Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 803 **VERSION:** AMENDED JULY 27, 2020

AUTHOR: BEALL **SPONSOR:**

- California Association of Mental Health Peer Run Organizations (CAMHPRO)
- County Behavioral Health Directors Association of California (CBHDA)
- County of Los Angeles Board of Supervisors
- Steinberg Institute

PREVIOUS POSITION: SUPPORT

SUBJECT: MENTAL HEALTH SERVICES: PEER SUPPORT SPECIALIST CERTIFICATION

Overview:

This bill requires the State Department of Health Care Services (DHCS) to establish a certification body for peer support specialists. It also requires DHCS to seek federal waivers or other state plan amendments to achieve certain objectives such as including peer support specialist services as a distinct service type under the Medi-Cal program.

Existing Law:

States that certain essential mental health and substance use disorder services are covered Medi-Cal benefits effective January 1, 2014. (Welfare and Institutions Code (WIC) §14132.03)

This Bill:

1) Establishes the Peer Support Specialist Certification Program Act of 2020. (WIC Article 1.4, §§ 14045.10 – 14045.23))

2) Outlines the expected achievements of the peer support specialist certification program, including providing increased family support, providing a continuum of services in conjunction with other community mental health and substance use disorder treatment, and collaborating with others providing care or support. (BPC §14045.11)

3) Defines “peer support specialist” as a person 18 or older who self-identifies as having lived experience with the process of recovery from mental illness,

substance use disorder, or both, either as a consumer of services or as the parent or family member of the consumer. (WIC §14045.12(g))

4) Defines "peer support specialist services" as culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of skills learned in other support services. The services include support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified peer support specialist. (WIC§14045.12(h))

5) By July 1, 2021, requires the State Department of Health Care Services (DHCS) to establish a certification body, either through contract or through interagency agreement, to provide for peer support specialist certification. (WIC §14045.13(a))

6) Requires DHCS to define responsibilities, practice guidelines, and supervision standards for peer support specialists using best practice materials, and to determine curriculum and core competencies for certification, including, at a minimum, the following (WIC §14045.13(c) and (d)):

- Hope, recovery, and wellness
- Advocacy
- The role of consumers and family members
- Psychiatric rehabilitation skills and service delivery, and addiction recovery principals
- Cultural competence training
- Trauma-informed care
- Group facilitation skills
- Self-awareness and self-care
- Co-occurring disorders of mental health and substance use
- Conflict resolution
- Professional boundaries and ethics
- Preparation for employment opportunities
- Safety and crisis planning
- Navigation of and referral to other services
- Documenting skills and standards
- Confidentiality

7) Requires the DHCS to specify training requirements, including core competency based training and specialized training. (WIC §14045.13(e))

8) Requires DHCS to establish a code of ethics, continuing education requirements, a process for biennial certification renewal, a process for investigating complaints and corrective action, and a process for an individual employed as a peer support specialist on January 1, 2021 to obtain certification. (WIC §14045.13(f)-(j))

9) Provides minimum requirements for applicants for certification as a peer support specialist to include the following (WIC §§14045.14):

- Is at least age 18 with a high school diploma or equivalent;
- Self-identify as having experience with the process of recovery from mental illness or substance abuse as a consumer of services or as a parent or family member of the consumer.
- Is willing to share their experience
- Demonstrates leadership/advocacy skills
- Is strongly dedicated to recovery
- Agrees in writing to adhere to a code of ethics
- Successfully completes the required curriculum and training
- Passes a certification exam approved by DHCS
- Signs an affirmation of the code of ethics biennially
- Completes any required continuing education, training, and recertification requirements to maintain certification

10) Provides that this Act does not imply that a certification-holder is qualified or authorized to diagnose an illness, prescribe medication, or provide clinical services. It also does not alter the scope of practice for a health care professional or authorize delivery of health care services in a setting or manner not authorized under the Business and Professions Code or Health and Safety Code. (WIC §14045.15)

11) Requires DHCS to consult with the Office of Statewide Health Planning and Development (OSHPD), peer support and family organizations, mental health services and substance use disorder treatment providers, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council to implement this program. This includes holding stakeholder meetings at least quarterly. (WIC §14045.16)

12) Allows community health workers to partner with peer support specialists to improve linkage to services and facilitate early intervention for mental health services. (WIC §14045.17)

13) Permits DHCS to establish a certification fee schedule to support the activities associated with ongoing administration of the program. (WIC §14045.18)

14) Requires DHCS to seek federal waivers or other state plan amendments, as necessary, in order to do all of the following (WIC §14045.19):

- Include a peer support specialist as a provider type.

