Will Federalism Improve the U.S. Health Care System?

Princeton, New Jersey, May 21-23, 2019

Michael Doonan, PhD, Schneider Institute for Health Policy, Director, Council on Health Care Economics and Policy
The Heller School for Social Policy and Management, Brandeis University

Brooke Evans, PhD, MSW, LCSW, CSAC, Assistant Director, Council on Health Care Economics and Policy
The Heller School for Social Policy and Management, Brandeis University

© 2019 Council on Health Care Economics and Policy

The Council on Health Care Economics and Policy would like to thank our 2019 sponsors:

Table of Contents

Conference Opening: Federalism in the U.S. Health Care System

Michael Doonan, Associate Professor, The Heller School for Social Policy and Management, Brandeis University and Executive Director, The Massachusetts Health Policy Forum

Stuart Altman welcomed the conference participants to the 26th Princeton Conference and thanked the generous sponsors.

To open the session, Doonan provided background on American federalism and moderated the discussion. Federalism, he noted, can be understood as a power and authority relationship between the federal government and the states. The founding documents and debates centered on the distribution of power between different levels of government. This early debate led to the creation of the first political parties and how the system was structured. Federalism, according to Doonan, remains political and is still hotly debated today.

Doonan provided four take away messages surrounding federalism:

1. Positions on federalism are more related to interest than to any notion of the proper distribution of power.
2. Conservatives use or want to use federal power as much as liberals. They just have different goals.
3. Resources, oversight, and administrative expertise at the federal and/or state level influences federalism.
4. States are more innovative when they have federal money to spend.

Doonan then introduced the panelists and moderated a lively discussion regarding federalism in U.S. health care policy.

Stuart M. Butler, Senior Fellow, Economic Studies, The Brookings Institution

Butler argued that federalism is an important tool for testing ideas and being responsive to state differences. He pointed to the example of welfare reform where ideas were initially generated at the state level, with some later being nationally implemented.

Cindy Mann, Partner, Manatt, Phelps & Phillips

Mann agreed that states have a role in testing innovations. She went on to discuss how different levels of government have a comparative advantage in certain areas. The federal government, for example, can deficit spend during economic downturns. States do not have this luxury, however, which often creates different priorities. She cautioned that federal oversight is necessary to ensure that states spend resources on the goals and objectives of federal programs.

Discussion

During the discussion, there was agreement between the panelists that flexibility between regulatory corridors could lead to innovation and better programs. The speakers, however, differed in their views on how wide or narrow to set these parameters. The conversation then moved to the politics of federalism. As the nation becomes more politically polarized, federalism is increasingly being used as a tool to forward policy interests and to fight for beliefs at various levels. The current debate—and how state and national efforts differ—surrounding abortion rights illustrates this type of a battle.

The discussion uncovered considerable debate on intergovernmental relations, including the Medicaid program and state waivers. Waivers can change policy, and often disproportionately reflect the ideological preferences of the

administration (and political party) in power. Butler supported wide innovation, but also argued for the importance of oversight—perhaps from an independent board. Mann noted that flexibility should be restricted to the goals of the program and historical protections.

Welcome

Stuart Altman, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Altman opened the first morning of the 26th Princeton conference by thanking the 2019 sponsors. He also set the stage for how the conference sessions were organized and the theme of federalism playing through each session.

Pamela S. Dickson, Associate Executive Vice President, Robert Wood Johnson Foundation

Dickson welcomed conference participants to the Robert Wood Johnson Foundation (RWJF) and acknowledged the long-time connection and association between the Princeton Conference and the RWJF. In her welcome, Dickson touched on the Foundation's focus on the *culture of health*. This culture includes an acknowledgement of the complex factors that influence health. Dickson spoke of the RWJF vision of promoting opportunities to strengthen communities and supporting all people in living their happiest, healthiest lives. This goal requires that everyone works together. Dickson added that when striving toward a culture of health, it is critical to focus on what happens outside of the health care system.

Session I: Washington Update

Stuart Altman, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Altman introduced each of the panelists and the perspective that they would discuss. He also moderated the discussion and probed into current topic areas.

Melanie Anne Egorin, Deputy Health Staff Director, Committee on Ways and Means

Egorin discussed recent activities in the Democrat controlled House of Representatives. One critical goal of House Democrats, she mentioned, is to strengthen the Affordable Care Act (ACA). This includes more than the exchanges and Medicaid expansion. A recent action was the first vote to allow the House to be part of the Texas lawsuit focused on pre-existing conditions. The constitutional oversight responsibilities of the Congress go far beyond what is in the news—to how programs are operating and/or could be improved. Congress is also working on prescription drug pricing regulations, community health center funding, disproportionate share hospital (DSH) payments, price transparency, and having conversations about incentivizing health care value.

Universal coverage, under the title of "Medicare for All," is another focus, although there is no clear consensus on what this means. The goal is how best to reach affordable universal coverage where everyone benefits and finds value. Egorin noted that there could be bipartisan action on surprise billing, as well as additional efforts to more fully address the opioid crisis. She also discussed social determinants of health, including their role with dual eligible populations and the issue of maternal mortality. Even though racial and cultural differences are hard to talk about, these conversations are happening in the House.

Thomas Barker, Partner, Foley Hoag, LLP

Barker, who previously worked for the Secretary of Health and Human Services Alex Azar, offered his perspective on the Administration. He suggested the possibility of action on drug pricing, surprise billing, transparency, hospital reimbursement issues, and Medicaid. He discussed strong Administration support for reducing drug costs and noted that there could be bipartisan action in this area. The Administration's year-old drug pricing blueprint requires price disclosure in pharmaceutical advertisements, an international price index, changing the rebate, and certain design restructures for Medicare Part D.

Further, multiple bipartisan proposals and hearings have been held on the issue of surprise medical billing. National efforts are essential, he mentioned, as the Employee Retirement Income Security Act (ERISA) prevents states from fully addressing the issue. More transparency is needed to understand the master price, negotiated prices, bundled prices, and the price charged to different payers.

Barker discussed how the Administration is becoming increasingly aggressive with Medicaid waivers, including work requirements and allowing federal matching funds for states to partially expand ACA Medicaid coverage. Finally, Barker predicted continued regulatory change out of Health and Human Services (HHS). It may also be possible to achieve bipartisan support for addressing high drug prices and addressing Medicaid DSH payments in light of the ACA cuts in the DSH caps that are scheduled to take effect on October 1, 2019. Congressional action on the ACA is likely to be a "sleeper" issue, however, unless the Texas circuit court finds the ACA unconstitutional.

