R95 Frequently Asked Questions
Updated: FY 26-27

This FAQ documents common questions about R95 Payment Reform Value-Based Incentives activities. Boxes in light grey have been transferred over from previous R95 Workgroup FAQs and updated accordingly.

Jump to topic:

QUESTIONS		ANSWERS
General R95 Value-Based Incentives Questions		
1.	Our agency would like to participate in the Value-Based Incentives (VBI) Program for this fiscal year. Where can I find information?	Refer to the Payment Reform – Value-Based Incentives website for more detailed information on all the Value-Based Incentive activities, including invoices, reports, deliverables, and associated deadlines for the current fiscal year.
2.	Is there a single VBI attestation document that needs to be submitted?	All VBI invoices are to use the VBI Year 4 Invoice Form. Select the appropriate Activity Name from the drop-down menu.
3.	How does payment and recoupment work? How do I request R95 funds or	Value-Based Incentive payments will be distributed through your DMC-ODS contract and are subject to all federal, state, and county audits and verification reviews. Providers must account for funds in accordance with County accounting procedures, including separate cost centers. For additional questions, please email SAPC's Finance Services Branch at DPH-SAPC-VBI@ph.lacounty.gov.

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	submit for augmentation?	To request additional funds as earned through successful R95 participation, apply for an augmentation. Finance monitors monthly billing and Contracts/Programs are alerted of any providers that are identified as needing an augmentation. Providers are encouraged to monitor their funding utilization and request any increases or decreases as needed. Funding augmentations are approved based on utilization, (providers must have utilized at least 50% of their contracted allocation), performance, and community needs. Please refer to the SAPC Substance Use Disorder Treatment Services Provider Manual – Version 11.0 (p. 240), the SAPCIN22-14ContractAmendments and SAPCIN22-14ContractAmendmentForm for more information on this process.
4.	Does setting up transportation through the Medi-Cal benefit fall under care coordination?	Yes. Clients of SAPC contracted providers are eligible for the managed care transportation option. NEMT – Non-Emergency Medical Transport is covered by Medi-Cal.
5.	If we are using a language line during a screening is the screening activity with interpretation services reimbursable by DMC? Is TA available for solving language assistance in group settings?	The ASAM CO-Triage is an appropriate screening tool to use for language assistance for screening and rapidly assessing and engaging the patient. The interpretation (e.g., oral and sign language) add-on is for **outpatient and opioid treatment programs ONLY**. T1013 is the add-on code for use of interpretation services during the delivery of care. This code should be used in addition to the primary service codes (e.g., individual counseling, care coordination, etc.) to indicate that service was delivered with the assistance of language interpretation services. This is an add on code with no lock outs, meaning it can be used with all primary service codes. As an add on code, it also cannot be billed individually without a primary service code. For example, if you are an SUD Counselor and used a language line to provide Spanish interpretation while administering the ASAM CO-Triage for 30 mins, you would bill 2 units of H0001 (Assessment) and add-on 2 units of T1013 (Interpretation services) onto the same claim. There is an additional $30.92 per unit for T1013 (Interpretation Services). If a county submits more units of T1013 than are allowed by the sum of all the primary services provided, the interpretation services line will be cut back to the time of the primary service. Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the per diem rate.

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		Please note: For the language add-on to be eligible, interpretation services must be provided by another person and NOT services delivered in a 2nd language by bilingual staff and ONLY be used by an in-person professional interpreter, or in-person interpretation provided by a separate bilingual staff member. Add-on rates DO NOT apply for automated/digital translation or relay services. Group counseling is a beneficial and significant intervention in SUD treatment and the purpose of language assistance is to ensure that those with limited English proficiency have equitable access to all treatment interventions, as such, it is ideal to have groups separated by language, but there are times this may not be feasible (primarily when there is only one person who speaks a different language). In this case, simultaneous interpretation with the use of headsets (reimbursable via the language add-on if performed in person) or effective translation applications (not reimbursable via the language add-on) may be options. For more information, please contact EAS@ph.lacounty.gov. Please visit the following CLAS Resource List of Language Assistance Vendors available on the SAPC website.
ACCESS TO CARE R95 Client-Facing Agreements (3-I)		
6.	Where can I find the policy and agreement templates? Have there been updates from previous fiscal years?	The policy and agreement policies are available in Word and PDF format on the Access to Care page of the Payment Reform website. Expand the R95 Client-Facing Agreement (3-I) section for view/download links. There have been minor updates to the Admission Policy, Admission Agreement, Discharge Policy, and Toxicology Agreement. A summary of the updates can be found in the Summary of Revisions. Agencies that were approved for earlier versions of these policies and agreements are not required to resubmit for approval, however, are expected to integrate these updates, within three months from the start of FY 26-27, for use going forward.
7.	Are the Admission Agreement levels of care and services typed in blue	While the blue text on templates signifies required text, include only the levels of care and services offered by your agency.

