THIRD READING

Bill No: AB 96
Author: Jackson (D)
Amended: 1/5/26 in Assembly
Vote: 21

SENATE HEALTH COMMITTEE: 9-0, 6/3/26
AYES: Weber Pierson, Valladares, Caballero, Durazo, Gonzalez, Grove, Menjivar, Padilla, Pérez
NO VOTE RECORDED: Rubio, Smallwood-Cuevas

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

ASSEMBLY FLOOR: 73-0, 1/26/26 - See last page for vote

SUBJECT: Mental health services: peer support specialist certification

SOURCE: Cal Voices
County Behavioral Health Directors Association

DIGEST: This bill deletes the requirement that a certified peer support specialist applicant possess a high school diploma or equivalent degree.

ANALYSIS:

Existing law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. [Welfare & Institutions Code (WIC) §14001.1]

2) Requires DHCS to perform the following functions regarding peer support specialist (PSS) certification:

   a) Establish statewide requirements for counties, or an agency representing counties, to use in developing certification programs;

b) Define the qualifications, range of responsibilities, practice guidelines, and supervision standards;
c) Determine curriculum and core competencies, including curriculum that may be offered in areas of specialization and various core competencies-based elements, such as the concepts of hope, recovery, and wellness; trauma-informed care; group facilitation skills; cooccurring disorders of mental health and substance use; documentation skills and standards; and, confidentiality;
d) Specify employment training requirements, including core-competencies-based training and specialized training;
e) Establish a code of ethics;
f) Determine continuing education requirements for biennial certification renewal;
g) Determine the process for initial certification issuance and biennial certification renewal;
h) Determine a process for investigation of complaints and corrective action, including suspension and revocation of certification and appeals;
i) Determine a process for an individual employed as a PSS prior to January 1, 2022, to obtain certification;
j) Determine requirements for PSS certification reciprocity between counties, and for PSS from out of state; and,
k) Seek any federal approvals, related to the statewide certification standards, necessary to implement a PSS certification program. For any federal approvals that DHCS deems necessary related to the statewide certification standards, the PSS certification program is implemented only if and to the extent that DHCS obtains those federal approvals. [WIC §14045.13]

3) Permits a county, or an agency representing the county, upon DHCS approval, to develop a PSS certification program, which that county or representing agency is responsible for overseeing and enforcing the certification requirements. [WIC §14045.14]

4) Requires a PSS certification applicant to possess a high school diploma or equivalent degree, in addition to specified age, training, and continuing education requirements. [WIC §14045.15]

5) Does not authorize a PSS to diagnose an illness, prescribe medication, or provide clinical services. [WIC §14045.16]

This bill deletes the requirement that a certified PSS applicant possess a high school diploma or equivalent degree.

Comments

According to the author of this bill:

> This bill will strengthen California's behavioral health workforce and enhance care for those in need. Requiring a high school diploma or equivalent may create artificial barriers to entry and limit access for individuals with the potential to excel in peer support roles. The lived experience of PSS in recovering from mental illness and substance use disorders is the crucial component of their role, enabling them to save lives and empower individuals with behavioral health conditions to lead fulfilling lives.

Background

In July 2021, DHCS released PSS certification standards for the specialty mental health and substance use disorder delivery systems (known as County Behavioral Health Plans). These plans designated the California Mental Health Services Authority (CalMHSA) as the certifying entity for PSS. CalMHSA is responsible for implementing and monitoring a statewide training and certification program and assisting county behavioral health plans to meet requirements. In February 2024, RAND released a report on the early implementation of the PSS certification program that was requested by CalMHSA. RAND noted that one of the chief barriers to obtaining certification, per various program participants, was obtaining necessary documentation to support that an applicant had a high school diploma or equivalent degree—the other complaint being the financial cost. RAND stated that obstacles mentioned were requesting diplomas from school districts that have unclear instructions, for peers who completed high school in another state, and for peers who completed high school many years ago. Obtaining copies of diplomas was also difficult for peers whose education was delayed or negatively affected by their lived experience. One peer noted that she had dropped out of high school, and it took her many years to go back and complete her general education diploma. As she put it, "sometimes not getting a diploma is a part of the person's journey."

