HB 3610 Task Force on Alcohol Pricing, Addiction Services
Review questions from Task Force Members
Thursday, April 11, 2024

Recovery providers said that they had capacity, but that they are withholding it from patients who lack private insurance or cash because the reimbursement rates are too low from Medicaid. One provider indicated that a patient with insurance could get help anywhere in the state immediately while a Medicaid patient could be on waiting lists for weeks or months.

Recovery providers also indicated that they had beds going unused because they couldn't hire the staff to service the beds. They indicated that they couldn't afford to pay wages to attract more staff because they lose money by serving Medicaid patients.

Rep. Sanchez confirmed that the state does not track how often existing beds are being used, what percentage of beds are available to Medicaid patients vs private insurance patients or how many patients are turned away and for what reason.

If the state isn't tracking recovery bed usage, where is the narrative that we are lacking beds coming from and by what metrics are they making that determination? And, if new beds were built, but providers are still not getting reimbursed for servicing patients on Medicaid, how would the new beds improve service for Medicaid patients if providers remain unwilling to provide them with the service? What is the total dollar figure allocated to new bed capacity in the last 3 years?

I believe OHA provides a Medicaid reimbursement rate recommendation to the legislation as part of their budget requests. If so, can they provide us with what that recommendation was and any contextual arguments they made to justify that recommendation?

I believe OHA would also have to maintain a database of the costs by recovery service type so that the state knows how much it should expect Medicaid to be billed. It would be useful for our group to have these costs in a spreadsheet as well as the average private insurance billing rates for the same services so that we can compare them to understand the scale of the delta in reimbursement rates. Again, I understand that the state is not tracking the total number of recovery patients (according to Sanchez), but there should be records for all Medicaid billings I would assume? Can we get a count on the number of Medicaid paying recovery patients the state served per year for the last couple of years? If we're not able to get these figures, I don't know that we have any business discussing additional funding until the state can figure out how to obtain some base level of metrics.

I believe Oregon to be the 3rd or 4th highest in per capita expenditure on recovery services in the US (behind DC, Maine and maybe Vermont) and I'd like to understand how with that level of funding, we are not more able to address our needs compared to other states who are spending proportionately less. Could some percentage of new capacity expenditure be used to increase Medicaid reimbursement rates and thus increase our capacity to the group who seems to be lacking access? What are Medicaid reimbursement rates like in more successful states?

Q: Why did Joe (one of today's presenters) experience years of courts and none of them introduced him to sobriety? Is there a standard across the court systems in Oregon that people who show up in the court system are required to be assessed for having addiction issues?

Q: Is there any effort underway to examine the use of Oregon Health Plan to address early signs of addiction?

Q: If a person is placed in a local jail, and that person had addiction issues and need health care, do the jails pay for that or the state?

