California Association of Mental Health Peer Run Organizations

Strengthening Peer Support Services Through Improved Regulations In California

EXECUTIVE SUMMARY

Peer Support Services (PSS) are crucial in mental health and substance use treatment, and are recognized as best practices by the Centers for Medicare and Medicaid Services (CMS). These services utilize the lived experiences of trained peer support specialists to assist individuals in their recovery, fostering hope, self-efficacy, and community integration. With CMS's endorsement of PSS, and the collaborative efforts of the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish certification standards, the aim is to professionalize the peer workforce while ensuring delivery of high-quality services.

Despite significant progress, including the ability to bill Medi-Cal for PSS in 2022, California continues to face challenges in implementing PSS that may jeopardize the integrity of services and community support systems. This position paper, commissioned by the California Association for Mental Health Peer-Run Organizations (CAMHPRO), examines the implications of SB 803 and Proposition 1 on PSS delivery in California. It emphasizes the need for a regulatory framework that maintains fidelity to PSS models and strengthens community ties.

SB 803 establishes a certification process and standards for peer specialists, enabling Medi-Cal billing for PSS. However, it restricts billing to services specifically for individuals with severe mental illness. This limitation prevents the state from accessing a cost-effective option for those with mild to moderate mental health conditions. The benefits of Peer Support Services for individuals across all severity levels—mild, moderate, and severe—are well documented. Such services not only offer a cost-effective option for those with mild to moderate conditions, but also contribute positively to the overall mental health and well-being of the community.

Prop 1 has diverted funding away from community-based organizations, putting the viability of some peer-run organizations at risk. This is a concern because original data demonstrating positive outcomes comes from peer-run organizations that utilize the recovery model. Peer-run organizations, with their deep understanding of lived experience and community needs, foster trust, which significantly improves outcomes for individuals facing mental health and/or substance use challenges. As Peer Support Services (PSS) expand into other organizational settings, it is essential to ensure these beneficial results by maintaining fidelity to the model. We must also acknowledge that peer-run and community-based organizations essentially uphold the standard for quality peer support. By inadequately funding peer services in these organizations, the state is failing to uphold the standard for peer services.

Overall, the recommendations to enhance the delivery of PSS in California are critical. They outline necessary steps, including fostering collaboration, conducting regular assessments, incentivizing accreditation, and reinforcing the importance of the recovery model as well as the use of community-based and/or peer-run organizations in providing PSS. These steps are not merely suggestions; they are essential actions to ensure the quality and accessibility of PSS in California.

STRENGTHENING PEER SUPPORT SERVICES THROUGH IMPROVED REGULATIONS IN CALIFORNIA

A. INTRODUCTION

Peer Support Services (PSS) are considered best practices in the field of mental health and substance use treatment. The Centers for Medicare and Medicaid Services (CMS) recognizes PSS as an evidence-based model of care, emphasizing its effectiveness in promoting recovery and improving the quality of life of individuals with mental health and substance use diagnoses. PSS involves trained peer support specialists who use their lived experiences to assist others in their recovery journeys, fostering hope, self-efficacy, and community integration. CMS supports the integration of PSS into Medicaid programs because of evidence that PSS reduces hospitalizations while enhancing overall mental health outcomes. [1]

CMS's support for PSS is part of federal efforts to develop a peer specialist workforce able to deliver PSS consistently as the services are scaled up and disseminated across jurisdictions and workplace settings across the country. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been instrumental in establishing National Model Standards for Peer Support Certification to professionalize the peer specialist workforce in alignment with overall efforts to develop the behavioral health workforce. These standards, developed in partnership with federal, state, tribal, local entities, and people with lived experience, ensure that peer support services are consistently high quality and effective. By promoting the universal adoption and integration of PSS, SAMHSA and CMS are working together to transform the behavioral health landscape, making recovery-oriented care more accessible and impactful. [2]

CMS authorized the first U.S. state for Medicaid billing in 1999, and by 2018, 39 states had allowed Medicaid billing for PSS. While the use of Medicaid for PSS financing has grown significantly over the past 20 years, many states continue to rely on grant funding for PSS alongside Medicaid reimbursement. However, the implementation of PSS in California and other states presents challenges that could have unintended consequences that threaten the integrity of PSS and community support systems. An emerging body of literature suggests that state implementation strategies may be insufficient to ensure PSS is delivered as intended, that is, in fidelity to the model. This could reduce the effectiveness of PSS while undermining local community efforts to support mental health and substance use recovery.

