

November 2016

Making Sense of the MACRA Final Rule – Part 2 of 3: Alternative payment Models

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Many observers view the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a game changer for the delivery and payment of health care services.

On Oct. 14, 2016 the Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period (final rule) implementing the bipartisan MACRA legislation. The rule finalizes regulations to replace the Medicare sustainable growth rate (SGR) formula. Under the new system, fee-for-service payment rates under the Medicare Physician Fee Schedule (MPFS) are linked to care delivery, quality and value-based variables.

MACRA's implementation begins in earnest on Jan. 1, 2017. This article is part of a three-part series that examines various legal, operational and strategic considerations associated with MACRA. This article is based on the unpublished version of the final rule submitted to the Office of Management and Budget on Oct. 14, 2016.

Specifically, this article focuses on Alternative Payment Models (APM) under the “Quality Payment Program” (QPP), as established by MACRA and implemented by the final rule. Separate articles in this series examine:

- Essential elements of the QPP, including its policy objectives, participation alternatives, and operational details related to the program, and
- Details of the Merit Based Payment Incentive System (MIPS) participation vehicle.



Recap on MACRA Basics and Objectives

MACRA requires clinicians to participate in the evolving “value-based” payment and delivery system in a manner that is intended to impact the FFS Medicare program. Under MACRA, practitioners can influence what they are paid under Medicare Part B through two alternative participation vehicles:

- By participating in an Alternative Payment Models such as certain Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) and others, and becoming subject to the particular APM’s quality, cost, performance, data reporting and other requirements; or
- Attesting to various self-reported measures focused on clinical quality, technology and new approaches to care delivery under the Merit Based Payment Incentive System or MIPS.

MACRA impacts Medicare Part B professional service payments based on how practitioners and groups perform under these alternative participation vehicles.

Under MIPS, Medicare Part B professional service payments to clinicians will be subject to payment adjustments of +/- 4% in 2019, and +/- 9% beginning in 2022.

Conversely, through 2024 (the first six “QP performance periods” of the APM program), practitioners who participate in certain “Advanced APMs” are guaranteed to receive a 5% lump-sum “APM incentive payment” in the applicable APM payment year. That payment is in addition to any payments received (or losses incurred) under the APM program itself. Clinicians participating in APMs also have the potential to be exempted from MIPS payment adjustments.

Under MACRA, MPFS reimbursement through 2019 will be subject to slight (0.5%) updates. Between 2020 and 2025, MPFS rates will remain flat (without any update). Thereafter, the level of MPFS update will vary for clinicians who are subject to MIPS or participating in an Advanced APM. Beginning in 2026, Advanced APM clinicians will receive a 0.75% MPFS

payment update; those who are subject to MIPS will be limited to a 0.25% increase.

Overall, MACRA and the final rule are designed to incentivize clinicians to join and participate in APMs.

APM Participation Game plan – Timing Concerns

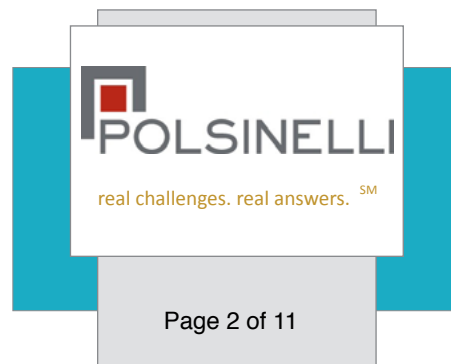
Importantly, as of the final rule’s publication date, most clinicians or their practices have already made a decision whether to participate in an APM in 2017. By illustration, the MSSP required physician groups (represented by tax-identification number or “TIN”) to choose whether to participate in a Medicare ACO by mid- to late-summer 2016. As a result, unless a clinician is currently planning to be part of an APM in 2017, the clinician will be subject to MIPS during the 2017 performance year.

Moreover, even those clinicians who will participate in an APM in 2017 are also “MIPS eligible clinicians”— meaning that despite their engagement with an APM, they may still be subject to MIPS if their APM does not qualify as an “Advanced APM” for any reason.

