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TO Substance Use Disorder
Contracted Treatment Providers

FROM: Gary Tsai, M.D., Director
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SUBJECT: **FISCAL YEAR 2025-2026 RATES AND PAYMENT POLICY UPDATES**

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative has now entered its third year, building on the foundation laid in 2017 when the Los Angeles County Department of Public Health's Bureau of Substance Abuse Prevention and Control (SAPC) launched the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. SAPC aims to build on the value-based reimbursement model it launched in 2023 to further advance the network and improve treatment outcomes.

SAPC is issuing this bulletin under the authority of the Los Angeles County Board of Supervisors and as described in paragraph 3.A., which states, "Contractor shall adhere to any and all Provider Network Bulletins as issued by SAPC from time to time throughout the term of this Contract," available at the following link: http://publichealth.lacounty.gov/sapc/NetworkProviders/Regulations.htm."

The Fiscal Year (FY) 2025-2026 changes include, but are not limited to:

- A 3.10 percent increase from FY 2024-2025 rates for all ASAM levels of care. Note

the FY2025-2026 Recovery Bridge Housing and Recovery Housing day rate will remain at the FY2024-2025 amounts.
- An updated set of optional Value-Based Incentives (formerly known as Capacity Building and Incentives) opportunities.
- Removal of the requirement to bill $0 services for patients in **residential and withdrawal management levels of care**, with the exception of H2010M/N.

This revised SAPC bulletin, effective July 1, 2025, outlines the implementation of the new rates under payment reform and includes additional important payment-related information.

FISCAL YEAR 2025-2026 RATES

In accordance with Paragraph 6(E) of your contract, "Invoices and Payments," "For DMC-ODS services, payments shall be made in accordance with the rates as described in the most current version of the Rate Matrix," available at the following link: http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins

The Rates Matrix will take effect on July 1, 2025, following SAPC's review and analysis of all DHCS bundled rate categories; stratification of rates by tiers, American Society of Addiction Medicine (ASAM) level of care, and practitioner type (non-residential only); and consideration of other programmatic, clinical, and operational factors necessary to ensure an effective and fiscally sustainable specialty SUD treatment system.

DHCS Rate Categories	Included Levels of Care
Inpatient Withdrawal Management (WM)	ASAM 3.7-WM ASAM 4-WM
Residential	ASAM 3.1 ASAM 3.3 ASAM 3.5 ASAM 3.2-WM
Non-Residential	ASAM 0.5 ASAM 1.0 ASAM 2.1 ASAM 1-WM ASAM 2-WM
Opioid Treatment Program	OTP

STAFF HOURLY RATES

The FY 2025-2026 Staff Hourly Rates for contracts with a staff hour reimbursement structure are described below. Unless otherwise noted in your contract, provider agencies must use the following rate to submit staff hour reimbursement invoices:

Fiscal Year	Rate
FY 2025-2026 Staff Hourly Rate	$81.07

SAPC leverages other contracts to better manage the County's SUD Network and to support services beyond treatment. Examples of these services include, but are not limited to, Sexual Reproductive Health Specialists, Client Engagement and Navigation Services (CENS), and the Building Relationships, Inspiring Development, Growing Engagement (BRIDGE) programs.

TIERED RATES AND TIER ASSIGNMENT METHODOLOGY

SAPC established a tiered rate system for specific levels of care as outlined in the table below. The tiered rate system establishes higher rates for providers that offer a more expansive continuum of services and account for higher associated costs, and it incentivizes a continuum of services within the organization to facilitate improved and more coordinated care.

Tiered Rate	Non-Tiered Rate
• Early Intervention (ASAM 0.5) • Outpatient (ASAM 1.0) • Intensive Outpatient (ASAM 2.1) • Outpatient WM (ASAM 1-WM, 2-WM) • Residential (ASAM 3.1, 3.3, 3.5) and • Residential Withdrawal Management (3.2-WM) • Care Coordination • Recovery Services • Medication Services • Peer Support Services	• Inpatient WM (3.7-WM, 4-WM) • Opioid Treatment Programs • Recovery Bridge Housing • Recovery Housing

Providers were assigned to one (1) of three (3) tiers based on their contracted and utilized levels of care as determined by FY 2024-2025 billing activities. The Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF) is counted as a level of care to reflect its value, ensuring delivery of quality care and incentivizing expanded network participation.