Jennifer Bell, Founding Partner, Chamber Hill Strategies

Bell shared recent activities from the Senate, suggesting that the Senate is where ideas go to thrive or to die. In particular, the Senate is in a position of having experienced health care politicians who know how to work for what they need and want.

She agreed with the other speakers on the possibility of addressing drug pricing, transparency, and surprise billing. However, the Senate is moving fairly slowly and there are no current deadlines or cliffs driving decisions on transparency or other issues. These and similar matters pit interest groups against one another and are difficult for Congress to deal with. Bipartisanship is continuing in some ways, however, which is promising. For instance, Senators Chuck Grassley (R-Iowa) and Ron Wyden (D-Ore.) are working on a drug pricing package that could potentially reach the Senate floor in July 2019. Despite activity, it is difficult to know what real action is possible or what is likely to actually pass this year. Any action will require real discussions between the President, the Speaker, and the Majority Leader.

Discussion

In discussion, it became clear that action is most likely to take place through Administrative rules, waivers and executive orders, rather than through Congress. Exceptions to this might include reauthorization funding for community health centers and fixing DSH payments, which are set to expire. Other discussion topics surrounded rural hospitals, which continue to close around the country, and are of particular concern to the Senate. However, there is no consensus on what to do, and these failures are happening despite increased Medicare funding to rural hospitals. A point discussed across the panel was how health continues to be a top concern of voters but is difficult as a legislative priority in the current political environment. This will continue to be a major election issue going forward.

Session II: Current Issues in the Medicare Program

Paul Ginsburg, Director, USC-Brookings Schaeffer Initiative for Health Policy, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution, and Professor of Health Policy/Director of Public Policy, USC Schaeffer Center

Ginsburg opened and moderated the panel discussing current issues and perspectives on Medicare. He framed the conversation and noted that the session would address three primary topic areas: (1) prescription drug payments, (2) Medicare Advantage, and (3) the growing gap between Medicare and commercial payments to hospitals.

Stacie B. Dusetzina, Associate Professor of Health Policy and Ingram Associate Professor of Cancer Research, Vanderbilt University School of Medicine

Dusetzina described the major spending increases for prescription drugs in Medicare Part B and Part D that have taken place in recent years. While most of the spending for drugs happens in Part D, drugs administered by physicians in Part B are significantly more expensive per drug. Some of the proposals to reign in drug costs include efforts to link prices to an international pricing index, increase the use of step therapy, relocate drugs from Part B to Part D (although this could result in higher cost for beneficiaries), re-classifying rebates as kickbacks, or even adding an out-of-pocket spending cap.

Avenues of reform that may work best, according to Dusetzina, include reference pricing or setting price to align with value. Another option is to provide the Centers for Medicare and Medicaid Services (CMS) the ability to negotiate Part D prices and/or regulate the market. She also discussed how other countries have used cost-effectiveness analysis, based on their willingness to pay and values/priorities, to address spending. There may be important lessons to learn by looking at the value proposition, but currently we lack the data about the value of these drugs. In the end, much of what happens is likely to center on leverage within the system – to manage costs and then the political support to make reform a reality.

Dan Mendelson, Founder, Avalere Health

Mendelson began his remarks by posing the question, “Is Medicare Advantage becoming de facto Medicare reform”? He discussed the steady growth within Medicare Advantage, which now covers over one third of beneficiaries, and is growing at approximately 5% per year. Medicare Advantage offers beneficiaries a choice of a health plan (e.g., HMO, PPO) and is an alternative to the traditional program. Medicare Advantage enrollment has grown across the country, but particularly in urban and high cost areas, in part, because of lower beneficiary costs and its range of flexible benefits. The program has also moved toward paying for quality in a meaningful way, including a range of value-based payment methods (e.g., bundled payments, global capitation), and strong quality programs are necessary to operate a profitable plan. Most plans have employed sophisticated programs to deploy data, predictive analytics, and targeted interventions, to improve quality of care.

Mendelson suggested that more investment is needed to analyze how plans are operating, what is working, and what should be done moving forward to encourage better quality and efficiency. He noted that plans and providers respond to payment systems, so how programs structure their payments are key to improving population health. Medicare Advantage is significantly changing and reforming the Medicare program. Over time, Congress and the Administration also need to build some of these elements into traditional Medicare fee-for-service (FFS). Mendelson said the Centers for Medicare and Medicaid Innovation (CMMI) are working on this, as well as a number of other important innovations, including new approaches to rural and underserved areas.

Stuart Altman, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Altman made the case that commercial hospital payments are what keep hospitals afloat, while Medicare and Medicaid pay significantly less. He shared data regarding 2012 hospital payments, which reported that private insurance pays hospitals 175% of what Medicare pays. In contrast, Medicare pays just 85% of what the costs are, and Medicaid pays even less. By 2017, the average private payments to hospitals (both outpatient and inpatient) were close to 180% of Medicare rates. A recent RAND study on the gap between public and private hospital payments suggests that in a sample of 25 states, private insurers paid hospitals, on average, 240% of Medicare rates. The growing gap between hospital payments affects hospitals differently depending on the state, as well as the type and location of the hospital (e.g., urban, rural, critical access).

Altman asked if we should be concerned. Private insurance companies have become the ATM machines for the rest of the health care system. If Medicare payments continue to be constrained and private payments grow, how might this change access for Medicare patients? Altman was not advocating for higher hospital payments, but he did suggest that it is dangerous to have the only cost constraints in the system come from the public side. More intervention is needed. He further suggested that in the absence of federal action, more states could take a cue from Maryland, Massachusetts, and others that are beginning to think about ways to address total health care spending. The problem, Altman argued, cannot be ignored.

Discussion

The discussion began with more thoughts on an International Price Index (IPI) and the types of mechanisms needed for a proposal like this to move forward. There was both support and opposition to using cost-effectiveness analysis in coverage and pricing decisions. It was suggested that instead of relying on other countries' data, which reflect their own preferences, the United States should invest more in this analysis.

The Medicare Advantage conversation delved into the importance of considering the rising costs associated with Advantage plans. Recent studies demonstrate that, on average, Medicare Advantage receives higher payments than traditional FFS Medicare. This reality impacts areas differently and is a heightened issue in rural areas.

Another idea put forward is that true cost containment would require global budgets and "Medicare for All" type plans. The panel urged caution in shifting trillions of dollars within the health care system. We are not like other countries with global health care budgets. The system has deep roots, and any large-scale modifications are going to have to deal with what exists and be cautious of unintended consequences. That said, the panelists agreed that we have created an unsustainable system in many ways. It was suggested that the ability to make change may be more within the delivery system than with insurance companies. While we may be able to squeeze hospitals in some ways, over time this strategy is not likely to work as not all hospitals are the same in terms of payer mix and market power. The pressure will disproportionately impact some hospitals and not others.