In light of these practical realities, many clinicians and their practices will need to manage for MIPS in 2017, while making strategic choices relative to APM participation in 2018 and beyond.

APM Incentive Payment Overview

The final rule adopts the bulk of the proposed rule’s requirements applicable to APM incentive payments authorized to be paid to under MACRA. In general that means that beginning in 2017, if an eligible





clinician participates in an Advanced APM that meets certain thresholds during the applicable APM performance period, the clinician (called a “Qualified APM Participant” or QP in the final rule) will not be subject to MIPS adjustments. Instead, the QP will receive a lump sum incentive payment equal to 5% of the clinician’s estimated Part B professional billings in the year preceding the applicable APM payment year.

This means, for example, that participation in an Advanced APM during the 2017 “QP performance period” will yield an additional 5% APM incentive payment in the 2019 payment year. That APM incentive payment amount will be based on the estimated Part B professional services furnished by the clinician in 2018. Participation in an Advanced APM will yield the additional 5% lump sum incentive payment through the 2024 QP participation period.

The timing and mechanics of APM incentive payments has the potential to create potentially counter-productive financial incentives for APM participants. Under the final rule, the QP performance period determines whether a APM incentive payment will be paid two years hence. However, because the APM incentive payment amount is equal to 5% of Part B professional services furnished in the intervening year, clinicians may be inclined to furnish more services in the intervening period. That would likely enhance clinician payments in the near term, but potentially undermine the APM’s longer-term ability to achieve its cost containment goals. As a result, APM Entities will need to help their clinicians understand that the long-term value of managing risk under APM models will exceed short-term financial benefits available under MACRA’s APM incentive payment structure.

Overview of Advanced APM Requirements

By law, MACRA limits APMs to certain payment models under Federal law, involving:

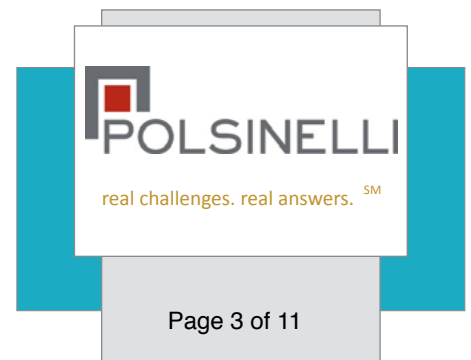
- Payment arrangements authorized by Social Security Act (SSA) Section 1115A (other than health care innovation awards),

- The Medicare Shared Savings Program,
- Demonstrations under SSA Section 1866C, and
- Certain other demonstrations.

Only Medicare FFS payment arrangements that are subject to or authorized by one of the above referenced authorities can qualify as an APM. However, qualifying as an APM is not enough to qualify for the incentive payments, as only “Advanced APMs” will be eligible for MACRA’s APM payment incentive and other financial benefits.

Under the final rule, to qualify as an Advanced APM, the respective APM arrangement between CMS and an APM Entity must meet the following three basic requirements:

1. Require the use Certified Electronic Health Record Technology (CEHRT), with the exact utilization requirements varying based on the type of APM. In the final rule CMS generally required that 50% of eligible clinicians in the APM must use CEHRT, including APMs in which hospitals are the APM Entities. CMS declined to finalize a proposal requiring 75% of eligible clinician usage in future years. However, this 50% requirement does not apply to APM Entities participating in the MSSP since the MSSP applies a penalty or reward to the APM Entity based on the degree of the use of CEHRT by the ACO’s eligible clinicians.
2. Include quality measure results as a factor for determining payment for covered professional services (with the quality measures being comparable to those in the MIPS quality performance category). To qualify as an Advanced APM, the APM arrangement





with CMS must include quality measure results in determining payment. The final rule imposes specific requirements on the quality measures, including that at least one must have an evidence-based focus, and in most instances, include an outcome measure.

3. Require participating APM Entities to bear “financial risk” for monetary losses of more than a “nominal amount”.

Additional information on MACRA’s requirements related to CEHRT and quality measures is discussed in our separate article on MIPS.

