Using Settlement Funds to Finance SUD Treatment: An Investment Approach

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Forum on Mental Health and Substance Use Disorders
National Academies of Science, Engineering, and Medicine
December 5, 2024

Disclosure

- I serve as an expert witness to the city of Baltimore in its litigation against opioid manufacturers and distributors

Water on Parched Soil

Opioid Settlement Funds are Being Spent Quickly, Sometimes on Dubious Projects

- In some jurisdictions funds are being spent to backfill other ongoing appropriations (supplantation) or even to pay off local debt

- Some spent funds on law enforcement tools like new police cruisers and body scanners

- Funds should be used for treatment, but the model for allocating treatment dollars to maximize the return needs to be scrutinized

Moving From a Reactive System of SUD Care

Reactive

- Limited public health surveillance
- Allocates and spends funds on a year-to-year basis
- Rigid, limited inputs to care
- Pays for care without regard to quality or societal return
- Segregates funds within sectors

…to a Proactive System of SUD Care

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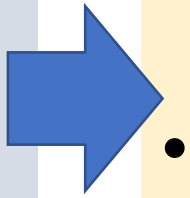


Proactive

- Early detection and tracking of population needs
- Invests in care of cohorts over their lifetime
- Adaptable inputs to services
- Rewards providers for improving health
- Allows funds to follow people, not systems

An Effective System Starts with Surveillance

- Most states and localities still cannot accurately measure the number of people who:
  - need treatment
  - get treatment
  - Recover after treatment

- It is time to modernize data collection systems:
  - Drug checking programs
  - Small, rapid-cycle targeted samples
  - Dashboards
  - Linked administrative data systems

Planning For Services over a Longer Time Horizon

- The opioid crisis is a multi-generational challenge
- Model the needs of cohorts as they age and enter recovery
- Place some of the allotted settlement funds in a trust
- Allow for challenge to evolve over time as new threats emerge (e.g., novel synthetic drugs) and old threats recede

Fixed versus Adaptable Inputs

- Because of NIMBYism and regulations the current system is built around highly fixed settings of care like OTPs and “detox” facilities
- Workforce is also relatively fixed

- Need to create more nimble infrastructure and workforce that can respond to emerging challenges:
  - Mobile units
  - Drop-in centers
  - Street outreach workers

- Encourage programs to periodically redefine their services and purview based on new needs

Reward quality, disadopt low-value care

- Very few examples of value-based purchasing in SUD care

- Implementation challenges:
  - Quality metrics like HEDIS SUD measures don’t have a long track record
  - Requires integration/collaboration that rarely exists
  - Need more models for risk adjustment, want to encourage treatment of relatively unstable patients

- Disadoption of low-value care
  - Start with care that actively harms patients like standalone withdrawal management without medications

Money should follow people, not systems

- Status quo: separate pots of money for specialty care, office-based care, harm reduction, hospitals, jails and prisons

- Unified funder approach would likely be built around Medicaid:
  - Would need to dovetail with the authorities and funds of public health agencies and Single State Authorities
  - Would need to loosen some of the programmatic funding barriers
  - Current 1115 waivers on Reentry provide some proof of concept for carceral health, but need to look more expansively

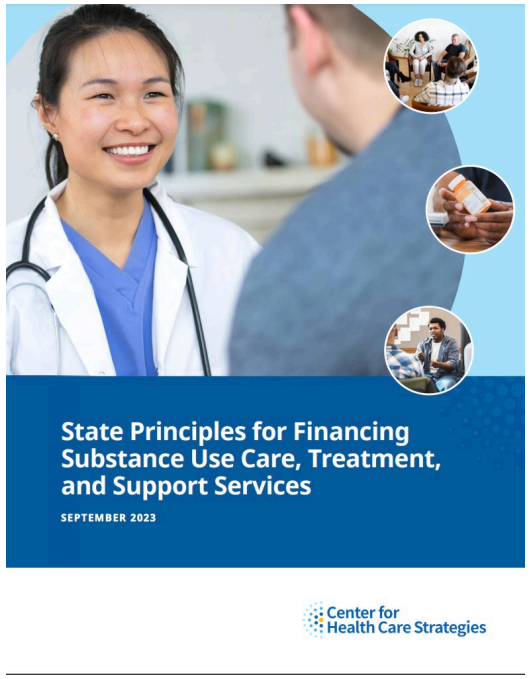
How to get there?