The conversation then moved to state actions, including rate setting in Maryland and global budget targets in Massachusetts and Delaware. In these types of designs, states can use their leverage of Medicaid and state employee coverage and join with other purchasers to increase purchasing power. These may provide examples for national action down the road.

Session III: Twenty Years After 'To Err is Human': Where Next?

Karen Wolk Feinstein, President and Chief Executive Officer, Jewish Healthcare Foundation

Feinstein began with a story about the recent Boeing crisis, which shut the airline system down, led to top company officials needing to take responsibility, and ultimately large-scale change in the industry. In the U.S. health care system, however, more people are impacted than with the Boeing crisis, but there is often a lack of leadership and countless errors in the system go unchecked. Feinstein suggested that hospital board members should act, freestanding safety committees be established, and that whistle blowers be saluted. She provided a call to action, stating that this is the time to align multiple stakeholders who are invested in improving health care to devise a common platform and put forth an action plan.

Michael Millenson, President, Health Quality Advisors LLC

Millenson referenced back to the Boeing analogy, noting that leadership is crucial and must be taken seriously. While an organization's leadership may not deliberately compromise safety, the effect of its actions or sustained inaction can still do so. Millenson noted that in a 2018 Agency for Health Care Research and Quality (AHRQ) hospital safety culture survey, 80% of hospital employees self-reported a "safety culture," although 40% agreed that hospital management seemed interested in addressing patient safety only after an adverse event takes place. That result indicated that safety is not always a priority for hospitals.

Millenson suggested that a safety culture becomes a priority when those who are in charge—like the pilots in the Boeing example—are the first to die. In contrast, very few medical doctors die of errors. The goal for patients should be no less than the idea of the Hippocratic oath, "First, do no harm". In reality, however, Millenson said he, and other experts he's informally surveyed, believe that less than 5% of hospitals have a genuine strategic plan for zero harm. The issue is often not taken seriously. Change and movement in this area is gravely needed.

Carolyn M. Clancy, MD, Deputy Under Secretary for Health for Discovery, Education and Affiliate Networks, Department of Veterans Affairs

Clancy outlined critical safety issues and spoke about Veteran's Administration (VA) actions to move toward a zero-harm policy. Significant problems in all U.S. health care include diagnostic errors, the lack of timely follow up for abnormal tests, fragmented care for opioid and other substance use disorders (SUDs), and delayed or absent referrals to appropriate specialty care. Diagnostic errors are found in about 5% of patients each year, she reported. Common diseases, like cancer or cardiovascular diseases, go unnoticed. Further, there are significant wait times in addressing abnormal lab results and abnormal imaging. The reasons for these problem areas typically relate to workflow, follow up responsibility, information overload, and/or technical issues. The VA's move towards zero harm is changing the conversation.

The VA is working on building learning health care systems designed to identify problems, implement proactive solutions, and measure effectiveness. Accreditors are being used to test error prone systems and determine appropriate courses of action. Further, Clancy reported, the right incentives are needed to encourage employees to uncover problems and work to address and resolve issues. Better involving patients is critical in this process. A redesign of the system is warranted, and should be organized more around patient, rather than provider, needs.

Ken Segel, Managing Director, Value Capture / Value Capture Policy Institute

Segel reported that while there are glimmers of hope, most institutions do not have systems in place to fully address patient safety. Where clear, proven safer practices have been determined, overall, we can give ourselves a "C"

grade as a nation in embedding those across the board, grading generously, Segel said. But beyond those few practices, very few institutions have adequate learning and prevention systems in place. In most cases, Segel noted, when safety issues come to light, they are addressed in segmented, fragmented ways. The systems are disconnected and disjointed. Leadership is required to establish powerful connections between players in complex, high-risk systems that are dynamic. Segel reiterated the importance of a system that is designed to learn and adapt. However, having a system in place in not enough. Information on safety should be readily available, shared, and acted upon. All employees should know the week's incidences and/or near misses, the root causes, and actions to prevent reoccurrences. This requires a daily, weekly, and longer-term understanding of workflows that is built into the system and continually assessed and acted on. To drive such a learning system, management needs to make it the core of their daily standard work to connect all of the pieces together, ensuring that problems are solved and solutions are shared.

The challenge, Segel stated, is that there is no collective move to make such learning systems the required standard. Hospitals do not want to talk about it, and it is challenging to find the political will to move toward a goal of zero harm. Instead, the solution to complex problems often is to "add more stuff" to what already exists, instead of addressing root causes. The alternative needs to be learning systems that strive to be perfect. Further, patients need to be engaged in this effort and be part of the solution. Currently, the lack of transparency and data that is hidden and complicated by design keeps patients and advocates at an arm's length. Segel challenged participants to rethink their approach to lawmaking, regulation and oversight and focus on whether the core capability he outlined—rapid problem solving and learning—was in place and producing evidence of increasing safety, from the front line to the CEO of our health care organizations.

Discussion

In the discussion, panelists agreed that systems need to be held accountable and inspired to take ownership for dramatic improvement, but that this is a difficult undertaking. It is challenging to change people when they believe that what they have been doing all along is correct. The conversation then turned to defining zero-safety. One response was that we need more specific actionable definitions such as "no falls." Everyone knows what this means, systems can be established, and results can be measured. Additionally, there is often a disconnect between responsibility and the authority necessary for change. States can play a role in this area and should make information available on adverse events to foster a culture of transparency.

In closing, Feinstein recapped for the audience that improving patient safety moving forward will require that none of us be a bystander. Everyone needs to be a proud whistleblower. To emphasize this point, conference participants were provided with whistles and the reminder to feel empowered and break out of the bystander role.

Session IV: Medicaid and Federalism

Matt Salo, Executive Director, National Association of Medicaid Directors

Salo opened the session by framing the role of federalism and the Medicaid program. States are the middle name of our country, he noted, and Medicaid is the largest health program and backbone of the U.S. health care system. The Medicaid program is difficult to discuss with federal policy makers, however, because it is incredibly complicated and varies tremendously across states. The program, which was created at the same time as Medicare, was designed in a very different way than Medicare and built to be incredibly flexible. In fact, Medicaid is optional for states, although all states run some level of the program. It operates under the framework of federal rules and structures but leaves a high level of autonomy for states to choose who they cover, what benefits they offer, and how to design delivery system and payment policies. While most of the money spent on Medicaid includes federal dollars, a majority of decisions for Medicaid are made on a state level. As such, Medicaid is politically relevant across the country in state

capitols. To keep the program politically viable, some states may need to consider policy strategies and interventions such as work requirements.

