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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
P.O. Box 8013
Baltimore, MD 21244-8013

The Florida Association of Community Health Centers, Inc. (FACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

FACHC is the Florida primary care association (PCA), representing the state's 45 federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") and over one million Florida residents (patients). Our organization is a private and non-profit, whose goal is simply to advance the quality and effectiveness of the most cost-effective form of providing primary care in the State.

FACHC is following in the precursor footsteps of NACHC (the National Association of Community Health Centers), in focusing our comments primarily on provisions in the Medicare Accountable Care Organization (ACO) proposed rules that appear to prohibit FQHCs from any meaningful participation in the Medicare ACO-Shared Savings Program. By doing so, the rule has the potential of jeopardizing the successful achievement of the intent that Congress and President Obama had for this program.

Regards,

Andrew Behrman
President and CEO
Florida Association of Community Health Centers

I. Background

At present, there are approximately 45 FQHCs with more than 300 sites, employing nearly 6,000 FTEs who provided care to more than 1 million patients[1] during nearly 4 million encounters across Florida[2]. A majority of these FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS.

Under this authority, health centers generally fall into four care-provision categories, though a number of them qualify for more than one category of funding – and ALL of them see every single patient that walks through their door or seeks healthcare services:

(1) Those that Serve medically underserved areas,
(2) homeless populations within a particular community or geographic area,
(3) migrant/seasonal farmworker populations within similar community or geographic areas, and/or
(4) residents of public housing.

A handful of Floridian FQHCs do not receive a Section 330 PHS Act grant. However, these CHCs have been determined by CMS (per recommendation of HRSA) to meet all the requirements that must be met by Section 330 grantees (Sections 1861(aa)(4)(B) and 1905(l)(2)(B)(iii) of the Social Security Act). These FQHCs are often referred to as "FQHC look-alikes."

To qualify as a Section 330 grantee, a health center must:

(1) be located in a designated medically underserved area (MUA) or serve a medically underserved population (MUP)
(2) a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center
(3) must offer services to all persons in its area, regardless of one's ability to pay.[3]

In Florida, 33.7 percent of health center patients are Medicaid recipients, 49.0 percent are uninsured and approximately 6.2 percent are Medicare beneficiaries. This 6.2 percent Medicare patient load translates into more than 64,400 Medicare beneficiaries receiving services from Florida's FQHCs. Of those for whom their income information is known (82.9% of FL FQHC patients), 69.8 percent are at or below 100 percent of poverty – but this increases to 88.1 percent (720,000) when including those at or below 200 percent of poverty.

The simple fact that these centers can provide these services for the lowest price in the state – at this level of uncompensated care – and end each year (statewide) with an operating margin in the black is nothing short of a miraculous testimony to the value and fortitude of the FQHCs in one of the most populous states in the country.

Congressional Recognition of the Value of FQHCs and its Intent to Expand FQHC Services

Congress has consistently and frequently recognized and supported the role of health centers in providing critical primary care services in medically underserved communities throughout the country. It has done so by repeatedly passing legislation that has enabled health centers to expand and increase their services, including

[1] Providing comprehensive health care services for about 1/18th of the 4th largest state's entire population and growing every year

[2] Data compiled by FACHC through receipt of each FQHC member's audited 2010 UDS report

[3] BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (e.g. translation, transportation services, disease management Collaboratives, etc) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure.

for example, the provision of discounted drugs to FQHCs through the Section 340B program, the provision of Federal Tort Claims Act coverage for FQHCs and their employees, and most important, provisions in the Social Security Act (SSA) that require fair and adequate reimbursement to FQHCs to cover their costs in treating Medicaid and Medicare (and, recently, CHIP) patients.[4]

II. CMS' Proposed Rule Regarding FQHC Participation in the Medicare ACO/Shared Savings Program (MSSP)

Essentially, CMS' proposed ACO/MSSP rule, as we understand it, provides the following with regard to FQHC participation:

1. Though able to meet criteria laid forth in 1899(b)(1)(A) through (E) of the Affordable Care Act, FQHCs/RHCs cannot be "self-governed ACOs" and participate in the MSSP[5]
2. FQHC Medicare patients cannot be included in ACOs for purposes of shared savings[6]
3. A "one-sided" ACO can be exempt from the 2 percent net savings threshold adjustment, and thereby increase its shared savings, if 50 percent or more of its assigned beneficiaries have at least one encounter with a participating FQHC[7]; and both "one sided" and "two-sided" ACOs can increase their shared saving by up to 2.5 percentage points and 5 percentage points, respectively, if the ACO includes a FQHC[8]

CMS's explanation for points 1 and 2 above is based on the agency's belief that under 1899(c) and (d) of the Social Security Act (42 USC 1395jjj), as added by the Affordable Care Act (ACA), it can only assign a Medicare beneficiary to an ACO based on the beneficiary's utilization of primary care services provided by a "physician" as defined in the Medicare statute. To exclude FQHC patients would appear to be shortsighted in future attempts to calculate cost savings generated by ACO implementation, as over 1.5 million Medicare patients receive their primary care services at CHC medical home locations nationwide.

The agency maintains that patients treated by an FQHC cannot be assigned to an ACO because, prior to January 1, 2011, Medicare claims filed by FQHCs only included revenue codes and did not include HCPCS codes that identify the service provided. CMS suggests that, since it lacks the "requisite data elements" in the claims and payment systems[9] (particularly specific attribution of services to the rendering health care professional), it is not able to assign an FQHC patient to an ACO because it is unable to determine if the service was rendered by a physician[10].

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[4] Sections 340B and 233(g)-(n) of the PHS Act and Sections 1902(bb) and 1833(a)(3) of the Social Security Act

[5] Conclusion based upon underlying facts, such as those in Proposed rule: CMS-1345 (I, B), (I, D, 4), (II, B, 1)

[6] Conclusion based upon underlying facts, such as those in Proposed rule: CMS-1345 (II, B, 1)

[7] Proposed rule: CMS-1345 (II, G, 3, d. (2)); As depicted in Table 8: Proposed rule: CMS-1345 (II, G, 3)

[8] Proposed rule: CMS-1345 (II, G, 3, d. (2)); As depicted in Table 8: Proposed rule: CMS-1345 (II, G, 3)

[9] Similarly, CMS maintains it is unable to establish a three year benchmark as required in Section 1899(d) for Medicare patients treated solely by an FQHC provider, due to the lack of reporting criterion consistency. Hence, CMS discerned yet another reason to exclude FQHCs from participation in the MSSP.

[10] The express concentration upon a selection of professional groups at the exclusion of numerous other trained, certified and educated professional classes may result in a detrimental impact on the health and healthcare provision of patients. One potential result may be that ACOs find themselves rationing care and creating a new form of cherry-picking/lemon-dropping, acceptable within the guidelines of the ACO rules. With only a small number of professionals (e.g. doctors) that will be compensated for savings generated, the incentive will

It certainly seems curious that Congress would define the term "ACO professional" in such a way that recognizes practitioners other than physicians furnish primary care services and then not use that term consistently throughout the section. For example, section 1899 (b)(2)(D) requires ACOs to "include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c)". This requirement appears premised on the notion that ensuring an adequate supply of ACO professionals would directly correlate with the assignment of beneficiaries to the ACO.

At the very least, the contents of the rule that proposes FQHCs be excluded from full participation in the MSSP should give CMS pause to consider whether the internal citation under 1899(c) to an ACO professional described in subsection (h)(1)(A) is nearly as comprehensive as may be necessary to fully comprehend and measure the impact and fiscal innovativeness of ACO participants. The ACA text refers to a significant inclusion of a number of healthcare professionals through citing Sections 1861(r)(1) and 1842(b)(18)(C)(i) of the Social Security Act[i]. The ACA (and, therefore, by default, CMS), however, self-restricted itself in terms of ACO participants in such a way that allows for the Secretary to make the necessary adjustments. For example, the Secretary may wish to expand this definitive list to include, at a minimum, all of Section 1842(b)(C) – not limiting eligible providers to only those in the subsection (i) of this part of the Social Security Act.