- Include peer support specialist services as a distinct service type provided to eligible Medi-Cal beneficiaries in a county, if the county elects to opt in to

provide peer support specialist services and fund the nonfederal share of those services.

- Develop and implement billing codes, reimbursement rates, and claiming requirements for peer support specialist services.

15) Allows DHCS to implement this law via notices, plan letters, bulletins, or similar instructions, without regulations, until regulations are adopted. Regulations must be adopted by January 1, 2022 (WIC §14045.22)

16) Subject to authorization in the Budget act and authorization by the Mental Health Services Act, allows DHCS to use Mental Health Services Act Funds to develop and administer the certification program. (WIC §14045.23)

Comments:

1) Intent of This Bill. In their fact sheet, the author's office states the following:

> *"Studies demonstrate that use of peer support specialists in a comprehensive mental health or substance disorder treatment program helps reduce client hospitalizations, improve client functioning, increase client satisfaction, alleviate depression and other symptoms, and diversify the mental health workforce. Often, peers serve as the first and sustained point of contact for people living with mental illness and assist them with the treatment they need at the earliest moment."*

The author notes that California lags behind the rest of the country in implementing a peer support specialist certification program. Currently, the Department of Veteran's Affairs and 48 states either have or are developing such a program. They also note that in 2007, the federal Centers for Medicare and Medicaid released guidance for establishing a peer certification program to enable the use of federal Medicaid financial participation with a 50% match (**Attachment C**).

2) Examples of Requirements in Other States. Several other states recognize certified peer counselors. Staff surveyed a few of these states to determine their requirements.

Washington
The state of Washington allows peer counselors to work in various settings, such as community clinics, hospitals, and crisis teams. Peer counselors must be supervised by a mental health professional. Examples of things they may do include assisting an individual in identifying services that promote recovery, share their own recovery stories, advocacy, and modeling skills in recovery and self-management.

To become a peer counselor in Washington, a person must be accepted as a training applicant. They must complete a 40-hour training program and pass a state exam.

Tennessee
According to the State of Tennessee's Department of Mental Health and Substance Abuse Services, Certified Peer Recovery Specialists must complete an extensive application. If accepted, they complete a 40-hour training program and 75 hours of supervised peer recovery service. They must be supervised by a mental health professional or a qualified alcohol and drug abuse treatment professional.

New Mexico
The State of New Mexico offers peer support specialist certification. Applicants must demonstrate 2 years of recovery, complete a written application, complete 40 hours of supervised experience, complete required training, and pass an examination.

3) **Previous Position.** At its June 5, 2020 meeting, the Board considered a previous version of this bill and took a "support" position. However, some amendments have been made since that time, and the author's office has indicated that a position based on the most current version would be helpful.

4) **Previous Legislation.** The Board has considered several similar bill proposals in recent years:

- SB 10 (2019, Beall) The Board took a "support if amended" position on SB 10, requesting the two amendments discussed above relating to specifying allowable supervisors and scope of practice clarifications.

  SB 10 was vetoed by Governor Newsom. The Governor stated the following in his veto message: *"Peer support services can play an important role in meeting individuals' behavioral health care needs by pairing those individuals with trained "peers" who offer assistance with navigating local community behavioral health systems and provide needed support. Currently, counties may opt to use peer support services for the delivery of Medicaid specialty mental health services. As the Administration, in partnership with the Legislature and counties, works to transform the state's behavioral health care delivery system, we have an opportunity to more comprehensively include peer support services in these transformation plans. I look forward to working with you on these transformations efforts in the budget process and future legislation, as improving the state of the state's behavioral health system is a critical priority for me. This proposal comes with significant costs that should be considered in the budget process."*

- SB 906 (2018, Beall) The Board took a "support if amended" position on SB 906, requesting the following amendments:

  - An amendment to include LPCCs as acceptable supervisors of peer support specialists (SB 906 included psychologists, LCSWs, and LMFTs as allowable supervisors, but omitted LPCCs); and

  - An amendment to require that peer support specialists be fingerprinted.

