MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Payers

Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.
If a question is not applicable to your organization, please indicate so in your response.

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   ii. **Priority 2**: Reduce growth in prescription drug spending
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

CCA has been on the forefront of reducing unnecessary hospital utilization since its inception. These efforts have been focused on the following areas:

A. Investment in Comprehensive Primary Care that support patient's in their home living environment and reduce both the medical and non-medical triggers for unnecessary acute care utilization. These include primary medical teams that see patients in their homes to provide effective, on time primary care, integrated behavioral health (BH), durable medical equipment (DME) and personal care attendants (PCA's) all utilized by CCA and leveraged to meet patient's needs both in acute and chronic care systems.
B. Development of Innovative Disruptions to Address Acute Exacerbations of Chronic Disease. CCA has three specific programs that are designed to disrupt the reactive medical care model that often drives acute care utilization.
   1. The Life Choices Palliative Care Program which offers an open ended, end of life approach, grounded in the primary care team approach. This normative end of life process transitions a patient from aggressive to palliative to true end of life care in a trajectory that matches the patient's clinical course and not the dichotomous structure of aggressive / hospice care. CCA members often enter into less aggressive care plans that are based at home leading to decreased ICU and acute care utilization in the final years or months of life. In addition, by not requiring CCA members to formally elect a Medicare Hospice benefit, but instead to receive palliative and end of life care coupled with an open approach to this discussion, CCA is able to maintain a significant rate of advanced directive engagement.
   2. CCA's Crisis Stabilization Units provide an effective alternative to avoid unnecessary inpatient psychiatric admissions for patients who may be treated on an open unit but have not achieved the requisite level of stability for immediate home discharge. By stabilizing

behavioral health issues, both the immediate and subsequent ER/Inpatient utilizations can be avoided.

3. CCA's Mobile Integrated Health Program, currently operating under a DPH waiver, allows specially trained paramedics to see and treat patients in their homes. Services include physical examination, I stat labs, EKG, IV fluids, and both IV and oral medications. This program gives us the ability to respond, evaluate, and appropriately triage treatment, creating an innovative and dynamic solution to avoid unnecessary ER visits and subsequent admissions.

ii. What barriers does your organization face in advancing this priority?

The main barrier encountered with these innovative programs has been in scaling. Specifically, CCA's Mobile Integrated Health Program is limited to a small geography in Eastern MA as well as the time of day during which it may operate. Regulations allowing for expansion of the Mobile Integrated Health Program have been delayed since December 31, 2015. As another example, the lack of a rapid development of CPT codes to support innovative disruptive clinical innovations has been a barrier to scale. Mobile Integrated Health would scale quicker if CPT codes were developed during pilots to allow rapid dissemination once regulations are promulgated.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

CCA recommends the following policy changes to advancing these innovations:

1. Statutory authorization to conduct Mobile Integrated Health across the Commonwealth would help reduce the Emergency Department usage by CCA members.

2. Bundled, risk adjusted premium for specific populations such as end stage dementia would allow for patients to receive focused non-medical care that could greatly decrease the need for acute care due to breakdown in social support. If dementia care were bundled and PCA's other home health supports were readily available and funded, care giver burnout and social determinant issues would be reduced.

3. Appropriate funding for patients with high end palliative care and end of life needs who are pre-hospice to allow for home based care that would avoid much of the futile care experienced in the end of life that is both costly and often not aligned with patient goals.

4. Waiving the three night requirement for skilled nursing facilities rehab placement to allow for more timely transition to appropriate less acute facilities.

c. Please complete the following questions for **Priority 2** (listed above).

i. What is your organization doing to advance this priority and how have you been successful?

To contain prescription drug spending, CCA utilizes an operational approach, such as formulary and utilization management strategies in addition to maximizing generic dispensing rates and rebates. Due to the high complexity, adverse effects, and patient discontinuation rates associated with specialty medications, CCA will be reducing waste for specialty medications by limiting to 30-day supply in 2018. CCA's integrated care model also allows the ability for improved education and care coordination between clinical teams and pharmacy to help support quality, safety, and reduced cost.

ii. What barriers is your organization facing in advancing this priority?

CCA faces many barriers in reducing drug spending including, but not limited to (1) drug price inflation; (2) new to market approvals for oncology and other specialty drugs often with limited outcomes and high cost pricing structure; (3) a

prohibition from mandating a preferred specialty pharmacy provider; and (4) limited knowledge regarding cost of medications.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

CCA recommends the following policy changes:

A. Increased transparency and regulation in the pharmacy drug supply chain to help ensure market appropriate pricing.
B. Increased transparency into cost generators for pharmaceutical development (e.g. research vs. marketing).
C. Improve prescriber education into drug pricing, including increased Part D or MassHealth drug based risk contracts.
D. Enhanced authorization for pharmacists, as healthcare providers, to allow billing in specified sites of care.