With respect to the establishment of tiered base rates, the utilization of contracted levels of care within provider agencies is based on consistent and ongoing use of billing activity throughout the fiscal year, as verified by Sage. Providers must bill monthly to receive credit for utilized levels of care. SAPC staff will monitor billing activity and determine each provider agency's tier based on billing data from July through March, in advance of the next fiscal year's determination. Provider agencies must also maintain their accreditation to continue

receiving credit in the tier determination process. A lapse in accreditation may result in the reassessment and reclassification of a provider agency's assigned tier. Please submit new, renewed, and/or revised accreditations to your assigned Contract Program Auditor.

SAPC will reassess a provider agency's contracted and utilized levels of care, as well as their accreditation status, as part of the end-of-year activities. Additional analysis may include a review of fiscal reports, which will be conducted at the end of the third (3rd) quarter of the fiscal year. This is why it is essential that provider agencies submit treatment claims timely and accurately, including resolving and resubmitting any denied claims, as appropriate. Provider agencies are reminded to contact the Sage Helpdesk with any billing issues or concerns. The section below further describes the methodology:

- Rule #1: Existing provider agencies – Levels of care counted toward Tier considerations must be contracted and utilized for at least six (6) months of the current fiscal year, from July 2024 through March 2025;

  OR

- Rule #2: Existing provider agencies with new levels of care and/or NEW provider agencies (2nd Year) – Levels of care counted toward Tier considerations must be contracted and utilized for at least six (6) consecutive months for the current fiscal year, from July 2024 through March 2025.

Provider agencies may contact the SAPC Finance Services Division at SAPC-Finance@ph.lacounty.gov for more information or questions on their assigned tier.

Below is the list of contracted levels of care that were considered in this analysis and the tier methodology:

Tier Levels of Care	Tier Methodology
• ASAM 1.0: Outpatient • ASAM 2.1: Intensive Outpatient • ASAM 1-WM: Outpatient WM • ASAM 3.1: Residential • ASAM 3.3: Residential • ASAM 3.5: Residential • ASAM 3.2-WM: Residential WM • ASAM 3.7-WM: Inpatient WM • ASAM 4-WM: Inpatient WM • Opioid Treatment Program • Recovery Bridge Housing • Accreditation by Joint Commission or CARF	**Tier 1** 1 or 2 Levels of Care **Tier 2** 3, 4, or 5 Levels of Care **Tier 3** 6 or more Levels of Care

REIMBURSEMENT AND CLAIMING CHANGES

CalAIM's Payment Reform provisions include several changes that impact how provider agencies submit claims and are reimbursed. The following changes are effective July 1, 2025:

Fee-for-Service Reimbursement

Beginning July 1, 2023, and in accordance with the payment reform provisions of CalAIM, DMC treatment services are reimbursed via a fee-for-service (FFS) structure. This reimbursement approach, combined with the transition away from cost-based reimbursement, allows providers to reinvest excess funds at the organization's discretion while still adhering to the County of Los Angeles Department of Auditor-Controller's (A-C) Contract Accounting and Administration Handbook. This structure also significantly streamlines Fiscal Reporting requirements and excludes subsequent cost reconciliation.

While the new reimbursement model creates efficiencies and opportunities for provider agencies to invest in programs, it also requires that agencies have systems in place to ensure that revenue meets organizational expenditures. Once a claim has been approved and reimbursed, provider agencies must ensure that the revenue is sufficient to cover the costs associated with providing that unit of service. No additional funding will be provided for services rendered.

Fiscal Reporting

Per DMC-ODS guidelines, SAPC will no longer use DHCS' Cost Report Template for DMC-reimbursable services. SAPC will implement a significantly streamlined Fiscal Reporting process to collect financial information at the organizational level as part of the ongoing effort to ensure rates are appropriately supporting providers and enabling the transition to value-based care. This information will also inform the determination of Rate Tiers if the tier structure is continued in future years. Additionally, SAPC will continue to conduct fiscal compliance audits/reviews via its partnership with the A-C.