Diane Rowland, Executive Vice President, Kaiser Family Foundation

Rowland posited, should states have the flexibility to build football stadiums with Medicaid dollars? Or is it appropriate that congress has mandated that all states are required to cover all children below poverty on Medicaid?

Rowland reiterated the importance of the Medicaid program and its historical significances in covering some of the most vulnerable. Her main concern was how to balance flexibility for states with the substantial investment of federal dollars and what should be required as national standards for the investment of federal tax dollars. States can do what they wish with state dollars but there should be the obligations on states for the use of federal dollars. For example, it would not be appropriate to use federal Medicaid money to build things like sports stadiums. It is essential that there be appropriate oversight and that the funding and administration be true to the goals and purpose of the program.

The Medicaid program is essential across the country, as Kaiser Family Foundation analyses have continually documented. For many, it is the only support available for long term care and support services (LTSS). Further, 40% of community health center funding comes from Medicaid dollars. Rowland went on to note that as an entitlement program, Medicaid can provide counter-cyclical support to the economy during a recession and that it is also a timely source of revenue for states during national disasters. It provides essential support to address the opioid crisis and early on it helped target the HIV/AIDS crisis. Rowland suggested that proposals like Medicaid block grants would jeopardize the program's role as an entitlement and limit guaranteed funding to the states.

Over time, Rowland reported, the program has moved away from categorical eligibility toward a program based on income standards. The ACA similarly was a move in this direction. Federal waivers traditionally provide an opportunity for states to test ideas and innovations, but they are also increasingly being used to change the program and move away from its core structure in fundamental ways. Questions of federalism center on where the balance is between state flexibility and responsiveness and federal accountability to the goals of the program.

Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services, State of Kentucky

Putnam discussed the evolution of the State of Kentucky's Medicaid waiver. She noted that the overarching goal of the waiver is to drive better health outcomes among state Medicaid beneficiaries. Despite incredibly high spending in the program, health outcomes among beneficiaries were some of the worst in the country, Putnam reported. A cabinet of policy makers and stakeholders found that the program was not working and began to work on solutions for how best to improve Kentucky Medicaid.

Kentucky HEALTH (Helping to Engage and Achieve Long-Term Health) was developed as a strategy to build support elements into Medicaid and address social determinants of health. Another program goal was to help beneficiaries move from Medicaid into private insurance. While the program has been somewhat mischaracterized as solely focused on work requirements, according to Putnam, it is better understood as a move toward supporting greater community engagement among beneficiaries. Health and the economy are linked, she noted.

The Kentucky waiver is based on private insurance with the idea of implementing particular components into the Medicaid program and then evaluating what works best under what circumstances. This includes strategies like recipient cost sharing, which gives beneficiaries a better sense of what the real costs of health care are, and in what settings it is appropriate to receive specific types of care. For instance, premiums might range from $1 to $15 dollars and include some level of cost sharing if a beneficiary went to the emergency room for nonemergent care. For the community engagement goals of the program, beneficiaries are required to participate in at least 20 hours per week of qualifying activities (e.g., work, job training, job search, GED preparation, volunteer). Putnam suggested that the

threat of the losing insurance will engage recipients in work or other activities that will ultimately connect people to the community.

Discussion

The Medicaid conversation centered on the extent of state flexibility and federal accountability within the program. One suggestion was that the federal government move to cover all low-income individuals meeting poverty guidelines. Others asserted that moving Medicaid beneficiaries into private insurance should be a primary goal. These fundamental differences also appear in how states view and structure their Medicaid programs.

The conversation also reinforced the reality that Medicaid spends more of its dollars on long-term care and acute care services for dual eligible beneficiaries than it does for parents or children. Salo noted that in order to address rising costs in Medicaid, we also need to consider Medicare policy and what is going on in the private sector. It is important that Medicaid continue to test innovative models to better integrate care and support beneficiaries (many who are dual eligible) with multiple chronic conditions and/or disabilities. While it was agreed that waivers and state flexibility are important program innovation, there was no consensus on how wide this flexibility could be without jeopardizing program integrity.

Session V: State Activities and Innovation

Trish Riley, Executive Director, National Academy for State Health Policy

Riley opened this session by outlining a myriad of issues where states have played the role of innovators and laboratories, testing ideas that inform federal policy. States acted, creating children's coverage before Congress, and enacting mental health parity, the ACA, gag clauses, and surprise billing laws ahead of Congress.

The panel discussion began with a conversation on state actions to lower prescription drugs costs. States are limited in what they can do in this arena (e.g., financial concerns, federal regulation, patent law), Riley noted. Nonetheless, states, which must balance their budgets, cannot wait for Congressional action and are enacting laws to, regulate prescription benefit managers (PBMs), expand pricing transparency, allow for importation of lower cost drugs, outlaw price gouging, propose rate setting, and use volume purchasing. Beyond prescription drugs, the panel also discussed state strategies to address rising health care costs, waivers and market strategies, regulation, and other state-specific topics.

Richard M. Scheffler, Professor In The Graduate Schools of Public Health and The Goldman School of Public Policy and Director of the Petris Center for Healthcare Markets and Consumer Welfare, UC Berkeley

Scheffler noted that California Governor Gavin Newsom's first executive order after taking office centered on prescription drug purchasing. The governor has directed state agencies to purchase drugs collectively and has invited local governments, private payers, small businesses, and self-insured employers to join the collaborative. Medi-Cal pharmacy services spending is currently about $8 billion annually. Los Angeles County alone serves 10 million people, and each of the 58 counties are responsible their own employee health plans. Joining forces would allow them to pool resources and power. Other states are talking with California about joining in this effort. However, all of the purchasers in the state signed non-disclosure agreements regarding the deals they made with insurers, which makes joint action more difficult. Progress in this area is likely to be met with legal challenges from industry.

Hemi D. Tewarson, Director, Health Division, Center for Best Practices, National Governors Association

Tewarson identified three buckets of state innovation in the prescription drug arena—value-based pricing, caps on drug spending, and negotiation for supplemental rebates. Over time, she stated, all three of these types of strategies can save money and provide greater access to needed pharmaceuticals. There is the New York model, which has set limits on Medicaid spending. Another model—similar to the subscription model in Louisiana—is to set up a lump sum dollar amount for all the costs of a particular drug in a state. This could be used to, for example, purchase all the HEP C drugs needed to eliminate the disease in a state.

