

September 13, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
PO Box 8016  
Baltimore, MD 21244-8016

**Re: CMS-1772-P**

**Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating**

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Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Calendar Year (CY) 2023 Outpatient Prospective Payment System (OPPS) Proposed Rule, as some of the proposed policies and requests for information have a significant impact on our members and the patients we serve.

**Rural Emergency Hospitals**

In this rule, CMS proposes specific policies related to rural emergency hospitals (REHs), following up on the REH Conditions of Participation (CoP) proposed rule<sup>1</sup> that was published in the Federal Register on July 6, 2022. ACEP submitted a detailed response to the REH CoP proposed rule<sup>2</sup> and offers the following comments on the proposed policies included in this program.

***Rural Emergency Hospital Quality Reporting (REHQR) Program***

CMS is proposing to create a new quality reporting program for REHs. Specifically, CMS is requesting information on: (1) measures recommended by the National Advisory Committee on Rural Health and Human Services and additional suggested measures for the REHQR Program, and (2) and comments on rural telehealth, behavioral and mental health, and maternal health services.

<sup>1</sup> Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates Proposed Rule. 87 FR. 40350, (July 6, 2022).

<sup>2</sup> ACEP's response can be found at: <https://www.acep.org/globalassets/new-pdfs/advocacy/acep-response-to-cops-for-rural-emergency-hospitals.pdf>.

ACEP strongly believes that there is a need to improve the quality of care delivered in rural areas. Research suggests that patients being treated in rural emergency departments (EDs) may overall have less acute conditions but experience worse outcomes when compared to patients receiving care in urban EDs.<sup>3</sup> Therefore, it will be important that CMS establish a core set of measures that help REHs focus on improving patient outcomes.

The National Advisory Committee on Rural Health and Human Services recommended eight measures for inclusion in the REHQR Program, and CMS seeks comment to understand how these measures may help achieve the goal of selecting measures for the REHQR Program that focus on REH areas of care, especially ED care. The selected are as follows:

- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-4: Aspirin on Arrival
- OP-10: Abdomen CT—Use of Contrast Material
- OP-18: Median Time from ED Arrival to ED departure for Discharged ED Patients
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-22: Left Without Being Seen
- OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

In our response to the CY 2022 OPPI Proposed Rule, ACEP recommended all but two of these measures (OP-4 and OP-32). In addition, we supported one measure that is not included in this list: OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival. ACEP especially supports the ED boarding measure—OP-18—as it will be important to track whether REHs have the capacity and staff necessary to appropriately treat their patients in a timely manner.

We also believe that it will be critical for CMS to support REHs' efforts to collect data, report quality measures, and improve performance. A potential barrier to quality reporting that REHs may encounter is accessing the data they need to improve their quality performance and availability of staff to analyze the data. While the landscape for the collection and analysis of ED performance measure data has become incredibly sophisticated, access to that data by frontline users is typically contingent on providing data to and paying fees for a subscription service. REHs may not have the capital to invest in a registry or other mechanism for receiving and analyzing data. Thus, CMS should consider contributing additional resources to REHs to specifically help them with their quality reporting and data analytic capabilities.

The most common barriers to accurate and timely reporting of quality measures are the functionality of critical access hospitals' (CAHs') electronic health record (EHR) systems and IT support for the information system to capture and report data. Development and implementation of a uniform reporting system (software) for all REHs would be helpful. Another barrier is the availability of trained professionals to evaluate medical records and accurately extract and report data in smaller communities and rural hospitals. Establishing regional networks of trained health information professionals who can work remotely and access hospital information systems would be a potential solution.

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<sup>3</sup> Joynt KE, Harris Y, Orav EJ, Jha AK. Quality of care and patient outcomes in critical access rural hospitals. JAMA. 2011 Jul 6;306(1):45-52. doi: 10.1001/jama.2011.902. PMID: 21730240; PMCID: PMC3337777.

## *REH Payment Policy*

Under the Consolidated Appropriations Act, covered outpatient department services provided by REHs will receive an additional five percent payment for each service. Beneficiaries will not be charged a copayment on the additional five percent payment. CMS is proposing to consider all covered outpatient department services that would otherwise be paid under the OPSS as REH services in these facilities. REHs would be paid for furnishing REH services at a rate that is equal to the OPSS payment rate for the equivalent covered outpatient department service, increased by five percent. CMS is also proposing that REHs may provide outpatient services that are not otherwise paid under the OPSS as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services would not be considered REH services and therefore would be paid under the applicable fee schedule and would not receive the additional five percent payment increase that CMS proposes to apply to REH services. Finally, CMS is proposing that REHs would also receive a monthly facility payment. After the initial payment is established in CY 2023, the payment amount will increase in subsequent years by the hospital market basket percentage increase.