Commissioned by the California Association for Mental Health Peer-Run Organizations (CAMHPRO), this position paper critically examines the implications of SB 803 and Proposition 1 for the effective delivery of PSS in California. Based on emerging research, it offers a comprehensive analysis of how these policies affect the peer workforce and peer-run organizations (PROs). The analysis provides a framework for exploring regulatory options to address the challenges uncovered in the literature, emphasizing the need for fidelity to the model and the importance of maintaining strong connections with communities of people with lived experience. Ultimately, this paper aims to maximize the positive impact of existing legislative measures and position California as a leader in creating a robust and effective behavioral health system that honors the principles of recovery while optimizing the potential of the peer workforce.

B. POLICY ENVIRONMENT

SB 803 established a certification process for peer specialists and standards for ethics, training, and supervision (see Appendix Table A.1). It also developed a regulatory framework for Medi-Cal billing for PSS delivered by certified peer specialists. The final rules governing PSS reimbursement are detailed in Behavioral Information Notice (BHIN) No. 23-0XX (see Appendix Table A.2), including progress notes and other documentation requirements, guidance on medical necessity criteria for peer support services, and requirements for counties to ensure beneficiaries under age 21 receive medically necessary PSS. Combined, these rules help ensure consistent quality of PSS across the state, potentially more stable and sustainable PSS, and greater potential for wider adoption of PSS.

> "Fidelity to the model" refers to the degree to which an intervention is delivered as intended, encompassing adherence, quality of delivery, and participant engagement." [3]
>
> "Interventions are more likely to be effective when they are implemented with fidelity." [4]

SB 803, however, restricts billing to services specifically for individuals with *severe* mental illness. This limitation prevents the state from accessing a cost-effective option for those with mild to moderate mental health conditions. The benefits of PSS for individuals across all severity levels—mild, moderate, and severe—are well documented. These services not only offer a cost-effective option for those with mild to moderate conditions but also contribute positively to the overall mental health and well-being of the community. For example, research demonstrates the role of PSS in improving clinical and personal recovery outcomes [5]; reducing depressive symptoms and hospital admissions [6] [7]; and self-care, community belonging, and life satisfactions among individuals with mild to moderate mental health conditions. [8] Medi-Cal could reap greater cost savings by covering PSS for enrollees with mild to moderate mental health conditions, many of whom are living in the community and reached by PROs.

Proposition 1 includes the Behavioral Health Services Act (BHSA) and provisions for a $6.4 billion Behavioral Health Bond (see Appendix Table A.3). [9] This includes enhanced funding for housing and workforce interventions and continued funding for behavioral health services. Proposition 1 increases the percentage of BHSA funds allocated to state-level initiatives from 5% to 10%, at the expense of county-level programs. [10] This will require counties to make difficult budgetary decisions that may lead to fewer resources for PSS. In such an environment, it is crucial to economize resources without compromising the availability and quality of the services and supports that people need.

Compared to other states, California was late in introducing state certification and Medicaid billing for PSS. Proposition 1, however, provides an opening for the Behavioral Health Services Oversight and Accountability Commission, county boards of supervisors, and mental/behavioral health boards and commissions to develop innovative strategies based on emerging research that other states have not adequately considered. Current research suggests that state implementation

strategies for PSS often fail to adequately monitor and regulate organizations to ensure delivery of services in fidelity to the model, leading to suboptimal outcomes for peer participants and peer specialists.