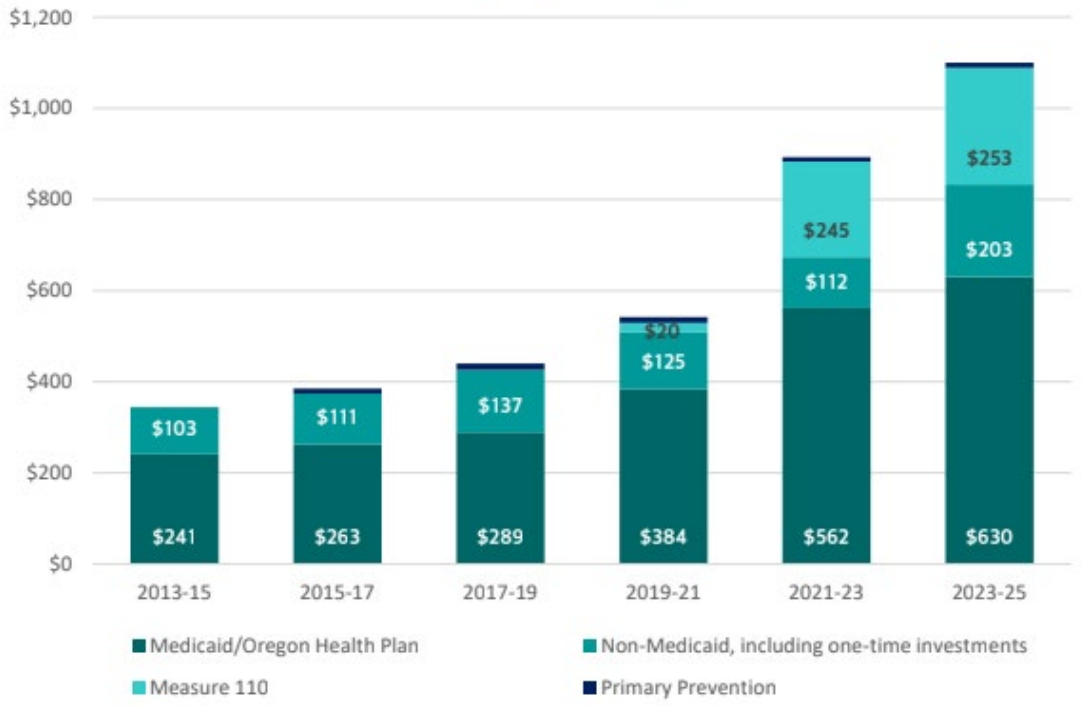
Q: If the state were to increase taxes on beer and wine, how would they use the additional funding? Is there a plan?

Q: Solera said if you have OHA you wait in line for treatment. If you have private insurance, you get in today. My guess is that the majority of the population of suffering alcohol-induced deaths are on OHA. Do we have any data on the economic makeup of those suffering the greatest from addiction?

Q: Solera commented that "when pay rates by OHA went up, so did the staffing", offsetting the additional funding increases recently provided. Was this state mandated staffing levels? Is there anyone who thinks that perhaps the benefit of increasing minimum staffing levels at hospitals might not be worth the fact that people aren't getting access to addiction services?

Was the budget presented the current budget (2023-2025), or was it the previous budget cycle (2021-2023)? The measure 110 audit conducted by the secretary of state indicates that the current budget is roughly $200 million larger than what was presented (see chart below).

Figure 5: M110 is a substantial addition to the state's funding of substance use disorder services (funding in millions)



Source: Auditor constructed based on data provided by OHA

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- The budget presented indicated ~$58 million in funds were unaccounted for (roughly 6% of the total budget presented). What is the status of this funding?
- The budget presented indicated ~$4.2 million in funds as "Out of State Spending." What are these funds being used for?

- The recovery services cost estimates in hiring additional needed work force appeared to have significant errors in the math that overestimated the costs by over $418 million dollars (see chart below).
- Did OHA present these figures because there is an intention that all or some of the labor/education costs are to be covered out of the SUD service budget, or just to illustrate that it will be expensive in general for the recovery industry to hire additional staff?
- Are the total number of positions needed coming from the GAP analysis report? What is the theoretical number of patients that this capacity is intended to service and what is the current capacity?

Determining Costs – Workforce - Wages

Total Annual Cost of Wages and Administration for Needed SUD Positions

Cost Component	CPS	CADC	CRM	QMHA	QMHP
Annual Salary	$68,461	$53,650	$43,995	$51,315	$74,054
Benefits	~~$88,588~~ $20,127	~~$69,423~~ $15,773	$12,935	$15,087	$21,772
Total Wages	~~$157,049~~ $88,588	~~$123,073~~ $69,423	$56,929	$66,402	$95,826
Administrative + Program Support	$37,692	~~$152,610~~ $29,537	$13,663	$15,936	$22,998
Total Cost Per Position	~~$194,741~~ $126,280	~~$275,683~~ 98,960	$70,592	$82,338	$118,825
Number of Positions Needed	906	2,018	612	17,717	11,740
Total Annual cost for all Positions	~~$176,435,309~~ $114,409,680	~~$556,329,267~~ $199,701,280	$43,202,587	$1,458,788,758	$1,395,003,063
	WAGES OVERESTIMATED BY $418,653,617			**Total for all positions**	~~$3,629,758,985~~ $3,211,105,368

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