ACEP supports this payment approach as it aligns with the methodology outlined in the Consolidated Appropriations Act. However, we also note that the statute only addresses additional facility payments to REHs under the OPSS—not added reimbursement for physicians and other clinicians under the Physician Fee Schedule (PFS) who actually deliver the services in REHs. **In order to incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP strongly recommends that CMS consider creating an add-on code or modifier that clinicians could append to claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each Current Procedural Terminology (CPT) code that is billed—consistent with the additional OPSS payment that the statute provides.**

## *Rural Emergency Hospitals (REH) Provider Enrollment*

Providers and suppliers are required to enroll in Medicare to receive payments for services and items furnished to Medicare beneficiaries. The purpose of the provider enrollment process is to help confirm that providers and suppliers seeking to bill Medicare meet all federal and state requirements to do so. CMS is proposing several provisions that identify the enrollment requirements with which REHs must comply as part of the enrollment process. This proposed rule would update existing Medicare provider enrollment regulations in 42 CFR Part 424, subpart P, to address enrollment requirements for REHs. One of the most important REH enrollment provisions in the proposed rule is that the facility may submit a Form CMS-855A change of information application (rather than an initial enrollment application) in order to convert from a CAH to an REH. CMS believes that not requiring an initial application, which generally takes longer for a Medicare Administrative Contractor (MAC) to process than a change of information application, would help expedite the CAH-to-REH conversion.

ACEP supports these proposals but cautions CMS to recognize that there will be significant variation among different rural communities in terms of the types and volumes of services that are provided, the supply of providers, and the emergency medical services (EMS) overall organizational structure, capabilities, and resources. Thus, the enrollment requirements for REHs must be sufficiently broad and flexible to accommodate the diverse needs of rural communities.

## *Use of the Medicare Outpatient Observation Notice by REHs*

Under current regulations, hospitals and CAHs are required to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours. The notification must explain the status of the individual as an outpatient, not an inpatient, and the implications of such status. REHs are not currently required to provide required notification under the NOTICE Act, known as the Medicare Outpatient Observation Notice (MOON), because REHs are excluded from the definition of “hospital” in section 1861(e) of the Social Security Act, and the requirements at section 1866(a)(1)(Y) of the Act apply only to hospitals and current CAHs. CMS seeks comment on the potential need for REHs to notify beneficiaries of their status as outpatients, the implications of such status, and whether the MOON would be the appropriate notice for communicating this information.

ACEP believes that it is important to be transparent and let beneficiaries know what their cost-sharing obligations are when they are receiving non-emergency outpatient services. We also recognize that patients who receive emergency, observation, and other outpatient services from REHs may not know they are receiving outpatient services since REHs are a new facility-type and were previously hospitals that provided inpatient services.

However, it is important to note that, with respect to emergency services, knowing what patients’ total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. A large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are “chest pain” and “abdominal pain.” These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat. Further complicating the issue is the fact that emergency care is billed in two separate components, the facility fee and the professional fee. Therefore, patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it.

As emergency physicians, we are bound by Emergency Medical Treatment and Labor Act (EMTALA), which guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. EMTALA stipulates that a hospital may not place any signs in the ED regarding prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from “coming to the emergency department.” To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA and one of the most foundational principles of an important patient protection that was enacted over three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that constitute an EMTALA violation, but it could also potentially cause the patient’s health to deteriorate since it could delay the patient from receiving critical care. The last thing we want to do is put our patients in a position of making life-or-death health care decisions based on costs.

**Thus, beneficiaries should only be provided information about their status as outpatients after they are stabilized and the REHs have fulfilled their EMTALA obligation.**

## ***Rural Emergency Hospitals (REH) Physician Self-Referral Law Update***

CMS is proposing two updates to the physician self-referral law for the new REH provider type: (1) a new exception for ownership or investment interests in an REH; and (2) revisions to certain existing exceptions to make them applicable to compensation arrangements to which an REH is a party. ACEP supports these proposals and believes that it is appropriate to apply similar physician self-referral law requirements to REHs as those that currently apply to critical access hospitals and small rural hospitals.

### **Proposed Services That Will Be Paid Only as Inpatient Services**

CMS identified 10 services described by the following codes that the agency proposes to remove from the IPO list for CY 2023. ACEP appreciates CMS' rationale for removing these specific services, as we have opposed previous proposals to eliminate the entire IPO list. In our previous comments,<sup>4</sup> we had expressed concerns about the effects that eliminating the IPO list would have on observation stay reimbursement policies. Observation stays have proven to be an excellent mechanism for ensuring that patients are not unnecessarily admitted to the hospital or prematurely sent home. Due to the safety and efficiency benefits of observation status, we have found that these claims are not subject to heavy audits for site-of-service review. However, the removal of the IPO list could result in an increased audit burden across the board as two-midnight case reviews increase. We had therefore asked CMS to consider the potential auditing and documentation burden on health care practitioners more carefully prior to finalizing any policy as significant as the complete elimination of the IPO list.

We also believed that other healthcare payors will use the lack of an IPO list as a tool to force cases that are appropriate for the inpatient setting into other places of service. While these are not procedures that would typically be conducted in EDs, if payors were to attempt to shift even a portion of the more than 1,700 cases into other places of service, the potential effects on outpatient departments, EDs, and observation units could be debilitating.

### **Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients**

CMS is proposing to revise existing supervision requirements to clarify that nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, and certified nurse midwives may provide general, direct, and personal supervision of outpatient diagnostic services to the extent that they are authorized to do so under their scope of practice and applicable State law.

