2015

ARIZONA SUMMER STATE-OF-THE-STATE

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PROVIDERS

HEALTHCARE CHANGES

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CONNECTS THE ARIZONA
HEALTHCARE COMMUNITY

32ND EDITION

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2015 ARIZONA SUMMER

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THE HERTEL REPORT

June 2015

Dear Friends and Colleagues,

Welcome to the 32nd Arizona State-of-the-State.

Thank you for choosing The Hertel Report (THR) as your trusted resource for news and information impacting the Arizona healthcare industry. THR is proud to follow in the footsteps of Jim Hertel, founder of the Arizona Managed Care Newsletter and former State-of-the-State host and sponsor.

As the publisher of The Hertel Report, I'm responsible for ensuring the information you receive on THR's website, monthly newsletter, data editions and this State-of-the-State is timely, accurate and impartial. With three decades in the healthcare industry and a passion for healthcare policy, I'm equally committed to encouraging professional collaboration and dialogue on the important topics facing the healthcare industry today.

During this morning's presentation we're excited to provide you a Medicare & AHCCCS industry update, an opportunity to explore how Accountable Care Organizations (ACOs) are growing in Arizona and how the new Regional Behavioral Health Authority is progressing in the state.

ACOs are accelerating the pace of change across the country, and Arizona is leading the effort. The Affordable Care Act encourages the healthcare industry to create organizations designed to improve quality and reduce costs for the traditional Medicare population. Arizona has one of the 19 remaining Pioneer ACO's and 11 Medicare Shared Savings ACO's. The Medicare ACO's are the focus of today's panel discussion. We have Medicare ACO leaders from across the state joining us to share information and data with us.

Integrating behavioral and physical health is the impetus behind the new Regional Behavioral Health Authority (RBHA) structure in Arizona. The new RBHA in Maricopa County, Mercy Maricopa Integrated Care (MMIC), has been delivering coordinated care for five months now, and we will hear a progress report from Jennifer Sommers, Director, Network Development & Contracting at Mercy Care Plan and MMIC.

My thanks to Jennifer and the representatives of our state's leading Accountable Care Organizations, as well as my friend and colleague Steve Rees for joining me in today's discussion. We encourage you to be a part of the discussion, too.

Thank you for joining us today.

Jim Hammond
CEO/Publisher
The Hertel Report, LLC

Continue the conversation as a member of The Hertel Report at www.thehertelreport.com or contact us at admin@thehertelreport.com

STATE OF THE STATE 2015

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When it really matters, the people, products and services that Coram provides can have a lasting positive impact on people's lives. As an industry leader in home infusion services and as a division of **CVS Health**, Coram cares for patients through a national network of more than 85 locations and over 65 ambulatory infusion suites. We provide infusion therapies and services to over 20,000 patients each month, supporting care through all phases of their healthcare continuum.

Comprehensive Infusion Services:

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- Alpha-1 therapies
- Hemophilia services
- Pain and palliative care
- Ambulatory infusion suites
- Clinical and compliance monitoring
- Patient counseling and education

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Patient Satisfaction
Press Ganey, Inc., 2014

24x7
Access to Clinicians

Serving
20,000
Patients a Month

A Name You Trust

With over 30 years of experience providing infusion care, Coram employs a dedicated staff of more than 1,100 clinicians to manage patients with complex infusion needs. We know that infusion care provided in the home or at an alternate site infusion suite can help promote better health and an improved quality of life. And that's good for everyone!

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Arizona Foundation

Connecting People to Healthcare

About Arizona Foundation

Arizona Foundation is an independent, not-for-profit Preferred Provider Organization. Originally established by physicians in 1969 as an alternative to health maintenance organizations, we have grown into Arizona's largest statewide, independent network by providing highly-accessible, quality care.

We work directly with brokers, consultants, general agents, third party administrators, and insurance companies to provide the freedom of choice by offering and/or endorsing a variety of healthcare solutions.

Our Workers' Compensation Plan, Foundation Comp, was designed for self-funded employers and workers' compensation carriers. Foundation Comp offers its clients aggressive discounts and the largest, most accessible network of hospitals, occupational health medical centers, urgent care centers, physical therapy centers, and outpatient surgery centers, as well as a comprehensive network of physicians.

To help control the rising costs of healthcare, Arizona Foundation - through our strategic partnerships - has compiled a comprehensive package of nationwide Medical Management services and Wellness Programs that include:

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- Disease Management
- 24-hr Nurse Care Line
- Maternity Management
- Telephonic Medicine

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Navigating the Healthcare Industry

About VyStream

VyStream - was established in Phoenix, Arizona in 1988 as a "one-stop-shop" medical billing repricing clearinghouse. VyStream utilizes its own proprietary repricing system that is maintained internally. Since its inception over 25 years ago, VyStream has expanded its services to include Medicare-Like Rates Repricing, Chiropractic Cost Containment, and Digital Imaging. VyStream has the experience and our service is impeccable.

Our repricing process is one of the most efficient and accurate in the industry. We have a 99% accuracy rate thanks to our multiple levels of system and quality control measures that are built into our process. With an average turn-around-time of 1 hour, we are able to Auto-Adjudicate over 90% of our claims.

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Health Choice Preferred is a physician-led, non-exclusive accountable care organization (ACO) focused on delivering value to our patients and partners by providing high-quality integrated healthcare services. With ACOs operating in four states, **Health Choice Preferred** is one of the largest and most established commercial value-based care organizations in the southwestern United States.