She also shared state examples for benchmarking (e.g., Massachusetts) and discussed 1332 waivers, which enable states to waive ACA provisions. In addition, Tewarson outlined innovative state marketplace models, like the newly implemented Washington State Public Option. Under the Washington plan, the state will offer a public option on the exchange with the ability to compete with private insurance.

Steven Costantino, Director of Health Care Reform and Financing, Delaware Health and Social Services

Costantino discussed Delaware's effort to control health care costs. Delaware is a high-cost state, ranking as the third highest state for per capita health care expenditures. Costantino noted that this is a major problem because high, rapidly growing health care costs crowd out funding for other priorities in the state. Delaware has recently moved toward a global health care spending model, similar to Massachusetts. Like the Massachusetts experience, Delaware is setting a benchmark, which is a target but not a fixed cap on spending. The Delaware benchmark aims to keep costs below 3.8% of spending, and the reform effort also includes eight quality benchmarks.

Implementing this type of strategy required a lengthy stakeholder process and overcoming barriers like opposition from hospitals. Costantino pointed out that the state held six summits with out-of-state experts. Before movement in this area, the state had only focused on Medicaid costs. Other states (e.g., Rhode Island, Oregon) are moving in a similar direction.

Kacey Wulff, Deputy Chief of Staff and Senior Policy Advisor, Colorado Lieutenant Governor Dianne Primavera

Wulff first outlined work taking place in Colorado to control prescription drug costs. She reported that a week before the Princeton Conference, the state signed a Canadian import deal with a start date of 2020. The law identifies a list of high-cost drugs that will be made available to consumers at a discounted rate.

Wulff also emphasized the importance of leadership in creating Colorado's Office for Saving People Money in Health Care. Under the leadership of the Governor and Lieutenant Governor, a coordinated effort was put forth to examine health care expenditures and determine the most effective interventions to address rising spending. In addition, the state has overhauled its SUD treatment system. Other state efforts included a reinsurance bill in the individual market, with a focus on the rural areas where beneficiaries are faced with higher average premiums. (This was approved recently, and initial rates demonstrate an average reduction of 18% in individual market premiums statewide.) Colorado also modified the state co-op laws so that local communities can pool their purchasing power to negotiate better rates. Additionally, there is a requirement from the legislature to develop a "Colorado option"—a proposal for how the state can offer a health insurance option to put downward pressure on costs and increase access.

Discussion

The discussion turned to federal action and state health care reform efforts. The Administration is moving to support state work in areas such as association health plans, rolled back essential benefits, and work requirements. For instance, a total of eight 1332 waivers have been approved, with seven of these pertaining to reinsurance. Some participants noted that reinsurance is not a solution in that it acts as a Band-Aid by offering only short-term stability, without the ability to address larger issues. Significant state reform, like movement toward a single payer model or "Medicare for All" approaches would require federal action, which the current administration is not likely to support.

States have few tools at their disposal and are often limited by the need for federal buy-in (e.g., waivers), but despite this, states are moving on multiple fronts. For instance, CMMI and the Delivery System Reform Incentive Payment (DSRIP) Program have supported progression toward alternative payments and value-based purchasing. States are looking more broadly at systems reform including public and private alternative payment models and the role of provider capacity (e.g., Arkansas). Washington is implementing a public option, which will pay providers 160% of Medicare rates. Further, as some of the panelists noted, states are also trying all-payer models, like the Maryland approach, although these changes do require a waiver. Other recent state actions include the Vermont Green Mountain Care board approving insurance premiums and hospitals rates for the state and Pennsylvania, which is considering a rural global budget option.

All of this is happening in a period of hospital consolidation, which is going largely unregulated by the federal government. It was suggested that consolidation raises prices approximately by 40%. Much of the consolidation is vertical, with hospitals buying up physician groups. In fact, more than half of physician groups are owned by hospitals now and it is predicted that in five years nearly two-thirds of physicians will be associated with hospitals. Further, estimates show that Medicare pays physicians 25% more when they are affiliated with hospitals. Hospital physician groups have more power to negotiate with insurance companies.

A question from the audience centered on the need for transparency given that price is often a black box. Wulff noted that Colorado is moving in this direction, but cautioned that transparency is not a policy solution, although it is necessary for change. While it was suggested that hospitals be subject to an annual audit, the politics of this would be difficult to overcome. Health plans are also reluctant to open up their data on costs, price, and premiums. Tools for change are necessary in this area, but the path forward is unclear for many states right now.

Uwe Reinhardt Memorial Lecture: Learning from Analogies and Embracing Constraints in Health Care

Tsung-Mei Cheng, Health Policy Research Analyst, Woodrow Wilson School of Public and International Affairs, Princeton University

Cheng opened the Uwe Reinhardt Memorial Lecture. She noted what an honor it is to have this annual dinner event in the memory of Uwe and his extraordinary work in the health policy field. She went on to discuss Reinhardt's recent book, *Priced Out: The Economic and Ethical Costs of American Health Care*.

In this book, Reinhardt discusses two trends that were central to his work and that he believes drives U.S. health care policy—cost and the uninsured. Often, the debate in U.S. health policy is conducted around jargon of economics and constitutional federal-state relations, but that is not at all what it is about, according to Reinhardt. Rather, the problem is about social ethics. Unlike many other countries, Reinhart stated in his book that there is no political consensus in the United States on a fundamental question: "To what extent should the better-off members of society be made to be their poorer and sick brother and sisters' keepers in health care?" Distributive ethics is not a

key component of the health care context in the United States, Reinhardt wrote in the book. This reality has led to two developing trends in the United States in recent years. The first is rapid growth in the cost of health care in the face of the second—growing inequality of the distribution of income and wealth in the country.

Cheng provided recent data to illustrate how this is currently playing out. She went on to echo Reinhardt by asking how we will meet growing health care challenges as a nation. This is a question for all of us, Cheng asserted. We all have a role to play.

David A. Asch, MD, John Morgan Professor, University of Pennsylvania

Rather than a traditional lecture format, the dinner event for this year's Uwe Reinhardt Memorial Lecture centered on an interactive game that conference participants worked through. Asch opened the activity, explained the rules, and led the audience through a group exercise on "Learning from Analogies and Embracing Constraints in Health Care." In this activity, participants worked in groups to solve health care dilemmas. This included thinking outside the box and devising innovative approaches to move beyond constraints.