ACEP is concerned about CMS' overall position regarding care delivered by non-physician practitioners. When making any policy choices, CMS should rely on fact-based resources, including a thorough review of the education and training of nonphysician health care professionals and the impact on the overall cost and quality of care. CMS should review the true impact of state scope of practice laws on access to care across the country.

As the most highly educated and trained health care professionals, we believe that physicians should lead the health care team. There is a vast difference in the education and training of physicians versus other health care

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<sup>4</sup> ACEP's previous comments can be found at: <https://www.acep.org/globalassets/new-pdfs/advocacy/acep-response-to-cy-2022-ops-proposed-rule.pdf>.

professionals, including nurse practitioners (NPs) and physician assistants (PAs). The well-proven pathways of education and training for physicians include medical school and residency, and years of caring for patients under the expert guidance of medical faculty. Physicians complete 10,000-16,000 hours of clinical education and training during their four years of medical school and three-to-seven years of residency training. Physician assistant programs are two years in length and require only 2,000 hours of clinical care — it is very important to note that these PA programs do not include a residency requirement. The difference does not stop there, as physicians are also required to pass a series of comprehensive examinations prior to licensure as well as further examinations for specialty board certification. By contrast, physician assistants must pass a single 300-question multiple choice exam. We encourage CMS to take a close look at the stark differences in education and training as outlined above, which clearly demonstrates the education and training of PAs are not commensurate with physicians.

<b>Comparison of Training Requirements</b>			
	<b>Physicians</b>	<b>Nurse Practitioners</b>	<b>Physician Assistants</b>
<b>Clinical education</b>	4 years	2-3 years	2 years
<b>Residency training</b>	3 – 7 years	--None--	--None--
<b>Clinical care training (including during medical school for physicians)</b>	10,000-16,000 hours	500-720 hours	2,000 hours
<b>Examinations</b>	<u>21 hours, 820 questions:</u> - USMLE/COMLEX I: 8 hours, 280 questions - USMLE/COMLEX II: 9 hours, 315 questions - USMLE/COMLEX III: 16 hours, 412 questions, 13 case simulations - Emergency medicine specialty board: 4 hours, 225 questions <i>or</i> Family medicine specialty board: 6 hours, 300 questions	3 hours, 150-200 questions	5 hours, 300 questions

Medicare patients are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs, and they account for nearly 20 percent of ED encounters each year.<sup>5</sup> As such, they deserve care led by physicians — the most highly educated, trained, and skilled health care professionals. Patients agree and overwhelmingly want physicians leading their health care team. In fact, an AMA survey found that four out of five patients prefer a physician to lead their health care team and 86 percent of patients say patients with one or more chronic conditions benefit when a physician leads their health care team.<sup>6</sup> Further, according to an August 2021 public opinion survey from ACEP and

<sup>5</sup> The Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2018 Emergency Department Summary Tables, [https://www.cdc.gov/nchs/data/nhamcs/web\\_tables/2018-ed-web-tables-508.pdf](https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf).

<sup>6</sup> The AMA's survey results are available at: <https://www.ama-assn.org/system/files/corp/media-browser/public/arc/plr-survey-2015.pdf>.

Morning Consult, nearly 80 percent of adults trust a physician to deliver their medical care in an emergency, compared to a nurse practitioner (9 percent), physician assistant (7 percent), or nurse (5 percent).<sup>7</sup>

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require PAs to collaborate with or be supervised by a physician. Similarly, most states require nurse anesthetists specifically to collaborate with or be supervised by a physician, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York, and Texas. These states represent more than 85 percent of the U.S. population. Moreover, no state has enacted legislation to allow nurse practitioners full-immediate independent practice in the last five years.

A common argument for expanding the scope of practice of non-physician professionals is that it will increase access to care. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear that nurse practitioners and primary care physicians tend to work in the same large urban areas. There are significant shortages of nurse practitioners in rural areas—the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level.

*Overall, while all health care professionals play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians.* The scope of practice of health care professionals should be commensurate with their level of education and training. Patients – and in this case, Medicare patients in particular – deserve nothing less.

### **Proposed Payment Adjustments under the IPPS and OPSS for Domestic NIOSH-Approved Surgical N95 Respirators**

To improve hospital preparedness and readiness for future threats, CMS proposes to provide payment adjustments to hospitals under the Inpatient Prospective Payment System (IPPS) and OPSS for the additional resource costs they incur to acquire domestic NIOSH-approved surgical N95 respirators, which faced severe shortage at the onset of the COVID-19 pandemic and are essential for the protection of beneficiaries and hospital personnel that interface with patients.

ACEP appreciates CMS recognizing the shortage of personal protective equipment (PPE), including N95 respirators, that existed at the beginning of the COVID-19 PHE, as well as CMS' effort to determine how to address this issue for future pandemics. Insufficient PPE and other ancillary medical supplies in the initial stages of the COVID-19 PHE resulted in a notable amount of contention and animosity between different hospital services (e.g., ED vs. inpatient ward vs. critical care units), health care staff, and hospital administrators, as well as health care personnel and the Centers for Disease Control and Prevention (CDC). Multiple incidents occurred in which hospital administrators did not allow health care staff to utilize personally acquired PPE to supplant that which the hospital was conserving or could not supply. Therefore, health care workers were given the impossible choice of going without sufficient protection or reporting insufficient protection and potentially facing retaliation.

