Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2138 (Krell) – As Amended March 24, 2026

SUBJECT: Medi-Cal: enhanced care management: peer support specialists.

SUMMARY: Limits how criminal background checks can be used when assessing a Peer Support Specialist (PSS) for employment, certification, contracting and other activities, and requires all Medi-Cal Enhanced Care Management (ECM) care teams to include at least one PSS, as specified. Specifically, **this bill**:

1) Prohibits the Department of Health Care Services (DHCS), a county, a Medi-Cal managed care plan, or a Medi-Cal provider, as applicable, from disqualifying a PSS solely or primarily on the basis of a criminal background check, fingerprint-based background check, or similar screening that is a condition of employment, contracting, certification, credentialing, enrollment, or participation in providing peer support services.

2) Specifies an individual's criminal record may be considered as part of their overall fitness for the position of PSS and contains a number of safeguards to ensure consistency with federal law and regulation.

3) Makes implementation of 1) above contingent on any needed federal approvals and the continued availability of federal financial participation.

4) Requires DHCS to require, as a condition of providing ECM, that each ECM provider maintain an interdisciplinary care team that includes at least one PSS who is integrated into ECM service delivery and available to support ECM members.

5) Requires DHCS to ensure Medi-Cal managed care plan contracts, policies, and guidance reflect the requirement described 4) above, and to establish monitoring and compliance mechanisms to ensure that ECM providers implement the requirement.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, and under which qualified low-income individuals receive health care services. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]

CalAIM and ECM

2) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative effective from January 1, 2022 until December 31, 2026. Establishes the goals of CalAIM as follows: to identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health; transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC § 14184.100]

3) Includes in the CalAIM initiative the requirement for a statewide ECM benefit, designed to address the clinical and nonclinical needs on a whole-person-care basis, for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, in accordance with CalAIM Terms and Conditions. [WIC § 14184.205]

4) Defines target populations for ECM and requires DHCS to develop, in consultation with the Medi-Cal plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM and to publish an annual report on ECM utilization data. [*Ibid*.]

Peer Support Specialists

5) Establishes a state-defined and county-administered system for certifying PSS, at county option, for purposes of the Medi-Cal program, as follows:

   a) Requires DHCS to establish statewide requirements for counties, or an agency representing counties, to use in developing certification programs for the certification of PSS;

   b) Requires DHCS to define the qualifications, range of responsibilities, practice guidelines, supervision standards, curriculum, and core competencies for PSS certification; and,

   c) Permits a county or agency representing a county to develop, oversee, and enforce a certification program. [WIC § 14045.10, *et seq*.]

6) Defines PSS as an individual who is 18 years of age or older, who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder (SUD), or both, either as a consumer of these services or as the parent or family member of the consumer, and who has been granted certification under a county PSS certification program. [WIC § 14045.12]

7) Requires an applicant for PSS certification to meet all the following:

   a) Be at least 18 years of age;

   b) Possess a high school diploma or equivalent degree;

   c) Be self-identified as having experience with the process of recovery from mental illness or SUD, either as a consumer of these services or as the parent or family member of the consumer;

   d) Be willing to share their experience;

   e) Have a strong dedication to recovery;

   f) Agree, in writing, to adhere to a code of ethics;

   g) Successfully complete the curriculum and training requirements for a PSS; and,

   h) Pass a certification examination approved by DHCS for a PSS. [WIC § 14045.15]

8) Requires DHCS to seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of PSS in a county that opts to participate in a demonstration or pilot program to certify PSS and cover PSS services under the Medi-Cal program. Requires such a county to fund the nonfederal share of the program costs. Prohibits General Fund moneys from being used to fund the nonfederal share of program costs. [WIC § 14045.19]

Community Health Worker Services

9) Makes community health worker (CHW) services a covered Medi-Cal benefit. Defines CHW as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Specifies a CHW is a frontline health worker either trusted by, or who has a close understanding of, the community served. Specifies that CHWs include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other non-licensed health workers, including violence prevention professionals. Requires a CHW's lived experience to align with and provide a connection to the community being served. [WIC § 14132.36]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, PSSs can make a world of difference for behavioral health patients by providing relationship-based support grounded in shared lived experiences. This builds trust and helps patients navigate complex systems. However, the author notes, current barriers deprive many patients of access to peer support. The author explains this bill takes a two-pronged approach to improve access. First, it helps address the PSS workforce shortage by preventing the results of a criminal background check from being the sole reason an applicant is denied from becoming a Peer. Secondly, it requires that every ECM provider include at least one certified PSS as part of their interdisciplinary care team.