Session VI: Alternative Payment and Delivery System Innovation

Robert E. Mechanic, Senior Fellow, The Heller School for Social Policy and Management, Brandeis University

Mechanic opened the session remarking that we may be approaching a tipping point in the movement toward alternative payment models (APMs). Although there has been substantial growth in provider adoption of APMs since the ACA, he also suggested reasons for skepticism. For example, Massachusetts has arguably had the highest adoption of APMs nationwide with about 40% of commercial members covered under global budget models. Most of these lives are in health maintenance organization (HMO)-type plans which are shrinking as employers continue to shift into open-access preferred provider organization (PPO) products (where less than 20% of lives are in global budget arrangements). Across the rest of the nation, PPO-type plans are the dominant model and those that utilize APMs typically have very weak incentives for providers to manage spending. Additionally, of the limited level of risk in APMs, very little makes its way down to the provider level.

The market takes many of its cues from Medicare, Mechanic went on to discuss, so how the administration decides to approach payment reform is extremely important. Health plans, physician groups, and hospitals are continually assessing the environment, but it appears that much of the industry has one foot on the dock and only a toe in the boat. He questioned whether there are any private entities that could shake things up and accelerate APM adoption, and whether employers who control the money would more actively push payment reform. Mechanic then introduced the panel and moderated the session.

Bruce E. Landon, MD, Professor, Health Care Policy, Harvard Medical School

Landon cautioned that just because Medicare ACOs have not shown major success, this does not mean that progress is not taking place. It is hard to change the health care delivery system, and change does not happen overnight. Landon focused on how successful ACOs have been to date and highlighted areas of concern. ACOs have saved money. The true measure of comparison (a valid counterfactual), Landon noted, is what spending would have happened without ACO implementation. This, he argued, should be more important than hitting pre-established benchmarks, which are established for policy goals, but do not necessarily represent what might have occurred in the absence of ACOs. Further, the total value of savings from ACOs likely is underestimated because of positive spillover effects of the program to the private side and Medicare Advantage Plans. More consistency is needed within the system to set reasonable targets so that providers have the proper incentives. One major problem for the

ACO program in general is that new targets are set based on the previous year's achievements. In this sense, if an ACO saves money, it gets rewarded with a lower benchmark the next year, which does not help with forward movement and improvement, and ultimately will be self-defeating for successful organizations.

Landon also discussed the need for more movement to two-sided risk arrangements. Most savings are from independent medical groups—many of which might not be able to assume full downside risk. Medical group incentives are clear with most savings anticipated through reduced hospital use. This is in contrast to larger system based ACOs where savings for the ACO also represent losses to the system's hospitals. One concern with requiring all ACOs to assume two-sided risk, Landon stated, is that it might scare away the independent medical groups who have been the most successful to date. Regardless, he suggested that larger groups could be moved to two-sided risk arrangements expeditiously. Landon did caution against the potential problem of moving toward regionally based benchmarks within the context of a voluntary ACO program. These incentivize participation by only those already doing well, with the result that higher spending organizations (the most important for realizing overall savings) will drop out of the program. Ultimately this would result in providing subsidies to already low spending organizations without additional cost savings.

Katherine A. Schneider, MD, President and Chief Executive Officer, Delaware Valley Accountable Care Organization

Schneider started her remarks by acknowledging the great variation in what is called an ACO. "If you've seen one ACO, you've seen one ACO," she stated. While there is major variation, most are using similar tools. However, Schneider noted, there are some clear differences between physician and hospital led ACOs. For instance, companies that aggregate small practices into ACOs can access claims data in order to curate which providers or even regions are most favorable for inclusion, whereas health systems are generally working within their existing community relationships. While ACOs have not been as successful as hoped, there have been clearly delivered improvements, cost and quality savings, and overall system change, according to Schneider. The question, however, is how much improvement has taken place and are things getting better over time?

One concern is the lag time between results achieved and when ACOs receive incentive payments. Starting a new ACO requires significant upfront capital investment. Further, there are a plethora of APMs based on common care transformation infrastructure, which can make it a confusing landscape to navigate. In the past, we did not use tools like data and predictive care models, care coordinators, preferred post-acute care partnerships, or telehealth. These tools can be transformative, but they take an investment in time and money to implement and perfect. It is critical to get all of the stakeholders moving in this direction, Schneider argued. Workflows needs to be reworked and even changes such as when to "drop a bill" (right away or in 30 days as required for some new services) should be purposeful. The real challenge is to explain all of this for ACOs, which is not an easy undertaking. CMS has not fully worked out all of the existing overlap issues, and yet, still continues to push and test additional models.

JP Sharp, Director, Healthcare Strategy and Transformation, Blue Cross and Blue Shield of North Carolina

Sharp reported how CMMI put forward multiple alternative ACO options but did not envision all of these taking shape in one market. They were looking for experiments of major system change, he stated, and did not plan for these pieces to collide. What happened was that similar systems are now in multiple incentive programs and configurations, which is extremely difficult to assess. Sharp also discussed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), noting that the unintended consequences of the Merit-Based Incentive Payment System (MIPS) being poorly designed and implemented is that physicians are then more likely to want to be in APMs where they have better control. More needs to be done to find an effective shared savings path for

physician practices, Sharp stated. He suggested that there does not need to be much downside risk to be an advanced APM.

Glenn D. Steele, MD, Vice Chair, Health Transformation Alliance

Steele agreed with Landon that two-sided risk is extremely important, and also argued that physician fear of taking on risk is another important problem to address. Further, he discussed how the ability to maintain independent practices is finite, and concern about finances and administration will likely drive them toward integrating into larger group practices. There is not a promising future for these practices; there have to be winners and losers. With estimates that acute care costs can be reduced between 15% and 40%, there is significant room for efficiency and optimization in acute care. We cannot declare success yet, Steele reported, but we are moving in the right direction.

Discussion

A robust conversation with the audience addressed many of the nuances within alternative payment and delivery system change. In response to a question on commercial markets, Schneider stated that while national payers are not necessarily "all-in", the right set of tools exist and payers have made investments in the model. Local, smaller payers may not have the belief or investment capability for holistic change, however. Payers are often more interested in price per unit than in total cost of care. Steele added that while purchasers are concerned about total spending, it is often easier to focus on price per unit. Further, benefit managers and purchasers have an aversion to narrow networks.

The discussion then transitioned into challenges moving toward alternative payment, in part because of the complexity and interaction of multiple models, reporting requirements, varying quality measures, and different risk adjustment tools across payers. More education and learning must happen before value-based networks are widely accepted. Despite these impediments, progress is being made—particularly in the area of shared savings. The conversation also addressed how health plans need to be catalysts for change in this arena, and that they are the most important players to take the first step. This could begin with a modest percent of payment tied to APMs and a move toward 50% throughout the first few years.