2. STRATEGIES TO IMPROVE CLINICAL DATA COLLECTION

In each of its four annual reports, the HPC has called for the improvement and alignment of quality measures, particularly for the measures used in APM contracts, and has recognized the burden of reporting different quality measures for different purposes. Please answer the following questions regarding how your organization collects clinical quality data.

a. How does your organization currently collect clinical data from contracted provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process? [check all that apply and explain the purpose for which you collect the data for each] Collection of clinical data from provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process is not currently a significant component of CCA's APM activities. However, CCA does annually collect and report on data with regard to HEDIS measures. In addition, CCA is planning to increase quality measurement efforts for use in future APM contracts.

☒Excel document or equivalent
Purpose: Focusing on highly aligned provider relationships, CCA has a limited number of provider contracts with financial incentives tied to performance on clinical quality measures. With regard to performance incentives, CCA uses claims data for some measures and for other measures providers annually generate an Excel report for CCA.

☐Direct data feed
Purpose: Click here to enter text.

☐Chart reviews by third-party vendor
Purpose: Click here to enter text.

☐Web-based portal
Purpose: Click here to enter text.

☐Other: Click here to enter text.
Purpose: Click here to enter text.

b. How frequently do you collect clinical quality data from contracted providers? Required Answer.

☐Ongoing
☐Monthly
☐Quarterly
☒Annually
☐Other: Click here to enter text.

c. What is the estimated cost of staff and resources to collect and report on provider clinical quality data each year? Below are CCA's annual estimated costs for HEDIS measurement and reporting.
   i. Estimated cost (in dollars): $350,000
   ii. Estimated FTEs: 3

3. STRATEGIES TO ADDRESS DRUG SPENDING

The HPC, other state agencies, payers, providers and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. In its 2016 Annual Cost Trends report, the HPC highlighted a range of strategies to reduce drug spending increases, including value-based contracting.

a. Are you pursuing value-based drug contracting? Required Answer.
   ☐ Yes ☒No

   If yes, with whom?
   Required Answer: Click here to enter text.

b. If yes, have you found that your value-based contracts have resulted in meaningful cost savings and/or quality improvement? Required Answer
   ☐Yes, cost-savings only
   ☐Yes, quality improvement only
   ☐Yes, both
   ☐No
   ☒Unknown (insufficient time to measure improvement)

c. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply. Required Answer.
   ☒Lack of appropriate quality measures
   ☒Administrative and operational implementation costs
   ☒Inability to negotiate performance incentives with manufacturers
   ☒Other (please specify):

CCA has recently initiated discussions with its Pharmacy Benefit Manager ("PBM") regarding value based drug contracting. The goal was to incorporate our PBM's experience with indication-based formulary, indication-based pricing, and outcomes-based contracting. Although CCA has not moved forward with value based contracting due to the challenges described below, we continue to monitor the market and evaluate for opportunities. The following are some additional challenges:

1. Lack of Appropriate Quality Measures - CMS core measures are a good starting point but many quality measures are lifestyle dependent and would require significant improvement in current standards of patient, provider, payer, and pharmacy coordination.

2. Administrative and Operational Implementation costs - Significant time and resources are required to capture and analyze the immense amount of data which health plans need to utilize in order to determine if a drug produced the desired outcome. CCA believes that these measures must be meaningful to patients, consumers, and physicians while reducing variability in measure selection and data collection. Technology and motivation for patient participation are also limiting factors.

3. Negotiation - The core of pharmaceutical contracting continues to be volumetric in order to meet payment and profit goals. CCA is a relatively small plan that lacks the prescription volume to more effectively negotiate and offset administrative and operational implementation costs.

4. STRATEGIES TO SUPPORT INNOVATIVE CARE DELIVERY THROUGH PAYMENT POLICIES

Public payers are implementing new payment policies to support the development and scaling of innovative, high-quality and efficient care delivery, such as, for example, Medicare's readmissions penalty for acute care hospitals, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, and MassHealth's new flexible services spending allocation in its new ACO program to address patients' non-medical needs.

a. Has your organization adopted any new payment policies related to the following areas of care delivery improvement and innovation? [check all that apply] Required Answer.

