



October 20, 2023

Ellen Montz, PhD  
Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW, Room 445-G  
Washington, DC 20201

**Re: No Surprises Act: Recommendations for Additional Guidance to Certified IDR Entities**

Dear Deputy Administrator and Director Montz:

As the Centers for Medicare & Medicaid Services (CMS), working on behalf of the Department of Health and Human Services and together with the Departments of Labor and Treasury (collectively “the Departments”), continues to refine federal Independent Dispute Resolution (IDR) processes required under the No Surprises Act (NSA), the American Academy of Emergency Medicine (AAEM) offers the following additional input for consideration. AAEM is the specialty society for board-certified emergency physicians, representing over 8,000 members across the nation.

The payment challenges and administrative burdens that out-of-network providers face in the current reimbursement landscape have led to drastic reductions in revenue for emergency group practices, whose business models must already withstand the mandates of EMTALA, insufficient Medicare and Medicaid reimbursement rates, and other financial pressures created by law. The losses that providers have been forced to absorb in this dynamic period have been substantial, and perhaps no specialty has been impacted more than emergency medicine, particularly those emergency practice groups that have remained independent and do not receive the financial backing and support of large corporations or private equity investors. Not all “independent groups” are similar. Some independent groups are backed by a large national contract management company, often involving private equity (“**National CMG**”). Other independent emergency medicine groups live up to the spirit of the term “independent group” and are not backed by National CMGs or private equity investors, but are instead physician owned and locally managed (“**Local Independent Emergency Group**”). Many of these Local Independent Emergency Groups are presently at risk of going out of business and will not be able to sustain the ongoing starvation of revenues much longer. Many, in fact, can already project, based on current trajectories, the precise year and month that they will be forced to exit their hospital contracts and shutter their operations.

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555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823

(800) 884-2236 • info@aaem.org • www.aaem.org

While enabling payors to pay reduced rates for out-of-network emergency care provided to their members may at first glance appear to result in a lowering of healthcare costs,<sup>1</sup> the opposite result will be achieved if Local Independent Emergency Groups are driven to insolvency. What will be left standing will be National CMGs, which are generally able to extract higher payment rates from payers. We understand, of course, that CMS is continuing to work to achieve the balance of interests that Congress designed and enacted in the NSA, but as part of this effort, we urge CMS to establish affirmative protections for Local Independent Emergency Groups that will safeguard not only their interests, but the broader aims of cost-savings and value-based reimbursement underlying the NSA.

The Departments have already implicitly acknowledged the need for these safeguards. Specifically, in Part II of their interim final rule, the Departments highlight a September 2020 issue brief published by the Kaiser Family Foundation, which “suggests that the market dominance of a provider or facility ... can drive reimbursement rates up or down in a given region.”<sup>2</sup> Paralleling the concerns outlined above, the cited research suggests that rates of provider consolidation could increase as a result of the financial pressures placed on providers as a result of the COVID-19 pandemic.<sup>3</sup> Based on this research, we believe it is clear that (1) depriving Local Independent Emergency Groups of revenues will hasten and increase provider consolidation, and (2) greater provider consolidation will lead to higher health care prices for private insurance.<sup>4</sup>

Depending on the severity and duration of revenue loss, some hospitals and physician practices may find it difficult to operate independently, which could increase the rate of consolidation among health care providers. Lower margins among some providers may create new opportunities for large chains to acquire smaller providers. ... Even if sufficient government assistance is provided, the disruption of the COVID-19 pandemic may make operating independently seem less attractive and riskier to some smaller providers. Therefore, financial assistance to providers may not be sufficient to prevent an increase in the pace of consolidation.

...

A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance; this is true for both horizontal and vertical consolidation.

...

There is now a large body of research showing that health care provider consolidation tends to raise prices without clear indications of quality improvements.

The researchers further observe that private equity firms have begun to play an increasing role in this consolidation in recent years. “These firms typically invest in businesses by taking a majority

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<sup>1</sup> See, e.g., *TMA II*, p. 28 (“The Departments’ goal has not changed: ‘The goal of the [Final] [R]ule is to keep costs down’”).

<sup>2</sup> “Requirements Related to Surprise Billing; Part II” (“IFR II”), 86 Fed. Reg. 55997.