If, in fact, part of the intent of the proposed rule is to decrease inpatient costs and keep the patient as healthy as possible[11], then amending the proposed rule in such a way that FQHCs are included should be an increased priority. The MedPAC findings (quoted below) are a testament to much of the innovative work being undertaken at Florida's FQHCs through ER Diversion programs at more than a third of FACHC's Centers. Specific data and methods for tracking patients over extended timeframes are still being developed, but preliminary data point to millions of dollars in savings generated thus far by the creativity and ingenuity of Florida's FQHCs.

> *"The MedPAC notes that hospitals working with physician teams can prevent further hospitalizations after discharge and provide ongoing services to keep the patient as healthy as possible. Also, the savings generated by ACOs, in many cases, are expected to result from reduced inpatient admissions."*

FACHC believes that CMS' conclusions may benefit from a reexamination and we are encouraged by the fact that the law allows the agency to promulgate policies that will allow for full FQHC participation in the MSSP. After all, the expansion funds and efforts that have been promoted by the ACA[12], Congress and State and local governments (such as those throughout Florida via the Low Income Pool program[13]) have a significant concentration and reliance upon the growth, expansion and success of FQHCs nationwide.

It may benefit CMS efforts to make efforts to correlate FQHC data and patients to the desired coding conditions, as these health care providers have consistently proven themselves to be the most affordable means through which care is provided and controllable diseases are managed.

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be to focus treatment towards the "most expensive patients" by doctors and push the "less expensive patients" to healthcare professionals who may not be properly trained to identify and treat the symptoms of a patient's ailment. In effect, this process may result in greater long-term costs and a restriction of access to the full utilization of the medical home model, under which FQHCs in Florida are currently operating – regardless of provisions outlined and bird-dogged by CMS under (II, H, 1) of the Proposed Rule.

[11] Proposed rule: CMS-1345 (II, B, 1) (MedPAC findings)

[12] In Section 10503 of the Affordable Care Act (ACA) Congress provided for an $11 billion investment in the expansion of FQHCs over the FY 2011-2015 time period

[13] Florida's federal-state-local matching program of $1 billion for uncompensated care that has been in place since the implementation of the state's 1115 Research and Demonstration Waiver http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

III. The Importance of Meaningful FQHC Involvement in the ACO/MSSP

FQHCs Provide Cost Efficient, Coordinated & High Quality Primary and Preventive Care

Rather than going on at length quoting studies and reports that prove that FQHCs are successful providers of high quality, coordinated cost-effective primary and preventive care, FACHC has included below a number of studies and reports that support this premise[14]. In its preamble to this proposed rule[15], CMS accepts and underlines this very point. Specifically, the agency states:

> *"FQHCs and RHCs have long delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay, and increase access to health care through innovative models of community-based, comprehensive primary health care that focus on outreach, disease prevention, and patient education activities. FQHCs provide high-quality care to rural and urban populations alike by focusing attention on improving public health through preventive care in addition to direct patient care. Not only do health centers provide critical, high quality primary care in the Nation's neediest areas, but reports have shown that the health center model of care can reduce the use of costlier providers of care, such as emergency departments and hospitals… For example, regarding FQHCs, data show health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care."*

CMS's proposed Rule Takes Medicare's Neediest Patients Out of the ACO/MSSP.

FQHCs serve almost 1.5 million Medicare beneficiaries nationwide. The Medicare population treated by FQHCs is a growing part of the FQHC patient population. According to data from HRSA's Uniform Data Systems (UDS)[16] covering the period 1996-2009, the FQHC Medicare patient population increased by 124 percent. It seems reasonable to assume that the Medicare beneficiary growth rate at centers will continue to increase in the upcoming years since the ACA has laid out a plan substantial health center expansion. Medicare patients being treated at FQHCs tend to be an at-risk population. This can be attributed partially to the fact that health centers are located in medically underserved areas, which often are low-income areas and patients have had difficulty accessing care.

Health centers treat a large population of dual eligibles (those that qualify for Medicare *and* Medicaid). Dual eligibles are over 1.5 times more likely to experience serious health limitations, more than twice as likely to experience fair to poor health, nearly three times as likely to experience diabetes, and twice as likely to experience asthma.[17] In short, dual eligibles are significantly more likely to experience worse health arising from conditions whose outcomes can be improved through ambulatory care and are the very patients whose health outcomes might improve though health care furnished in a clinically integrated system such as an ACO.

