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Opioid Measurement Toolkit

Leveraging Aligned Data and Measures to Sustain Opioid Settlement Fund Investments

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Key Takeaways

- Opioid settlement funds provide new, flexible funding streams exceeding $50 billion for states and localities to invest in infrastructure and other initiatives to reduce opioid-related deaths and in substance use disorder (SUD) prevention, treatment, harm reduction and recovery services.
- Momentum toward value-based payment within health care and the current influx of opioid settlement funding provides an opportunity for stakeholders to think creatively about how to holistically meet individual, family and community needs in the long-term.
- When opioid settlement funds are expended, not all interventions will have sustainable funding sources through existing channels (e.g., philanthropy, federal block grant funding), which presents an opportunity to look to the health care sector to integrate interventions within their care models.
- State and local leaders involved in opioid settlement fund investments can demonstrate the value of their interventions to health care stakeholders by incorporating measures that are relevant to health care, such as cost, quality and utilization.
- In order to incorporate measures relevant to health care, organizations may need access to additional data. Given that the collection of health care data presents a challenge to many counties, partnering with existing data infrastructure in the state, like Health Information Exchanges, or creating new pathways to access information will be necessary to support effective measurement.
- While growing interest exists, few health care measures assess social determinants of health, patient-reported outcomes or include patient generated measures.

Background

Opioid settlements provide new, flexible funding streams exceeding $50 billion for states and localities to invest in infrastructure and other initiatives to reduce opioid-related deaths and in substance use disorder (SUD) services across the care continuum—prevention, harm reduction, treatment, and recovery. Settlement funds are paying for a wide range of investments over the next 18 years, with local counties and state governments selecting investment opportunities in a variety of ways—requests for proposals, settlement fund advisory councils and tasks forces, and formal legislation and rulemaking outlining allowed uses. While much attention has been given to concerns about appropriate use of funds, less consideration has been given to sustaining effective and impactful investments, both in the short-term as use of funds becomes more competitive and in the long-run as funds cease.

One opportunity to sustain these investments is through health care funding. In particular, health care providers and public and private health care payers (especially state governments and Medicaid managed care organizations that support behavioral health services) are increasingly prioritizing whole-person care models that better integrate behavioral health along with the full care continuum of physical health care. As part of this shift to person-based systems of care, payers and providers are moving away from fee-for-service (FFS) reimbursement that has a specific dollar amount attached individual services and toward value-based payment arrangements that reward high-value, cost-effective care and promote population-level accountability, such as through the recently announced Innovation in Behavioral Health Model from the Centers for Medicare & Medicaid Services (CMS). This shift allows

providers and payers to think more longitudinally about caring for patients and the potential to include services and supports that are not consistently or adequately covered in FFS models like supportive housing, job training, and recovery supports. Many of these more accountable payment arrangements reimburse and cover the same types of investments and whole-person care elements that are also being supported by opioid settlement funds.

The influx of opioid settlement funding provides an opportunity to break down silos between public health, health care, and community and social services stakeholders, to fill existing gaps in care and infrastructure, create integrated care models, and achieve accountable population health payment models that enable whole-person care.

Indeed, while health care, especially behavioral health, remains challenged by health disparities, historic rates of burnout and workforce shortages, and reduced life expectancy of which the opioid epidemic has been a critical driver–progress is being made toward whole-person models of care that integrate behavioral health, physical health, and social care. As described in **Figure 1,** the influx of opioid settlement funding provides an opportunity to break down silos between public health, health care, and community and social services stakeholders, to fill existing gaps in care and infrastructure, create integrated care models, and achieve accountable population health payment models that enable whole-person care. In particular, opioid settlement funds provide an opportunity for local and state governments, as well as organizations implementing interventions funded with settlement dollars (implementers), to invest in the necessary **infrastructure around data sharing to inform common quality measures** and the development of increasingly **integrated care models.** When opioid settlement funds run out, not all interventions will have sustainable funding sources through existing channels. This potential gap presents an opportunity to look to the health care sector **to integrate interventions within their care models,** given the influence of the health care system on appropriate opioid prescribing, preventing opioid misuse, and connecting people in acute treatment to recovery systems of care. For integration to occur, state and local implementers must demonstrate the value of these interventions by incorporating **common quality measures** that are relevant to health care, such as cost, quality and utilization. These interim steps focusing on data infrastructure, data sharing, and aligned quality measures can support **accountable payment arrangements that prioritize population health** and create a sustainable system that can provide a whole-person and recovery-oriented system of care.