☒Readmissions
☒Avoidable ED visits
☐Serious reportable events
☐Behavioral health integration into primary care (e.g. collaborative care model)
☒Care management (e.g., serious or chronic illnesses)
☐Telehealth/telemedicine
☐Non-medical transportation
☐Services to maintain safe and healthy living environment
☐Physical activity and nutrition services
☐Services to remove/protect patients from violence
☐Other: Click here to enter text.

b. For each area identified above, please describe the payment policy in more detail, including whether it is a payment penalty or non-payment, fee-for-service reimbursement for new service codes, per-member-per-month fee, etc.

Readmissions:

See Care management (below)

Avoidable ED Use:

As indicated in Question 1.c.ii., CCA's Mobile Integrated Health program has been highly successful at diverting members away from use of the ED, however no new payment policies have been adopted nor can any expansion or change of the program occur until DPH promulgates regulations or the legislature authorizes Mobile Integrated Health statewide.

Serious reportable events:

Click here to enter text.

Behavioral health integration into primary care (e.g. collaborative care model):

Click here to enter text.

Care management (e.g. serious or chronic illnesses):

CCA contracts with "Health Home" community partners (such as health centers and behavioral health providers) for delegated care management for thousands of One Care members. The partnerships are highly integrated to support the partners to successfully execute CCA's model of care coordination with a high level of quality. In the past year, CCA adjusted two components of its Health Home contracts to incentivize high quality care management:

1. **Admissions rate**: CCA offers performance bonuses to Health Homes for:
    a. Reduction in admission rate as compared to the Health Home's own baseline; and
    b. Achievement of a severity-adjusted admissions rate lower than CCA's total One Care admissions rate.
2. **Shared Savings**: CCA added an up-side only shared savings opportunity for Health Homes tied to medical expense ratio (MER) for:
    a. reducing the Health Home's MER as compared to their own baseline; or
    b. achieving a set target.

Telehealth/telemedicine:

Click here to enter text.

Non-medical transportation:

Click here to enter text.

Services to maintain safe and healthy living environment:

Click here to enter text.

Physical activity and nutrition services:

Click here to enter text.

Services to remove/protect patients from violence:

Click here to enter text.

Other:

Click here to enter text.

5. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool." This requirement does not apply to CCA because CCA is not a carrier as defined in Chapter 176*O*. Furthermore, all of CCA's member are MassHealth eligible and none of CCA's members share in the cost of their care. Therefore, CCA members are unlikely to inquire about cost of their care.

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2016-2017			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2016	**Q1**		
	Q2		
	Q3		
	Q4		
CY2017	**Q1**		
	Q2		
	TOTAL:		

6. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2014 to CY2016 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2014 to 2016, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). Through careful and regular analysis of utilization management trends for both One Care and SCO, CCA has observed several drivers to utilization management trends in both programs over time. These drivers include, but are not limited to, enrollment growth, CCA's ability to engage new members soon after enrollment, the extent to which care in a fee for service model drives supply sensitive care needs in both SCO and One Care and the relative differences among clinical demands of members entering the plan.

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2014	-1.9%	-13.0%			-14.9%
CY 2015	-8.1%	16.6%			8.6%
CY 2016	-2.7%	3.4%			0.7%

1. The main driver of changes for 2014 are related to increase in One Care enrollment compared to 2013. One Care costs PMPM are much lower than Senior Care Options ("SCO").
Medicare Part C risk score (proxy for member severity) increased by 10% from 2014 to 2015.

2. Unit cost: Pharmacy had a major per unit cost increase from 2013 to 2014, which then leveled out in subsequent years.
Acute care hospital expenses were reduced by level of care review (fewer IP, more Observation).

3. Utilization: while pharmacy had major decreases in unit cost, utilization increased steeply from 2014 to 2015.

7. INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND APMS

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2016 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2018. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a. Please answer the following questions related to risk contracts spending for the 2016 calendar year, or, if not available for 2016, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
   i. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

HMO/POS	None
PPO/Indemnity Business	None

   ii. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	N/A
PPO/Indemnity Business	N/A

b. Please answer the following questions regarding APM expansion.
   i. How is your organization increasing the use of APMs? Are you expanding the participation in risk contracts to providers other than primary care providers (e.g., hospitals, specialists, behavioral health providers) or into new product types (e.g., PPO)?

The One Care and SCO programs operated by CCA are significant components of MassHealth's commitment to APMs. As a fully integrated payer/provider, CCA operates with capitated, monthly payments from both MassHealth and the Centers for Medicare and Medicaid Services (CMS) and are responsible, and at risk, for all of the health care needs of our members. As a fully integrated payer/provider, CCA itself is the recipient of APMs from the state and federal governments, and we see significant value resulting from this financial and clinical alignment approach.

