5. Count loss of guaranteed payments as losses for all APMs, not just medical homes, as all APM participants should be able to treat repayment of performance-based payments as financial risk.

- **Increase medical home flexibility.** The NPRM proposes more realistic financial risk standards for medical homes than other APMs, but CMS should: eliminate the 50-clinician cap on medical homes eligible for this standard, expand eligibility to specialty medical homes, and maintain the initial risk standard instead of increasing it to five percent. CMS should also prevent the risk requirements from being extended to primary care medical homes serving vulnerable populations, such as children with Medicaid coverage.

- **Provide more APM opportunities.** MACRA provided two pathways for physician participation, MIPS or APMs, but the NPRM limits the opportunities for participation in Advanced and MIPS APMs to just a handful of physicians. Several proposed policies need to be changed to provide a more robust APM pathway:
  1. Although MACRA defined nearly all Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation models as APMs, very few existing models qualify as APMs under the NPRM. A process needs to be established to allow other models to be modified so that they can qualify.
  2. Final regulations should establish a timely and predictable CMS review process for stakeholder APM proposals, including models for specialists and those recommended by the Physician-Focused Payment Model Technical Advisory Committee, in order to increase MACRA APM opportunities. Physicians are especially concerned by comments from some CMS officials that stakeholder models proposed by the independent advisory committee established by Congress will then have to go through the entire CMS model review process, which suggests it will be years before any physician-focused APMs are available.

Low-Volume Threshold

The undersigned organizations strongly recommend that the low-volume threshold be raised significantly in the final rule. Since the release of the MACRA NPRM, many concerns have been voiced about the potential impact of MIPS on solo and small physician practices. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians with less than $10,000 in Medicare allowed charges AND fewer than 100 unique Medicare patients per year from MIPS. The proposed threshold, however, would help very few physicians and other clinicians. An AMA analysis of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier" file found that just 10 percent of physicians and 16 percent of all MIPS eligible clinicians would be exempt under the $10,000/100 beneficiary proposal, and that these clinicians account for less than one percent of total Medicare allowed charges for Physician Fee Schedule services. As one example, by raising the threshold to $30,000 in Medicare allowed charges OR fewer than 100 unique Medicare patients seen by the physician, CMS would provide a better safety net for small providers. This would exclude less than 30 percent of physicians while still subjecting more than 93 percent of allowed spending to MIPS.