2) BACKGROUND.

a) Peer Services. According to the federal Substance Abuse and Mental Health Service Administration, in the context of mental health and SUD services, a peer is a person who uses lived experience of recovery from mental illness and/or a SUD, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. This mixture of personal experience plus formal training is a distinguishing characteristic of peer support, as peers are specifically trained to use their own experience to help others recover from severe mental health conditions or SUD. PSS is the term formalized in California law to describe peers who work in this capacity.

Evidence suggests peer services can increase social support and functioning, decrease psychotic symptoms, reduce hospital stays, and decrease substance use and depression, among other positive outcomes.

b) PSS Certification and Services in California. SB 803 (Beall), Chapter 150, Statutes of 2020, established PSS certification in state law. PSSs worked in various capacities in county-administered behavioral health systems prior to the passage of the bill, but Medi-

Cal did not reimburse for these services and the state lacked consistent standards for certification. Prior legislative attempts in 2015, 2018, and 2019 to implement PSS certification at the state level were unsuccessful, leaving the "county opt-in" model as a viable path forward to establish a certification program and coverage of PSS as a Medi-Cal benefit. This structure is unusual compared to other states, which often certify, cover, and fund PSS at the state level. Since PSS is an optional service for counties, the nonfederal share of benefit costs is funded with local funds (non-General Fund).

DHCS launched the Medi-Cal Peer Support Services benefit in July 2022, in compliance with SB 803. As of December 2025, DHCS lists 53 of 58 counties as participating in PSS services, most of which provide PSS services in both mental health and SUD treatment services.

c) Fair Chance Act. The Fair Chance Act, also known as "Ban the Box," limits employers' ability to make employment decisions based on job applicants' conviction histories (criminal records). The Fair Chance Act is part of the California Fair Employment and Housing Act, a law enforced by the California Civil Rights Department. The Fair Chance Act aims to reduce job barriers for people with criminal records. It prohibits employers with five or more employees from asking about an applicant's criminal history until after a job offer is made. Although it applies to public and private employers, some health care positions are not covered and it exempts employers when other laws mandate background checks or restrict employment based on criminal history for specific positions. This bill would implement similar provisions, specific to PSS, for employment, credentialing, and similar processes, to the greatest extent allowable under federal law.

d) Peers in Justice-Involved Settings; Criminal Background Checks. According to a 2024 RAND evaluation report on the early implementation of California's PSS certification, there is literature describing successful integration of peers into intensive case management teams, inpatient units, and criminal justice settings. According to the state Council on Criminal Justice and Behavioral Health (CCJBH), CCJBH continues to advocate for the use of peers and CHWs within and across the multiple public sectors that serve the behavioral health and justice-involved population. CCJBH notes that as of 2023, their Diversion and Diversion and Reentry Workgroup found that background checks continue to be a barrier for hiring individuals with lived experience. According to CCJBH, despite having initiatives such as the Fair Chance Act, agencies (e.g., counties, community- based organizations, and social services agencies) continue to have challenges with navigating background checks and integrating an individual with lived experience into their work settings.

e) ECM and CalAIM. CalAIM is a collection of major initiatives spearheaded by the DHCS to improve Medi-Cal, including addressing social drivers of health, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. ECM is a statewide Medi-Cal benefit created as part of CalAIM. It is available through Medi-Cal plans to provide care management to Medi-Cal enrollees with the highest needs. ECM identifies these enrollees as "populations of focus." ECM populations of focus include:

i) Adults, unaccompanied youth and children, and families experiencing homelessness;

ii) Adults, youth, and children who are at risk for avoidable hospital or emergency department care;

iii) Adults, youth, and children with serious mental health and/or substance use disorder needs;

iv) Adults living in the community and at risk for long-term care institutionalization;

v) Adult nursing facility residents transitioning to the community;

vi) Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s);

vii) Children and youth involved in child welfare (foster care);

viii) Adults and youth who are transitioning from incarceration; and,

ix) Pregnant and postpartum individuals; birth equity population of focus.