Federal guidance. On August 15, 2007, via SMDL#07-11, the Centers for Medicare and Medicaid Services (CMS) sent a letter to all State Medicaid Directors to provide guidance to states interested in PSS services under the Medicaid program, citing the increasing emphasis on recovery from even the most serious mental illnesses, and states' desire to cover PSS as a distinct provider type in order to draw down federal financial participation. CMS reiterated that PSS services are an evidence-based mental health model of care that consists of a

qualified PSS who assists individuals with their recovery from mental illness and substance use disorders. CMS recognized that the experiences of PSS, as consumers of mental health and substance use services, can be an important component in a state's delivery of effective treatment. CMS also reaffirmed its commitment to state flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services, and provided policy guidance that included requirements for supervision, care-coordination, and minimum training criteria for PSS. CMS further encouraged states to consider comprehensive programs but noted that regardless of how a state models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service. As part of the minimum requirements for PSS certification, CMS required the training and credentialing component, stating that PSS must complete training and certification as defined by each state's certification program. Training must provide PSS with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. And similar to other provider types, ongoing continuing educational requirements for PSS must be in place. CMS's guidance did not set a high school diploma or equivalent degree as a qualifying criterion.

What is a PSS? According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the role of the peer has been defined as "offering and receiving help, based on shared understanding, respect, and mutual empowerment between people in similar situations." Peer support has been described as "a system of giving and receiving help" based on key principles that include "shared responsibility, and mutual agreement of what is helpful." Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness. SAMHSA further states the development of additional core competencies may be needed to guide the provision of PSS to specific groups who also share common experiences, such as family members. The shared experience of being in recovery from a mental or substance use disorder or being a family member of a person with a behavioral health condition is the foundation on which the peer recovery support relationship is built in the behavioral health arena.

PSS core competencies. In 2015, SAMHSA led an effort to identify the knowledge, skills, and abilities (leading to core competencies) needed by anyone who provides PSS services to people with or in recovery from a mental health or substance use disorder. Via its Bringing Recovery Supports to Scale Technical Assistance Center Strategy project, SAMHSA convened diverse stakeholders from the mental health consumer and substance use disorder recovery movements and, with subject matter experts, conducted research to identify core competencies for peer workers in behavioral health. The core competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use disorders and delivered by or to adults, young adults, family members, and youth. The competencies may also apply to other forms of peer support provided by other roles known as peer specialists, recovery coaches, parent support providers, or youth specialists. SAMHSA notes the following are not a complete set of competencies for every context in which peer workers provide services and support but can serve as the foundation upon which additional competencies for specific settings that practice peer support and/or for specific groups could be developed in the future:

- Engages peers in collaborative and caring relationships;
- Provides support;
- Shares lived experiences of recovery;
- Personalizes peer support;
- Supports recovery planning;
- Links peers to resources, services, and supports;
- Provides information about skills related to health, wellness, and recovery;
- Helps peers to manage crises;
- Values communication;
- Supports collaboration and teamwork;
- Promotes leadership and advocacy; and,
- Promotes growth and development.