  SB 906 was vetoed by Governor Brown. In his veto message, the Governor stated the following: *"Currently, peer support specialists are used as providers in Medi-Cal without a state certificate. This bill imposes a costly new program which will permit some of these individuals to continue providing services but shut others out. I urge the stakeholders and the department to improve upon the existing framework while allowing all peer support specialists to continue to work."*

- SB 614 (2015-2016, Leno) proposed a similar program, although some modifications have been made. The Board took a "support if amended" position on SB 614, asking for a clear exclusion of psychotherapy services, a better-defined scope of services, and the inclusion of LPCCs as acceptable supervisors. SB 614 was ultimately gut-and-amended to address a different topic.

5) Support and Opposition.

Support:
- California Association of Mental Health Peer Run Organizations (cosponsor)
- County Behavioral Health Directors Association of California (cosponsor)
- Los Angeles County Board of Supervisors (cosponsor)
- Steinberg Institute (cosponsor)
- 2020 Mom
- Alameda County District Attorney's Office
- Association of California Health Care Districts
- Bay Area Community Services
- Cal Voices
- California Access Coalition
- California Alliance of Child and Family Services
- California Association of Alcohol and Drug Program Executives, Inc.
- California Association of Public Hospitals and Health Systems
- California Association of Social Rehabilitation Agencies
- California Behavioral Health Planning Council
- California Chapter of the American College of Emergency Physicians
- California Council of Community Behavioral Health Agencies
- California Pan-Ethnic Health Network

- California Psychiatric Association
- California Psychological Association
- California Schools Nurses Organization
- California State Association of Counties
- CaliforniaHealth+ Advocates
- Children Now
- Children's Defense Fund – California
- Community Research Foundation
- County of Ventura
- County of Santa Clara
- Depression and Bipolar Support Alliance California
- Disability Rights California
- Juvenile Court Judges of California
- Kelechi Ubozoh Consulting
- Local Health Plans of California
- National Alliance on Mental Illness, California
- National Alliance on Mental Illness, Fresno
- National Alliance on Mental Illness, Solano
- National Association of Social Workers, California Chapter
- Occupational Therapy Association of California
- Orange County Board of Supervisors
- Peers Envisioning and Engaging in Recovery Services
- Racial and Ethnic Disparities Mental Health Coalition
- Santa Clara Valley Health Plan
- Seneca Family of Agencies
- The Arc and United Cerebral Palsy California Collaboration
- The Children's Partnership
- Transitions-Mental Health Association
- Ventura County Board of Supervisors
- Western Center on Law & Poverty

Oppose:
- California Right to Life Committee

6) History.

2020

07/27/20	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
06/29/20	Referred to Com. on HEALTH.
06/24/20	In Assembly. Read first time. Held at Desk.
06/24/20	Read third time. Passed. (Ayes 39. Noes 0.) Ordered to the Assembly.
06/23/20	Ordered to special consent calendar.
06/22/20	Read second time. Ordered to third reading.

06/18/20	Read second time and amended. Ordered to second reading.
06/18/20	From committee: Do pass as amended. (Ayes 7. Noes 0.) (June 18).
06/11/20	Set for hearing June 18.
06/09/20	June 9 hearing: Placed on APPR. suspense file.
06/03/20	Set for hearing June 9.
06/02/20	Hearing rescheduled due to Capitol closure.
05/26/20	Set for hearing June 1.
05/13/20	From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 9. Noes 0. Page 3533.) (May 13). Re-referred to Com. on APPR.
05/11/20	Set for hearing May 13.
03/26/20	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
01/15/20	Referred to Com. on HEALTH.
01/09/20	From printer. May be acted upon on or after February 8.
01/08/20	Introduced. Read first time. To Com. on RLS. for assignment. To print.

7) Attachments.

Attachment A: *"Peer Certification: What are we Waiting For?"* by the California Mental Health Planning Council, February 2015.

Attachment B: "*Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders" by* Susan A. Chapman, PhD, RN, Lisel K. Blash, MPA, Kimberly Mayer, MSSW, Joanne Spetz, PhD. American Journal of Preventive Medicine, June 2018.

Attachment C: Letter to State Medicaid Directors, Letter No. 07-011, issued by federal Centers for Medicare and Medicaid Services; August 15, 2007

California Mental Health Planning Council

CHAIRPERSON
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PEER CERTIFICATION:

WHAT ARE WE WAITING FOR?

