

April 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

CMS-6084-P

Re: Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities

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 “Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities” proposed rule.

In this rule, the Centers for Medicare & Medicaid Services (CMS) is proposing implementing portions of section 6101 of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), which require the disclosure of certain ownership, managerial, and other information regarding Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities. The information would be made publicly available within one year after the rule, if finalized, is published in the Federal Register, on data.cms.gov. CMS is proposing these changes in order to ensure that they have sufficient data on owners and “can thus better monitor and hold accountable their nursing facilities.”

As another rationale for proposing this new requirement, CMS cites concerns about the quality of care and operations of nursing facilities, referencing several reports implying the correlation between private equity acquisitions of nursing facilities and the decline in nursing facility quality. This includes a November 2021 analysis published in the Journal of the American Medical Association, stating that “private equity companies seek annual returns of 20% or more; with this pressure to generate high short-term profits, private-equity-owned nursing homes might reduce staffing, services, supplies, or equipment, which could adversely affect quality of care.”¹ The analysis also concluded that private equity ownership of nursing facilities was associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions.”²

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¹ Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., JAMA Health Forum, November 19, 2021.

² Ibid.

ACEP is similarly increasingly concerned about the expanding presence of private equity and corporate investment in health care, including emergency medicine. In all, we believe that full transparency regarding private equity and corporate investment is essential in the health care industry, and that objective data is critically needed to measure the impact of private equity and corporate investment in health care on patient care and outcomes. Thus, we commend CMS for their efforts in increasing transparency by requiring disclosure of ownership information and making this information available to the public. We echo CMS' encouragement for states to establish reporting requirements in order to have accurate and updated information regarding nursing facilities' owners and operations.

We believe that there is a particular need for CMS to explore the role that private equity and consolidation plays in emergency medicine. 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 2020.³ 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 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 emergency department (ED) without worrying about whether the services they receive will be covered by their insurance. Given this vital responsibility that emergency medicine 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 emergency medicine 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 emergency medicine 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 seem 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

³ 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

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. Further, according to a [recent market report](#) conducted by Ivy Clinicians, private equity-owned firms manage clinicians in roughly 25 percent of U.S. emergency departments. In aggregate, private equity-owned firms staff EDs that are in lower-income, higher uninsurance, and more rural counties.

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.

Last year, 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.

Our survey results are summarized in our [response](#) to the Calendar Year 2023 Outpatient Prospective Payment System proposed rule. All in all, with some notable exceptions, the results clearly show that the current practice of consolidation in the emergency medicine 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.

These results reinforce our strong belief that CMS should continue its efforts to increase transparency in health care. 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. In addition, 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:

- **Reduced wages and/or non-cash benefits;**
- **Infringement of the right to due process;**
- **Interference with provider autonomy to make independent medical decisions that benefit their patients;**
- **Inability to find a job or undue imposed restrictions on ability to switch jobs; and**
- **Practices, such as the use of a less-skilled health care workforce, that put profits over quality of patient care.**

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.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Kang", with a stylized flourish at the end.

Christopher S. Kang, MD, FACEP
ACEP President