Another dialogue focused on primary care. Primary care physicians are important players in shifting the delivery system. The foundation of primary care should better integrate social determinant of health into the treatment philosophy and approach, with some idea of rate of return as an alternative to charitable contribution. Reducing acute care is where the biggest savings are, but ultimately this can adversely impact hospitals. The panel responded that some hospitals are closing and others are reducing beds. For instance, Geisinger acquired a series of smaller hospitals and closed their acute care beds or repurposed these to be chronic care centers. Savings can also come from reducing unnecessary procedures, drugs, and specialty care.

The panel was also asked about the role of technology in helping drive efficiency. Panelists agreed that technology is essential, but it needs to be in service to a care model. It was suggested that progress can be made by starting with small data and scaling up from there. More can be done with virtual care. While other institutions (e.g., banking) offer a far different experience for people than a decade ago, health care has not changed much. Technology has the potential to increase and improve communication between employers, payers, providers, and patients and lead toward further system improvement.

Session VII: Drug Pricing Policy: Prospects and Timing

Elizabeth J. Fowler, Vice President, Global Health Policy, Johnson & Johnson

Fowler opened the session by asking how the range of current alternative cost control strategies being considered for drug pricing might impact patients.

John M. O'Brien, Senior Advisor to the Secretary for Drug Pricing Reform, U.S. Department of Health and Human Services

O'Brien described President Trump's *American Patients First* blueprint to reduce drug prices and costs for patients. He noted that the plan is comprehensive, and, if implemented, would lower patient costs. O'Brien discussed the four pillars of the plan, which include the following: (1) increase competition, (2) improve negotiation, (3) create incentives to lower list price, and (4) bring the first three together in order to reduce patient out-of-pocket costs. None of these proposals are intended to be a silver bullet on their own, but when integrated together they are envisioned as a method to streamline and resolve many of the problem areas. O'Brien also described the perverse incentives in a broken system where everybody but the patient wins when list prices go up and outlined the Administration's proposals that would reward lower list prices.

Adam J. Fein, Chief Executive Officer, Drug Channels Institute

Fein began by highlighting the complexity of drug pricing and unintended consequences of the current system. An important issue today is list prices, which have been rapidly increasing (roughly 12% in the last five years). Rebates and other payment discounts reduce the list price, but the net price remains flat. In fact, the gap between the list price and net price has been compounding yearly. In 2012, it was about $83 billion, but last year that gap grew to $166 billion. This has created a distorted system because the difference in the gap becomes monetized.

Fein identified a number of problem areas. One surrounds the reality that most patients with health insurance are exposed to the list price. Patients taking essential medicine often pay full price on something that the insurance company discounts 80%. This creates a reverse insurance effect. Individuals with multiple prescription drugs generate rebates that come back to health plans and payers, which reduces premiums for healthy people. A drug with a list price of $100 and a $50 rebate is more attractive than a drug with a $50 list price. If we do not fix what is happening with price right now, we are not going to be able to afford the next round of therapies.

Avik Roy, President, Foundation for Research on Equal Opportunity and Policy Editor, *Forbes*

Roy made the case that reforms—including market-based reform—are essential to help low-income patients afford medications. Prescription drugs account for approximately 10% of national health expenditures, with this statistic closer to 13% when drugs administered in hospitals are included. Roy discussed how the United States leads the world in generic prescription drug utilization, yet still spends far more per capita than in other countries. Innovation is not the reason for high drug prices, he argued. The price of branded drugs has gone up 50% in the last five years, but the cost of innovation has not. Further, rebates might reduce net prices, but they increase volume, profits, and overall spending, meaning that there is a strong voluntary incentive for manufacturers to offer rebates. Roy also noted that prices are being driven in large part by monopoly pricing power in biosimilars and orphan drugs. It is becoming less profitable to develop drugs that treat a lot of people. The FDA requires large and very expensive studies on drugs that treat larger populations, which involves a massive investment, with uncertain outcomes. In contrast, drugs that treat small populations require smaller, less expensive trials, and if they work out, the drug prices can then be set at very high levels.

Mark E. Miller, Executive Vice President of Health Care, Arnold Ventures

Miller reported that prescription drugs have become unaffordable for many patients in the United States. In total, one in three people cannot fill a prescription because of affordability. Many drugs that were once affordable have become less so in recent years, with more expensive specialty drugs coming online. He reiterated that net prices are increasing and that most of these higher costs are being directly transferred to patients. Manufacturers are taking maximum advantage of patent and exclusivity rules, which discourage competition. The supply chain is also a major problem since every player in the chain benefits from high list prices. Miller further discussed that the rebate model and coupons distort the market. Drug development and pricing happen within a larger context. While Congress, as well as state governments, are beginning to tackle these concerns (e.g., international pricing, negotiations, cost-effectiveness analysis), we have a long way to go.

Discussion

The discussion first delved into the role of PBMs and rebates. Among the panel, there appeared to be consensus that rebates distort the market and create a bubble between gross and net costs. PBMs were seen as the major stakeholder in power, with just four PBMs currently controlling 80% of the market. Moreover, manufactures are generally not happy with high cost/high rebates. However, there was no certainty among the panelists about who would benefit if rebates were removed, and how this might transform the system.

A heated discussion also took place regarding international price benchmarks. It was suggested that there is no economic theory behind this approach. Many items are more expensive in the United States, so why would prescription drugs be different? It was countered, however, that strategies like price negotiation, using budgets, and paying for value are essential to making prescription drugs affordable. Tools like these should be considered in the United States.

Another area mentioned was the integration of drug payment programs under Medicare Parts B and D, along with allowing Medicare to negotiate drug prices. One idea involves pegging the growth in prices to the consumer price index. There was no consensus on the merits of these strategies and the true impact they would have. In the United States, the issue is complicated because all drugs must be covered, and when there is no ability to negotiate a lower price, it becomes a market where you cannot say “no”.

Miller suggested that we need something like the Institute for Clinical and Economic Review (ICER) model, which involves negotiation and international reference pricing. It was also suggested that prices would be lower if they reflected basic research supported by the NIH. However, this was countered by the idea that other sectors of the economy also do not pay for government supported basic research that helps their fields. While the panelists disagreed on many points, there was general agreement that something needs to be done. It was clear that debates like these will continue as activities and innovation persist in the states, in Congress, and with the Administration.

Session VIII: What Are States Doing Around the Opioid Crisis?