Using **Health Choice**'s extensive portfolio of population health and care management capabilities as our platform, **Health Choice Preferred** provides the framework for physicians and health systems to work collaboratively to manage patient care and engage in innovative contracts that reward high-quality, cost-efficient performance.

Humana's approach to value-based healthcare

Focused on improved care, improved population health, and lower care costs

"The partnership with Humana allows Iora to help improve the lives of seniors in Phoenix and Seattle. Seniors deserve care matched to their specific needs and Iora's people-first primary care operating system helps do just that. We're thrilled to partner with Humana to continue to restore humanity to health care."

– Rushika Fernandopulle, M.D., M.P.P.
CEO and Co-Founder of Iora Health

Humana has a 26-year Accountable Care relationship history with more than 1.3 million members that are cared for by 42,000 primary care physicians, in more than 900 Accountable Care relationships across 43 states and Puerto Rico.

- 26 years of diverse accountable care expertise
- Primary-care centric
- Capabilities that support population health

For more information, visit Humana at Providerengagement@humana.com.

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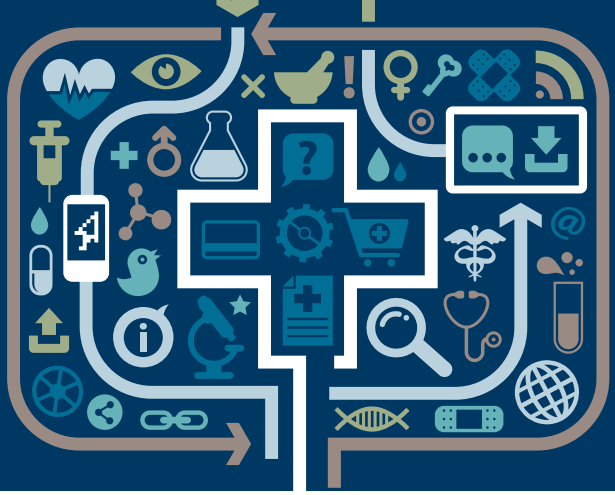

Our expertise helps optimize results for health payors

In today's constantly shifting healthcare landscape, Milliman consultants help healthcare organizations navigate policy and market changes. We offer clients the deep knowledge they need in today's environment, with unparalleled industry experience in actuarial science, pricing analysis, policy developments, and regulatory matters.

Milliman brings substantial experience in healthcare financing and delivery. We advise clients on a wide range of issues—from assessing the impact of healthcare reform on organizations and populations to streamlining operations. We work with organizations to better price premiums, work with complex regulations, and win bids with state and federal agencies. Ultimately, we help clients improve profitability while advancing the quality of patient care. Our services include:

- **Medicare Advantage pricing and actuarial management.** We conduct the actuarial work to price and model various benefit packages for Medicare Parts C and D, Part D standalone plans, and dual Special Needs Plans (SNPs). Our work includes financial analysis, projections, and scenario testing. We also guide clients through the complicated and cumbersome process of bid development.
- **Medicaid pricing and financial projections.** We help carriers navigate the requirements of each state in which they do business, including those of the Arizona Health Care Cost Containment System (AHCCCS) and similar programs in other states.
- **Traditional actuarial support for ongoing health plan operations.** For large HMOs, we provide actuarial departments with the necessary support work they need, including valuations and pricing analysis.
- **State licensure and regulatory requirements.** For start-up health plans looking to get licensed or existing plans looking to expand to other states, we are expert at meeting the mandated actuarial requirements. We help clients navigate challenging filing requirements, including those for managed care plans, such as the Knox-Keene licensing process in California.
- **Pharmacy benefit manager (PBM) consulting.** We help health plans assess the value and efficacy of PBM services and related issues, including formulary composition, contracts with pharmacies, and discounts with manufacturers.
- **Provider contracting consulting.** We help physician groups, independent practice associations (IPAs), and provider organizations negotiate with health plans on contracting and financial analysis. We work to ensure that the structure of contracts is fair and reasonable, helping develop realistic compensation and risk-reward mechanisms. We also assist in negotiating equitable division of financial responsibility (DOFR) between providers and health plans.
- **Correctional healthcare.** We assist various correctional healthcare systems to better manage utilization of services and cost containment through routine actuarial work, including pricing, pro-forma projections, and extensive trend analysis. We also help institutions with requests for proposals and evaluation of bids.

We help health plans estimate pricing and the financial impact of the ACA and the law's developments.

The Patient Protection and Affordable Care Act (ACA) has dramatically changed the marketplace in ways that are difficult to predict. We use models that address the extraordinary complexity of the law, and have helped a variety of carriers in several states to develop rates for individual and small-group plans.

To learn more, contact:

Tom Snook
tom.snook@milliman.com

Jon Hendrickson
jon.hendrickson@milliman.com

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The Arizona Care Network advantage

CHANGING THE WAY ARIZONA EXPERIENCES HEALTH CARE

Arizona Care Network's healthcare providers are working together to bring you the highest quality care, and a better patient experience. Our team is passionate about improving healthcare and putting your health needs first.

- Over 3300 providers practicing in over 750 locations ready to care for you and your family.
- More than 900 Primary Care Providers and 2300 Specialists, including over 300 General Pediatricians and over 80% of local Pediatric Specialists
- 13 Acute Care/Specialty Hospitals and 2 Children's Hospitals
- 39 Urgent Care/ Emergency Centers and 24 Retail Clinics
- 37 Imaging Centers
- Nearly 60 Hospice, Home Health and Skilled Nursing Facilities

Three nationally-recognized health systems coming together to serve you.