- Advocacy
- Evaluation
- Inclusion

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Examining the Opportunities, Barriers, and Precedents for the Official Recognition and Certification of Peer Specialists in California.

February 2015

[1] *"When you talk to people who have been through these programs and ask them what helped them, it is not the drugs, not the diagnosis. It's the lasting, one-on-one relationships with adults who listen…."*

1 *http://www.npr.org/blogs/health/2014/10/20/356640026/halting-schizophrenia-before-it-starts*

Leading the Way, yet Lagging Behind:

California is accustomed to being at the forefront of progressive, compassionate policy and legislation. Voters passed the Mental Health Services Act because they couldn't stand to see the misery of unaddressed mental illness and the state was an early adopter of parity laws and Medicaid expansion. As a state, we have been proud of our leadership. So, where has California lagged behind? California has yet to follow the example of 31 other states and the Veterans Administration in establishing and utilizing a standardized curriculum and certification protocol for Peer Specialists' services.

Peers are persons with lived experience as consumers and family members or caretakers of individuals living with mental illness. Their experiences make Peer Specialists invaluable members of a service team. Employment and certification simultaneously bridges the gap between those that need it and those that can best provide it while reinforcing the peer provider's own wellness and sense of purpose.

Right now, more than half of the United States has a Peer Certification Program in place – people practicing, producing, and billing. Making a difference in the lives of people they intimately understand because they have already staved off the same potential devastation. Because if you ask somebody struggling with a life-altering, all-consuming episode of any type of mental distress if they have sought help yet, the response - more often than not - would be "'*they don't understand*" or "*I just can't deal with the process of getting that help*". California has not been able to summon up the political will it would take to make the most basic and meaningful connection with somebody who needs it the most.

"A leader is not someone who stands before you, but someone who stands with you[2]*"*

What are Peer Specialists?

Peer Specialists are empathetic guides and coaches who understand and model the process of recovery and healing while offering moral support and encouragement to people who need it. Moral support and encouragement have proven to result in greater compliance with treatment/services, better health function, lower usage of emergency departments, fewer medications and prescriptions, and a higher sense of purpose and connectedness on the part of the consumer.

Peer Specialists also model and train on communication between health care provider and consumer in order to educate both on potential barriers or side effects of existing medications or treatment plans. In a world where primary care intersects with mental health care, but

[2] Native American Proverb

medical records are not necessarily shared, this alone is huge. Bridging that gap becomes one of the single highest predictors of effective treatment plans and positive outcomes. In a population with mortality rates that average 25 years sooner than non-SMI groups - for conditions that could be easily managed or cured - this one benefit alone is worth the investment.

It might be easier to describe Peer specialists by defining what they are NOT. Peer Specialists differ from Case Managers in that they do not identify resources, arrange for social or supportive services, or facilitate job trainings, educational opportunities, or living arrangements. They are not certified to offer medical advice or diagnoses, psychiatric or otherwise, or suggest, prescribe, or manage medications. Their function is not to "do for" but rather to "do with" and ultimately model and train wellness principles and self-sufficiency.

What is Peer Specialist Certification?

Peer Specialist Certification is an official recognition by a certifying body that the practitioner has met qualifications that include lived experience and training from a standardized curriculum on mental health issues. The standardized curriculum has been approved by the certifying body and includes a mandatory number of hours of training in various topics pertaining to mental health care, coaching, and ethics. The "specialist" designation is conferred when additional hours of training specific to special populations or age groups has been completed and the candidate has demonstrated thorough knowledge, skills, and ability within that subgroup.

The standardized curriculum includes topics such as documentation, boundaries and ethics, communication skills, working with specific populations, developing wellness plans, systems of care, principles of practices (i.e., engagement, strength-based planning, WRAP plans, case management); and advocacy, to name a few. At this time, there are several courses available through the community college system, but not on a statewide basis. Working Well Together has compiled an excellent comprehensive report - *Certification of Consumer, Youth, Family, and Parent Providers; A Review of the Research* – which provides detailed information, background, and context.[3]

Why Certification?