While states have leeway to shape PSS delivery, policy development is often complicated by heterogeneity in organizational and service settings. Disparities in Medi-Cal financing for PSS—across organizational and service settings—may introduce market distortions that could crowd out community-based peer-run organizations (PROs). This, in turn, could compromise the core services PROs provide, disrupting the community support that is vital for people struggling with mental health wellness and substance use recovery.

In the next section, we discuss strategies for maintaining model fidelity using an implementation science lens. We then specify the threats to fidelity uncovered in the scientific literature and make recommendations for eliminating or mitigating these threats.

C. ENSURING FIDELITY

Maintaining fidelity is crucial for achieving the same observed outcomes when implementing evidence-based models in new contexts, organizations, and regions. As a professionalized form of mutual support, PSS can be implemented across community, healthcare, and criminal justice settings. [11] We utilized an implementation science lens to consider some of the challenges involved in maintaining model fidelity when scaling up or disseminating PSS across settings (clinical, non-clinical, institutional), organizational types (peer-run, non-peer run, and commercial), and jurisdictions (state and local). We hereby report the implications of this analysis for California.

1. Implementation science

Executing PSS with fidelity poses several challenges from an implementation science perspective, particularly within the regulatory framework established by SB 803 and Medi-Cal rules in California. These regulations specify requirements for peer worker certification and organizational billing for PSS delivered under supervision. Supervisors must be licensed practitioners of healing arts or certified peer support specialists with additional training in supervision. [12] Some implementation challenges include undefined roles, limited financial support, inconsistent boundaries, and philosophical differences among organizations about how to implement peer models. The complex professional structure of healthcare settings, stigma towards people with substance use disorders, and high caseloads can also hinder the successful integration of peer recovery support specialists. [13]

While current regulations address issues such as role clarity, they may not fully account for the organizational factors crucial for effective PSS implementation. The emerging peer workforce development literature suggests that organizations lacking a recovery culture conducive to peer-specialist self-disclosure may require stricter regulation. [13] In addition, workforce issues stemming from organizational factors, such as fluctuations in peer availability (due to personal circumstances or competing financial interests), are not adequately addressed by current regulations. State and local policymakers should consider these factors to ensure that organizations deliver PSS consistent with the model's design and intent.

2. Organizational characteristics

Organizational barriers can significantly impact the fidelity of PSS. The following five barriers are shaped by organizational policies, practices, and culture:

- **Hierarchical structures**: Rigid organizational layers that create power imbalances.
- **Limited worker autonomy**: Restricted freedom for peer workers to make decisions or act independently.
- **Inconsistent policies**: Lack of standardized guidelines or frequent policy changes.
- **Top-down decision-making**: Decisions made by upper management without input from lower levels.
- **Lack of resources**: Insufficient funding, staffing, or materials to support peer work.

Table 1 considers the mechanism by which each organizational barrier can reduce fidelity to the model, leading to reduced PRSS quality and weaker outcomes. These organizational barriers are closely linked to the workplace problems faced by peer support specialists. For instance, hierarchical structures and top-down decision-making can contribute to a lack of role clarity and the invalidation of peer experiences. Limited worker autonomy may lead to tasks unrelated to PSS and a lack of opportunities for advancement. Inconsistent policies can exacerbate issues of stigma and discrimination, while a lack of resources often results in high caseloads, poor training, and inadequate support for peer workers. Addressing these organizational characteristics is crucial for mitigating workplace problems and enhancing the fidelity and effectiveness of peer support services.

TABLE 1: ORGANIZATIONAL BARRIERS LINKED TO FIDELITY

Organizational Barrier	**Dimensions of PSS Delivery Required for Fidelity to the Model [14]**			
	Relationships based on shared lived experience	**Mutuality and reciprocity**	**Leadership, choice, and control**	**Discovering strengths and making connections**
Hierarchical structures	Impedes authentic peer relationships	Undermines non-hierarchical nature of peer support	Limits peer leadership opportunities	Restricts peers' ability to connect with community resources
Limited worker autonomy	Restricts use of lived experience	Hinders mutual learning and shared decision-making	Reduces peers' ability to promote choice	Constrains flexibility in strength-based approaches
Inconsistent policies	Creates confusion in relationship boundaries	Disrupts reciprocal interactions	Leads to inconsistent application of peer-led principles	Creates barriers to consistent community connections
Top-down decision-making	Limits peer input in relationship development	Reduces opportunities for mutual decision-making	Diminishes peer involvement in program decisions	Restricts innovative approaches to discovering strengths
Lack of resources	Limits time and support for relationship building	Constrains activities that foster reciprocity	Reduces opportunities for peer leadership development	Limits ability to connect with diverse community resources