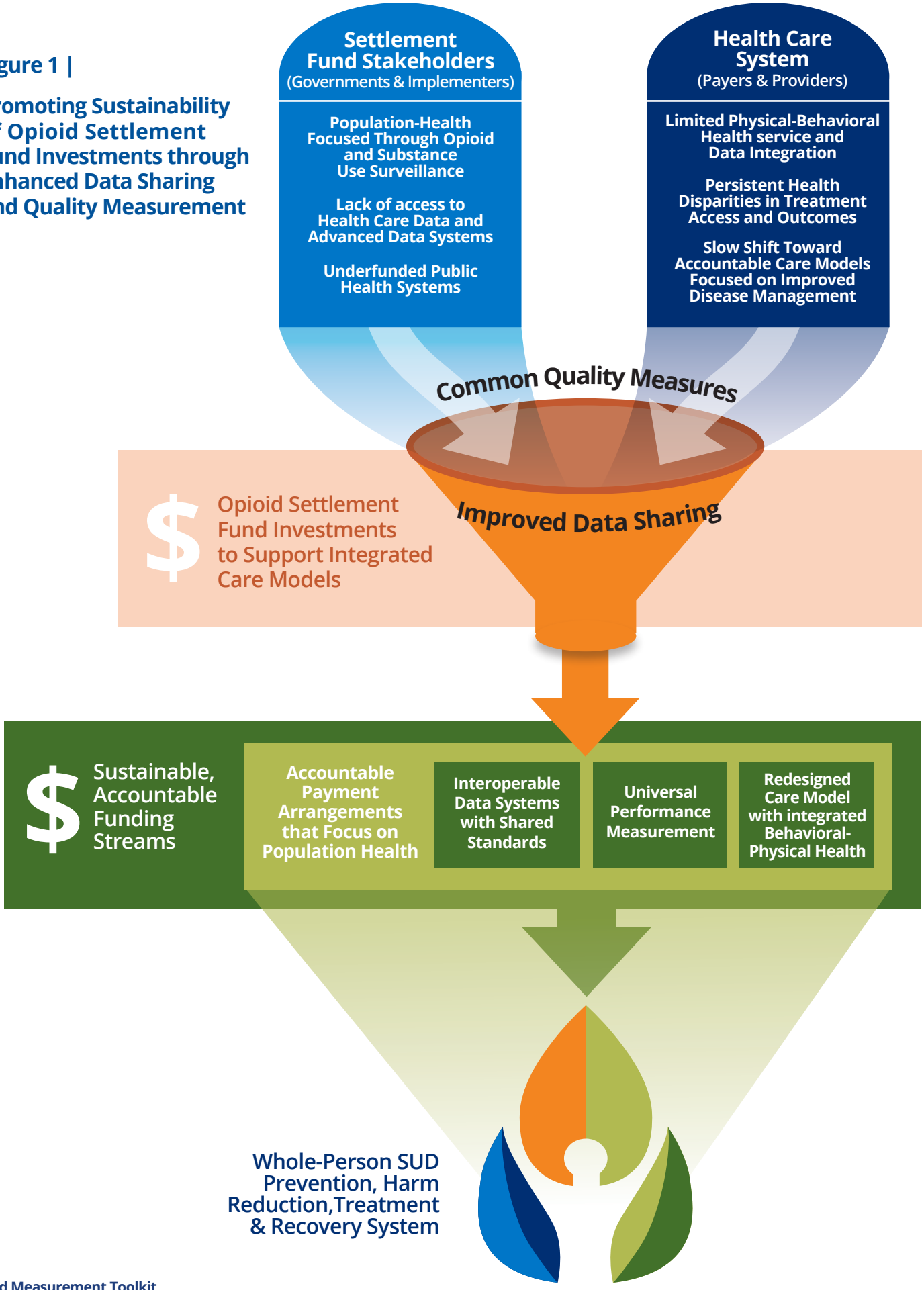
This toolkit outlines a practical approach for state and local organizations that have received opioid settlement funds and other key entities (e.g., state attorneys general offices, state Medicaid agencies, opioid abatement commissions) can use to make the case to public and private health care payers for integrating settlement-funded interventions into accountable payment and whole-person care model structures. In particular, this toolkit discusses the health care measures that opioid settlement stakeholders can track to demonstrate both the positive impacts on the health of individuals and show the importance of the investments in terms of metrics for which health care payers are held accountable.