Practitioner Rates

For non-residential levels of care (e.g., ASAM 1.0, 2.1, 1-WM, 2-WM), reimbursement rates are based on the practitioner level delivering the treatment services. This enables provider agencies to financially support a diversified direct service workforce to include more Licensed Practitioners of the Healing Arts (LPHA), expand on-site service options such as Medications for Addiction Treatment (MAT) and family therapy, and compensate them at a higher level to support competitive salaries and benefits. Differential rates for registered versus certified counselors also acknowledge that increased education and training should be supported with enhanced rates and more competitive compensation packages.

To fully leverage and benefit from this opportunity, provider agencies need to develop and implement billing processes to ensure that treatment services are billed under the

accurate and actual practitioner level(s). Services must be billed under the staff member who provided the service (e.g., services provided by a registered counselor can only be billed under the registered counseling rates), and staff must be delivering services in accordance with all applicable local, state, and federal rules and requirements, including scope of practice requirements. Intentional and/or accidental inappropriate billing may result in non-compliance and contractual actions.

Residential Rates

In preparation for a future re-bundling of residential treatment rates - which will eliminate the ability to submit separate claims for care coordination, medication services, peer services, and recovery services, in addition to the day rate - it is imperative that residential provider agencies consistently and immediately submit appropriate claims for these services. This will ensure that the true cost of delivering this care can be incorporated into DHCS's future calculations when determining revised DMC rates. If DHCS bundles residential rates as currently indicated, providers will no longer be able to submit separate claims for Care Coordination, Medication Services, Peer Services, and Recovery Services. To ensure the future bundled residential rates reflect the actual cost of care, most, if not all, residential agencies must take action by billing these claims separately, and in addition to the day rate. Insufficient participation is unlikely to result in an appreciable increase in future reimbursement rates.

Changes to Service Codes and the Rates Matrix

DHCS and SAPC have implemented changes to the service codes effective July 1, 2025. These changes have been updated on SAPC's Rates Matrix. A summary of changes is included in the attachment titled "FY 2025-26 Service Codes & Rates Matrix Change Update."

Medicare Enrollment

As a reminder, federal guidelines require that provider agencies first bill Medicare and/or Medicaid for patients enrolled in these benefits. As such, providers must enroll in the federal Medicare program to be in compliance with this policy. Medicare enrollment information is available at the following site: Medicare Enrollment.

VALUE BASED INCENTIVES (FORMERLY CAPACITY BUILDING AND INCENTIVES)

The launch of Payment Reform in July 2023 marked a significant step in transitioning Los Angeles County's specialty SUD system from a volume-based to a value-based reimbursement structure. Since then, SAPC has steadily advanced the system into a value-based environment.

As a key component of this Payment Reform strategy, SAPC will continue to provide treatment provider agencies with additional resources to fully capitalize on opportunities under CalAIM. These resources will support the organizational changes needed to implement updated guidelines and program requirements through Value-Based Incentives (formerly known as Capacity Building and Incentive Initiatives).

Value-Based Incentives are payments made by SAPC to treatment provider agencies as rewards for meeting specific benchmarks, deliverables, or performance metrics. These funds may be disbursed either upon completion of a deliverable or after the achievement of a defined performance goal associated with the Value-Based Incentives.

To receive full payment, providers must submit verification of completion and expenditures, along with any required deliverables, documentation, or data. If all criteria for the Value-Based Incentive activity are met, providers may retain the full amount of the incentive.

Funds received through Value-Based Incentives may be reinvested into the treatment program as needed. This includes, but is not limited to, supporting activities or initiatives related to the Value-Based Incentive goals.

For Year 3 of Payment Reform, SAPC built upon the FY 2023-2024 incentives package and continues to move the SUD system toward this new model. SAPC's Payment Reform Webpage includes more information on the current year's package.

SAPC is offering optional Value-Based Incentives funds to support provider agencies with development in the following areas:

- Finance and Business Operations
- Workforce Development: Recruitment, Retention, and Training
- Access to Care

Billing for Value-Based Incentives

Value-Based Incentive payments are structured according to a provider agency's assigned Rate Tier. Provider agencies interested in Value-Based Incentives need to submit the appropriate attestation and invoice for the effort(s) being claimed.