3. Workplace challenges as fidelity signals

We reviewed the peer workforce literature and identified 13 workplace challenges that not only impair the effective delivery of PSS but can also harm peer workers themselves (see Table 2). The effective delivery of PSS is often compromised by various workplace challenges that occur at different levels within the service delivery system. At the service provision level, issues such as poor training, lack of role clarity, invalidation, vicarious trauma, and burnout directly affect peer specialists' ability to perform their roles effectively. High caseloads, tasks unrelated to

TABLE 2: THREATS TO PSS EFFECTIVENESS

Workplace challenges	Description	Impact on PSS
1. Poor training [15]	Inadequate or insufficient training for peer support specialists	Peers feel unprepared and potentially provide inaccurate information
2. High caseloads [16]	Excessive number of clients assigned to peer support specialists	Burnout and reduced quality of support
3. Tasks unrelated to PSS [17]	Assignment of tasks outside the scope of peer support services	Dilution of the peer support role and compromising the unique value of peers
4. Invalidation [18]	Dismissal or undervaluing of peers' experiences, insights, or contributions	Decreased confidence and reduced effectiveness
5. Lack of diversity among peer specialists [19]	Insufficient diversity to match diverse backgrounds of clients	Reduced relatability and less effective support
6. Lack of social, emotional, and professional support [20]	Insufficient support systems for peer support specialists themselves	Isolation and burnout
7. Lack of role clarity [21]	Unclear expectations and boundary challenges	Confusion and ineffective service delivery
8. Stigma and discrimination [22]	Peers facing stigma and discrimination in the workplace	Undermining peer credibility and creating a hostile work environment
9. Low compensation [23]	Lower salaries compared to other positions	High turnover rates and difficulty in attracting qualified peers
10. Limited opportunities for advancement [24]	Limited professional development and career progression	Skill stagnation and reduced motivation
11. Supervision by non-peer staff [25]	Supervision by licensed clinicians or other non-peer staff	Misunderstandings about the peer role
12. Vicarious trauma and burnout [26]	Experience of vicarious trauma and burnout due to nature of work	Decreased effectiveness and potential reoccurrence of use or stress of the peer specialist
13. Lack of workplace inclusion [27]	Struggles with inclusion in traditional healthcare settings	Isolation and difficulty integrating peer support principles

PSS, and supervision by non-peer staff can hinder the quality and focus on PSS. Lack of support for peer specialists, low compensation, limited advancement opportunities, and inadequate workplace inclusion reduce job satisfaction and retention. Over time, this can lead to poorer outcomes and lower quality. Finally, at the organizational level, systemic issues—such as a stigma, discrimination, and the lack of diversity—can undermine the effectiveness of peer support programs.

PSS is delivered by people who are themselves on a journey of recovery or wellness. Workplace stigma, burnout, discrimination, and other factors can lead to stress, relapse, or mental health problems among these individuals, who are responsible for supporting the recovery and wellness of others. Such an ironic situation runs counter to a vision for California to lead the nation by creating "wellness and hope to all residents and families with mental health and substance use disorder treatment needs." [28]

