



BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

ANISH P. MAHAJAN, M.D., M.S., M.P.H.
Chief Deputy Director

GARY TSAI, M.D.
Bureau Director
Substance Abuse Prevention and Control Bureau
1000 South Fremont Avenue, Building A-9 East, 3rd Floor, Box 34
Alhambra, California 91803
TEL (626) 299-4101 • FAX (626) 458-7637

www.publichealth.lacounty.gov

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SAPC INFORMATION NOTICE 26-08
Supersedes Information Notice 25-09, Effective 07-01-26

June 15, 2026

TO: Substance Use Disorder
Contracted Treatment Provider Agencies

FROM: Gary Tsai, M.D., Bureau Director *AT*
Substance Abuse Prevention and Control Bureau

SUBJECT: **FISCAL YEAR 2026-2027 RATES AND PAYMENT POLICY UPDATES**

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative has entered its fourth year, building on the foundation established 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 seeks to build on the value-based reimbursement model it introduced in 2023 to further strengthen the treatment provider network and improve treatment outcomes.

SAPC is issuing this Information Notice (IN) 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) 2026-2027 changes include, but are not limited to:

- A 6.2 percent increase from FY 2025-2026 rates for American Society of Addiction Medicine (ASAM) levels 0.5, 1.0, 2.1, 3.7 WM, and 4.0 WM, as well as enhanced PPW services, and Staff-Hour type contracts, i.e., Client Engagement and Navigation Services.
- A 9.3 percent increase from FY 2025-2026 rates for ASAM levels 3.1, 3.2 WM, 3.3, and 3.5.

- A \$5.00 per bed, per night increase for Recovery Bridge Housing and Recovery Housing.
- An updated set of optional Value-Based Incentives.
- Removal of the requirement to utilize modifiers for Clinical Trainee services.

This revised SAPC IN, effective July 1, 2026, outlines the implementation of the new rates under payment reform and includes additional important payment-related information. These more substantive rate increases for FY 2026-2027 compared to prior fiscal years is intended to help SAPC’s treatment provider network prepare for needed investments related to the State of California Department of Health Care Services’ (DHCS) upcoming transition to the ASAM 4th edition. These more substantive rate increases are considered to be one-time and future rate increase amounts will be re-evaluated and considered within the context of future needs and resources.

FISCAL YEAR 2026-2027 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-andforms.htm?tm#bulletins>.

The Rates Matrix will take effect on July 1, 2026, following SAPC’s review and analysis of all DHCS bundled rate categories; stratification of rates by tiers, 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 substance use disorder (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 2026-2027 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 2026-2027 Staff Hourly Rate	\$86.10

SAPC leverages other contracts to strengthen the management of the County’s SUD Network and support services beyond direct treatment delivery. 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, and 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 structure provides higher reimbursement rates to provider agencies offering a broader continuum of services that reflect higher associated costs, while also incentivizing organizations to deliver coordinated care across multiple service levels.

Provider agencies were assigned to one (1) of three (3) tiers based on their contracted and utilized levels of care as determined by FY 2025-2026 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.

For the purposes of tier assignment and base rate determination, utilization of contracted levels of care is based on consistent and ongoing billing activity throughout the Fiscal Year, as verified through Sage. Provider agencies must bill monthly to receive credit for utilized levels of care. SAPC staff will monitor billing activity and determine each provider agency’s tier assignments using billing data from July through March, in advance of the next Fiscal

Year's tier determination. Provider agencies must also maintain Joint Commission or CARF 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. Provider agencies should submit new, renewed, and/or revised accreditations to their assigned Contract Program Auditor.

SAPC will reassess a provider agency's contracted and utilized levels of care, as well as its 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 in a timely and accurate manner, 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 2025 through March 2026;

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 2025 through March 2026

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
<ul style="list-style-type: none"> • 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 	<p style="text-align: center;"><u>Tier 1</u></p> <p style="text-align: center;">1 or 2 Levels of Care</p> <p style="text-align: center;"><u>Tier 2</u></p> <p style="text-align: center;">3, 4, or 5 Levels of Care</p> <p style="text-align: center;"><u>Tier 3</u></p> <p style="text-align: center;">6 or more Levels of Care</p>

REIMBURSEMENT AND CLAIMING CHANGES

CalAIM’s Behavioral Health Payment Reform provisions include several changes that impact how provider agencies submit claims and are reimbursed.

Fee-for-Service Reimbursement

Since July 1, 2023, and in accordance with CalAIM payment reform provisions, DMC treatment services have shifted to a fee-for-service (FFS) reimbursement structure. This reimbursement approach, combined with the transition away from cost-based reimbursement, allows provider agencies 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. DMC activities and funds continue to be monitored, both contractually and fiscally, and subject to recoupment. Additional information and guidance on fiscal compliance can be found in the most current SAPC Information Notice – Annual Fiscal Compliance Reviews for Substance Use Prevention, Harm Reduction, Treatment, and Related Service Agreements.

While this reimbursement model creates efficiencies and opportunities for provider agencies to invest in programs, it also requires that they have systems in place to ensure revenue covers organizational expenditures. Once a claim has been approved and reimbursed, provider agencies must continue to 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 revised guidelines under CalAIM, SAPC will no longer use DHCS's Cost Report Template for DMC-reimbursable services. SAPC implemented a significantly streamlined Fiscal Reporting process to collect financial information at the organizational level as part of the ongoing effort to ensure rates appropriately support provider agencies and enable them to succeed within value-based reimbursement. This information will also inform the determination of Rate Tiers if the tier structure is continued in future years. Additional information and guidance may be found in the most current SAPC Information Notice – Implementation of Fiscal Reporting Process for All Substance Abuse Prevention and Control Bureau Services Provider Agencies. Additionally, SAPC will continue to conduct fiscal compliance audits/reviews through 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, including 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 staff at higher levels 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 must develop and implement billing processes to ensure treatment services are billed under the appropriate practitioner level. Services must be billed under the staff member who provided the service (e.g., services provided by a registered counselor must only be billed at the registered counseling rates), and staff must deliver 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 is expected to 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' 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 support services, community health worker services, caregiver services, and recovery services. To ensure that 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. Sustained participation will be critical to supporting future reimbursement rate increases.

