Task Force on Alcohol Pricing and Addiction Services: Questions and Answers on the SUD Financial Analysis

Does the report include information on dollars allocated vs. spent?

The spending inventory only includes dollars expended in the 21-23 Biennium. Members may contact individual agencies to get additional information on allocations (budgeted dollars) and/or obligations.

Do we know what cities spent on SUD services and supports?

City spending was not included in the SUD Financial Analysis.

Do we have information on how other states fund SUD treatment? Is Oregon different in terms of how we fund/finance care?

The SUD Financial Analysis does not include a 50-state comparison of financing models for SUD. We anticipate this topic will, however, be included in the scope for the upcoming Joint Task Force on Regional Behavioral Health Accountability, which has been established under Sections 16 and 17 of HB 4002 (2024 short session.) Among other things, the Task Force has been directed to make recommendations on: "Policy changes recommended based on a comparative analysis of policies in other states that spend less on treatment but demonstrate better behavioral health and substance use disorder treatment outcomes, including better outcomes for groups that are disproportionately impacted by health inequities." Draft recommendations are due to the Legislature by September 15, 2025 and final recommendations are due December 15, 2025.

What wages are needed to attract SUD workers to the profession?

The PCG study estimates workforce cost estimates using wage data from a Mental Health and Addiction Certification Board of Oregon (MHACBO) survey of credentialled workers, adjusted for inflation. These figures were compared against "good enough" rates that were provided by the Oregon Council for Behavioral Health, a behavioral health trade association in Oregon. In most cases, the inflation-adjusted wages exceeded the "good enough" rates provided by OCBH. PCG recommends additional modelling on wage increases that may be needed to attract and retain workers.

Recommendations on wage increases were also covered in a 2021 report, "Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature." There is also an active workgroup on behavioral health workforce recruitment and retention, which was created by HB 2235 (2023 regular session.) Initial recommendations are due January 15, 2025 and final recommendations are due December 15, 2025.

Why are benefits for CPS and CADC so much higher than other workers?

The algorithm for the benefit figures for Certified Prevention Specialists and Certified Alcohol and Drug Counselors contained an error that the contractor did not catch prior to the release of the preliminary report. They corrected these figures for the final report:

TABLE 28: TOTAL ANNUAL COST OF NEEDED SUD POSITIONS

Cost Component	CPS	CADC	CRM	QMHA	QMHP
Annual Salary	$69,004	$54,076	$44,344	$51,722	$74,642
Benefits	$20,287	$15,898	$13,037	$15,206	$21,945
Total Wages	$89,291	$69,974	$57,381	$66,929	$96,587
Administrative + Program Support	$21,430	$16,794	$13,771	$16,063	$23,181
Total Cost Per Position	$110,721	$86,767	$71,152	$82,992	$119,767
Number of Positions Needed	906	2,018	612	17,717	11,740
Total Annual cost for all Positions	$100,313,156	$175,096,702	$43,545,300	$1,470,360,869	$1,406,069,182
				Total for all positions	**$3,195,385,208**

For county spending: what is included in statewide and out of state?

"Statewide" spending includes spending across multiple counties, which could not be disaggregated for the county breakout. Out-of-state spending is largely attributed to Medicaid expenditures for services provided outside of Oregon.

Why does the report focus on certain types of workers, e.g. RNs are not included?

Quantitative data on behavioral health workforce gaps were only available via the OHSU-PSU School of Public Health's Oregon SUD Services Inventory and Gap Analysis. The study authors of that report were charged with using SAMHSA's Calculating for an Adequate System (CAST) methodology for unmet need estimates, and the CAST methodology does not provide for gap estimates for all categories of workers. Additional quantitative gap estimates would be needed to understand cost estimates for RNs and other workers that PCG could not include in their report.

Did any of the M110 funds go toward workforce development?

Some M110 organizations use their funding for workforce development activities, such as staff trainings. The report does not examine workforce spending outside of major investments dedicated to workforce development (e.g. those provided for through HB 2949, HB 4071, and HB 4004.) Additional analysis is required to determine how organizations leverage other funds to support workforce.

What does "undetermined" mean?

Spending items listed as “undetermined” are those which PCG could not code into a certain category or subcategory based on available data.

Answers to Questions about the OHSU-PSU School of Public Health Oregon SUD Services Inventory and Gap Analysis, Provided by Lead Author Elizabeth Waddell, PhD.

If I'm understanding this correctly, it appears that the gap in services was determined primarily by looking at the number of SUDs in the 2020 NSDUH survey and projecting capacity to handle that population assuming that those SUDs were in need of recovery. The document indicates this was done via the CAST methodology. I have a few questions below:

The methodology for the CAST (linked here) does NOT assume that all individuals with SUDs would seek recovery services. Estimates of those with SUDs who would seeking services are based on responses to the National Survey on Drug Use and Health, state/county population characteristics as well as existing literature on utilization patterns of individual services.

Wasn't the 2019-2020 NSDUH state level data rescinded by SAMHSA and deemed unusable?

See links below:

a. The **SPH 2022 report** was published in September 2022.
b. NSDUH pulled the 2019-2020 state estimates on Jan 7, 2023.
c. Estimates for 2021-2022 were posted Feb 15, 2024.

Is 2020 the first year that NSDUH transitioned from DSM-4 to DSM-5 methodology?

In 2020, NSDUH began using the DSM-5 use disorder criteria in its estimates, but these updated criteria have not yet been applied to regions. Therefore, we used NSDUH 2020 state level prevalence estimates for all estimates about use disorders and those needing but not receiving treatment at a specialty facility for a use disorder. All estimates of treatment need and SUD are calculated using DSM 5 criteria.

Does the CAST method assume that 100% of SUDs are in need of recovery, or is there some algorithm to determine what portion of them are in need of recovery?

There is an algorithm, as described above.

After reading through the document, it appears that there was no analysis of the actual utilization rates of current recovery beds, or counting of patients turned away due to lacking capacity, rather a theoretical analysis based on the NSDUH data only. Am I reading this correctly? If so, did the state conduct any analysis in some other document to determine the capacity needs for recovery beds based on actual usage that you're aware of?

Utilization rates were not available when the report was published. Our survey included items to assess utilization rates, but during COVID-19 pandemic and frequent changes in capacity due to outbreaks, this information was not available.