TABLE 3: WORKPLACE CHALLENGES BY FIDELITY DOMAIN

Fidelity Domain	Related Workplace Challenges	Accountability Limitations
A. Relationships based on shared lived experience	• Poor training • Invalidation • Lack of role clarity • Tasks unrelated to PSS • Lack of diversity among peer specialists	Limited accountability measures; no specific metrics to evaluate quality of relationships
B. Mutuality and reciprocity	• Lack of workplace inclusion • Lack of role clarity • Supervision by non-peer staff	No explicit measures to assess mutuality and reciprocity in peer support relationships
C. Leadership, choice, and control	• Limited opportunities for training and advancement • Tasks unrelated to PSS • Lack of social, emotional, and professional support	Limited mechanisms to ensure peer leadership opportunities; no specific requirements for peer involvement in organizational decision-making
D. Discovering strengths and making connections	• High caseloads • Stigma and discrimination • Vicarious trauma and burnout	No specific metrics to evaluate success in strength discovery or community connection; limited accountability for organizations in this dimension

These workplace challenges in an organization delivering PSS could be considered symptomatic of lost or weak fidelity to the model. Table 3 specifies workplace challenges, associated fidelity domains, and accountability limitations. Each challenge can be associated with the failure of at least one aspect of fidelity. For example, even highly trained, certified peer specialists may find it difficult to form and maintain relationships based on lived experiences if they feel invalidated and are given assignments unrelated to peer support. In organizations employing a single peer specialist (or multiple yet non-diverse peer specialists), the specialist in question may find it more challenging to form relationships with peer participants from more diverse backgrounds.

Such problems may signal a crisis of fidelity that requires organizational intervention. However, peer-run organizations embedded in a community of people with lived experiences are far less likely to experience many of these phenomena. For example, recovery community organizations are peer-led and governed. Those that are accredited or certified by the Council on the Accreditation of Peer Recovery Support Services (CAPRSS) or the Alliance for Recovery Centered Organizations (ARCO) are required to demonstrate that they meet all fidelity requirements. Accreditation offers reassurance that PSS is delivered with fidelity to the model, but SB 803 does not require or recognize accreditation or certification. Moreover, there are limited measures to hold organizations accountable for a lack of fidelity (see Table 3). While certification addresses the problem of poor training, organizational factors can impair the delivery of PSS. This suggests the need to regulate organizations offering PSS by identifying services that experience a crisis of fidelity and intervening with corrective measures.

D. ADDRESSING MARKET DISTORTIONS

The introduction of Medicaid billing through SB 803 offers the potential to increase access to PSS across the care continuum while expanding opportunities for peer specialists. This authorization, however, is likely to transform the PSS market from a grant-based, community-oriented system to one that increasingly resembles other healthcare markets, with reimbursement

rates and billing capabilities playing more significant roles in service provision and workforce distribution. [29][30][31]

Many workplace issues are shaped by market factors, including the supply and demand for PSS and peer specialists. The demand for PSS depends on available funding, and disparities in access to various funding opportunities can introduce market distortions that may magnify some of the workplace issues discussed above. Community-based organizations (CBOs) finance PSS primarily through braided and blended budgets composed of local, state, and federal grants, along with fundraising efforts [29]. This dynamic has created a relatively level playing field among CBOs, with competition based on service quality and community engagement rather than billing capacity. As a result, the market is somewhat fragmented, with various organizations offering services based on available grant funding and community needs. Additionally, because these CBOs are often peer-run and embedded in communities of lived experience, they tend to deliver PSS in fidelity with recovery values and principles.

Medi-Cal billing can distort the market by introducing disparities in financing. Organizations able to bill Medi-Cal for PSS can offer higher wages and better benefits, pulling more qualified peer specialists away from community-based organizations (CBOs) that lack this billing capacity. [32] This provides greater opportunities for peer specialists, but if institutional settings with established billing infrastructure can more easily access Medi-Cal reimbursements, economic theory predicts an oversupply of PSS in these settings while creating shortages in CBOs. [33][34][35][36] The complexity and cost of implementing Medi-Cal billing systems create barriers to entry for smaller CBOs, limiting their ability to compete in the PSS market. [35] The result is a stratified PSS market with organizations capable of Medicaid billing gaining a significant market advantage.