More specifically, the toolkit:

- Describes the health care data that can demonstrate the effectiveness of opioid settlement-funded initiatives and provide examples of strategies states and localities can use to access health care data;
- Describes common measures used by health care payers for SUD that settlement fund stakeholders should seek to align on; and
- Provides an approach for selecting health care measures that could be used to demonstrate the impact of opioid settlement fund interventions to health care payers.

Figure 1 |

Promoting Sustainability of Opioid Settlement Fund Investments through Enhanced Data Sharing and Quality Measurement



The Role of Data and Data Infrastructure in Measurement

Recent transparency efforts and media reports highlight the important role of data for accountability of opioid settlement fund uses, especially given the challenge in ensuring appropriate use of settlement funds in many regions of the country. **However, data and data infrastructure also are important for demonstrating the overall impact of settlement funded interventions from a health care perspective, especially given that health care funding provides a viable path for the sustainability of investments.** As state and local implementers consider the sustainability of their interventions in both the long-term and near term, they will need to collect, share, and analyze data in a timely manner to demonstrate the effectiveness and benefit of settlement funded interventions. However, collecting health care measures can be difficult, especially for behavioral health, social service, and other prevention and recovery service-oriented providers, given their current data capacity.

Many stakeholders engaged throughout this Duke-Margolis Institute for Health Policy project stressed the lack of data availability and limited completeness of health care data, due to a number of long-standing challenges, such as privacy regulations. In particular, local governments, public health stakeholders, behavioral health providers, recovery community members, social service entities, and others noted that data necessary for measuring impacts (e.g., health care claims data on traditional Opioid Use Disorder [OUD] and SUD treatment utilization, and data on fatal and non-fatal overdoses, etc.) are not shared. In order to track and demonstrate progress on measures relevant to health care payers, organizations will need access to additional data.

While a multitude of new policies have aimed to improve data sharing, including the 21st Century Cures Act, The United States Core Data for Interoperability (USCDI), Fast Health care Interoperability Resources (FHIR), and Trusted Exchange Framework and Common Agreement (TEFCA), collection and sharing of health care data presents a challenge to many counties, non-traditional care service providers, and others implementing settlement funded interventions. Partnering with existing data infrastructure in the state (e.g., Health Information Exchanges) can support effective measurement. In particular, leveraging these existing data resources can help improve data sharing.

One data strategy may be to leverage All-Payer Claims Databases (APCDs) for population-level measurement to inform effectiveness in a way that matters to health care organizations. These databases compile health care claims from various sources, including Medicaid, private insurers, and--depending on their standards--Medicare as well, offering a comprehensive view of health care trends and outcomes. By analyzing APCD data, states and localities can track opioid prescription patterns, overdose incidents, and the effectiveness of treatment programs. These data are crucial for evaluating health policies and interventions, leading to informed decision-making and the development of targeted health strategies at the community level. Approaches to developing APCDs vary—some are led by state governments whereas others are public-private partnerships. All require significant stakeholder collaboration, sustainable funding, and attention to data quality and privacy. While not a short-term fix to data access needs, reports like this two-part series from the Commonwealth Fund describe approaches, challenges and strategies for implementation. States like Colorado and Virginia have used APCDs to monitor prescriber patterns, whereas New Hampshire leveraged APCD data to explore the impact of pain management services provided by chiropractors.