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<sup>7</sup> The ACEP and Morning Consult poll results are available here: <https://www.emergencyphysicians.org/article/access/poll-adults-view-247-access-to-the-er-essential-prefer-care-led-by-physicians-in-a-crisis>.

[Current standards](#) established by the Occupational Safety and Health Administration (OSHA) around PPE require employers to implement “PPE programs.” These programs should “address the hazards present; the selection, maintenance, and use of PPE; the training of employees; and monitoring of the program to ensure its ongoing effectiveness.” Unfortunately, some emergency physicians have found that the PPE programs instituted by hospitals during the pandemic have failed to protect them from the virus. First, many hospitals did not supply their employees with a sufficient level of PPE, requiring health care workers to reuse PPE beyond their intended use. While supply chain issues contributed to this practice initially, the reuse of PPE continued even after these supply issues were resolved. Second, as alluded to above, many of these PPE programs made it extremely difficult for health care workers to use their own PPE. Although it was technically allowed, hospitals would create numerous steps and hurdles before officially approving a health care worker’s own PPE for use. Lastly, there were concerns over the PPE properly fitting health care workers. Hospitals often changed the brands of PPE that were used, and there has not been sufficient fit testing of supplies to ensure that the PPE have been properly worn.

Given these issues with PPE programs, ACEP does not think that providing an IPPS adjustment to account for the increased cost of domestically made NIOSH-approved surgical N95 respirators would entirely solve the problem. While this policy may help address any PPE supply challenges that may come about in a future pandemic, it would not address the other issues unrelated to the supply chain that health workers have experienced receiving high-quality PPE from hospitals. Therefore, ACEP encourages CMS to work with OSHA to ensure that health care workers have the flexibility they need to feel properly protected during future pandemics or COVID-19-driven surges.

### **Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces**

CMS is seeking information from the public on how data that CMS collects could be used to promote competition across the health care system or protect the public from the harmful effects of consolidation within healthcare. Specifically, ACEP wishes to respond to the following questions:

- Do commenters suggest that CMS release data on any mergers, acquisitions, consolidations, and changes in ownership that have taken place for any additional types of providers beyond nursing facilities and hospitals? If so, for which types of providers?
- What additional information collected by CMS would be useful for the public or researchers who are studying the impacts of mergers, acquisitions, consolidations, or changes in ownership?

ACEP has been carefully tracking competitive drivers in the entire healthcare marketplace, and we urge CMS to consider this issue in all sectors, rather than limiting focus to providers. The American Medical Association (AMA) published a [comprehensive study](#) last year of health insurance concentration for 384 metropolitan statistical areas (MSAs), the 50 states, and the District of Columbia. The report detailed some stark, but not shocking, results about the level of concentration of many health care markets across the country. ACEP encourages you to read the report, but overall, the AMA finds that:

- 73 percent of the MSA-level markets were considered highly concentrated according to [federal guidelines](#) set by the Department of Justice and Federal Trade Commission.
- 46 percent of MSA-level markets and [fourteen states](#) had one insurer with a share of 50 percent or more of the commercial health insurance market.
- 57 percent of markets became more concentrated in 2020 compared to their concentration level in 2014.

The AMA report concludes that health insurer consolidation can lead to monopsony power—the ability to reduce and maintain input prices (e.g., prices paid to physicians) below competitive levels. It makes intuitive sense that the more power a particular insurer has in a market, the greater its ability to lower payments to physicians. The Kaiser Family Foundation [confirms that finding](#) and states that health insurers do NOT pass along the savings from lower provider payments to consumers through lower premiums.

As emergency physicians, the Medicaid managed care market is of particular concern, since on average across the country, most of the people who come to the ED are covered by Medicaid. According to a [2021 analysis conducted by the Georgetown University Health Policy Institute](#), “the federal government and states combined spend in the neighborhood of \$360 billion per year paying these MCOs to provide covered services to approximately 70 percent of all Medicaid beneficiaries and 80 percent of child beneficiaries.” The Georgetown analysis goes on to note that close to half of all Medicaid enrollees are covered by just five publicly traded insurance companies.

Whether related to mergers and acquisitions within health care insurers and payers, health care facilities and systems, or physician practices, there is no question that emergency (EM) physicians and the patients they serve have felt the good, the bad, and the ugly effects of vertical and horizontal consolidation. However, in general, it has been difficult to gather the data necessary to assess the overall impact of consolidation on health care costs and quality. While there have been numerous assessments conducted to determine these effects, some of them have not drawn definitive conclusions. For example, a couple of years ago, Congress commissioned the Medicare Payment Advisory Commission (MedPAC) to assess whether provider consolidation has led to higher health care costs and impacted quality of care. In 2020, MedPAC issued a [report](#) which looked at all of the available research at the time and concluded that consolidation leads to higher prices for commercially insured patients. While provider consolidation leads to higher prices, MedPAC found that in areas where insurers have more market power, prices decrease—but those savings are not necessarily passed on to consumers in the form of lower premiums. MedPAC also looked at whether provider consolidation affects the quality of care that hospitals and clinicians provide but could not come to any conclusions.