Michael Botticelli, Executive Director, Grayken Center for Addiction at Boston Medical Center

Botticelli, who has worked for many years in the SUD field, at the state and federal levels, moderated this session on state responses to the opioid epidemic. He opened the session by discussing the toll that opioids are taking on the United States. This ongoing crisis accounts for significantly more deaths each year than motor vehicles and has lowered overall life expectancy in the country. Moreover, while there has been a dip in the reduction of deaths recently, this varies by state with some states disproportionately impacted.

Botticelli highlighted the need for access to evidence-based, quality treatment. Further, while over prescribing has been a major contributing factor to the epidemic, this crisis did not happen in a vacuum. Historically, drug policy focused on law enforcement, not treatment. There was also a failure on the part of medical education, he contended, to identify SUDs and to provide effective treatment. Beyond this, stigma remains a major problem and common barrier. For instance, only 10% of individuals with a SUD receive treatment, with significant variation in the quality of treatment. States are playing a major role in addressing the crisis, but far more needs to be done.

Patrice A. Harris, MD, President-Elect (now President), American Medical Association

Harris discussed work taking place in partnership with the American Medical Association (AMA) and states to address the opioid epidemic. Fentanyl, she began, is a major driver in most of the current opioid overdose deaths. Data is necessary, but we cannot forget the people behind each statistic, she noted. Solutions include improving the use of Prescription Drug Monitoring Programs (PDMPs) to support treatment, better physician training on pain and prescribing, expanded access to treatment, stigma reduction, and greater access to Naloxone and other harm reduction strategies. Further, health plans need to eliminate prior authorization for medication assisted treatment (MAT), she argued. Access to drug therapy should be on the lowest cost share tier to not pile on additional treatment barriers. Harris also discussed how expansion states—in comparison to states that have not expanded Medicaid—have significantly increased access to treatment. Additionally, parity laws are also a key ingredient. While parity laws have been on the books for over 10 years, they are often not enforced, which is an important intervention needed at the state and federal level.

She went on to discuss how with all of the policy approaches, we cannot forget patients in pain. Opioid prescriptions are still a needed medication for some patients and they should not be made out as criminals if they use this as a tool for pain management. In the end, there is a grave need to keep an eye on the big picture, she asserted. This is not a crisis that happened in isolation and there is a need to look at the infrastructure that made this crisis grow, and to build in protective systems and services to affect change and address epidemics like this moving forward. This includes evaluating current policies to determine whether they are helping improve patient outcomes—or whether they need to be amended/rescinded; and that we need to identify best practices and programs that are saving lives—and see if they can be scaled to other communities.

Van Ingram, Executive Director, Kentucky Office of Drug Control Policy

Ingram discussed how Kentucky, which has been hit hard by the epidemic, has addressed the opioid crisis. He opened by providing historical highlights for the state. For instance, Kentucky was the first state in the country to require a PDMP for all controlled substances. While initially there was massive pushback from physicians in the state, most are now on-board and have applauded the state's efforts. Ingram recounted that prior to this, Kentucky was lenient with who could own and run pain clinics. At one point, there were 76 pain clinics and many of these were not physician owned or operated. This led to massive overprescribing and greatly contributed to the opioid epidemic in the state. Additional state legislation has also passed to regulate these establishments, which helped tremendously.

The next bill being considered in the state centers on harm reduction, including greater access to naltrexone, protecting people who stay with overdose victims, and implementing needle exchange programs. People need to be alive in order to receive treatment, Ingram noted. Strategies like these are all important ingredients of a state response to the problem.

Hemi D. Tewarson, Director, Health Division, Center for Best Practices, National Governors Association

Tewarson, from her vantage point at the National Governors Association, discussed state responses to the opioid crisis. She noted that priorities often change for governors, but that the opioid epidemic has continued to top all states' agendas. Some states, she contended, are responding in more effective ways, however. Often, this is because change begins with strong leadership and local communities. For instance, Kentucky leadership empowered a taskforce in the state. Bottom-up strategies across communities, however, need to be complemented with a Czar or someone in charge to stay abreast of implementation and what is happening with all of the moving pieces. Data is also critical for tracking the problem and targeting effective resources. Tewarson went on to discuss how programs and resources must go where the problem is, including rural populations and in correctional settings. Peer supported recovery including peers in emergency rooms have also shown to be effective.

Discussion

The discussion centered on a range of topic areas, including MAT and other treatment approaches, emergency department responses, stigma, geographic variation, and additional contributing factors to the epidemic. One topic surrounded how despite significant evidence of its effectiveness and ability to save lives, Medicare was late to cover MAT. Some of this could be due to stigma, which continues to be a problem. Later in the conversation, a participant asked why MAT is optional for providers? It was argued that it should be required for all physicians in order to provide patients with the best care. Harris cautioned, however, that physicians need to practice in areas that they have experience and expertise, but that it is important to move more physicians into MAT.

Emergency departments are also innovating and attempting to address the issue, but hopefully this is not happening in isolation. Treatment needs to be matched to the individual and cannot be a one-size-fits-all approach. In Massachusetts, each emergency department must be ready to institute treatment protocols. In Rhode Island, there are bridge clinics in the emergency department to help patients move into longer-term treatment. Further, a point was made that the culture within emergency departments will need to change in order to make this approach more widespread.

Considerable geographic variation exists across states regarding the response to the opioid crisis as well. Four states were awarded major grants with the goal of reducing mortality by 40%. Some of the best ideas come from community-based coalitions and grounding responses around social determinants like employment stability, housing options, and available support services in the local area. The conclusions were that while there is much going on, it still remains a crisis that needs persistent attention at every level of government.

Closing Remarks

Michael Doonan, Associate Professor, The Heller School for Social Policy and Management, Brandeis University and Executive Director, The Massachusetts Health Policy Forum

Doonan ended the 26th Princeton Conference with a quick recap. From the Washington update, we learned that major change is unlikely in the current Congress, but something might be done to fund community health centers and DSH payments. The groundwork is being laid for activities after the election, and much can still be done by executive and administrative action. The Medicare panel provided insight into drug pricing in Parts B and D, how Medicare Advantage is transforming the program, and concerns about disparities between public and private payers. The next panel highlighted how medical errors and safety continue to be important issues not receiving adequate attention and

lives are being lost because of it. The Medicaid and State panels examined a wide range of innovation taking place in states, but also discussed how federal financial support and waivers are essential for transformation.

The second day began with an examination of alternative payment and delivery system change and innovation. Optimistically, we see changes towards ACOs, but this is not as wide or deep as is necessary for system transformation. The prescription drug panel was contentious with diverse ideas both about the problem and potential solutions for addressing prescription drug prices. Finally, the opioid crisis is being addressed at every level of government, and yet it remains an epidemic requiring prolonged and persistent attention. This concluded the 26th Princeton Conference.