Advanced APM Financial Risk Arrangements with CMS

As noted above, to qualify as an Advanced APM, the APM Entity must be required to (1) bear “financial risk” under its arrangement with CMS, and (2) that risk must be in excess of a “nominal” amount. Note that this overall risk standard applies to the relationship between CMS and the APM Entity under the APM, so the APM Entity’s clinicians need not personally bear financial risk so long as the requisite financial risk exists under the arrangement with CMS.

Financial Risk Requirements

The final rule adopts both general and Medical Home Model-specific financial risk standards.

General Standard. Under the general financial risk standard, the APM arrangement must permit CMS to use withholds or reduce payments to the APM Entity or its eligible clinicians, or impose repayment obligations on the APM Entity as a vehicle to satisfy the APM Entity’s financial responsibility to CMS for an applicable performance period.

Medical Home Models. For Medical Home Model APMs, the financial risk arrangement with CMS may include the same repayment mechanisms listed under the general standard above, plus an additional option that the APM Entity may lose

the right to all or part of otherwise guaranteed payments.

Under the final rule, beginning in the 2018 performance year, Medical Home Model APMs will be limited to entities that are owned and operated by organizations with 50 or fewer eligible clinicians. Where the APM Entity (including its parent organization and subsidiaries of that parent) has more than 50 eligible clinicians, it will be subject to the general (rather than medical home-specific) standards.

Excess of Nominal Risk Requirement

To qualify as an Advanced APM, the APM Entity’s arrangement with CMS must also require the entity to bear financial risk that is in excess of a “nominal” amount. The final rule defines a general standard and a unique Medical Home Model-specific standard applicable to this excess of “nominal” risk requirement.

General Standard. In the final rule, CMS modified its proposed general standard to provide that an APM will meet the nominal risk standard if the total annual amount that an APM Entity potentially owes CMS or foregoes under an APM is equal to at least:

1. During the transitional 2017 and 2018 performance periods, a “revenue-based standard” set at 8% of the average estimated total Medicare Parts A and B revenues of the APM Entity; or
2. For all performance periods, a benchmark-based standard set at 3% of the expected expenditures for which an APM Entity is responsible under the APM. For episode payment models, expected expenditures means the target price for an episode.





CMS plans to increase the revenue-based standard beginning in the 2019 QP performance period, noting that it anticipated eventually increasing the revenue-based standard to 10-15% of the APM Entity's Medicare Part A and B revenues.

Medical Home Models. CMS adopted a different revenue-based standard for Medical Home Models given that medical homes have a relatively small number of providers, more limited revenues and limited, if any, experience with financial risk.

During the 2017 transition year, Medical Home Model APMs will meet the "nominal" risk standard where the total annual amount that the entity potentially owes CMS or forgoes is at least 2.5% of the average Medicare Parts A and B revenues of participating APM Entities. These amounts increase on an annual basis to 5% applicable in 2020 and later years. Where a Medical Home Model APM Entity meets the general financial and nominal risk standards applicable to all APMs, then the unique medical home-specific standards will not apply.

Overall, to the dismay of many observers, CMS clarified that the APM Entity must have direct financial risk to CMS under the APM, and the agency expressly rejected the notion that APM Entities could have financial risk through the investment in infrastructure and other operating costs that themselves can be significant.

Eligible Advanced APM Arrangements

In the final rule CMS noted that various payment arrangements will qualify as Advanced APMs based on the financial risk and other criteria listed above. In 2017, these include MSSP ACO (Tracks 2 and 3), NextGen ACO, Comprehensive Primary Care Plus (CPC+), Oncology Care Model and certain other programs sponsored by the Center for Medicare & Medicaid Innovation (CMMI).

CMS confirmed that entities that are in Track 1 of the MSSP (with upside only) will not qualify as Advanced APM models, but it announced that the agency will be working on a "MSSP

Track 1+" ACO arrangement that will be able to qualify as an Advanced APM under the final rule in the future. Beginning in 2019 (for performance year 2021), APM Entities can qualify as "All-Payer Advanced APMs" based on the combination of their Medicare FFS, commercial payer and other arrangements.