While consolidation is occurring across the health care sector, it is important for CMS to understand the unique qualities of the EM market as the agency begins to collect and use data to promote competition. In less than ten years, the number of emergency physicians working in large, national groups increased from one in seven in 2012, to one in four in 2020.<sup>8</sup> Coupled particularly with consolidation of hospitals and payers, ACEP has been hearing about labor-related impacts of the acquisitions and mergers and the effect they have had on physician wages, non-wage benefits and other aspects of emergency physicians’ contracts with their employers, and physician autonomy in their medical decision-making. Our overall goal is to support emergency physicians and ensure that they are treated fairly by their employer and practice in an environment where they can serve their patients to the best of their abilities.

Emergency physicians serve the essential role of strengthening the health care safety net for our communities. They treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency health care safety net, including EMTALA, which (as described in the Rural Emergency Hospital section above)

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<sup>8</sup> Pollock JR, Hogan JS, Venkatesh AK, et al. Group Practice Size Consolidation in Emergency Medicine. *Annals of Emergency Medicine*. 2022;79(1):2-6. doi:10.1016/j.annemergmed.2021.07.122

requires hospitals to provide a medical screening examination to every individual who “comes to the emergency department” seeking examination or treatment. The “prudent layperson” (PLP) standard, first established under the Balanced Budget Act of 1997, is another such law which allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. Given this vital responsibility that EM plays in our health care system, ensuring that EDs across the country are appropriately staffed so they can provide care 24 hours a day, 7 days a week, 365 days a year is essential. Hospitals and EM groups have tried to achieve this goal in different ways, and as described below, mergers and acquisitions have at times come into play.

Emergency physicians work in a variety of employment models. While some are employed directly by hospitals, many are employed by independent entities that contract with the hospital to provide 24/7 ED coverage. These independent entities range in size, from small, independent democratic (i.e., owned by the physicians) groups that serve only one or two local hospitals to larger groups that staff EDs (and sometimes service lines of other specialties) nationwide. In recent years, physician practices, including independent EM practices, have been acquired by hospitals, health systems, and corporate entities (such as private equity and health insurance companies) at a relatively high rate. [A study in Health Affairs](#) found that between 2014 and 2018, there was an 89 percent increase in hospital and health system ownership of physician practices. The pressures of staying financially viable during the COVID-19 pandemic seems to have accelerated this trend even further. According to [a report from the Physicians Advocacy Institute \(PAI\)](#), there was a sharp rise in the number of physician practices being acquired by hospitals and corporate entities throughout 2019 and 2020—especially in the first half of 2020 as the pandemic began. Now, PAI reports that 70 percent of physicians are employed by hospital systems or other private entities—meaning that only 30 percent of physicians practice independently.

Although we understand the general trends of EM practice ownership, it has been difficult to find a comprehensive source of information about the parent organizations for individual practices. ACEP has attempted to study this issue itself with consultants, who determined that even among public and proprietary databases, any effort to collect data on ownership becomes outdated relatively quickly and would be inaccurate when attempting linkage to other metrics on quality, cost, and physician autonomy, due to the lack of standardization and the rapid pace of consolidation and contracts changing hands every month. The ever-changing nature of health care markets, like the EM market, may pose challenges for CMS as it attempts to collect data on consolidation.

### ***Impacts of Consolidation on Emergency Physicians***

Earlier this year and in response to the Antitrust Division of the Department of Justice’s (DOJ’s) and Federal Trade Commission’s (FTC’s) joint [Request for Information on Merger Enforcement](#), ACEP asked our members a series of both structured and open-ended questions to gain specific and up-to-date information on how mergers and acquisitions are impacting their lives, their jobs and the care they provide. Specifically, for those members whose practice had undergone a merger recently, we asked questions about the merger, such as how they were notified about it, along with how that merger impacted their wages, non-cash benefits, right to due process, and autonomy for medical decision-making. We also asked for their general views about the labor-related impacts of mergers or acquisitions in emergency medicine. We received over 110 responses to this questionnaire.

The questionnaire results, including both quantitative analyses and actual anecdotal quotes directly from emergency physician responders (all italicized), are described below. The results revealed numerous examples

of where mergers within hospital systems, insurers, and physician practices have had both positive and negative effects on competitiveness in the EM labor market and to the emergency physician, notably in terms of their wages, workload and hours, and their ability (or lack thereof) to find or keep employment. **By sharing these results with CMS, ACEP hopes that the agency will understand the issue better and figure out ways of collecting data (and releasing such data) that can be eventually used to develop policies to address the impacts of consolidation on emergency physicians and their patients.**

### Negotiation with Insurers

There are some major factors in the current EM practice environment that make it extremely difficult for smaller, independent EM practices to stay in business. With respect to our questionnaire, nearly 27 percent of respondents cited profit as the primary reason for acquisition – and these same individuals were often concerned that this came at the expense of quality of patient care.