Similarly, a number of organizations and stakeholders have developed tools that leverage publicly available health care data sources to track progress at a geographic level. For example, the Opioid Abatement Needs and Investment Tool is a helpful resource for local, municipal, and state-level leaders dedicated to combating the opioid epidemic. This interactive data tool, crafted with insights from opioid experts, policymakers, and settlement fund advocates, offers targeted assistance by providing geographic-specific information. It outlines the potential demand for OUD treatment and recovery services at the

county level, juxtaposed with the locality's capacity to meet that demand. States have also developed their own data dashboards that integrate a variety of sources, such as North Carolina's Opioid and Substance Use Action Plan Data Dashboard. As described by this article authored by the Pew Charitable Trusts, Vital Strategies, and the National Association of Counties, Michigan has implemented a new data sharing program with its MiCelerity system, an automated surveillance tool that collects information on fatal and nonfatal drug poisoning events in the state. MiCelerity has admission, discharge, and transfer data along with relevant opioid-related diagnostic information. This data is available to certain state, health care organization, and local health department staff whose role involves overdose surveillance.

Key Takeaways

- **Collecting health care measures can be difficult with the data normally collected with OUD and SUD initiatives funded by opioid settlements.**
- **To improve data sharing to be able to demonstrate health care impact, the most feasible approach is to partner with existing sources of aggregated health care data, such as health information exchanges or all-payer claims databases.**

Commonly Used Health System Measures for Substance Use Disorder

In order to demonstrate the potential utility of opioid settlement-funded interventions to health care payers, state and local leaders, and organizations implementing interventions funded with settlement dollars (implementers) should consider which health care quality measures could be incorporated into their measurement approaches. Payers and providers have been increasingly leveraging measures in accountable care arrangements to incentivize improvements and monitor outcomes. Health care metrics often focus on reducing unnecessary utilization, including emergency department (ED) and hospital use, but also are becoming more patient-centered and focused on assessing elements of chronic disease management (e.g., hypertension, diabetes), patient satisfaction with their care experience, and use of preventive screenings, including for depression.

As the single largest payer of behavioral health services in the country, Medicaid state authorities and Medicaid managed care organizations (MCOs) bear much of the responsibility for paying for behavioral health services and tracking outcomes. Through its Medicaid Adult and Child Core Measure Sets, CMS has outlined reporting requirements for substance use disorder measures, which include measures like Initiation and Engagement of Substance Use Disorder Treatment, Follow-Up After Emergency Department Visit for Substance Use, and Use of Pharmacotherapy for Opioid Use Disorder. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 made reporting of the behavioral health measures on the Adult Core Set mandatory for states beginning in 2024.

These and other behavioral health measures also also tracked by commercial health insurers and included in other core sets, such as the Core Quality Measures Collaborative (CQMC) Consensus Core Set: Behavioral Health, which is intended for use in value-based payment (VBP) programs and to drive improvement in priority areas like SUD. **Table 1** (page 8) provides a crosswalk of where common measures for SUD treatment are used by health care

payers and in core sets. While this list is not comprehensive of all SUD-related measures used in health care, core set measures are often a bellwether for aligned implementation of measures by commercial payers and states through their Medicaid 1115 Demonstration Waivers. Said differently, core sets are also part of the movement to align quality measures across different health care payers (e.g., Medicare, Medicaid, commercial health insurance) and reduce the number of measures used in health care.

Initiatives, such as the Meaningful Measure Initiative and the creation of the CMS Universal Foundation, reflect this desire to promote a unified approach to measurement to improve outcomes for patients and reduce burden on clinicians and providers. Narrowing the number of measures collected and standardizing data collection practices may help track progress, compare outcomes, and reduce administrative burden.