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	necessary for a provider that does not render those levels of care or services?	
8.	How do we need to update our drug/urinalysis testing policy to align with R95?	Contracted providers can continue to have toxicology (known also as "drug" or "urinalysis") testing policies and participate in R95 efforts. However, they need to be flexible enough to address individualized patient needs. Toxicology testing is one available (but not required) tool that can be offered alongside other clinical interventions, and toxicology testing is not a required prerequisite to patient's achieving their treatment goals and/or to demonstrate treatment progress. For example, every patient may not need to submit to toxicology testing as a part of treatment participation, while others may request or be required (if authorized via consent to release information) as part of an agreement with Probation or DCFS. The toxicology testing policy just needs to outline what is done under these circumstances. The R95 Toxicology Policy and Client-Facing Toxicology Agreement templates are available in Word and PDF format on the Access to Care page of the Payment Reform website. Expand the R95 Client-Facing Agreement (3-I) section for view/download links.
9.	What does the State think about Residential Licensed facilities letting patients in while still using drugs?	SAPC does not speak on behalf of the State. However, in discussions with State leadership, our understanding is that there is general recognition that lapses and relapses are part of the recovery process and residential licensees/facilities will encounter these episodes. SAPC continues to engage with State leadership and staff to address these nuances and support enrollment of patients in the most appropriate level of care based on treatment goals. SB-992 (2018) Alcoholism or Drug Abuse Recovery or Treatment Facilities updates the State Health and Safety Code (11834.26(d)) to require licensees to develop a resident relapse plan and explicitly does not require a licensee to discharge a resident due to relapse episode, or lapse. *"A licensee shall **develop a plan to address when a resident relapses**, including when a resident is on the licensed premises after consuming alcohol or using illicit drugs. The plan shall include details of how the treatment stay and treatment plan of the resident will be adjusted to address the relapse episode and how the resident will be **treated and supervised while under the influence of alcohol or***

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		***illicit drugs**, as well as discharge and continuing care planning, including when a licensee determines that a resident requires services beyond the scope of the licensee. This **subdivision does not require a licensee to discharge a resident**."* AB 1037 (2025) Public Health: Substance Use Disorder removed the requirement for "an admission agreement to require a person to be abstinent and not intoxicated in order to be admitted to care or continue treatment," and "require[s] a licensee to prioritize the individual maintaining some level of connection to treatment, following a relapse." In 2026 DHCS finalized and published BHIN-26-006 Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities, mandating changes to State Health and Safety Code section 11834.26 following passage of AB 1037, which was sponsored by LA County and led by SAPC. These changes mandate certain aspects of SAPC's Reaching the 95% (R95) Initiative at the State-level and lowers barriers to SUD treatment and expands access to life saving SUD services. **Key Changes and Alignment with the R95 Initiative:** **Required updates to Admission Agreements:** SUD treatment facilities "shall not deny admission to any person seeking treatment based solely on that person having consumed, used, or otherwise been under the influence of alcohol or other drugs," as these "these circumstances represent symptoms of the condition of a SUD." Admission agreements signed by clients are "not required to contain an abstinence or sobriety requirement, thus ensuring that care is accessible to a wider range of individuals with SUD." • The R95 Admission Policy and R95 Admission Agreement are already in alignment with these changes. **Required updates to Return to Use Plans:** Should a client return to the SUD treatment facility after using substances, the facility is not required to discharge the client, "as relapse, lapses, and momentary reengagement with alcohol or other drugs are symptoms of the condition of SUD." Treatment facilities are to prioritize "maintaining some level of connection to treatment and shall consider options to avoid complete disconnection of the resident from treatment." • The R95 Discharge Policy explicitly states lapses or returns to use are to be approached as opportunities for connection and client-driven, clinical treatment planning.