**The inability to negotiate fair contracts with insurance companies that have a large market share is at the top of the list of reasons that smaller EM practices struggle to stay in business.** Ten percent of respondents employed by a large national physician group said that the main rationale for their smaller group moving forward with its acquisition was the inability to negotiate with insurers. Some independent practices struggle to even have insurance companies respond to exploratory inquiries, much less agree to work with them. Respondents noted that:

*“Our independent EM group (120 providers) had our contract with the hospital system for 50 years. We managed 12 EDs in [state]. The hospital no longer wanted (could afford) to subsidize our services with a stipend at their hospitals. As part of this contract many of the EDs were small volume and included several critical access hospitals and most were not profitable. Because we were a smaller to medium size independent group, the insurance companies would not negotiate or give us better rates/payments. As such, we were forced out of our 50-year contract and the majority of our providers were forced to join the EM Mega group that won the contract and has the ability to negotiate better payment rates from insurers and is able to take bigger risks.”*

*“We were a democratic group of only boarded EM physicians. We were finding it increasingly difficult to acquire cost effective benefits, malpractice insurance and dealing with insurance companies.”*

*“Because we were a small group, insurers gave us very poor contract rates which led to low reimbursement and difficulty recruiting. Now our pay rates and benefits are better and we are competitive in our market.”*

**The significant consolidation of health insurance companies (referenced above) has made contract negotiations even more difficult.**

### Wages

Overall, the impact on wages from these acquisitions seemed to vary. Sixty percent of respondents reported that their wages had been reduced, with around forty percent of them indicating a pay cut of more than 20 percent. Forty percent of respondents indicated that they experienced no change in pay or a pay raise after the merger. However, although these respondents’ pay itself stayed the same or increased, in many instances their overall hours were cut, still resulting in an overall wage decrease. Examples of responses included:

*“Roughly 25-30% reduction due to lowered hourly rate and fewer hours.”*

*“Compensation has remained flat or down. Under the democratic group, there were yearly cost of living and performance based increases. Those disappeared. Benefits like CME were cut. Performance demands increased, with productivity going from 1.9 patients per hour to 2.0 to 2.2 in the course of two years.”*

*“Actually a slight improvement with improved collections from insurance companies, they were screwing us before.”*

*“Increased current, decreased later earning potential”*

*“Hourly rate increased but overall much worse when factoring in benefits, insurance, retirement.”*

### Workload and Staffing

In addition to more direct wage impacts, physicians reported seeing more patients per hour without a commercial pay increase.

For example:

*“Huge pushes regarding patient disposition and turnaround times. I’m forced to see patients in the waiting room, violating HIPAA, due to these pushes, given that the hospital will not provide sufficient staff/ space to bed them within the emergency department in order to maximize profits.”*

*“There are endless cuts to staffing and hours that cause significant patient safety concerns and poor patient experiences and outcomes. I feel like my medical license is being exploited by private equity to maximize profits to shareholders at the expense of my patients and coworkers.”*

*“...the schedule changed for the worse as there was significantly less physician coverage. It became very dangerous for the patients.”*

*“They incorporated metric based pay on items we do not control, such as length of stay in the ED. We do not control many things that affect length of stay, such as nursing, radiology, labs, etc. This has led to a metric that is impossible to meet, and in effect, a pay cut.”*

### Ability to Find or Keep a Job

When asked how mergers and acquisitions affect competition in the local job market for EM physicians, 63 percent of respondents to our questionnaire indicated that the presence of larger national groups (often called contract management groups, or CMGs) made it more difficult to find and/or keep a job.

*“Merger made it harder to find jobs since the new group monopolized the market in my area. The monopoly essentially lowered over market value and drove down the pay significantly.”*

Many respondents remarked that they in fact had no job options other than the large national group that had acquired their practice due to regional consolidation and horizontal integration. Respondents felt pressured to conform to patient care practices that they believed were substandard and feared for their job security if they spoke out against the directives of the group:

*“[Large national group] own[s] nearly all of the contracts in emergency departments within driving distance to my home. I essentially have no choice but to work for them as I have a family and cannot travel. I do not agree with their practices, but have to comply due to this CMG having a regional monopoly of ED contracts.”*

*“Shortly after taking over, the corporation moved to cut physician hours...By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services.”*

### Signs of an Uncompetitive Labor Market

The ability (or lack thereof) to find employment, the transition to less skilled employees, and the impact on wages are all signs of an uncompetitive labor market. It is also important to assess the effects on other terms and conditions of employee contracts, particularly the right to due process, as well as the conditions by which employees were notified of the merger and the overall role they had in the process.

Fifteen percent of respondents to our questionnaire stated that no rationale for the acquisition was ever provided. Many respondents received very little warning about the merger, and, in one case, the respondent was only notified three days prior to the new contract taking effect. Other respondents provided examples such as:

*“Hospital administration misled my group, false point of meeting, to an offsite location and informed us our contract would not be renewed. Then the new company was waiting to try and recruit us on the spot.”*

*“I was on vacation in [overseas] and got an email saying I worked for [large national group] now. That's how I found out. We did not have any notice about it or say in the takeover...Within a year, 8 of the 14 doctors I worked with left the group. The people who stayed were tied down by family or a year from retirement.”*

Furthermore, emergency physicians do not have much of a choice but to go along with the terms of the merger. In some cases, their current EM group is their only employment option in the area. Further, some emergency physicians are forced to sign noncompete clauses in their contracts and told they cannot work at other health systems. From several respondents to our questionnaire:

*“[Large national group A] within a year began cutting pay and hours and making weekly changes in working hours. Incredibly hard to find a job in this market due to 80-90% of all EP jobs in the greater [metropolitan area in large state] area controlled by two entities, [large national groups A and B] (both beholden to private equity)...The two have engaged in anti-competitive behavior to drive wages artificially low, force the integration and supervision of non-physician providers (PAs and NPs) in roles beyond their training, and incorporate restrictive covenants within contracts to limit any possible competition (non-compete agreements for emergency physicians, indemnification agreements, accelerated termination clauses, elimination of due process for termination, and proscriptions against directly competing for emergency department staffing contracts).”*

*“Just before the merger, the previous CMG had us sign contracts with fairly vicious non-compete clauses, in attempt, I suspect, to keep their contract with the hospital.”*

## Hospital Consolidation

Responses to our questionnaire suggested a pattern of acquisition of many EM groups being triggered by the *hospital* first being acquired by another entity. This pattern points towards a growing trend of vertical integration in addition to the ongoing horizontal integration. Some respondents noted the following:

*“Very successful single contract of truly democratic EM physician group at the same hospital for 21 years. Hospital was acquired by a larger hospital system, and soon after, they replaced our group with a national corporate entity backed by private equity because this entity offered to provide hospitalist services at a substantially lower stipend than the existing hospitalist group as long as the hospital gave the entity the ED physician contract as well.”*

*“My nonprofit hospital was taken over by [large for-profit hospital chain ...] We were subsequently forced to sell our group to a contract medical group, which is backed by private equity.”*

*“Big private equity group bought the hospital, contracted a private equity CMG for ED physicians.”*

*“New hospital administration essentially forced the acquisition of our single democratic group that had provided services to the same hospital for over 20 years. CMG that provided services at the hospital system’s other facilities was brought in.”*

*“Our hospital wanted a bigger EM group with more resources. They allowed us to research and choose which group with which to merge.”*

It is a struggle for hospitals, especially those in rural areas, to remain solvent, much less profitable. Over 130 hospitals in rural areas have closed since 2010, and this number is growing due the effects of the COVID-19 pandemic. Nearly 900 rural hospitals — over 40 percent of all rural hospitals in the country — have been identified as at risk of closing in the near future.<sup>9</sup>

## Transition to a Less Skilled Workforce

Many emergency physicians noted that larger national groups tended to hire advanced practice providers (APPs) over EM physicians. This may be due in part to cut labor costs: for example, physician assistants have a [median annual pay of \\$115,390](#), whereas EM physicians have a [median annual pay of around \\$350,000](#). However, there is a vast difference in the education and training of physicians versus other health care professionals as described previously in our response to this proposed rule. Anecdotally, emergency physicians found that when APPs were hired over physicians after mergers, patient safety decreased, and although labor cost to the hospital decreased, cost to the patient often increased due to over-testing and over-consultation. Some examples of respondents’ concerns include the following:

*“[...] staffing policies that were extremely dangerous to the patients with over staffing of APPs and understaffing of physicians. Patients were hurt and likely killed because of these staffing policies by these contract management groups.”*

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<sup>9</sup> Center for Healthcare Quality and Payment Reform. The Crisis Facing Rural Healthcare. <https://ruralhospitals.chqpr.org>. Accessed Apr 2022.

*“Shortly after taking over, the corporation moved to cut physician hours and instead increase the use of non physician providers in the emergency department such as PAs and NPs. By cutting hours, it made it more difficult to get a job in the local area because there were not as many physicians required to perform the same services.”*

*“They are intentionally understaffing emergency departments as a driver of profit. Patient care is being dangerously impacted, as the physicians are being asked to see an unsafe number of patients because they do not want to staff the emergency departments appropriately.”*

### Medical Decision-Making

Physicians complete 10,000-16,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training. Therefore, they should be trusted to have the utmost expertise in medical decision-making, especially in the most urgent situations. However, 53 percent of respondents indicated that their medical decision-making autonomy was curtailed following the merger or acquisition. They noted that there was now “pressure to take short cuts [and] give inappropriate and potentially harmful care” to meet profit-driven metrics, that patients “are treated as numbers rather than individuals,” and care is no longer patient-centered but “metric-centered.” Some further examples from questionnaire responses include:

*“There are pressures from administration to avoid admitting certain patients that appear to relate to reimbursement reasons.”*

*“Worsened in that heavy handed pressure placed on meeting nonclinical metrics and removal of RVU payment for non-billable patients seen in the ER. Pressure on hospitalist to discharge all patients in 4 days which has led to significant increase in return visits and readmissions. Not to mention poor care and sicker patients in the community.”*

*“Directly, no change. Indirectly by increasing the required patients per hour, Press Gainey results, etc it resulted in a pressure to take short cuts, give inappropriate and potentially harmful care in the name of ‘customer satisfaction’.”*

*“Worsen. We have already had several emails from our more recent director re: test utilization. Instead of getting to the root cause of why these tests were ordered, such as looking at the patients that the physicians felt required them and why, these remains essentially targeted the physicians who ordered the most of whatever test they would like us to perform less.”*

*“Worsened my ability to do medical decision-making. The rate at which we see patients, now in the 5-7 patients per hour sustained for up to 8 hours at a time is too much. We do not have the mental bandwidth to make so many decisions on so many patients in that short of a period of time. In addition, we are unable to spend any time at bedside with patients to elucidate histories or physicians that would help our MDM.”*

### Due Process Rights

Over fifty percent of respondents indicated that their due process rights worsened or were eliminated after the merger, which can result in physicians being left unable to advocate for their patients or for their own mental well-being in fear of employer retaliation.