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Dignity Health

Arizona General Hospital • Arizona Orthopedic Surgical Hospital • Chandler Regional Hospital • Mercy Gilbert Medical Center • Oasis Hospital • St. Joseph's Hospital & Medical Center • St. Joseph's Westgate

Phoenix Children's Hospital

Phoenix Children's Hospital • Phoenix Children's at Mercy Gilbert

ACN | Arizona Care Network

For more information about Arizona Care Network, go to **www.azcarenetwork.org.**

Rev. 05 01 2015

CareCore NATIONAL | MEDSOLUTIONS

For more than two decades, CareCore and MedSolutions separately built strong businesses on the foundation of providing better quality, while lowering healthcare costs. Now, these two leaders are merging to provide our clients the very best of both companies, as the market leader in comprehensive Specialty Benefits Management.

AS 1 COMPANY

Together we combined each company's strengths. This creates greater capabilities to deliver lower costs in an evolving healthcare environment. The combination enables us to offer a more comprehensive portfolio of solutions that deliver measurable value while improving the quality of care for Americans.

Together we increased size and scale. Our deep experience allows us to continue ensuring a high level of service continuity to you, while positioning us to further your progress towards achieving your short- and long-term goals.

Together we provide even more innovative solutions across the entire healthcare continuum. We can operate at even greater efficiency, bringing a broader range of solutions to our clients, providers, and ultimately your members. Our comprehensive portfolio includes:

MOLECULAR AND LAB
includes both a comprehensive and updated genetic testing policy library and policy delivery portal

MEDICAL ONCOLOGY
utilizes disease-specific pathways to optimize clinical and financial outcomes by ensuring clinically appropriate treatment is received

RADIATION THERAPY
addresses a patient's specific disease state, stage, and treatment goals along with the entire episode of care

RADIOLOGY
decreases the use of unwarranted tests and exposure to unnecessary radiation

MUSCULOSKELETAL AND THERAPY
engages board-certified physicians in orthopedics, physical medicine and rehabilitation, spine surgery, and pain management

POST-ACUTE CARE AND BUNDLED PAYMENTS
helping patients to receive the right care in the right setting after a hospital stay: improving health outcomes, reducing readmissions, and lowering the overall cost of care

CARDIOLOGY
leverages innovative information technologies, unparalleled data management systems, and evidence-based clinical pathways

SLEEP
consists of integrated modules of medical necessity review, PAP therapy, PAP compliance monitoring, and network support

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Working together to make our community healthier

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AZ-15-05-18

Cancer Treatment Centers of America® Leads the State In Integrative Care

Cancer Treatment Centers of America® (CTCA) in suburban Phoenix, Arizona is revolutionizing oncology treatment. This innovative treatment center combines leading–edge treatments including chemotherapy, radiation and specialized surgery. Our traditional treatments are supported by scientically supported integrative therapies, including nutrition, naturopathic medicine, mind–body medicine, spiritual support, massage therapy, acupuncture, oncology rehabilitation and chiropractic care.

All of these therapies, as well as comprehensive digital imaging and lab services, are provided under one roof, while maximizing eciency and coordination of care and minimizing stress on patients. CTCA® is also the nation's 1st all digital cancer hospital.

We believe in providing the Mother Standard® of care in the delivery of that treatment. Choosing the right treatment facility is one of the most important decisions a patient and their caregivers will make. At CTCA, our highly trained healthcare professionals utilize state of the art technology and scientically supported complementary medicines, resulting in optimal comprehensive cancer care. Each day, cancer patients travel to CTCA from across the nation to receive care from a team of highly–skilled clinicians and physicians with expertise in treating all forms and stages of cancer. The hospital's travel program assists qualifying patients with expenses incurred while traveling for care. Upon arriving at CTCA, patients receive an individualized, comprehensive treatment plan developed by cancer experts across multiple disciplines who work together as a team.

Advocating for patient empowerment through health literacy, CTCA publishes on their website quality of life data and survival outcomes for the most common cancer types. To learn more about the unique, integrative treatment options available at CTCA, or to speak with an Oncology Information Specialist for more information, visit cancercenter.com or call 888–214–9488.

"I joined CTCA from MD Anderson because all of my research and work has been motivated by the thought of giving patients every option to beat their disease."

NATIONAL DIRECTOR OF MEDICAL ONCOLOGY
Maurie Markman, MD
Specialty: Medical Oncology
Years Practicing: 25 years
Medical School: New York University School of Medicine

"Memorial Sloan-Kettering gave me a solid foundation and better prepared me to practice at a cancer center with an integrated team of oncologic specialists. "

RADIATION ONCOLOGIST
Lanceford M. Chong, MD, MPH
Specialty: Radiation Oncology
Years Practicing: 21 years
Medical School: University of California, San Francisco School of Medicine

"Our Patient Empowered Care® model puts the patient at the center of a team of highly motivated oncology care providers, giving the patient more time with their providers, improving communication, and offering a high level of care and convenience for the patient."

DIRECTOR OF NATUROPATHIC MEDICINE
Shauna Birdsall, ND, FABNO
Specialty: Naturopathic Medicine
Years Practicing: 15 years
Medical School: National College of Natural Medicine

"At CTCA, our highly trained healthcare professionals utilize state of the art technology and scientifically supported complementary medicines, resulting in optimal comprehensive cancer care."