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10.	What is the definition of Same Day Admission?	Same Day Admission is defined as admitting someone the same day they seek services. For example, they call on Thursday and receive their first service on same Thursday.
11.	We have some R95 elements in other existing P&Ps (some in admissions, some in other documents). Will that be acceptable for the incentive?	Each required element in SAPC's R95 policies and agreements must be explicitly included in participating agencies' updated admission, discharge, and toxicology policies and client agreement packets to be compensated for the Value-Based Incentive R95 Client-Facing Agreements activity in any fiscal year.
12.	How can this be implemented with a criminal justice patient with timeline deadlines from the court and probation officers' requirements of abstinence?	Similar to implementation of DMC-ODS, SAPC's position is that while treatment may be mandated by courts, the specifics of that treatment (what setting, how long, what type of treatment, etc.) are based on clinical determinations made by substance use disorder (SUD) providers and not courts/judges. This is the approach taken with mental health (MH) services and there should be an equal approach taken with SUD services. If SUD agencies are asked to abide by court mandates on specifics of treatment, SAPC suggests highlighting this position with them and contacting SAPC (SAPC-R95@ph.lacounty.gov) so we can assist with these communications. While we expect some courts to question this approach, we have made progress after DMC-ODS implementation and also anticipate being able to achieve this more appropriate approach to SUD care delivery.
13.	Are we allowed to admit someone who has used substances in the past 24 hours?	Yes, SAPC has no restrictions on our providers admitting patients who are functionally able to participate in treatment regardless of recent substance use. Please reference DHCS recently finalized and published BHIN-26-006 Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities, mandating changes to State Health and Safety Code section 11834.26. Should provider agencies run into any regulatory or auditor barriers with providing treatment services for people who have recently used intoxicant, please alert us by contacting SAPC_Compliance@ph.lacounty.gov so that SAPC can support agencies with implementing R95 policies and agreements.
14.	How does one distinguish what a	Clients who are currently using drugs may have instances where they practice periods of abstinence and reduction in use, which can result in withdrawal. Withdrawal management is indicated for opioid, sedative, and/or

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	non-abstinence focused withdrawal management system might look like?	alcohol withdrawal syndrome, and patients who reduce the use of these substances may experience withdrawal even if they do not completely stop. Additionally, clients may experience withdrawal when they stop one category of substances (for example, opioid withdrawal syndrome when they stop using opioids), even if they do not stop using alcohol and/or sedatives. Client-centered withdrawal management accepts that clients may experience withdrawal variably and prioritizes access to monitoring and clinically appropriate medications and related treatments for withdrawal even if the patient is not abstinent from all intoxicants, and even if the client is not currently committed to long-term abstinence from substances. Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment are no longer in compliance with state policy requirements or in alignment with SAPC policies and the R95 Initiative especially with regards to efforts focused on evolving/changing Admission and Discharge policies.
15.	How do we balance serving those who are not committed to abstinence while ensuring a drug-free environment for others in a residential setting?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Even clients in long-term recovery experience moments where they question their desire to maintain their abstinence, and clients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around lowering barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment are no longer in compliance with state policy requirements or in alignment with SAPC policies and the R95 Initiative especially with regards to efforts focused on evolving/changing Admissions and Discharge policies. While there are unique considerations in residential settings that need to be individualized according to the circumstances of individual clients, the reality is that providers often mix these populations every day, so providers are already admitting people who are not currently practicing full sustained abstinence into their programs. The aim in these situations is to provide pathways for clients to feel open, comfortable, and trusting with providers to share where they are in their readiness for abstinence so providers can try to move them along the readiness continuum.

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		As is the case with all levels of care, the lower barrier approach to this situation would be to: 1. Ensure there are policies in place that not only avoid creating barriers to care, but widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services) 2. Address use of substances during treatment on a case-by-case basis that considers both the treatment of the patient using substances and the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual client as well as their peers to demonstrate that clients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and it is important for provider agencies to connect them with another level of care or other services, as appropriate, so as not to disconnect the client from treatment all together. For example, even if a client who used/relapsed needs to be discharged from a residential setting, an agency needs to attempt to discharge them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the client's discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a patient who recently relapsed to a lower level of care or having the patient be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those clients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together.
16.	How do A&D policy changes impact Class A deficiencies (the fine for those deficiencies can range from $50 to $150 per day)?	Following the signing of AB1037 into law, DHCS finalized and published BHIN-26-006 **Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities**, mandating changes to State Health and Safety Code section 11834.26. This new guidance clarifies that a licensee shall not deny admission to any person seeking treatment based solely on that person having consumed, used, or otherwise been under the influence of alcohol or other drugs. It also clarifies at licensees are not required to discharge a resident who is on the licensed premises after using alcohol or other drugs. Should SAPC contractors experience countervailing sanctions or guidance from their DHCS licensing analyst, they should provide the analyst with these state policies and also notify SAPC_Compliance@ph.lacounty.gov so that SAPC has the opportunity to support agencies with implementing A&D policies.

