CMS states that they view organizations with more than 50 eligible clinicians as the appropriate threshold because organizations of such a size have demonstrated the capability and interest in taking on higher levels of two-sided risk. The AAFP remains unclear as to how CMS determined 50 ECs was the appropriate number for this threshold. An arbitrary threshold should not be used when determining the amount of financial risk an entity can assume. The assumption of risk should not be determined by a general threshold number of ECs within the organization, rather it should be based on each entity's demonstrated capabilities. Taking on financial risk of any amount is a decision that is not taken lightly by the entities. CMS should afford the entities the same courtesy and develop an appropriate way to determine if an entity is capable of taking on risk. CMS proposes to remove the provisions of the law that were placed there to provide a safety net for small and solo practices and which were designed to help these practices succeed under value-based payment. To foster an environment in which a small or solo physician can succeed, CMS needs to remove this provision.

(4) Nominal Amount of Risk
(a) Advanced APM Nominal Amount Standard
CMS interprets the meaning of "nominal" to mean minimal in magnitude; however, they do not believe the assumption of nominal risk is a formality and should therefore be a meaningful amount. To develop their proposal, CMS reviewed MIPS adjustments and current APM risk arrangements, including Tracks 2 and 3 of the SSP, the Pioneer ACO, and Bundled Payments for Care Improvement Initiative (BCPI). The APM risk amounts are designed to motivate the changes in practices that will reduce costs and improve quality.

APMs where the generally applicable financial standards apply will be need to meet three dimensions of nominal risk to be considered an Advanced APM. First, an APM must contain marginal risk. CMS proposes that marginal risk must be at least 30 percent of losses in excess of expected expenditures. The second dimension of risk is a minimum loss rate (MLR). This must be no greater than 4 percent of expected expenditures. Finally, CMS proposes an APM must include total potential risk of at least 4 percent of expected expenditures. Expected expenditures will be defied by the level of expenditures in the APM's benchmark. In an episode payment model, expected expenditures would be reflected in the target price.

CMS proposes a process by which they would determine a risk arrangement to satisfy the nominal risk requirements with an MLR higher than 4 percent, provided that the other portions of the standard are met. CMS would take into consideration the size of the attributed population, the relative magnitude of the expenditures, and whether the difference between actual and expected expenditures would not be statistically significant. These exceptions would be granted on rare occasions.
Payments made outside the risk arrangement related to expenditures would not count towards the nominal risk standard. CMS requests comments on appropriate levels on the Advanced APM nominal amount standard.

AAFP Response
The AAFP believes the nominal risk standard as proposed by CMS is complicated and confusing. Eligible clinicians need to be able to understand the amounts of risk they are being asked to assume. Requiring an eligible clinician to become an actuary to understand this regulation is unrealistic. Such a structure will function as a deterrent to eligible clinicians wishing to join an APM entity. There is a vast amount of variability in the risk arrangements this structure could create. A physician who joins an APM with a complex risk arrangement they are unable to understand will set them up for failure.