Matt McGuire
President and CEO
CTCA, Phoenix

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State of the State

Summer 2015

AGENDA

- Introductions
- Headline News
- Medicare Update
- AHCCCS/RBHA update
- ACO Panel Discussion
- Closing Comments

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News Tweet

SCOTUS Hears

King vs. Burwell

Ruling on subsidies for citizens of states using healthcare.gov is crucial to ACA's success

News Tweet

Congress passes by landslide and Obama confirms new law

Medicare Access and CHIP Reauthorization Act of 2015

Medicare Access and CHIP Reauthorization Act of 2015

- **Bipartisan vote to repeal and replace the SGR**
- **Commitment to Value-based payment systems**
- **.5% increase for 5 years.** FFS revenue tied to quality
- Quality definition includes resource use
- Increased burden to track, report, improve Q
- 5% bonus for APM's
- **Higher premiums for wealthy. No first dollar coverage for Medicare Supplements**
- **CHIP expansion 2 years**
- ICD-10 unchanged

Medicare Access and CHIP Reauthorization Act of 2015

- Two Tracks
  - MIPS – Merit-based Incentive Payment System
    - MU, PQRS, VBM combined 2019
    - Budget-neutral adjustments
    - Incentives for Quality and Resource use
  - APM – Advanced Alternative Payment Model
    - Significant share of provider revenue in two-sided risk
    - 5% bonus and exemption from MIPS*

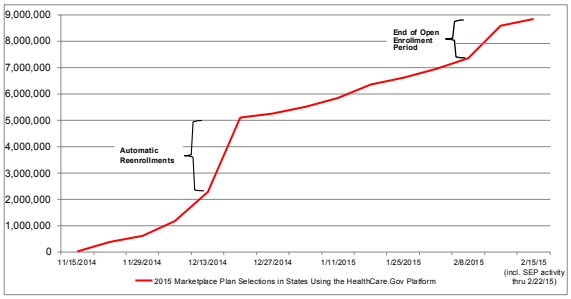
AHCCCS and RBHA Update

- AHCCCS Hot Topics
  - Growth
  - Move to value-based, shared savings or Risk Models
- RBHA Update
  - Jennifer Sommers, Director of Network Development and Contracting

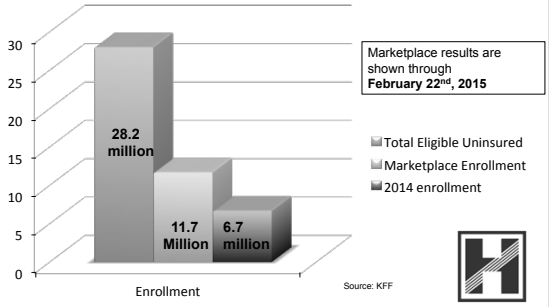
The Cornerstones of the ACA

.....Decreasing the Uninsured

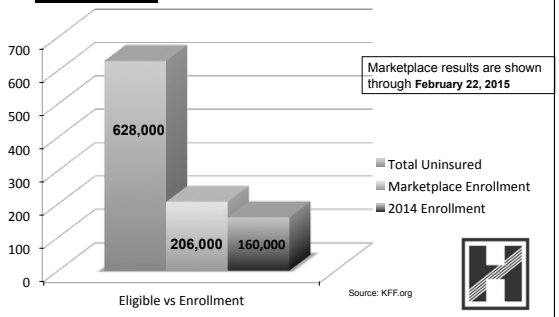
FFM Enrollment



National ACA HIM Enrollment



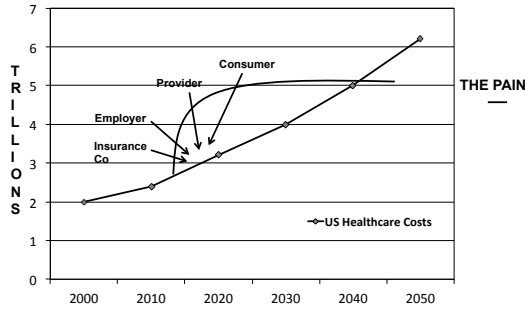
Arizona ACA FFM Enrollment



The Cornerstones of the ACA

…….Bending the Cost Curve

Bending the Cost Curve

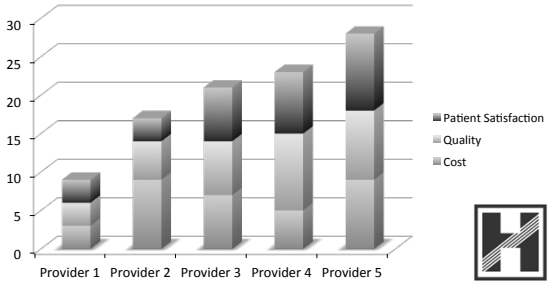


The Triple Aim

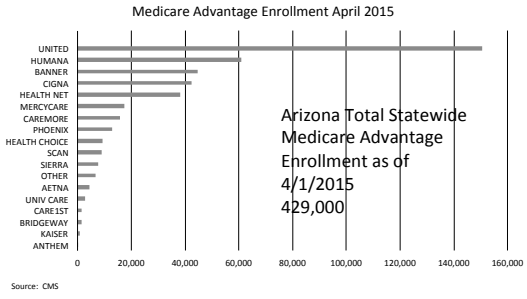
- Improve Quality
  - Measure Appropriate Data
  - Improve Patient Satisfaction
- Reduce Per Capita Cost
- Improve Patient Satisfaction