The proposed rules stress the importance of, and provide incentives for, ACOs bringing dual eligibles into their systems and, in fact, provide that CMS will monitor ACOs to assure that they do not attempt to avoid "at risk" beneficiaries. This concern and admonition only strengthens our initial point, that these proposed regulations

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[14] A comprehensive list of studies and reports can be found at:
http://www.nachc.com/client/documents/HC%20Quality%20Studies%2004.11.pdf
http://www.nachc.com/client/documents/HC%20Cost%20Effectiveness%20Studies%2002.11.pdf
http://www.nachc.com/client/documents/HC%20Disparities%20Studies%2004.112.pdf
http://www.nachc.com/client/documents/HC%20access%20to%20care%20studies%2004.11.pdf

[15] Proposed rule: CMS-1345 (II, F, 12)

[16] http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

[17] Geiger Gibson Policy Research Issue Brief No. 23, page 9

essentially leave out more than 1.5 million mostly high risk Medicare patients - whose numbers are increasingly being treated by FQHCs.

These proposed rules undercut the agency's attempt to assure that dual eligibles and other at risk Medicare patients are brought into the ACO system.

IV. Flexibility in Participants & Payment Structure

CMS states repeatedly that it believes it is compelled by the provisions of Section 1899(c) to assign Medicare patients based on primary care services provided directly by a primary care physician, hence, there can be no ACOs solely operated by FQHCs if that ACO wants to participate in MSSP, nor can patients of an FQHC be assigned to an ACO. The relevant statutory provision, however, does not require that services be provided directly by a physician. Notably, Section 1899(b)(1)(E) allows the Secretary to designate a broad range of ACO participants. Indeed, the whole point of establishing an ACO that would provide high quality, coordinated, primary patient care which would result in lower costs, and thereby allow for shared savings among its providers, is premised on the delivery of appropriate care by a team of providers including non-physician professionals.

With regard to establishing a benchmark for FQHCs, Section 1899(d)(1)(ii) appears to provide CMS further flexibility to bring FQHCs into the ACO/MSSP. This provision requires the Secretary to estimate a benchmark "using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO." This provision does not appear to require the specific methodology that has been proposed by CMS to determine the benchmark, and certainly does not require a single uniform methodology for all primary care providers. Under the wording of this provision, CMS appears to have the flexibility to apply a methodology to "estimate a benchmark" specifically for FQHCs.

This subsection also provides CMS options to implement payment models other than 1899(d) which is the provision that provides for the 3-year benchmark. Specifically, Section 1899(i) allows for a partial capitation model or "any other payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under" the Medicare program.[18]

V. Proposed Solutions

In light of the considerations outlined previously, CMS must approach these proposed rules from the perspective that any ACO/MSSP that can be read to exclude FQHCs and the associated low-income, high-risk Medicare patient population cannot be consistent with Congressional intent and undermines the goals of such a system and must be revised. There is sufficient flexibility to bring FQHCs and their patients into the program and adequate information and data available to CMS for it to do so.

Assigning FQHC Patients to ACOs

CMS' explanation in the proposed rule as to why it cannot assign Medicare FQHC patients to ACOs is that it reads Section 1899(c) of the Medicare law as requiring that beneficiaries be assigned to an ACO based on their utilization of primary care services furnished prior to January 1, 2011 and that "FQHCs do not include HCPCS codes that identify the specific service provided"[19]. However, as CMS states, since January 1, 2011 health centers' Medicare claims include relevant HCPCS codes. Since the ACO/MSSP program begins no earlier than

[18] Proposed rule: CMS-1345 (II, F, 1)
[19] Proposed rule: CMS-1345 (II, B, 1)

January 1, 2012, CMS will have one year's worth of health center claims with the necessary coding data to assign health center patients to ACOs[20]. As already noted, we believe that the assignment can and should be based on treatment provided by professionals at FQHCs rather than solely physicians. For the same reason, the final CMS rule could and should allow for ACOs that are formed by professionals who are at FQHCs.