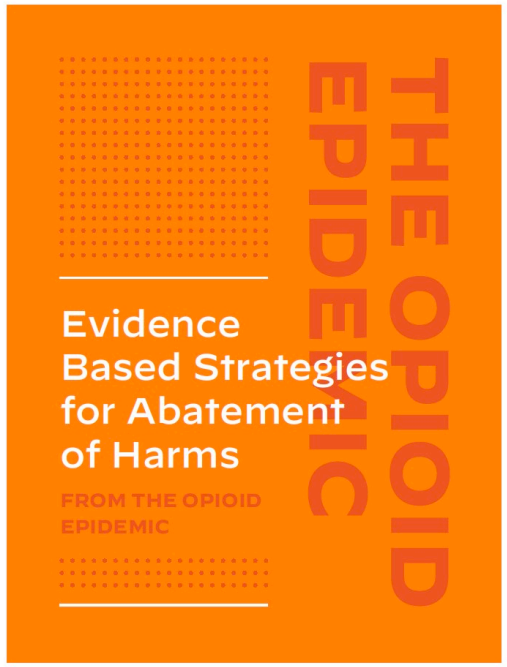
- Some of the changes require more explicit federal assistance, not only with matching funds but also with regulatory changes

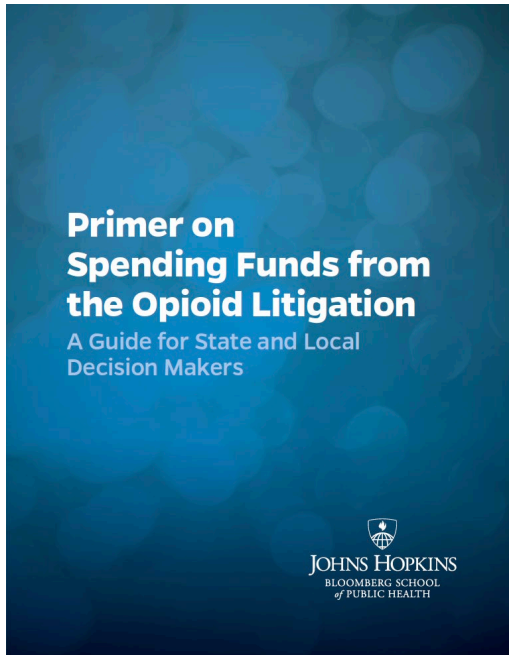
- States and localities can be transparent on how they are allocating funds for treatment in ways that meaningfully expand capacity on the ground

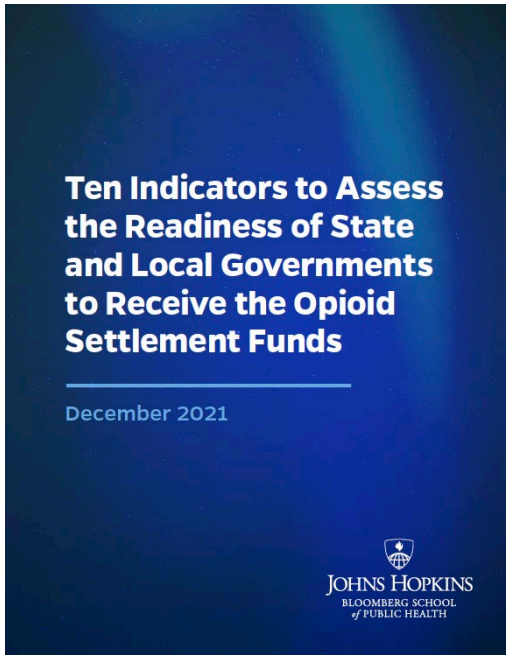
- Building data infrastructure can and should be part of the broader conversation about tracking the outcomes from settlements

Some More Resources









Johns Hopkins Opioid Principles: https://opioidprinciples.jhsph.edu/