Qualified APM Participant (QP) Determination

Under the final rule, only Qualified APM Participants or "QPs" in Advanced APMs will qualify to receive an APM incentive payment. An eligible clinician is a QP for a payment year if the eligible clinician is in an APM Entity group that achieves a "Threshold Score" that meets or exceeds certain Medicare payment or patient count thresholds through the Advanced APM for the applicable QP performance period. The final rule sets forth special rules for eligible clinicians who participate in more than one Advanced APM (e.g., concurrent participation in MSSP and Oncology Care Model or CPC+).

For the 2019 and 2020 payment years, the Threshold Score must be met based on Medicare Part B payments or Medicare FFS beneficiary or patient counts. Beginning in the 2021 payment year, a Threshold Score can be met through a combination of Medicare, commercial and other patients through an All-Payer Advanced APM.

For Medicare only APMs such as the MSSP that submit a participation list to CMS, eligible clinicians (and therefore QP determinations) are assessed as a group. For APMs that involve other payers or where the APM does not involve the submission of a participation list to CMS (such as certain episode-based APM models), eligible clinicians will be assessed individually for purposes of QP determinations for a year.





In both cases, where the APM Entity meets the applicable Threshold Score, eligible clinicians listed on the participation list or affiliated with the APM Entity on March 31, June 30 or August 31 of the applicable performance period will qualify as a QP. CMS will perform QP determinations on each such date based on claims information from Jan. 1 of the respective performance period.

Where one or both of the payment or patient count thresholds are met, then the individual or groups of eligible clinicians will qualify as QPs such that they will earn the APM incentive bonus and enhanced MPFS payment updates.

Payment Amount and Patient Count Thresholds

CMS will use a standard process to calculate the payment and patient count threshold. For the payment threshold, CMS will divide the aggregate Medicare Part B payments for professional services furnished by APM Entity's eligible clinicians to attributed beneficiaries during the QP performance period, by the aggregate Medicare Part B professional service payments furnished by those same eligible clinicians to all attribution-eligible beneficiaries during the QP performance period. For the beneficiary or patient count threshold, the aggregate number of attributed beneficiaries will be divided by the aggregate attribution eligible beneficiaries.

In both instances, "attributed beneficiaries" are beneficiaries who are attributed to the Advanced APM Entity based on the APM's particular attribution rules (e.g., with different rules applied under the MSSP, Next Generation ACO and other APM models). "Attribution-eligible beneficiaries" are those beneficiaries who meet the attribution criteria (e.g., are not enrolled in Medicare Advantage, do not have Medicare as secondary and others), and who have at least one claim for E&M services by an eligible clinician in an APM Entity during the QP performance period (or who meet an alternative attribution process defined by CMS for the particular APM).

CMS will calculate both the payment and patient count thresholds and use the most beneficial of the two calculations to determine the QP status of an eligible clinician for the year.

The payment and patient thresholds increase incrementally over time.

Clinician Alignment with APMs—QPs and Partial QPs

Where a clinician is deemed to be a QP through participation or affiliation with an Advanced APM that meets the payment amount or patient count thresholds, then QP status (and the incentive bonus) will apply to every TIN to which the QP clinician has reassigned Medicare payment rights -- not solely to the TIN that is participating in the Advanced APM.

The final rule adopts the proposed rule's lower thresholds for "Partial QP" status. Where the lower threshold is met, the eligible clinicians will qualify as "Partial QPs" such that they can elect to avoid the payment adjustments under MIPS. In essence, CMS is providing "partial credit" to encourage participation in Advanced APMs—even if that participation is not sufficient to earn the APM incentive payment.

Medicare Option and All-Payer Combination Option Thresholds

The final rule adopts the proposed rule's transitional implementation of the payment and patient count QP and Partial QP thresholds for both the Medicare only option and the "All-Payer Combination" Advanced APM option.