Changes to Service Codes and the Rates Matrix

DHCS and SAPC have implemented changes to the service codes effective July 1, 2026. These changes have been updated on SAPC's Rates Matrix. A summary of changes is included in the attachment titled "FY 2026-27 Rates Matrix and Code Changes."

Medicare Enrollment

As a reminder, federal and State guidelines require that provider agencies first bill Medicare for clients who have both Medicare and Medi-Cal. For more information on SAPC requirements see the most current version of the Treatment Provider Manual.

VALUE-BASED INCENTIVES

The launch of Behavioral Health 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 continued advancing the system within a value-based environment.

As a key component of this Payment Reform strategy, SAPC will continue providing treatment provider agencies with additional resources to help maximize opportunities under CalAIM. These resources are intended to support the organizational changes needed to implement updated guidelines and program requirements through Value-Based Incentives.

SAPC is offering optional Value-Based Incentives funds to support provider agency development in the following priority categories:

- Finance and Business Operations
- SUD Workforce Development
- SUD Clinical/Access to Care

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

To receive full payment, providers must submit verification of completion, along with any required deliverables, documentation, or data.

Funds received through Value-Based Incentives must be reinvested into the SUD program and organization. This includes activities or initiatives within the three (3) Value-Based Incentives priority categories: financial and business operations, SUD workforce development, and SUD clinical/access to care. For more information, refer to [SAPC Information Notice 26-06](#).

Billing for Value-Based Incentives

Provider agencies interested in Value-Based Incentives need to submit the appropriate attestation and invoice for the activities being claimed.

Budgeting for Value-Based Incentives

Provider agencies should include the expected Value-Based Incentives funding in their FY 2026-2027 DMC Contract Budget to ensure proper tracking and utilization. Provider agencies must review the relevant Value-Based Incentives materials, determine which activities to engage 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

In addition to the Rates Matrix, the DMC-ODS Contract also includes an invoice process for the following services under the treatment services benefit:

- Value-Based Incentives
- Select Youth and Pregnant/Parenting Women Services

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

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

FIELD-BASED SERVICES (FBS) ENHANCED BENEFIT

During FY 2026-2027, SAPC will offer a quarterly incentive payment for Field-Based Services (FBS). SAPC will reimburse providers an additional 10% of total approved claims for services delivered through FBS. To qualify for the benefit, provider agencies must:

- Provide FBS in accordance with [SAPC Information Notice 26-01](#).

- Adhere to the documentation requirements when completing progress notes and submitting claims. Claims must include the appropriate Place of Service code for the FBS location, which aligns with the Place of Service code and location documented within progress notes.
- Submit an invoice every four (4) months based on the FBS claims report provided by SAPC.

SAPC's Systems of Care Division will conduct reviews of Sage billing data and progress notes every four (4) months to identify eligible claims to determine payment amounts. Claims must have appropriate Place of Service codes. 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 must include the client name, Sage-PCNX client ID, date of service, service provided, FBS location name and/or address, and Place of Service code. As such, provider agencies must adhere to the documentation requirements of [SAPC Information Notice 26-01](#) and BHIN 22-019 and include the service site information. Questions regarding this benefit may be sent to SAPC-SOC@ph.lacounty.gov.

REACHING THE 95% (R95) ENHANCED ACTIVITIES

SAPC will offer incentives to treatment provider agencies for workforce training to support the shift to low-barrier Reaching the 95% (R95) treatment design. This is an optional incentivized activity for treatment provider agencies. The incentive will run from July 1, 2026 through March 31, 2027, and the Fiscal Year 2026-2027 structure will be:

- Agencies interested in qualifying for this incentive must submit the total count of client-facing staff via email to SAPC-R95@ph.lacounty.gov. Client-facing staff includes all personnel who interact with clients during the admission, treatment, and discharge processes, including clerical staff, drivers, cooks, peer support specialists, registered or certified counselors, Licensed Practitioners of the Healing Arts (LPHA), license-eligible LPHAs, etc. Include all employed staff across all sites for multi-site agencies.
- R95 training (\$15,000 opportunity) – 85% of client-facing staff must attend at least one (1) qualifying in-person R95 training or workgroup meeting.
- Harm reduction integration (\$15,000 opportunity) – 85% of client-facing staff must attend at least one (1) qualifying in-person harm reduction training or Harm Reduction and Treatment Integration Meeting.

More details to follow in an upcoming R95 FY 2026-2027 Enhanced Activities Information Notice. Questions should be sent to SAPC-R95@ph.lacounty.gov, or calls can be made to the R95 Consultation line at (626) 210-0648.

RESOURCES

The following resources provide additional information and guidance:

- The SAPC [Provider Manual](#)
- [Sage 837P Companion Guide](#)
- [Sage 837I Companion Guide](#)
- [Behavioral Health Information Notice 24-001](#)

EFFECTIVE PERIOD

This guidance will be effective July 1, 2026, through June 30, 2027, unless otherwise revised.

ADDITIONAL INFORMATION

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

Attachments

GT:dd