= effective Population Health Management

Provider Performance Metrics



Medicare Advantage



Arizona Total Statewide Medicare Advantage Enrollment as of 4/1/2015
429,000

Arizona Medicare ACO's

ACO	Start Date	Ownership/Structure Service Area	PCP's	Attributed members/ #Beneficiaries
Banner Health Network*	1/1/2012	Banner Health Maricopa and Pinal	NR	80,000
Arizona Care Network	1/1/2012	Dignity Abrazo Arizona	393	32,000
Yavapai Accountable Care	1/1/2012	Independent Physicians Yavapai and Coconino	NR	5,000
Commonwealth PCACO	1/1/2012	Independent PCP's Arizona, New Mexico	250	43,333
Arizona Connected Care	4/1/2012	Community Providers, TMC Southern Arizona	NR	7,200
Arizona Priority Care	7/1/2012	Privately Owned - IPA Model Maricopa	70	8,500
Lincoln ACO	7/1/2012	JC Lincoln Health Phoenix Metro	140	12,000
Yuma Connected Community	1/1/2013	Yuma IPA Physicians Arizona	NR	5,000
Premier	1/1/2014	Independent Physicians Lakewood CA	NR	5,000
Scottsdale Health Partners	1/1/2014	SHC & SPO Maricopa	100	15,000
ASPA-Connected Care	**1/1/2015**	**Independent Physicians Arizona, New Mexico**	**30**	**5887**
North Central AZ Accountable Care	**1/1/2015**	**YRMC, NAH, Affiliates Yavapai & Coconino**	**54**	**10,800**

*Pioneer Model

ACO Panel Discussion

- Introductions
- Ownership models, funding, stark waivers
- Hospital and hospitalist relationships
- EHR conversion- interoperability
- Specialty attribution
- New Generation ACO plans
- Unique patient population health management or cost reduction efforts

Q & A

Closing Comments

THE HERTEL REPORT

Thank You for Your Attendance and Continued Support

Have a Great Day!

The Hertel Report

Remember to visit our new website at:

www.thehertelreport.com

Be part of our elite membership and sign up today for regular market news updates and exclusive reports!

AFFORDABLE CARE ACT AZ

2015 by the numbers

205,666 Health Insurance Marketplace enrollments (as of March 2015)

+

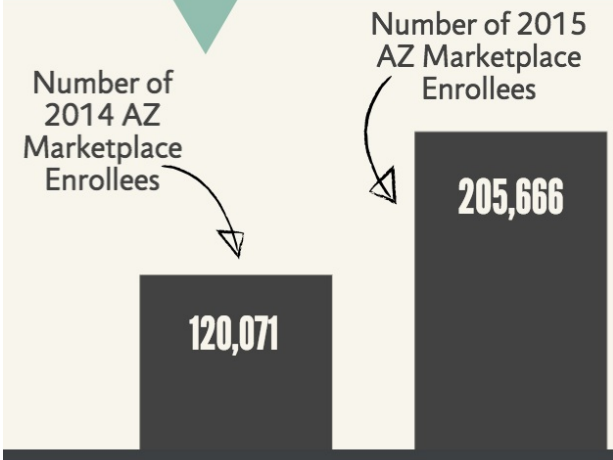
268,391 AHCCCS enrollments (as of May 2015)

=

474,057 Total enrollments in AZ related to the Affordable Care Act

Nearly **7 times** the population of Flagstaff

MARKETPLACE ENROLLMENT



71% growth of enrollment in Arizona from 2014 to 2015

64% growth of enrollment nationally from 2014 to 2015

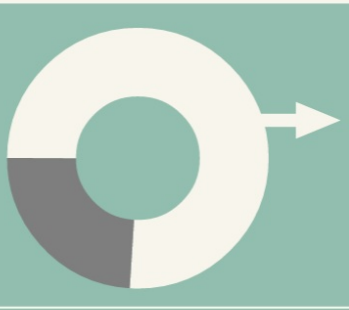
33% of Arizona's potential marketplace population enrolled for health coverage.

ENROLLMENT DEMOGRAPHICS

Among all Arizona Marketplace signups:

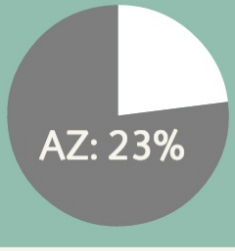
52% were new to the Marketplace

were **48%** re-enrollees



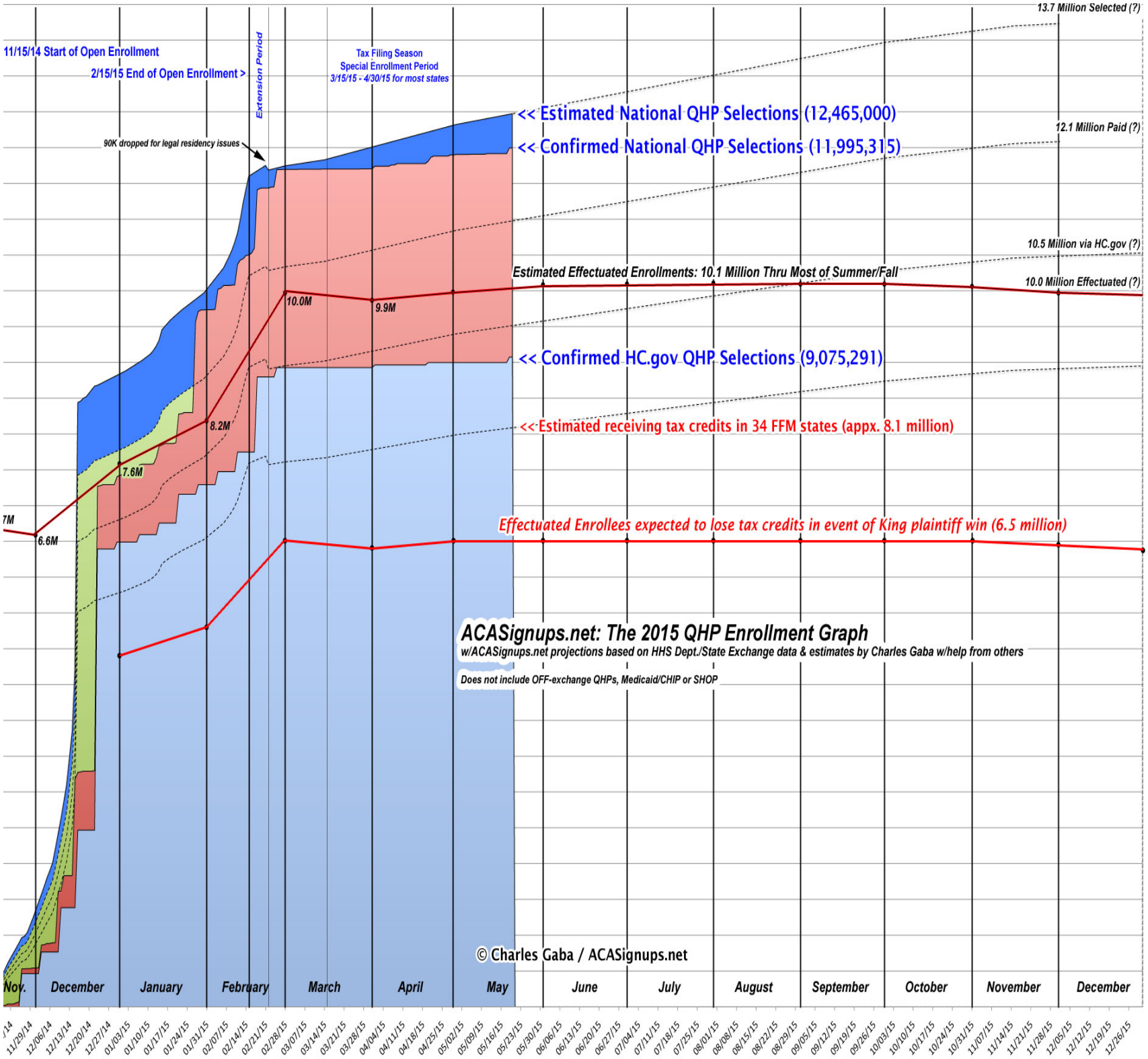
76% of AZ marketplace enrollees received financial premium assistance

Nationally, Arizona has the largest percentage of children (0-17) enrolled in the marketplace



Sources:
The U.S. Department of Health and Human Services.
The Arizona Health Care Cost Containment System.
The Kaiser Family Foundation.

Infographic by
St. Luke's Health Initiatives


11/15/14 Start of Open Enrollment
2/15/15 End of Open Enrollment >
Extension Period
Tax Filing Season
Special Enrollment Period
3/15/15 - 4/30/15 for most states
90K dropped for legal residency issues
<< Estimated National QHP Selections (12,465,000)
<< Confirmed National QHP Selections (11,995,315)
13.7 Million Selected (?)
12.1 Million Paid (?)
10.5 Million via HC.gov (?)
Estimated Effectuated Enrollments: 10.1 Million Thru Most of Summer/Fall
10.0 Million Effectuated (?)
10.0M
9.9M
<< Confirmed HC.gov QHP Selections (9,075,291)
8.2M
<<Estimated receiving tax credits in 34 FFM states (appx. 8.1 million)
7.6M
7M
6.6M
Effectuated Enrollees expected to lose tax credits in event of King plaintiff win (6.5 million)
ACASignups.net: The 2015 QHP Enrollment Graph
w/ACASignups.net projections based on HHS Dept./State Exchange data & estimates by Charles Gaba w/help from others
Does not include OFF-exchange QHPs, Medicaid/CHIP or SHOP
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Nov.
December
January
February
March
April
May
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August
September
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November
December

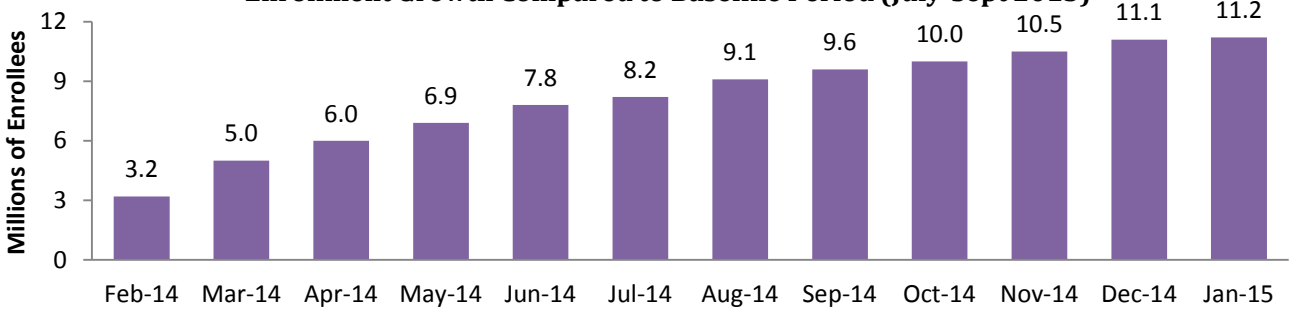
MEDICAID ENROLLMENT AND THE AFFORDABLE CARE ACT