Enrollees have a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. The lead care manager role is designed to "meet enrollees where they are" to meet their needs, build a trusting relationship, and provide intensive coordination of health and health-related services. DHCS estimated that between 3% and 5% of all Medi-Cal plan members statewide are potentially eligible for ECM. Over 4,000 ECM providers are contracted by Medi-Cal MCPs to offer these services. In Quarter 2 of 2025, about 206,000 unique members received ECM, an increase of 61% from a year prior.

f) **CHW Services.** DHCS added CHW services as a Medi-Cal benefit starting July 1, 2022. The benefit was later codified through AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022. CHW services are defined to include those delivered by promotores, community health representatives who work in tribal communities, navigators, and other non-licensed public health workers. CHW services include health education; navigation to health care and other community resources that address health-related social needs; screening and assessment that does not require a license and that assists a beneficiary to connect to appropriate services to improve their health; and individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence. CHW services are defined as medically necessary for individuals meeting a wide range of criteria and who have different types of health conditions. CHWs can address mental health conditions and SUDs, as well as preventive care and other diseases and conditions.

The National Academy for State Health Policy (NASHP) recently highlighted how CHWs are being engaged in state criminal justice reentry efforts. According to NASHP, under the Transition Clinics Network (TCN) Model:

> TCN hires and trains formerly incarcerated CHWs, along with primary care teams, to provide culturally competent patient-centered services. CHW services include conducting both in-reach into jail and prison, as well as outreach into communities to support continuity of care. CHWs also assist patients in navigating the health system, including health insurance, medication assistance, or specialty appointments, and

social services, such as housing, employment, and education systems. In addition, CHWs provide emotional support, mentorship, and family reunification support, along with individual and system-level education and advocacy. CHWs also provide cultural interpretation for primary care teams. Evidence shows that TCN programs have contributed to greater engagement with primary care services, reduced emergency department utilization and hospitalizations, and improved health and reentry outcomes for returning community members.

3) **SUPPORT.** This bill is sponsored by the Steinberg Institute and supported by criminal justice and mental health advocates. Supporters write that this bill removes barriers to expanding access to peer support services for Californians with behavioral health needs. Supporters note current categorical exclusions can unnecessarily shrink the peer workforce and that this bill instead requires individualized, job-related hiring determinations while preserving federal Medicaid screening requirements and maintaining appropriate exclusions—for example, serious, violent, and child-related felony convictions. Supporters also argue that ensuring that peers are more consistently integrated into ECM teams will help make relationship-based, recovery-oriented support available to individuals who often face the greatest barriers to care.

4) **OPPOSE UNLESS AMENDED.** Local Health Plans of California (LHPC) writes in opposition to this bill unless it is amended to narrow the scope of the requirement to apply only to ECM providers that primarily serve members with behavioral health conditions, allow plans and providers to determine when peer support specialists are appropriate based on member needs and local delivery systems, and allow for phased or optional implementation, aligned with workforce availability and regional readiness. LHPC raises concerns regarding its broad and prescriptive application across all ECM providers, regardless of population served or clinical focus. LHPC states ECM was intentionally designed to allow flexibility in care team composition to reflect local needs and varying member acuity, and that a one-size-fits-all mandate risks undermining this flexibility and may lead to inefficient allocation of limited workforce resources. LHPC explains that peer support specialists are most effective when deployed in behavioral health settings, where lived experience with mental illness or substance use disorder is directly relevant, and that expanding this requirement to all ECM providers may dilute the impact of peer support services and create operational challenges without clear clinical benefit. LHPC also notes that imposing a statewide mandate without sufficient workforce capacity, infrastructure, or phased implementation may disrupt existing ECM programs and create compliance challenges for providers and plans.

5) **CONCERNS**. California Association of Alcohol and Drug Program Executives (CAADPE) writes with concerns, stating they strongly supports the inclusion of peers as a core component of interdisciplinary care teams and the removal of unnecessary employment barriers, both of which align with the goals of CalAIM to provide whole-person, community-based care. However, CAADPE notes, without clear alignment between this new requirement and rate-setting, providers will be expected to absorb the cost of hiring, training, supervising, and integrating peer staff within existing payment structures. This raises concerns that it is an unfunded mandate, concerns around provider financial sustainability and access to ECM if providers cannot absorb these cost. CAADPE recommends requiring DHCS to account for the peer staffing requirement when establishing or updating ECM reimbursement rates and managed care plan contracts. Absent this amendment, CAADPE has significant concerns

about the feasibility of implementation and the potential for unintended consequences that could limit access to ECM services.

6) **RELATED LEGISLATION.** AB 96 (Jackson) would eliminate the minimum educational standard (possession of a high school diploma or equivalent degree) for a person applying for certification as a PSS. AB 96 is pending in the Senate Rules Committee.