These PSS billing disparities also distort the labor market for peer specialists. More experienced peer specialists may migrate to better-funded healthcare organizations, leaving CBOs with a deficit of qualified staff. [32] Peer specialists may be incentivized to pursue careers in larger healthcare organizations rather than in community-based settings, potentially reducing the diversity and community-rootedness of the workforce. [33][34] This distortion in the labor market could create a situation where the overall effectiveness of PSS diminishes, as peer specialists could be less productive in non-community-based settings, which lack the culture and understanding of recovery principles found in peer-run organizations.

E. RECOMMENDATIONS

Both state and county governments play a role in addressing the problems discussed in this position paper. We recommend six strategies to address threats to fidelity, five strategies to address market distortions, and a strategy to increase the reach of PSS to Medi-Cal beneficiaries who suffer from mild to moderate mental health conditions.

1. Recommendations to Ensure Organizational Fidelity

a. Recommendation: Community Behavioral Health Departments (CBHDs) should prioritize contracting with consumer-operated or peer-run organizations to provide PSS.
Rationale: Peer-run organizations are better positioned to maintain fidelity to recovery values and deliver effective PSS because of their deep understanding of lived experience and community needs. Higher levels of trust cultivated within peer-run organizations are also likely to improve housing and other outcomes for people with severe mental illness.

b. Recommendation: Require or incentivize certification or accreditation processes for organizations delivering PSS programs through independent agencies such as ARCO or CAPSS.
Rationale: This ensures quality and adherence to recovery principles across all PSS providers, maintaining the consistency and effectiveness of services.

c. Recommendation: Conduct semi-annual fidelity assessments using a standardized fidelity assessment tool for all providers reimbursed by Medi-Cal.
Rationale: Regular assessments help maintain high standards of service delivery and allow for timely interventions if fidelity issues arise.

d. Recommendation: Require supervisors of peers to have lived experience with mental health or substance use recovery.
Rationale: Supervisors with lived experience can better understand and support peer specialists, thereby enhancing the quality of supervision and service delivery.

e. Recommendation: Focus regulation of non-governmental organizations delivering PSS on organizational-level threats to fidelity and appropriate remediation.
Rationale: This approach protects the integrity of PSS while allowing adaptations in diverse organizational settings.

f. Recommendation: Avoid the provision of PSS by CBHDs when peer-run organizations are available.
Rationale: CBHDs are responsible for regulating organizations delivering PSS, and delivering services creates a conflict of interest.

2. Recommendations for Addressing Market Distortions

g. Recommendation: Establish a statewide collaborative network of peer-run organizations to form a group purchasing organization for PSS.
Rationale: Such a network could leverage collective bargaining power to negotiate better rates and ensure fair compensation for specialists.

h. Recommendation: Implement a tiered reimbursement system that offers higher rates to peer-run organizations.
Rationale: This recognizes the value of peer-run organizations and helps offset potential disadvantages in billing infrastructure.

i. Recommendation: Create a dedicated grant program for peer-run CBOs to develop Medi-Cal billing infrastructure and capacity.
Rationale: This levels the playing field by helping peer-run organizations overcome barriers to entry into Medi-Cal billing.

j. Recommendation: Implement preferential contracting policies that require a certain percentage of PSS contracts to be awarded to peer-run organizations.
Rationale: This ensures a stable market share for peer-run organizations, preserving their role in PSS delivery.

k. Recommendation: Support the formation of a peer specialist professional association in California.
Rationale: A unified voice for peer specialists can advocate for fair wages, healthy working conditions, and career advancement opportunities.

4. Recommendations to Improve Access to PSS for Medi-Cal Beneficiaries

l. Recommendation: Expand access to PSS for Medi-Cal enrollees with mild to moderate mental health diagnoses by making PSS a reimbursable service for these enrollees.
Rationale: Average Medi-Cal expenditures for beneficiaries with mild to moderate mental health diagnoses are over twice as high as the average expenditures for beneficiaries with no mental health diagnosis. [37] [38]. Early intervention and greater engagement through PSS can strengthen adherence to treatment plans, prevent progression to more severe and costly conditions, and reduce rates of hospitalization and emergency visits, leading to overall Medi-Cal cost savings. [39] [40].