Beginning in payment year 2021, eligible clinicians may meet the thresholds through arrangements with payers in addition to FFS Medicare. The "All-Payer Combination Option" permits clinicians with lower levels of Medicare participation in APMs to still meet the applicable threshold through similar at-risk arrangements with commercial, Medicare Advantage, Medicaid and other payers.





All-Payer Advanced APMs will be required to meet the same basic design criteria applicable to Medicare Advanced APMs (i.e., CEHRT, quality measures, and financial risk requirements).

The transitional implementation of the QP and Partial QP thresholds over the first few years for the All-Payer Combination Option are set forth below. The levels in each year represent the minimum amount, but in each year, a minimum amount of Medicare patients (evaluated using the Medicare-Option referenced above) will also need to be met, so a “commercial only” entity cannot alone be used to achieve QP status. The table below summarizes the thresholds adopted in the final rule.

Thresholds	APM Payment Year 2019 and 2020	APM Payment Year 2021 and 2022		APM Payment Year 2023 and Beyond	
<u>Medicare Only Advanced APM Option</u>					
QP Payment Amount	25%	50%		75%	
Partial QP Payment Amount	20%	40%		50%	
QP Patient Count	20%	35%		50%	
Partial QP Patient Count	10%	25%		35%	
<u>All-Payer Advanced APM Option</u>					
QP Payment Amount	NA	50%	Plus 25% Medicare payment threshold	75%	Plus 25% Medicare payment threshold
Partial QP Payment Amount	NA	40%	Plus 20% Medicare payment threshold	50%	Plus 20% Medicare payment threshold
QP Patient Count	NA	35%	Plus 20% Medicare payment threshold	50%	Plus 20% Medicare payment threshold
Partial QP Patient Count	NA	25%	Plus 10% Medicare payment threshold	35%	Plus 10% Medicare payment threshold

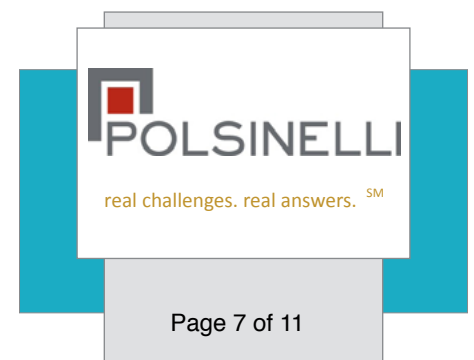
Because the All-Payer Combination Option will involve payers in addition to Medicare, Advanced APM Entities or eligible clinicians will submit information to CMS to permit CMS to calculate the thresholds using the same basic method outlined above, but each payer will also be required to attest to the accuracy of the submitted information. CMS will not count data for which payer attestation is missing, so APMs and their participating clinicians and TINs will want to negotiate the inclusion of such payer attestation in their commercial payer arrangements.

APM Incentive Payments

CMS finalized its proposal to calculate the APM incentive payments based on the “Incentive Payment Base Period” -- defined as the full calendar year prior to the payment year.

This means, for example, that calendar year 2018 is the Incentive Payment Base Period for the 2019 APM payment year, and so on through 2024 when the APM incentive payments cease. Therefore the amount of the APM incentive payment to be paid in 2019 will equal 5% of the estimated aggregate payments for a QP’s covered professional services during 2018. The aggregate payment will take into account covered professional services under Medicare Part B, but exclude certain payments (e.g., MIPS, VM, MU and PQRS payment adjustments, supplemental service payments such as care-management fees and others that are outside of the MPFS that are received during that period).

APM incentive payments will be paid to each TIN associated with the QPs participation in the Advanced APM





entity meeting the QP threshold during the applicable performance period. Where a single QP is associated with multiple Advance APMs, CMS will allocate the bonus payment among the TINs in proportion to professional services billed by the clinician through the TINs.