Health centers have been filing their claims with CMS for more than 18 years on the UB-04 form which is submitted to CMS for each Medicare encounter. That form contains the patient information, revenue code and "attending physician" information. Because health centers have a limited set of services that are considered "FQHC services" and virtually all FQHC services would be considered primary care services, we believe this information would be sufficient for CMS to establish a reasonable assignment process of health center beneficiaries to ACOs.

Establishing a Three-Year Benchmark

CMS's additional explanation for taking FQHCs out of the ACO/MSSP is that because, prior to January 1, 2011, FQHCs were not providing the requisite data elements in the claims and payment systems, CMS cannot determine expenditures for the 3 year benchmark.

There appear to be several approaches CMS could take to get past this barrier.

1. CMS could use the data and claims it will have from FQHCs for 2011 and assume similar and comparable data and claims for the two years prior with some adjustments as appropriate relating to inflation, etc.
    a. This approach should provide an accurate benchmark since the proposed rules provide that in setting the three year benchmark the most recent year is weighted 60 percent of the benchmark.
    b. CMS' proposed rule would weigh the second year of data at 30 percent and would allow for ACOs starting later than 2012 to use data as of June 1, 2012. FQHC HCPCS codes for claims will be available as of that date, and as weighted under CMS proposed rules, would provide the basis for 75 percent (60 percent and 15 percent (6 months of 2012)) of the three year benchmark.
2. CMS could establish a three year benchmark based on non-FQHC patients assigned to the ACO and adjust the benchmark based on the number of FQHC beneficiaries assigned to the ACO per the data provided for 2011.
    a. Notably, CMS described alternative methods in the proposed rule to address gaps in data in its discussion of establishing an expenditure benchmark[21].
        i. Under Option 2 of the discussion, CMS indicated that it could compute a weighted-average (using number of months as the weight) that blends the prior expenditure experience and the average per capita Parts A and B FFS expenditures for all Medicare beneficiaries during the year before the first year they are assigned to the ACO, adjusted for health status.

[20] By the eclipse of the submission date for comments regarding this Proposed Rule, there will remain a six month period prior to implementation, during which CMS can create a uniform methodology (such as HRSA has done with UDS data reporting) that enables a crosswalk between the 2011 Medicare data and that of the 2009 and 2010 calendar years. This would allow for FQHCs to be able to provide a full three years worth of data – which can be phased out throughout the pilot period.

[21] Proposed rule: CMS-1345 (II, F, 3)

ii. Alternatively, CMS indicated that it could use only those beneficiaries' prior expenditure experience.

Either of these approaches could compensate for the lack of three years' of claims data (if such data is lacking) for beneficiaries served by FQHCs.

3. FQHCs report revenue codes for services provided. CMS could assign members utilizing the 2011 data and recover billing data from the prior two years with use of health center office visit revenue codes to determine the three year benchmark.[22]

4. CMS has encountered a similar assignment issue with FQHC participation in the recent Multi Payor Advanced Practice Primary Care demonstration and recommend that CMS further investigate the methods that are being used to create a work-around in that demonstration, and apply a similar work around for the ACO models.

5. A number of FQHCs have been recording HCPCS codes for all of their patients and have this information stored in their practice management systems, dating to before the requirement to report to CMS on January 1, 2011. Those centers that are able to provide CMS with the data it requires to establish the three year benchmark should be allowed to do so.
   a. This approach is not meant to be offered in place of the other proposals, but to suggest that the Secretary should make sure that those FQHCs currently able to provide the information CMS seeks, should be allowed to opt into the ACO system**.**

Sections 1899(b)(1)(E) and 1899(i) together provide CMS the opportunity to establish essentially a separate track in which FQHCs could be designated as both ACO participants and as ACO leaders, and in which their patients could be assigned and payment arrangements could be fashioned that both recognize and make the maximum utilization of their potential ability to reduce downstream health care costs.

1. CMS could establish a separate benchmark and calculate savings for an FQHC-formed ACO based on hospital emergency room use, hospital admissions, hospital readmissions, post acute care (e.g. extended care facilities use) and other related high-cost Medicare expenditures.
   a. FACHC and other health center advocates offer their assistance in crafting these guidelines, should CMS have such a desire.