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17.	If someone comes in psychotic, due to substance use or mental health disorder, how should an agency determine the safest place for them? The challenge is over ever-increasing acuity levels, and the question is: are we SUD or Mental Health service providers or are we both?	Participation in R95 does not mean SUD providers need directly delivery crisis response or other specialty mental health services to clients with high mental health acuity, and DMH has specialty mental health system available to SAPC clients with high mental health acuity. However, even if a client has a serious mental illness, if the client is capable of participating in treatment SAPC provider should admit the client and provide treatment, regardless whether the client has a mental health diagnosis. The key determination whether a client with a psychotic and/or MH condition can be safely treated in your SUD care setting is based upon an assessment of their behaviors (aggression, ability to reasonably participate in SUD treatment, etc.). If, based upon the assessment, the client is functionally capable of participating in treatment (regardless of their diagnosis), that individual should be provided SUD services in your care setting. It is important to recognize that a client's MH diagnosis does not directly speak to their acuity level, as diagnoses are both sometimes incorrect (especially for people with co-occurring SUD and MH conditions) and also are time dependent. Someone with a severe MH diagnosis such as schizophrenia or schizoaffective disorder can be sufficiently stable to be safely and treated in an SUD treatment setting with good clinical outcomes. A key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems and make substance use services more accessible to the general healthcare and social service systems. An example of care integration is an SUD program that combines primary care and mental health services, all housed within the SUD treatment facility, to address clients with multiple healthcare needs in one location. Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to ensuring that COD treatment interventions are combined within a primary treatment relationship or service setting. For more information and guidance on this topic please review the SAPC Substance Use Disorder Treatment Services Provider Manual – Version 11.0 in the section titled "Co-Occurring Disorder Population: (p. 143).
18.	Will we keep the "Drug Free Environment" Policy? A Drug Free Environment is a State requirement.	California's Drug Free Workplace Policy is not a barrier. Drug-free workplaces are able to serve people who may have drugs on them (as not all staff or clients are regularly searched for possession of substances each time to arrive for care or to work). R95 policies do not promote drug use or possession; our R95 policies will promote serving people at different levels of readiness for abstinence.

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		The State does not require providers to discharge a client for using substances on or off site. For more information, please reference DHCS recently finalized and published BHIN-26-006 Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities, mandating changes to State Health and Safety Code section 11834.26. For additional guidance on this topic please review the SAPC Substance Use Disorder Treatment Services Provider Manual – Version 11.0 (p. 94), (p. 99).
19.	What about the liability and the potential for civil lawsuits stemming from: residential with patients who use, triggering others, possibly putting child residents at risk, and the risk of overdose? Some patients have prison sentences hanging over their heads and DCFS cases.	These will need to be individualized responses – perhaps connecting that person with other services even if your door isn't the door for help. If we discharge people who are at risk for having overdose it doesn't reduce their risk but rather reduces the risk for them to overdose on your site. We need to interpret risk carefully whereas it has been used to justify things that don't help people. We understand the purpose of having rules in place and residential requirements. We would also like to encourage providers to have a more nuanced approach that is focused on lowering barriers. SAPC has successfully advocated to bring state policy into alignment as evidenced by the passage of AB 1037 sponsored by LA County and led by SAPC. Please reference DHCS recently finalized and published BHIN-26-006 Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities, mandating changes to State Health and Safety Code section 11834.26. We will continue actively working at state level to make necessary shifts and modifications. SAPC has provided support to agencies in past in addressing concerns from the state and will continue to do so as needed.
20.	As counselors we cannot ethically conduct some services if person is under the influence as	There is not an ethical issue in treating people who are intoxicated. Clients can be treated based on their capacity to consent to and participate in treatment; being intoxicated does not universally impair a client from consenting to treatment. Client treatment should be aligned with the client's functionality, not intoxication status. SAPC supports providers who incorporate ethical practice into their work and who understand the welfare and trust of their clients are dependent on a