Qualifications for equivalent roles. The California Department of Health Care Access and Information (HCAI) maintains a website for the Community Health Workers, Promotores, and Representatives (CHW/P/R) Initiative. DHCS's All Plan Letter 22-016 outlines the Medi-Cal CHW Services benefit and notes CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. As part of the CHW minimum qualifications, HCAI states on its website that CHWs must have lived

experience that aligns with and provides a connection between the CHW and the patient or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services. Supervising providers (the organizations employing or otherwise overseeing the CHWs with which a managed care plan contracts) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising providers must maintain evidence of a CHW's stated experience. A high school diploma or equivalent degree is not noted in any of the listed requirements.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

Senate Rule 28.8

SUPPORT: (Verified 6/15/26)

Cal Voices (co-source)
County Behavioral Health Directors Association (co-source)
Alameda County Behavioral Health Department
Black Leadership Council
Black Men Speak, Inc.
California Alliance of Child and Family Services
California Association of Mental Health Peer Run Organizations
California Behavioral Health Association
California Behavioral Health Planning Council
California Coalition for Youth
California Pan-Ethnic Health Network
Commission for Behavioral Health
Communities Voices
County of Humboldt
County of San Diego
County of Santa Clara
County of Tulare
County Welfare Directors Association of California
Disability Rights California
Drug Policy Alliance

Help is Hope
Interim, Inc.
Law Foundation of Silicon Valley
Los Angeles Trust for Children's Health
Mental Health Advocacy Services
Mental Health America of California
Mental Health Association of San Francisco
National Alliance on Mental Illness
Painted Brain
Peer Recovery Services
Peer Voices United
Racial and Ethnic Mental Health Disparities Coalition
Steinberg Institute
Sunrays of Hope, Inc.
Sustainable Wellness Solutions
The Children's Partnership
The Happier Life Project
Youth for Change

OPPOSITION: (Verified 6/15/26)

California Consortium of Addiction Programs and Professionals
One individual

ARGUMENTS IN SUPPORT:

Cal Voices and the County Behavioral Health Directors Association, as co-sponsors, and other supporters from the mental health advocacy realm, state that the primary qualification for PSS is lived experience with mental health or substance use challenges, not formal education. A high school diploma or its equivalent is not essential to meeting the state-defined core competencies. Supporters argue PSS play a vital role in supporting individuals with behavioral health conditions on their recovery journeys, using personal lived experience to build trust and understanding, and that PSS services are a recognized evidence-based practice integrated within various medical and treatment settings, including peer-led organizations, respite centers, outpatient services, inpatient care, and mobile crisis teams. PSS are evaluated on their ability to connect with consumers, facilitate recovery, and provide support. Skills like communication, empathy, relatability, cultural competence, self-awareness, and conflict resolution are crucial and can be developed outside traditional high school settings. Supporters argue requiring a high school diploma or equivalent may create artificial barriers to entry

and limit access for individuals with the potential to excel in peer support roles. Currently, 8,014 PSS serve across California, embodying diversity in age, race, culture, and gender. They are crucial to addressing the mental health crisis by providing PSS services, which have been shown to decrease hospitalization rates and lower overall Medicaid costs. Supporters state California has a statewide shortage across all behavioral health roles and an imbalanced racial representation of providers relative to the population. To address these challenges, HCAI recommends a multi-pronged approach to supporting the behavioral health workforce, including funding peer and mentor networks for behavioral health professionals.

ARGUMENTS IN OPPOSITION:
The California Consortium of Addiction Programs and Professionals (CCAPP) states they support expanding access to the peer workforce; however, removing the high school diploma requirement must be paired with strengthened training and competency standards to ensure alignment with national peer support certification expectations. CCAPP urges the following amendments, which would ensure California maintains a qualified, nationally aligned peer workforce capable of meeting federal billing and service quality expectations:

- Adoption of SAMHSA Core Content Areas and the National Model Standards as the foundation for California's curriculum;
- Enhanced training hours to ensure adequate competency development;
- Prerequisite demonstration of proficiency in documentation and digital health literacy; and,
- Annual continuing education in documentation and digital literacy.

ASSEMBLY FLOOR: 73-0, 1/26/26
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Ávila Farías, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Johnson, Kalra, Krell, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO VOTE RECORDED: Arambula, Bains, Castillo, Lackey, Papan, Celeste Rodriguez, Ta

Prepared by: Reyes Diaz / HEALTH / (916) 651-4111
6/16/26 16:42:58

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