<sup>3</sup> See IFR II, 86 Fed. Reg. 55997, n. 32 citing Schwartz, K., Lopez, E., Rae, M., Neuman, T., *What We Know About Provider Consolidation*, Kaiser Family Foundation (September 2020), available at: <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

<sup>4</sup> *Id.*

stake with the goal of increasing the value of the business and potentially selling it at a profit. ... Acquisition by a private equity firm can lead to more consolidation later, as these firms often then acquire additional nearby practices as part of their business model.”<sup>5</sup>

Local Independent Emergency Groups are struggling to navigate the changes required under the NSA, and the challenges are compounded by the inability to obtain relief through the IDR process due to backlogs and delays, which are expected to create (if they have not already) unsustainable financial pressures and lead to waves of consolidation among emergency medicine providers, and the growth of National CMGs. Accordingly, we believe that the Departments must take additional steps to ensure that the federal IDR process does not become the death knell for Local Independent Emergency Groups and an accidental catalyst for provider consolidation and price increases for emergency care. To that end, we propose that CMS strongly consider issuing additional guidance to certified IDR entities that better controls for these concerns by further defining how to evaluate the market share held by the provider as an additional factor when determining the appropriate out-of-network rate.

**Specifically, we propose that CMS supplement its guidance to certified IDR entities to advise that when considering additional information submitted by a provider concerning the market share held by that provider in the geographic region in which the qualified IDR item or service was provided, the certified IDR entity should consider the provider’s size and overall market power relative to the payor, which may be informed by considerations that include, without limitation, (a) whether the provider is a Local Independent Emergency Group; (b) whether the provider receives financial backing or support from an affiliated entity; and (c) whether the provider receives financial backing or support from private equity investors. The guidance should further make clear that, when selecting one of the submitted offers by IDR parties, IDR entities should take into account information demonstrating that the provider is an independent group that does not have the ability to offset low reimbursement rates through support or investments by financial backers.**

Addressing the above-described concerns through supplemental guidance along these lines would have the added benefit of fulfilling the Departments’ previously stated intention to close an acknowledged gap in the current guidance. More specifically, though the NSA requires that certified IDR entities consider certain additional factors when selecting the appropriate out-of-network payment amount,<sup>6</sup> the Departments have correctly observed that Congress provided “relatively limited guidance on how to consider or define these additional circumstances.”<sup>7</sup> The Departments have acknowledged, nevertheless, that “[e]stablishing a standard framework for certified IDR entities to evaluate factors” would further their intent “to create equity and consistency in the Federal IDR process” and that ensuring “all certified IDR entities apply the same standards will help ensure that the Federal IDR process is appropriately predictable, fair, and equitable.”<sup>8</sup> For those reasons, the Departments announced, in IFR II, that they intended “to provide additional guidance to certified IDR entities as necessary to clarify how the allowable factors should be considered.”<sup>9</sup>

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<sup>5</sup> *Id.*

<sup>6</sup> See 42 U.S.C. § 300gg-111(c)(5)(C)(ii).

<sup>7</sup> IFR II, 86 Fed. Reg. 55996.

<sup>8</sup> *Id.*, 86 Fed. Reg. 55996-97.

<sup>9</sup> *Id.*, 86 Fed. Reg. 55997.

With respect to consideration of market share and additional factors IDR entities can consider, AAEM believes that the need for additional clarity remains. To be sure, the current guidance does little more than inform certified IDR entities that the parties may submit additional information regarding five additional factors, including the market share held by the payor or provider in the particular geographic region, and that the IDR entities must consider such information to determine the appropriate out-of-network rate.<sup>10</sup> The guidance includes no substantive explanation as to how the parties' respective market shares are meant to be considered by IDR entities, except to say that "[c]redible information should demonstrate how the market share affects the appropriate OON rate."<sup>11</sup>

For all of these reasons, we believe that CMS has ample justification for adopting and issuing the additional guidance to certified IDR entities that we have requested herein.

We further hope that, as you contemplate additional changes to the rules and documents that are within your purview, you will seriously consider the unique burdens that the NSA and the federal IDR process have imposed on Local Independent Emergency Group practices and the grievous consequences that will come to bear if they are allowed to be driven out of business.

We greatly appreciate your taking the time to review and consider this information. Please do not hesitate to reach out if you have any questions or if AAEM can provide you with any additional information that would be helpful to the Departments as they undertake this important work. You can direct any questions to Missy Zagroba, AAEM Executive Director, at [mzagroba@aaem.org](mailto:mzagroba@aaem.org) or at (800) 884-2236.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonathan S. Jones MD', with a stylized flourish at the end.

Jonathan S. Jones, MD FAAEM  
President

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<sup>10</sup> See *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* (October 2022), p. 20 - 21.

<sup>11</sup> See *id.*, at p. 21.