These recommendations aim to strengthen the role of peer-run organizations in PSS delivery, ensure high-quality services across all providers in California, and realize potential long-term cost-savings for Medi-Cal. By addressing both organizational fidelity and market distortions, these proposed policies can help create a more equitable and effective system of peer support services. As county boards of supervisors deliberate on the implications of Proposition 1, they should consider these strategies to ensure that their investment in community behavioral health leads to positive outcomes for those they serve.

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G. END NOTES

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H. APPENDIX

TABLE A.1: Key Provisions of SB 803

Provision	Description
Statewide Certification	Establishes a certification process for peer support specialists.
Medi-Cal Billing	Allows Medi-Cal reimbursement for certified peer support services.
Training Standards	Sets training standards based on SAMHSA guidelines.
Ethics and Supervision	Establishes standards for ethics and supervision, including the potential for supervisors with lived experience.
County Opt-In	Counties can opt-in to provide certified peer support services.
Stakeholder Input	Requires stakeholder input in developing certification guidelines.
Capacity Building Grants	Provides grants to build the capacity of peer-run organizations.
Eligibility	Only PSS delivered to people with severe mental illness is reimbursable.

Source: California Legislative Information. (2020). *Senate Bill No. 803: Mental health services: peer support specialist certification*. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB803

TABLE A.2: Key Provisions of Proposition 1, 2024

Provision	Description
Behavioral Health Services Act (BHSA)	Updates MHSA to include treatment for substance use disorders, prioritize care for serious mental illnesses, and provide ongoing resources for housing and workforce.
$6.4 Billion Behavioral Health Bond	Funds the development of behavioral health treatment facilities and supportive housing.
Housing Interventions	Allocates 30% of county BHSA funds for housing interventions for individuals with significant behavioral health needs.
Full Service Partnerships	Allocates 35% of county BHSA funds for comprehensive and intensive care programs.
Behavioral Health Services and Supports	Allocates 35% of county BHSA funds for general behavioral health services and supports.
State-Level Funding Increase	Increases state-level allocation of BHSA funds from 5% to 10% for workforce initiatives and prevention programs.

Source: California Legislative Information (2024). *Proposition 1: Behavioral Health Services Program and Bond Measure*. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB326

TABLE A.3: Regulatory Requirements for Peer Support Services Reimbursement

Requirement	Description
Certification	Peer Support Specialists must have a current state-approved Medi-Cal Peer Support Specialist Certification. This includes meeting ongoing education requirements.
Supervision	Services must be provided under the direction of a behavioral health professional who is licensed, waivered, or registered in accordance with California state requirements.
Service Components	Peer support services include educational skill-building groups, engagement activities, and therapeutic activities aimed at promoting recovery, resilience, and self-sufficiency.
Service Settings	Services can be provided in clinical or non-clinical settings and may include contact with family members or other support persons if it benefits the beneficiary.
Claiming and Billing	Peer Support Services can be claimed as standalone services or in conjunction with other SMHS, DMC, or DMC-ODS services. Claims must include the taxonomy code 175T00000X (Peer Specialist) and are billed in 15-minute increments.
Procedure Codes	Specific HCPCS and modifier combinations are used for claiming Peer Support Services, such as H0025 (Behavioral Health Prevention Education Service) and H0038 (Self-Help/Peer Services) with appropriate modifiers.
EPSDT Mandate	All counties must ensure that beneficiaries under age 21 receive medically necessary peer support services as part of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate.
Opt-In Requirement	Counties must opt-in to provide Peer Support Services as a Medi-Cal service. This involves submitting an opt-in letter and meeting specific claiming requirements.

Source: California Department of Health Care Services (2022). *Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services Peer Support Services* (BHIN 22-026). https://www.dhcs.ca.gov/Documents/BHIN-22-026-Drug-Medi-Cal-Drug-Medi-Cal-Organized-Delivery-System-SMHS-Peer-Support-Services.pdf