Due process plays a foundational role in ensuring a physician can carry out their promise to patients without fear of retribution or termination by their employer, so further erosion in contracts following acquisition is a significant concern. One respondent noted that their contract was terminated after attempting to address the issue of lack of PPE in the midst of the COVID-19 pandemic. Among other questionnaire responses:

*“[The acquisition] worsened our right to due process because the corporate entity’s contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff’s executive committee as our democratic group previously had.”*

*“The contracts with the new group have a clause that I will not resolve any “disagreements” in court, but through a mediator.”*

*“We used to have due process but the acquisition forced us to give up those rights through a 3rd party agreement between the hospital and [large national group].”*

*“[The acquisition] worsened our right to due process because the corporate entity’s contract with the hospital eliminated our rights as hospital medical staff physicians to be the same as other members of the medical staff with regard to a fair hearing before the medical staff’s executive committee as our democratic group previously had.”*

### Physician Burnout

Even before the COVID-19 crisis, emergency physicians have historically had higher rates of career burnout and post-traumatic stress disorder (PTSD) than other medical specialties. According to a [2017 study](#) published in the *Annals of Emergency Medicine*, upwards of 65 percent of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers. Further, approximately 15 to 17 percent of EM physicians and upwards of 20 percent of EM residents met the [diagnostic criteria for PTSD](#) in 2019. During the pandemic, these unsettling trends in emergency medicine have gotten worse. A [poll](#) from ACEP and Morning Consult released on October 26, 2020 found that more than eight in 10 (87 percent) of emergency physicians reported feeling more stress since the start of the pandemic, with an additional 72 percent experiencing burnout on the job.

Consolidation in the EM market may also have contributed to this high rate of burnout. Overall, respondents associated consolidation with decreased morale and burnout among physicians. Many EM physicians are citing the current working conditions at large national groups as reasons for quitting medicine altogether, for they feel that they are trapped in a system that does not respect their autonomy or mental well-being and that there are no other options for them. The potential of a significant exodus of EM physicians from the workforce threatens the maintenance of the healthcare safety net that emergency medicine provides. The following responses exemplify the frustration that many EM physicians are experiencing now:

*“I no longer feel that the medicine I practice is safe or good, and that I am pushed to see more patients in less time to turn a profit. I feel this is at odds with the oaths I took as a physician, and sadly, am actively searching for ways out of medicine.”*

*“These corporations taking over medicine need to be stopped. They are taking away basic rights employees should have and they are mandating profit related changes that are bad for patients and physicians making the burn out worse than it already is.”*

*“Medicine has changed for the worse with the rise of these stockholder driven corporate groups. I don’t recommend being a doctor to young people.”*

*“We are continually asked to do more with less resources, for less income, and work in unsafe environments, yet with the same liability. I am actively pursuing career opportunities outside of clinical medicine. “*

## ***Conclusions and Recommendations***

The personal anecdotes shared here truly reflect some of the non-financial-related effects that mergers and acquisitions have had on emergency medicine. **All in all, with some notable exceptions, it appears that the current practice of consolidation in the EM marketplace, at the hospital system, insurer, and physician practice level, detrimentally affects physicians’ interests and wellbeing, which in turn may impact their ability to serve their patients.**

Again, ACEP hopes that our survey results and corresponding analysis will provide CMS with a comprehensive view of the impacts of mergers in emergency medicine and perhaps in health care more broadly. Based on these responses, we provide the following conclusions and recommendations:

- While there are some benefits to acquisitions and mergers, including the ability for EM practices to stay economically viable and negotiate fairly with insurance companies, **the potential anti-competitive labor-related effects must not be ignored—since they could impact wages, non-cash benefits, right to due process, autonomy for medical decision making, and the ability to serve patients.**
- **CMS should collect data that assesses the labor-related impacts of consolidation in health care and how changes to the labor market affect patient care.**
- **CMS should release data and reports to help the public better understand how mergers and acquisitions can lead to anti-competitive and harmful practices, including, but not limited to:**
  - a. Reduced wages and/or non-cash benefits;
  - b. Infringement of the right to due process;
  - c. Interference with provider autonomy to make independent medical decisions that benefit their patients;
  - d. Inability to find a job or undue imposed restrictions on ability to switch jobs; and
  - e. Practices, such as the use of a less-skilled health care workforce, that put profits over quality of patient care.

ACEP is proud to have its own [antitrust policy](#) in place to ensure that as a medical society it does not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather, it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at [jdavis@acep.org](mailto:jdavis@acep.org).

Sincerely,

*Gillian Schmitz, MD, FACEP*

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