7) **PREVIOUS LEGISLATION.**

   a) AB 2697(Aguiar-Curry), Chapter 488, Statutes of 2022, codifies CHW services as a covered Medi-Cal benefit. Requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit.

   b) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes statutory authority for various aspects of the CalAIM initiative, including authority for ECM.

   c) SB 803 (Beall) establishes PSS certification in state law.

   d) AB 1008 (McCarty, et al.), Chapter 789, Statutes of 2017, prohibits an employer, with certain exceptions, from inquiring about or considering a job applicant's conviction history prior to a conditional offer of employment, and sets requirements regarding the consideration of conviction histories in employment decisions (this law is dubbed the "Fair Chance Act").

8) **AMENDMENTS.** Although PSSs can add value to ECM care teams, a stringent requirement that removes flexibility and requires specific types of trained personnel in health care delivery should be supported by a strong evidence basis proving its necessity and demonstrating that other types of personnel with lesser or different training cannot perform the task effectively or safely. For PSS in ECM care teams, that high bar of evidence has not been cleared for all ECM care teams.

   First, PSSs are not requisite or even appropriate providers for many ECM populations of focus—for instance, adult nursing facility residents transitioning to the community or children with severe chronic health conditions. Given PSS specialize in serious mental health conditions and/or SUD, it is clear a PSS is not a necessary member of every ECM care team.

   Second, even for those populations of focus for which PSSs have more relevant experience, there are alternative configurations of care teams that might be equally effective for these populations, depending on staffing models, population served, and workforce availability. For instance, it is unclear why every individual transitioning from a criminal justice setting or from homelessness would need a PSS trained in serious mental health and/or SUD recovery. Take a hypothetical ECM care team who hires CHWs or others with former criminal justice involvement to work with individuals transitioning from a criminal justice setting. Is there proof the care team be more effective if a PSS instead of a CHW with relevant lived experience was included on the team to do outreach and engagement?

   Additionally, although a PSS may be effective at engaging individuals through shared lived experience, in such a role as a member of an ECM care team, a PSS is not necessarily providing "peer support services," which is the specific, evidence-based model of care peers

uniquely can provide. Peer support services are a specific behavioral health and SUD treatment modality wherein peers are trained to specifically use their lived experience with recovery from SUD or living with a severe mental health condition to help other people on their recovery journey. In contrast, a PSS who is operating as part of an ECM care team to do outreach and engagement may add value because of their skills and lived experience, but their specific training and ability to provide peer support services may not be necessary.

Given there are alternative effective models available and given peer support services are not a required part of ECM care management, there is no evidence to support a **blanket** requirement for PSSs on ECM care teams for all populations.

Finally, imposing a new requirement to include PSS on all ECM care teams, or even on those for whom PSS have more relevant experience, has the potential to disrupt existing care team arrangements. ECM providers could also be faced with workforce challenges if certified PSS are not available or if they cannot hire PSS with the appropriate lived experience to match the populations they are serving. Imposing this requirement on care teams that are already operating could also add unanticipated additional costs and compliance effort for ECM providers.

Based on these concerns, and to ensure the background check provisions are appropriately tailored, the author and committee have agreed to amendments to:

a) Limit the requirement to include a PSS to ECM providers that serve at least 50 people, at least a quarter of whom are identified under the "adults with serious mental illness or substance use disorder" ECM population of focus.

b) Allow ECM providers to "count" individuals who are working towards certification as a PSS and will receive certification within six months of being hired, as a PSS for purposes of compliance with this bill, and make conforming changes.

c) Specify the PSS need not be physically co-located with a care team or member.

d) Provide until January 1, 2028 for ECM providers to achieve compliance, as specified.

e) Specify an individual's criminal record may be considered as part of their overall fitness for the position of peer support specialist if it has a nexus to that position or its duties.

Furthermore, the author and sponsor commit to continuing to work to address remaining opposition and committee concerns related to administrative burden and compliance flexibility.

REGISTERED SUPPORT / OPPOSITION:

Support

Steinberg Institute (sponsor)
All of US or None (HQ)
Alliance for Children's Rights
Amity Foundation
Cal Voices

California Peer Watch
Californians for Safety and Justice
Courage California
Legal Services for Prisoners With Children
Mental Health America of California
National Alliance on Mental Illness (NAMI-CA)
Racial and Ethnic Mental Health Disparities Coalition
Vera Institute of Justice

Opposition

None on file

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