Table 1 | Commonly Used Health System Measures for SUD

	CMS Core	Commercial*	CQMC	1115 Waivers**
Prevention				
Assessed for SUD treatment needs using a standardized screening tool (NQF #2597)				■
Early intervention–Number of beneficiaries who used early intervention services				■
Concurrent Use of Opioids and Benzodiazepines (CMIT #150)	■	■		■
Use of opioids at high dosage (CMIT #748)	■	■		■
Prescription drug monitoring (these are programs not one specific measure)		■		
Treatment				
SUD provider availability--# of providers enrolled in Medicaid and qualified to deliver SUD services				■
SUD provider availability Medications for Opioid Use Disorder (MOUD)				■
Number of Medicaid beneficiaries with SUD diagnosis				■
Follow-up after an ED visit for substance use (CMIT #26)	■	■	■	■
Withdrawal management--Number of beneficiaries who used withdrawal management services				■
Readmission rate for ED visit for SUD-related event				■
Initiation and engagement of SUD treatment (CMIT #394)	■	■		
Use of pharmacotherapy for OUD/Continuity of pharmacotherapy (CMIT #750)	■	■	■	■
Recovery				
Risk of continued opioid use--% of members beginning new episode of opioid use		■		

Note: While this figure contains commonly cited measures across health care payers and programs, it is not an exhaustive list and measures with overlapping criteria were excluded (e.g., Use of opioids at high dosage in persons without cancer, use of opioids from multiple providers, use of opioids at a high dosage from multiple providers in persons without cancer). Medicare Advantage and Part D measures focus on patient experience and preventions, such as screening and medication therapy management. These measures did not directly correspond to OUD/SUD and were not included in the figure.

*"Commercial" includes Blue Cross Blue Shield, United Healthcare, Aetna, and Cigna. A measure was considered to be included if public information for one or more of these companies indicated measurement. Many of these health payers are using similar measures, creating opportunity for alignment.

**Measures included are monitoring metrics for states with section 1115 demonstrations that focus on substance use disorder (SUD).

State and local leaders, and opioid settlement fund implementers should consider whether their opioid settlement-funded initiatives may impact these health care measures and whether there is an opportunity to incorporate or partner to receive data in order to align with the health care system. Leveraging commonly used metrics, such as those required for CMS core measures and 1115 waivers, strengthen the case for investment of health care resources in opioid settlement fund interventions. Specifically, they provide a clear value-proposition for payers and providers as to the improvements and effectiveness of interventions.

Key Takeaways

- **State and local leaders should consider whether opioid settlement-funded initiatives may impact measures that are tracked by health care payers across the prevention, treatment, harm reduction and recovery continuum.**
- **Leveraging commonly used measures, such as those required for the CMS core measure sets and state 1115 Demonstration waivers can strengthen the case for investment of health care resources in opioid settlement fund interventions.**

Considerations for Measure Selection

While many state and local OUD stakeholders are already engaging in measure reporting for their opioid settlement funding or other funding streams, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants and other federal block grants that provide billions of dollars in funding for states annually, few opioid settlement-funded initiatives are collecting or tracking health care-related measures. This section outlines the factors opioid settlement-funded initiatives should consider in identifying health care-related measures that can be feasible for demonstrating their value to health care payers.

- **Prioritize feasibility and simplicity.** Given that many stakeholders may not have experience with health care measurement, choose measures that can be reasonably collected with available or near-future data, including measures you are already collecting for other funders (e.g., using Government Performance And Results Act data collected for services funded by federal grants).
- **Consider privacy regulations.** In general, behavioral health data, especially SUD, has been highly controlled because of its sensitive nature. For many measures, the collection of individual-level data is needed to inform accurate assessments of performance, however for others (e.g., naloxone kits), this level of detail may not be needed to inform impact and future decision making.
- **Prioritize measures that can show impact for all people affected by opioid epidemic.** Many states have worked to include diverse voices in their opioid settlement decisions and allocate funding to all people affected by the opioid epidemic. Several groups have highlighted how opioid settlements can address the needs of people from different races and ethnicities, such as the Johns Hopkins Principles guiding the use of settlement funds and this Equity Considerations for Local Health Departments on Opioid Settlement Funds Checklist. One way to measure whether initiatives are equitable is by aligning with established frameworks,