2. CMS also could consider reducing the number of quality assurance requirements in this separate FQHC track since the vast majority of FQHCs are Section 330 PHS Act grantees and (by virtue of their receipt of Section 330 PHS Act grant funding) are already highly regulated and provide substantial quality of care data and information to HHS.

By allowing FQHCs entry into the ACO/MSSP model, dual eligibles would be assured to be included, since so many of the Medicare eligibles served by FQHCs are also low-income Medicaid recipients. Particularly important, this approach would assure that FQHCs and their patients are part of the mainstream ACO/MSSP which will increase the likelihood of their being brought into Medicaid ACOs, private payer ACOs, etc.

The only limitation in 1899(i) is that an alternative model cannot result in more program expenditures than would otherwise be expended for such ACO for such beneficiaries.

[22] CMS could gather information as necessary from its Fiscal Intermediaries or Medicare Administrative Contractors

VI. Governance

For all of the reasons presented above, FACHC strongly urges CMS to revise its proposed rules regarding FQHC participation in the ACO/MSSP. However, if CMS determines not to do so, we ask CMS to consider and respond to the following concern regarding its proposed governance rule:

> Under the proposed regulations, an ACO would be required to have a "mechanism for shared governance," such as a governing board, consisting of ACO participants and beneficiaries.[23] An ACO's governing board must contain a representative from each of the ACO's participants. That representative is required to have proportionate control over the ACO's decision making process.24

We support CMS' efforts to ensure that each ACO participant has a voice in the ACOs decision making process and strongly support CMS' proposal to require ACOs to describe in their applications how they will partner with community stakeholders.

The opportunity CMS has provided for FQHCs to participate in multiple ACOs is one of concern in the potential governance ramifications of this arrangement, wherein FQHCs and other participants permitted to join multiple ACOs will be represented on the governing boards of multiple ACOs. To the extent that those ACOs are within the same geographic area or serve the same populations, issues of competition and conflict of interest arise. As a result, FQHCs may be limited de facto to participate in one ACO, further reducing an FQHC's ability to participate to the maximum extent possible in the MSSP.

VII. Conclusion

The agency's response to a number of the concerns and issues raised in this letter may be that FQHCs and their patients have not been left out of the proposed ACO/MSSP system as CMS has built in specific shared savings incentives for ACOs that bring in FQHCs as part of their structure. However, in most instances, FQHC patients are being treated only by physicians and other providers at an FQHC. They are not likely to be treated by a non-FQHC provider as they live in a medically underserved area and the FQHC may be the only primary care provider accessible to them and/or may be their provider of choice. Since FQHC patients are not likely to be seeing or to have been treated by other primary care providers, they will never be assigned to an ACO under CMS's proposed rules.

Based on the track record of FQHCs, as acknowledged by CMS in the preamble to this proposed rule, bringing FQHCs and their patients into the ACO/MSSP will result in lower expenditures, not higher ones.

We also note (and appreciate) that in its recently published Pioneer ACO Model Request for Application, CMS states:

> *"CMS encourages applications from ACOs led by Federally Qualified Health Centers (FQHCs)…CMS would negotiate methods for expenditure baseline and benchmark calculations based on available Medicare data, and methods of patient alignment, with FQHCs that are selected for the Pioneer ACO Model."*[25]

We ask that CMS apply this same flexibility in its final ACO rule.

[23] Proposed rule: CMS-1345 (II, A) & (II, B, 1)
[24] Proposed rule: CMS-1345 (II, A) & (II, B, 1)
[25] http://innovations.cms.gov/wp-content/uploads/2011/05/Pioneer-ACO-RFA.pdf

Thank you for the opportunity to comment on CMS' proposed rules on ACOS and the Medicare Shared Savings Program.

If you wish to contact FACHC with any questions or comments:

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[i] **1842 (r)(1) [SSA]**: The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished. http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-r

1842(b)(18)(C) [SSA]: A practitioner described in this subparagraph is any of the following:
(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)). http://www.ssa.gov/OP_Home/ssact/title18/1842.htm

1861(aa)(5) [SSA]: (A) The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.
(B) The term "clinical nurse specialist" means, for purposes of this title, an individual who—
(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and
(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution. http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-aa-5