March 20, 2015

Medicaid Enrollment – The Affordable Care Act allows states to receive federal matching funds to cover 100% of the cost (until 2016) of expanding Medicaid coverage to non-elderly, non-disabled adults up to 133% of the federal poverty level (FPL), including parents and childless adults. To reduce the number of uninsured in their state and to improve the health status of their residents, 28 states and the District of Columbia have expanded Medicaid coverage.

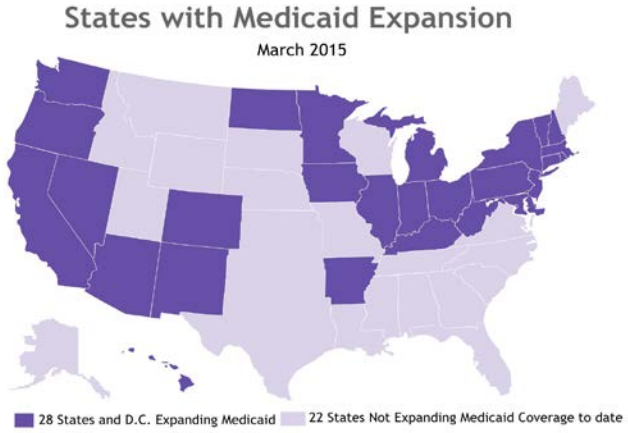
Since the Medicaid expansion took effect, there has been an increase in Medicaid enrollment with larger increases in states that have expanded Medicaid coverage as compared to those that have not (26 percent vs 8 percent). Medicaid enrollment has grown from 57.8 million enrollees in the baseline period (July-Sept 2013) to 70.0 million enrollees in January 2015, which represents a 19.3% growth in enrollment. The chart below shows the monthly change in enrollment compared to the baseline period.

Enrollment Growth Compared to Baseline Period (July-Sept 2013)



SOURCE: CMCS Monthly Enrollment Reports. All data are based on updated enrollment reports except for January, which are preliminary data. Monthly data are not directly comparable because the number of states reporting data has changed over time and several states have changed their methodology to better match CMS's data specifications. Data only include individuals with comprehensive benefits.

States Expanding Medicaid



- Six states (CA, CT, DC, MN, NJ and WA) expanded Medicaid coverage early – within two years after the passage of the Affordable Care Act (2010-2012). (CO expanded in 2013.)
- Nearly 950,000 individuals in these six states enrolled in Medicaid between the time of their expansion and January 1, 2014.
- As of March 2015, 28 states and the District of Columbia have approved and implemented Medicaid expansions.
- Of the 28 states, five states (AR, IA, IN, MI, and PA) expanded using a Medicaid demonstration.

Reduction in the Uninsured from Medicaid Expansion

- Expansion states had an average uninsured rate of 18.2 percent with a drop of 40 percent (7.4 percentage points). In these states, families with incomes at 138 percent of poverty or less had the largest percentage point drop (13 points).
- Among states that have implemented the Medicaid expansion and were covering newly eligible adults in January 2015, Medicaid and CHIP enrollment rose by over 26 percent compared to the July-September 2013 baseline period. This compares to an 8 percent growth during the same time period among states that have not implemented the Medicaid expansion.
- All states are in the process of implementing the ACA simplifications to the Medicaid and CHIP application and eligibility processes.

States Not Expanding Medicaid

- Enrollment in Medicaid has increased at a much slower pace in the states that have not yet expanded Medicaid coverage to the childless adult and parent populations.
- To date, 22 states have not yet expanded Medicaid coverage.
- In 2015, the average adult eligibility level among states that have not expanded Medicaid coverage is 53% of the FPL for parents of dependent children ($10,600 for a family of 3) and non-disabled, non-elderly childless adults are excluded from Medicaid coverage in all but one these states (WI).
- Non-expansion states had an average uninsured rate of 23.4 percent with a drop of 29 percent (6.9 percentage points). In these states, where they had a higher baseline uninsured population, families with incomes between 139-400 percent of FPL had the largest drop at 10.1 percentage points.

MEDICARE SPENDING GROWTH SINCE 2009

April 15, 2015

How substantial is the slowdown in Medicare spending growth?

From 2009 to 2012, Medicare spending per beneficiary (across Traditional Medicare and Medicare Advantage) grew at an average rate of 1.8 percent annually or less than 1/3 its rate of growth during 2000-2008. There was essentially no growth in Medicare spending on a per beneficiary basis in 2013 (see Table 1).