such as the CMS Framework for Health Equity, which is similarly structured to align with U.S. Department of Health and Human Services (HHS) initiatives and the Healthy People 2030 Framework. This framework emphasizes the importance of collecting individual-level demographic and social determinants of health data, understanding disparities, and tailoring interventions to address the specific needs of underserved populations. Other measures are included in value-based payment models, like ACO REACH and Making Care Primary models, in addition to aligned equity elements for the Medicare Advantage program. By synergizing evaluation efforts with equity measures, leaders can ensure that the impact of investments benefits all individuals, irrespective of their background or socioeconomic status.

Key Takeaways

- **State and local leaders should select which health care measures to track based on feasibility to access relevant data, data privacy regulations, and ability to show an initiative's equitable improvement for all populations affected by the opioid epidemic.**
- **Leaders also should consider how selected measures can align with existing value-based payment models that prioritize using data to understand and tailor interventions to the specific needs of underserved populations.**

Future of Health Care Measures for SUD

While it is important to consider the current state of SUD treatment and relevant measures in any approach, health care is increasingly moving more towards incorporating value-based payment models that further incentivize high-quality care, encourage longitudinal care coordination, and ensure appropriate linkages to support services as patients move through the continuum of care. With this shift, health care payers are considering ways to enhance existing measures or add new measures to their overall approach that are:

- meaningful to patients and more accurately reflect their experiences (e.g., patient-reported outcome measures).
- effective in assessing impact of interventions aimed at screening, coordination, and provision of social-determinants of health interventions.

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Patient-Reported Outcome Measures

Patient-reported outcome measures (PROMs), which are still emerging, gather direct data from patients regarding their health conditions and quality of life. These measures also play a crucial role in understanding the patient's perspective, though their implementation in the context of OUD can be complex. Using PROMs to accurately understand whether patients are meeting their own goals for recovery is an emerging and critical area, with existing

recovery assessments being utilized around the country by Recovery Community Organizations (RCOs), recovery homes, and others. Tools such as the Brief Assessment of Recovery Capital (BARC-10) and the Recovery Capital Index can be used to collect information on patient functioning and quality of life. Work is ongoing by the America Psychiatric Association, with support from CMS, to develop validated quality measures in SUD.

Social Determinants of Health

Social determinants of health, such as employment, housing, transportation, trauma, social support, and stigma, may impact opioid-related morbidity and mortality. Recognizing the interconnectedness of OUD and these social drivers is critical to producing lasting outcomes from interventions funded through opioid settlement funds. Therefore, in developing effective measurement practices, it is essential to acknowledge and incorporate the influence of social drivers of health on the development, treatment, and outcomes of OUD. Stakeholders within health care and public health sectors increasingly acknowledge the role of social drivers on outcomes and have taken steps in recent years to incorporate more direct forms of measurement through tools and initiatives, such as tracking social drivers in administrative health care claims data (expanded Z codes), community health needs assessments utilizing tools such as Duke Margolis's Opioid Abatement Needs and Investment Tool, and cross-sector collaborations for identifying measures. Measures used in value-based payment also have expanded to include screening for social determinants of health.

Conclusion

Opioid settlement funds and other limited-duration funding streams represent an unprecedented, near-term opportunity invest in improvements to the behavioral health system. However, long-term sustainability of these investments once settlement fund cease is a concern. Health care funding, especially from payers and providers that are leveraging accountable care payment models, offer one opportunity to sustain investments, but will require a coordinated effort across health care, local and state governments and other settlement fund stakeholders. To accomplish this coordinated effort, settlement fund stakeholders will need to leverage aligned measures across health care and public health fund stakeholders based on the data to which they have access. Specifically, by public health/settlement fund stakeholders incorporating and selecting measures used by accountable payers and providers (relying on the best of the current measures in the near term and then transitioning to more meaningful OUD patient-reported outcome and other measures) into their measurement plan, these stakeholders can create a powerful value-proposition for the health care industry about the benefits of these systematic improvements to the behavioral health system.