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	the patient may not be able to consent to services. How do we protect ourselves as a counselor, an organization and the patient?	high level of professional conduct. It is our hope that providers will use a low barrier approach while navigating the process of obtaining informed consent while prioritizing what is best for the client's wellbeing.
21.	Can the R95 Policy be specifically for the R95 population and we have another Admission Policy for criminal justice and DCFS populations?	No. Your agency's admission and discharge policies should be applicable to all clients in your care under SAPC contract. To receive reimbursement for an updated admission and discharge policy, agencies must apply it to all individuals served funded by the SAPC contract, including those involved with Probation and DCFS. These policies are not inconsistent with serving individuals who consent to release information to DCFS and/or Probation and who indicate a commitment to be abstinent and participate in toxicology testing, and who also may be ambivalent about abstinence or lapse during the treatment episode.
22.	Is SAPC going to submit admission and discharge policies for DHCS review and/or approval?	No. SAPC has communicated with DHCS on the local R95 initiative and DHCS is supportive of establishing lower barrier access to care. SAPC should be contacted if State representatives indicate concern or cite agencies as a result of implemented changes. For more information, please reference DHCS recently finalized and published BHIN-26-006 Admission Agreements and "Return to Use" Plans for Substance Use Disorder (SUD) Recovery or Treatment Facilities, mandating changes to State Health and Safety Code section 11834.26.
23.	Has there been any further consideration about extending the initial engagement authorizations	No, State policy does not currently permit authorizations for payment for residential LOCs without a full review that includes medical necessity documentation, so that is not a flexibility that SAPC can offer our provider network. For additional guidance please refer to the recently posted Substance Use Disorder Treatment Services Provider Manual Version 11.0 under Initial Engagement Authorizations (p. 44) here.

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	flexibilities to residential LOC's?	
24.	How should we verify medical necessity for 30–60-day authorizations ? Do referring agencies need credentials to authorize medical necessity for service or does a valid referral work?	Initial engagement authorizations are approved for non-residential levels of care without documentation of medical necessity, so referral agencies do not need specific credentials or specific referral sources to obtain a 30–60-day initial engagement authorization for non-residential services. This initial engagement authorization process is explained in several UM meetings, including at the 11/15/23 meeting posted here: http://publichealth.lacounty.gov/sapc/providers/treatment-provider-meetings.htm Initial engagement authorization specific slides 21-27 cover how initial engagement authorizations work: http://publichealth.lacounty.gov/sapc/NetworkProviders/qiumpm/111523/Provider-UM-Meeting.pdf With PCNX, providers indicate which of their non-residential treatment authorizations are initial engagement authorizations on page 4 of Sage-PCNX Service Authorization Request Guide. SAPC will run a count using this PCNX radio button to manage our count on initial engagement authorizations. Initial engagement authorizations are submitted within 30 days of the initial date of service and are submitted irrespective of the source of referral. For additional guidance please refer to the recently posted Substance Use Disorder Treatment Services Provider Manual Version 11.0 under Initial Engagement Authorizations (p. 44) here.
25.	We can provide Spanish interpretation for individual sessions but not for groups as it has proven to be disruptive. To what extent are we promising free	SAPC's provider network must comply with federal, State and local laws and regulations regarding non-discrimination, language assistance, and ensure that culturally, developmentally, and linguistically appropriate services are provided to patients in the SUD specialty system. For more information, please visit the SAPC IN 24-02 Requirements for Ensuring Culturally and Linguistically Appropriate Service SAPC recognizes the unique challenges posed in offering interpretation in group counseling sessions and is currently exploring the use of other new technologies to assist with updates forthcoming. Please refer to Question 5 above.

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	interpreter services? Is there new technology available to provide interpretation in a group setting?	
R95 General Questions		
26.	Where can I find R95 meeting presentation materials?	R95 Workgroup Meeting presentation slides and documents will be posted on the SAPC website meeting under Provider Meetings, under R95 Workgroup Meetings, under the most recent meeting date.
27.	Where can I find the R95 calendar?	The R95 FY 26-27 Calendar is posted on the Payment Reform Value-Based Incentives website under the Access to Care tab. Updates to the calendar will be shared following R95 Workgroup meetings and posted to the website as needed.