Table 1. Medicare per Beneficiary Annual Spending Growth Rates

Average Annual Growth	2000-2008	2009-2012	2013
Spending per Beneficiary	5.9%	1.8%	0.2%

Data Source: National Health Expenditure Accounts, Historical Tables
Growth for 2006 excludes growth due to introduction of Part D

We have updated our earlier estimate of Medicare spending growth by including an additional year now that 2013 spending data are available, and we have also included Medicare Advantage (a growing share of the Medicare program). This has resulted in a new estimate of Medicare spending $316 billion less over the 2009-2013 period than would have occurred if the 2000-2008 growth rates had continued through 2013 (Table 2). Our earlier estimate for Traditional Medicare alone was $116 billion in lower Medicare spending over the 2009-2012 period. Putting this into context, Medicare spent $551 billion dollars on benefit outlays in 2013. In other words, the accumulated difference in spending between 2009 and 2013 is equal to 57% of Medicare's benefit outlays in one year alone: 2013.

Table 2. Accumulated Difference in Medicare Spending between 2009 and 2013

Year	Actual Medicare Spending (2009-2013)	Medicare Spending for 2009-2013 Based on 2000-2008	Difference for Total Medicare	Difference for Traditional Medicare	Difference for Medicare Advantage
2009	$471.2	$480.0	-$8.8	-$3.5	-$5.3
2010	$489.2	$520.8	-$31.6	-$16.5	-$15.1
2011	$511.9	$564.8	-$52.9	-$34.7	-$18.2
2012	$532.2	$623.5	-$91.3	-$61.8	-$29.5
2013	$550.5	$681.8	-$131.3	-$81.5	-$49.8
Total (2009-2013)	$2,555.0	$2,870.9	-$315.9	-$198.0	-$117.9

Data Sources: National Health Expenditure Accounts, Historical Tables (Total Medicare)
Master Beneficiary Summary File (2000-2012 Traditional Medicare)
Medicare Enrollment Records, Common Working File, and Prescription Drug Event Files (2013 Traditional Medicare)
Growth for 2006 excludes growth due to introduction of Part D

How is the accumulated difference in spending calculated?

The difference in Medicare benefit spending in each calendar year between 2009 and 2013 is calculated as the difference between actual spending and what spending would have been if the average per beneficiary growth rate for 2000-2008 had continued through 2013. The 2000-2008 projected trends are calculated for Total Medicare and Traditional Medicare from their specific 2000-2008 growth trends. The Medicare Advantage spending differences are calculated as the residual after subtracting the Traditional Medicare differences from the Total Medicare differences. Annual per beneficiary spending growth rates in the National Health Expenditure data are very similar to those recorded in CBO's baseline estimates for Medicare spending when averaging across years, although individual year data may differ depending on when expenditures are recorded in each data source.

What policies have contributed to the Medicare spending growth slowdown?

- A CBO analysis in 2013 suggests that the recession appears to have played only a small role in reducing Medicare spending.[1] Its analysis estimated the effect of changes in wealth and income due to the recession on Medicare beneficiaries' use of health care services and found that the recession had little effect on the demand for health care services by beneficiaries. Moreover, the slowdown in per capita spending growth began prior to the recession suggesting that other factors have been at play.[2]

- Tying Medicare Advantage (MA) payment benchmarks to Traditional Medicare, and implementing the MA Quality Improvement Program, has created new incentives for MA plans to become more efficient while improving quality.

- The Medicare program is implementing a wide range of delivery system reforms to improve quality and lower costs such as fostering the growth of Accountable Care Organizations and testing bundled-payment arrangements. Initial results from some models suggest some promising impacts on both costs and quality. The Department has set a goal of having 30% of payments tied to quality and value through alternative payment models such as Accountable Care Organizations and bundled-payment arrangements by 2016 and 50% by 2018.

- Outside of these alternative payment models, Medicare is promoting better care coordination among providers by tying payment to value, such as by targeting excess hospital readmissions and hospital-acquired infections, and by adjusting provider payments based on the overall quality of care they provide.

- CMS has consolidated its enforcement efforts, expanded the scope of its program integrity activities, enhanced provider screening, and stiffened the penalties for fraud. The shift to preventing fraud before payments are made is complemented by CMS's use of advanced technology, such as predictive analytics, with a $5 to $1 return on investment. Anti-fraud programs recovered over $27.8 billion between 2009 and 2014, up from $9.4 billion during the prior five years (2004-2008). The CMS Open Payments Program is bringing transparency to financial relationships that physicians and hospitals have with health care manufacturing companies.

- Provider payment updates have been reduced by fixed amounts and adjusted for economy-wide productivity, which reduced updates in the hospital inpatient prospective payment system by approximately one half of one percent in fiscal year 2015. There are similar payment update reductions that apply to other providers except physicians. The competitive bidding program for durable medical equipment, which has already saved $400 million, is being expanded and is expected to save $17.2 billion for beneficiaries and $25.8 billion for the Medicare program over the next ten years.

- These savings to the program are also translating into savings for beneficiaries. For instance, just as there has been little to no growth in per beneficiary spending, Medicare beneficiaries are benefitting from Part B premiums remaining the same for the second year in a row. Premiums for Medicare Advantage plans have fallen nearly 6 percent since 2010.

In Summary

Medicare paid out approximately $316 billion less between 2009 and 2013 than would have occurred had pre-2009 spending trends persisted. This has substantially extended the projected solvency of the Hospital Insurance Trust Fund. Existing evidence suggests that these payment gains are in important part due to policy and administrative actions to improve Medicare's performance. These actions involve delivery system reform efforts as well as administrative actions to ensure prudent use of tax payer dollars.

[1] Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* (Washington, D.C.: Congressional Budget Office, August 2013).
[2] Council of Economic Advisors, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act.* (Washington, D.C.: The White House, November 2013)