In addition to receiving APMs from MassHealth and CMS, CCA pays many providers through alternative arrangements. For example, more than 20% of our One Care members are managed through one of several sites that operate as One Care delegated care management sites ("Health Homes") for CCA in return for which the sites receive per-member per-month (PMPM) care management fees. In addition to the premium-based, risk stratified care management fee, Health Homes have the opportunity to earn additional revenue based on performance on operational and utilization metrics aligning with CCA's global quality withhold incentive and care management/cost management goals. Measures target inpatient hospital admissions, post-discharge follow-up with members, and timeliness of annual assessments. CCA also expanded this partnership in 2017 to include a new up-side only shared savings opportunity tied to medical expense ratio. We continue to closely monitor the Health Home APM approach and modify it based on data and partnership experience.

CCA also contracts with primary care sites for care management and service decisions for approximately 30% of CCA's SCO membership. These sites have an established track record of providing care to frail seniors. Three of these sites operate PACE (Program of All Inclusive Care for the Elderly) programs. Our contractual arrangements with these sites range from (1) full financial risk to partial risk relationships against Medical Expense Ratio targets to (2) upside bonus eligibility only. Some of our sites are paid a primary care capitation payment while the others are paid fee-for-service for primary care.

CCA also has developed contracts with two of our largest independent primary care practices in the One Care program to incorporate utilization and quality incentives aligning with CCA's goals. The measures focus on appropriately managing emergency department and inpatient hospital admissions and readmissions, as well as HEDIS measures related to the management of chronic illness.

Across our partner network we are working to identify opportunities for enhanced financial alignment through the adoption of APMs, as we view this as a critical component to appropriately aligning incentives in the care of our members. Our provider partners are situated in a variety of positions relative to their ability to manage APM (small scale, ability to manage clinical and financial aspects of risk), and we are working to position provider partners on a trajectory from targeted performance-based incentives, to one-sided risk arrangements (shared savings), to, where appropriate, two-sided risk arrangements (shared risk, including downside). This is a core and growing component of our contracting strategy.

ii. What are the top barriers you are facing and what are you doing to address such barriers?

The challenges that CCA faces as barriers to expansion of APMs are similar to those across the Massachusetts and complex care markets, namely: 1) lack of sufficient risk adjustment methodologies, 2) sample size and population volatility, and 3) lack of community-based capacity for management of financial risk.

1. **Lack of sufficient risk adjustment methodologies for individuals with most complex needs**: CCA's capitated premium based on MassHealth rating categories and Medicare risk scores does not keep pace with expenses for members who have significant social determinants-driven complexity. For example, many of CCA's homeless or marginally-housed members have elevated rates of inpatient admissions and emergency department utilization, and elevated medical expenses. Further, as such members are often challenging to find and engage, our care teams often expend significantly more resources trying to provide outpatient services to them. Most conventional risk adjustment methodologies by design do not have high fidelity at the upper margins of complexity and cost. Where the vast majority of dually-eligible individuals (and other populations with complex needs) are reflective of those margins in any distribution, the insufficiency of these tools has profound impacts on CCA's ability to provide financially viable care to complex populations. The application of a risk adjustment methodology that better accounts for social determinants of health and ensures appropriate premium allocation – for both One Care and SCO programs - will be a key factor in facilitating success and expansion of APMs.

2. **Sample size and volatility**: A challenge CCA encounters in furthering financial alignment and expanding risk arrangements to some of our delegated community partner sites is the relatively limited membership for some community partners. Volatility in utilization and cost make it difficult to reliably measure performance and to expand risk arrangements with such partners. Tight alignment of APM methodologies across health care programs may allow providers to more effectively balance risk across different payers.

3. **Lack of community-based capacity**: A significant barrier to APM spread is also the technical capacity of community based providers to manage the operational and financial aspects of risk arrangements. Lack of care management technologies, financial management strategies that incorporate risk planning, and sufficient financial reserves that allow providers to bear risk continue to be barriers to entry.

iii. Currently, most APM contracts pay providers on a FFS basis with reconciliation at the end of the year. Is your organization taking steps to move payment toward population-based models (e.g. capitation) and away from FFS as the basis for the APM contracts?

☒ Yes ☐No

If no, why not? Yes. As noted in Section 7.b.i. above, across our partner network CCA is working to identify opportunities for enhanced financial alignment through the adoption of APMs. CCA's provider partners are situated in a variety of positions relative to their ability to manage APMs (small scale, ability to manage clinical and financial aspects of risk), and CCA is working to position provider partners on a trajectory from targeted performance-based incentives, to one-sided risk arrangements (shared savings), to, as appropriate, two-sided risk arrangements (shared risk, including downside).