> *"Regardless of the means selected to demonstrate competency, it is critical that the core competencies of a peer (knowledge, skills, job tasks, and performance domains of the profession) are identified according to a recognized process, such as a job task analysis or role delineation study.* ***This is because –all other program requirements, policies, and standards must tie back to the core competencies of the profession being credentialed."***[4]

[3] http://www.inspiredatwork.net/uploads/WWT_Peer_Certification_Research_Report_FINAL_6.20.12__1_.pdf

[4] Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014

Defining and standardizing the classification of Peer Specialist through certification prevents engagement outside one's expertise. Like any other profession, the certification defines the level of care and services so that the parameters established by the standardized curriculum and certification requirements are respected and understood statewide. Any hiring organization can expect these levels of qualifications, training, and expertise in the person they hire and can plan their organizational functions around the duties encompassed by that expertise. It also provides guidance to the peer practitioner through an established code of ethics. This means that roles and functions of other providers will not be usurped or second-guessed by the Peer Specialists.

The role of the certified peer specialist is to encourage partners and lead through example on the best ways to advocate for oneself. Sometimes it is not enough to suggest resources and make recommendations for services – sometimes you have to walk the walk along with the person for the first few steps, or even the first few miles. In this respect, the Peer Specialist is the Sherpa of the mental health care world. As partners, they teach participants how to communicate with care providers, navigate insurance companies and bureaucracies, and lessen the anxieties that arise from these various interactions. As models, they demonstrate that recovery *is* possible.

The Time is Now

First and foremost, the time is now because Affordable Health Care, Mental Health Parity, Coordinated Care Initiative, and potentially even the Public Safety Realignment create workforce shortages, particularly in the area of rehabilitative services. The time is now because recognizing the value of Peer Specialists does not translate into standardized training, skill sets, duties, or pay scales. This will make it difficult to operationalize and maintain utilization on a scale sufficient to meet the workforce needs or government standards and requirements for reimbursement. In other words "failing to plan is planning to fail".

The Center for Medicaid Services gave California permission to amend its State Plan to include Peer Providers in 2007, stating "*We encourage States to consider comprehensive programs but note 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*"[5].

The time is now because the state is starting to fully understand the concept and value of peer services as part of both mental health care and the larger arena of primary care. Examples of this are their inclusion in the SB 82 (Steinberg) Investment in Mental Health and Wellness Act

[5] Center for Medicare and Medicaid Services; SMDL #07-011; August 15, 2007

grant requirements for mobile crisis teams; the intent in the original Prop 63 language to include peers, family members, and parent providers as part of the MHSA workforce; and a one-time dedicated state budget allocation of training funds to the Office of Statewide Health Planning and Development for peers to be trained as mobile crisis team members. All of these components will be working together as part of the larger mental health network of care, but run the risk of operating at disparate training levels, scope of work, code of ethics, and pay levels from county to county.

Finally, the time is now because trying to standardize the classification after a piecemeal acceptance is put into place is inefficient and uninformative to potential employers. Moreover, it is unfair to people who are willing to share their expertise and demonstrate their commitment to this important and effective aspect of care and services.

To draw a timely comparison, the classification of drug and alcohol counselors, which often has a strong peer component as part of the qualifications for employment, received an early welcome into the workforce. However, this acceptance was unaccompanied by any defined training, experience, or education requirements. There has been an attempt to retroactively achieve some standardization across the lines, but proponents are finding that, due to the unstructured engagement of their services, there is no uniform requirement or skill level across treatment sites. Worse, there is a reluctance to champion a certification process, due to potential hardships and setbacks created for current successful peer employees who might not meet certification standards after the fact.

Is it Cost-Effective?

In Alameda County, a Peer Mentoring pilot project provided 40 hours of training to 26 peers called "The Art of Facilitating Self-Determination" and matched them with people recently released from psychiatric hospitals. Those accepting a peer mentor experienced a 72% reduction in readmissions to the hospital. The cost savings for Alameda County was over a million dollars with an initial investment of $238K- making a 470% return on investment[6].

The Pew Trusts reported recently "In Georgia, a 2003 study compared patients diagnosed with schizophrenia, bipolar disorder and major depression whose treatment had included peer support, with patients who received traditional day treatment services without peers. The patients who had peer support had better health outcomes—and at a lower cost. The average annual cost of day treatment services is $6,400 per person, while support services cost about $1,000."[7]

[6] http://www.oshpd.ca.gov/HWDD/pdfs/wet/PowerPoint-Peer-Support-Specialist-A-Galvez-S-Kuehn.pdf
[7] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage ; last accessed 11/5/2014

Who Employs Peer Specialists?