APM Compliance Requirements

In the final rule, CMS finalized compliance-related requirements that build on those used in multiple CMS payment initiatives such as the MSSP and others. Failure to satisfy the compliance requirements could result in a denial of all or some of an otherwise earned APM incentive payment. The compliance requirements include:

- Compliance with Medicare conditions of participation
- Maintenance of records under the program (including in connection with the All-Payer Combination Option) for at least 10 years
- CMS audit and recoupment rights
- Maintenance of Office of Inspector General (OIG) authority to audit, investigate, inspect and evaluate the APM Entity, eligible clinicians and other individuals and entities performing services related to its APM activities.

Physician-Focused Payment Model

In addition to MIPS and APMs, MACRA also authorized the creation of Physician-Focused Payment Models (PFPM) which the final rule defines as an APM:

- In which Medicare is a payer (but which can also include other payers),
- In which eligible clinicians that are Eligible Practitioners (defined in Section 1848(k)(3)(B) of the Social Security Act) are participants and play a core role in implementing the APM's payment methodology, and

- Which targets the quality and costs of services that the APM's eligible clinicians provide, order, or can significantly influence.

PFPMs serve as a vehicle to expand the existing portfolio of APMs. Notably, CMS' final PFPM definition is expanded from that contained in the proposed rule in that it encompasses APMs that include any eligible clinician—rather than solely physicians—as long as the clinician plays a core role in implementing the payment methodology.

PFPMs will be defined by a Physician-Focused Payment Model Technical Advisory Committee (PTAC). Stakeholders will be permitted to submit proposed PFPMs to the PTAC for review on an on-going basis. The PTAC is not required to use a specific review process, although the final rule requires the PTAC to consider the specific criteria relating to payment incentives, care delivery and information availability in reviewing proposed PFPMs. Moreover, under the final rule, the PFPM must aim to broaden or expand the CMS APM portfolio by addressing an issue or payment policy in a new way or by including APM Entities whose opportunities to participate in APMs previously have been limited.

Under the final rule, the PTAC will review proposed PFPMs and provide comments and recommendations regarding whether a proposed PFPM should be tested. CMS stated that testing will occur based on competing priorities and available resources, and observed that CMS generally requires 18 months to develop an APM.

CMS stated that it intends to provide more information about the PFPM testing process outside of notice and comment rulemaking.



Observations and Additional Information

Overall, the MACRA final rule generally adopted, with some refinements, the proposed rule's approach to APMs. Given the complexity of the law and its interplay with numerous other programs governing APMs (e.g., MSSP, CPC+), the final rule represents a pragmatic, but imperfect, approach to implementation. CMS acknowledges that the final rule and the specific details of APM participation vehicles will continue to evolve over time.

CMS is clearly seeking to encourage early adoption and significant migration of eligible clinicians and their patients to APM models as part of the agencies' drive to link 90% of Medicare fee-for-service payments to quality and value by the end of 2018. To this end, CMS continues to develop additional Advanced APM models, as illustrated in its announcement

on Oct. 25, 2016 that new models would be announced soon, including a new voluntary bundled payment model, a Comprehensive Care for Joint Replacement Payment Model (CEHRT track), and an Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track).

MACRA provides financial incentives and mandates the evolution of payment systems from volume to value over the next few years. As a result, even those health care organizations and clinicians who have not signed up to participate in an APM in 2017 are likely to find participation in an Advanced APM as a key component of their long term future strategy.

Consult Polsinelli's separate articles dealing with the final rule's requirements and practical implications associated with MACRA's essential elements and MIPS [here](#).



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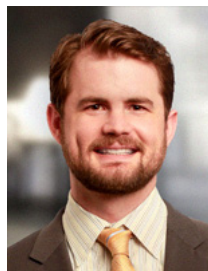
For questions regarding this information, please contact one of the authors below, a member of Polsinelli's **Health Care** or **Public Policy** practices, or your Polsinelli attorney.



Janice A. Anderson

312.873.3623

janderson@polsinelli.com



Ken Briggs

602.650.2042

kbriggs@polsinelli.com



Bruce A. Johnson

303.583.8203

brucejohnson@polsinelli.com



Marissa R. Urban

303.256.2750

murban@polsinelli.com

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