SAPC's Payment Reform Webpage will include documents detailing the FY 2025-2026 Value-Based Incentives package as well as required invoice templates.

Budgeting for Value-Based Incentives

Provider agencies should include the expected Value-Based Incentives funding in their FY 2025-2026 DMC Contract Budget to ensure proper tracking and utilization. Provider agencies must review the relevant Capacity Building and Incentive materials and determine which activities to participate in and notify SAPC accordingly.

Based on that determination, provider agencies should then budget that amount and enter it under the "Services and Supplies" section of the contract budget.

ADDITIONAL BENEFITS UNDER THE DMC TREATMENT CONTRACT

Reimbursement under the DMC-ODS Contract expands to include an invoice process, in addition to the Rates Matrix, for the following select services under the treatment services benefit:

- Value-Based Incentives (formerly Capacity Building and Incentives)
- Contingency Management (Recovery Incentive Program)
- Select Youth and Pregnant / Parenting Women Services

For information on which invoice to use, or more information on these services, see relevant sections in this Bulletin or other corresponding bulletins which are available at the SAPC website:

http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and- forms.htm#bulletins

FIELD-BASED SERVICES ENHANCED BENEFIT

During Fiscal Year 2025-2026, SAPC will offer a quarterly incentive payment for patients served at approved Field Based Service (FBS) sites. SAPC will reimburse providers an additional 10% of total approved claims for services conducted at contracted FBS sites. To qualify for the benefit, provider agencies must:

- Receive approval from SAPC to provide FBS. Agency must submit a complete FBS application for approval. For more information, please review SAPC Bulletin 23-14.
- Adhere to the documentation requirements when completing progress notes and submitting claims. Claims must include the appropriate place of service code for the approved FBS location, and the patient must have progress notes with appropriate documentation for FBS to be counted towards the enhanced benefit.
- After every four months, submit an invoice based on the FBS claims report provided by SAPC.

The Systems of Care Division at SAPC will conduct reviews of SAGE billing data and progress notes every four months to identify eligible claims to determine payment amount. Claims must have appropriate place of service codes, and a patient served through FBS. Secondary Sage users will need to submit a progress note report to Systems of Care for review using an approved Secure File Transfer Protocol**.** The progress note report needs to include patient name, PCNX patient ID, date of service, place of service code, FBS site

location, and services provided. As such, provider agencies must adhere to the documentation requirements of SAPC Bulletin 23-14 and BHIN 22-019 and include the service site information. Questions regarding this benefit may be sent to sapc_asoc@ph.lacounty.gov.

REACHING THE 95% (R95) ENHANCED ACTIVITIES

SAPC will offer incentives to provider agencies for engagement in Reaching the 95% (R95) workgroups and trainings to encourage active learning about how to expand outreach and engagement and how to lower barriers to specialty SUD treatment. In Fiscal Year 2025-2026, eligible meetings and incentives are:

- Harm Reduction Integration Meetings – Providers are eligible for a one-time $20,000 payment once a minimum of 85% of patient-facing staff attend at least one SAPC-led Harm Reduction and Treatment Integration meeting or SAPC-approved harm reduction training
- R95 Workgroups and Trainings – Providers are eligible for a one-time $20,000 payment once a minimum of 85% of patient-facing staff attend at least one SAPC-led or SAPC-approved R95 workgroup meeting or training.

The SAPC R95 team will track staff participation throughout the fiscal year in qualifying meetings and notify providers as they reach the 85% threshold. More details to follow in upcoming R95 Enhanced Activities IN. Questions should be sent to SAPC-R95@ph.lacounty.gov, or calls can be made to the R95 Consultation line: (626) 210-0648.

RESOURCES

The following resources provider additional information and guidance:

- The SAPC Provider Manual
- Sage 837P Companion Guide
- Sage 837I Companion Guide
- Behavioral Health Information Notice No. 23-001

EFFECTIVE PERIOD

This guidance will be effective July 1, 2025, through June 30, 2026, unless otherwise revised.

ADDITIONAL INFORMATION

For additional questions or requests, please contact your assigned Contract Program Auditor.

Attachment

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