling system. We were happy to support this bipartisan, bicameral bill.

Congress noted in its own legislative history of the IMPACT Act that the law will enable Medicare to:

(1) Compare quality across post-acute settings;

(2) Improve hospital and post-acute coordination planning; and,

(3) Use this information to reform post-acute payments (via site neutral or bundled payments or some other reform).

The IMPACT Act will provide the Centers for Medicare and Medicaid Services ("CMS") and Congress with the necessary information to design a post-acute care payment system that stresses quality of care while maximizing efficiencies in the delivery of care. I salute Congress for moving to a new system -- while ensuring continued beneficiary access to the most appropriate setting of care.

POINT #2: ACA also authorized a number of bundling demonstrations.

On a similar note, I would note the Affordable Care Act ("ACA") of 2010 established a number of new programs to test post-acute bundling in hundreds of sites across the country. CMS is currently in the midst of numerous pilot programs, testing numerous bundled payment concepts. In short, Congress and CMS have already largely commissioned a "bundled" future for post-acute care.

POINT #3: CMS may not be prepared to roll out bundling quicker than planned.

I recognize there is a range of opinion on this Committee about the capacity of the Department of Health and Human Services ("HHS") and CMS. CMS appears, to some degree, overwhelmed right now with the magnitude of its duties related to the ACA and the repeal of SGR. I confess that – after watching the roll-out of the ACA – yes, I do worry about whether the agency has the resources at this time to immediately implement something as big as post-acute bundling.

POINT #4: More experience is needed before we adopt comprehensive bundling.

While Select Medical supports post-acute bundling in theory, we have been watching as the Medicare program has rolled out its bundling demonstrations. My impression is that these demonstrations have raised as many questions as answers.

For instance, many post-acute providers signed up for the initial stage of the demonstrations but only a small fraction of these providers proceeded to the next "at-risk" stage of the demonstrations. The initial results confirm the great complexity involved with designing, testing and refining new payment models to ensure that they work in the real world – before they are rolled out on a national basis.

POINT #5: Bundled payments may lead to unintended consequences.

I ask you to also consider the possibility that rushing forward with any untested concepts of post-acute bundling may actually create new problems. For instance, as those of us who have lived through the evolution of managed care can attest, if not appropriately implemented and managed, a "bundled" payment provides incentives to reduce not only *unnecessary* care but also *necessary* care.

Establishing post-acute bundling without the necessary foundation creates a higher risk of unintended consequences that could adversely affect Medicare beneficiaries.

POINT #6: Current system has some flaws but also has many virtues.

As a physician, I feel compelled to note that the current post-acute system still has many virtues. I would still make the case that the post-acute continuum of care represents a fairly logical and rational progression of care. Yes, we need to address the issue of "readmissions" and yes, policy-makers should always be concerned about whether care is appropriate and medically necessary.

But all post-acute players – LTAC hospitals, rehabilitation hospitals, home health, and nursing homes – play a critical and distinct role in meeting the needs of the American patient population. Working together with each other, each provider category helps make a coherent whole of the post-acute continuum of care.

POINT #7: "Post-acute" came into existence after policy to discourage hospital stays.

As a historical aside, I ask you to consider that only about ten percent of Medicare spending is devoted to post-acute care. And please recall how the post-acute sector came into being in the first place: In 1983, the Medicare program adopted the first "prospective payment system" which greatly encouraged hospitals to discharge patients more quickly.

As the average patient stay in hospitals dropped from three weeks to five days, post-acute care facilities filled the gap left by the new system. Post-acute as we know it today only came into existence because of the incentives to discharge quickly from general hospitals.

My advice to Congress is that you try to preserve a range of post-acute providers that offer a range of services, from lower-acuity nursing homes to higher-acuity post-acute hospitals like rehabilitation hospitals and LTAC hospitals.

POINT #8: Post-acute providers are addressing public policy issues.

One public policy issue important to both taxpayers and post-acute providers is ensuring that patients are cared for in the most appropriate setting. We agree that patients who can be safely and effectively cared for in sometimes less-costly facilities – like nursing homes -- should not be treated and paid for in rehabilitation hospitals and LTAC hospitals.

Little more than a year ago, Select Medical supported a new law passed by Congress designed to ensure that only appropriate patients are admitted to LTAC hospitals even though the law also significantly reduced Medicare reimbursement for these facilities.

Treating patients in the most appropriate setting is not only right for our seniors, but also creates savings for the Medicare program. My larger point is that post-acute providers will continue to work with Congress to ensure that Medicare cost savings are achieved and beneficiary access to appropriate care is preserved.

POINT #9: BACPAC short-circuits IMPACT and ACA processes.

Finally, I was asked to comment specifically on Congressman McKinley's "BACPAC" bill. BACPAC has some positive attributes but it does not address many core elements of a bundled payment system – and leaves these to the HHS Secretary to develop.

Given BACPAC's gaps – *e.g.*, details on payments rates, a payment process, provider network requirements, a patient assessment process, and quality standards – the BACPAC bill appears to leave a great deal of policy work to CMS. This results in unanswered questions about how BACPAC would actually work in the real world.

More importantly, we have concerns about the BACPAC bill because we feel it would shortcut the comprehensive payment reform processes that Congress launched in 2010 under the ACA and built upon in 2014 with the IMPACT Act.

Rather than supporting the IMPACT plan -- to first test bundling in the marketplace on a small scale -- BACPAC would cut short this process. And, given the complexity of the issues, this process is needed to develop a reliable and evidence-based bundled payment program for post-acute care.