Between October 2013 and January 2015, the Advocacy Committee of the California Mental Health Planning Council (CMHPC) heard presentations from Peer Specialist Advocates and Peer-run programs throughout the state. The programs represented different models ranging from peer-run respites to peer partners in health care, but all of them reported positive outcomes for the participants, cost savings for their respective counties, and a bolstering of their own wellness commitment. Here is a brief review of a few of the models the Advocacy Committee heard from.

Health Navigators USC

The Peer Health navigator connects consumers to mental health, primary care, substance use, and specialty health care services; teaches them how to advocate for themselves and effectively communicate their needs; create a follow-up plan and other self-management skills through a "modeling, coaching, fading". They differ from Case Managers or care coordinators in that the health navigator will ultimately step away from the participant once the modeling/coaching/fading process is successful.

Typically a full-time navigator will have 12 – 15 clients at any one time, and averages 30-40 clients annually, depending on how quickly the clients moves into full self-management. Many of the services are Medicaid billable under Targeted Case Management or Rehabilitation providing the documentation reflects justification for the services rendered. Participants are trained on billing codes and documentation. The program has developed its own curriculum and provides its own training and certification.

2nd Story, Santa Cruz

2nd Story is a SAMHSA-funded program that is an entirely Peer-Run Crisis Center in Santa Cruz. All staff are trained in "Intentional Peer Support" and all wellness class topics are determined by the guests. The program provides its own training. The length of stay is no longer than two weeks, and guests are encouraged to maintain their "normal" life (school, work) during their stay. Outreach is conducted by staff posted at County mental health departments telling potential guests about the program. Referrals are also made by psychiatrists, care managers, and Telecare, a county mental health services provider/contractor, sometimes diverts people to 2nd Story rather than enrolling them in a longer term, more structured social rehabilitation facility. The program is proving to be a key preventative service in Santa Cruz that forestalls or reduces the need for crisis residential and sub-acute stabilization programs.

In-Home Outreach Team (IHOT), San Diego

As Assisted Outpatient Treatment steadily gains ground in more California counties, a small program in San Diego is providing an effective and legitimate alternative at promoting and facilitating voluntary access to services. IHOT teams consist of a Peer Specialist, family member, personal service coordinator and team lead. They provide in-home outreach to adults with serious mental illness (SMI) who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and/or caretakers of IHOT participants. They work with individuals living with severe mental illness and who may also be dually diagnosed with a substance use disorder or drug dependency. Teams serve a combined 240-300 consumers per year (80-100 per team).

A 2013 San Diego Health and Human Services report notes that the average cost per IHOT participant amounts to $8,100, compared to an annual cost per individual in a Full Service Partnership ($20,000 including housing) and Assisted Outpatient Treatment ($34,000). Staff ratios are similarly proportionate: IHOT = 1:25 staff to client ratio; FSP and AOT each have a 1:10 staff to client ratio.

What Other States Employ and Certify Peer Specialists?

As of 2013, Certified Peer Specialists were certified and employed in 31 states and the federal Department of Veteran's Affairs. The extent of engagement and responsibility varies from state to state, but all services are Medicaid billable. These 31 states are consistent in their belief and trust in Peer Specialists – when will California join them?

What is Stopping California?

Despite all of the merits, fiscal and clinical, of Certified Peer Specialists, California has not been able to match its actions to its talk in this area. California embraces the concept of recovery, wellness, and resilience – and recognizes the essential components of both employment and inclusion as part of those processes – but it has failed to turn those concepts to tangible actions.

No State Department feels that it is in their purview to establish, implement or oversee a state certification process. Education may approve a curriculum, but it is not empowered to grant certification. Department of Health Care Services may be able to approve billable services, but is not empowered to establish curriculum or gage mastery of the subject matter. The Office of Statewide Health Planning and Development (OSHPD) has a Workforce Development Division, and is specifically charged with mental health workforce development issues, but without specific language or policy permitting OSHPD to include or pursue the specific classification of Peer Specialist, OSHPD does not felt comfortable facilitating it. In short, the single, largest barrier has been the identification of a lead agency or organization that can be charged with facilitation, implementation, and identification of a certification and oversight

body. There may be philosophical or conceptual agreement on the importance of Peer Specialists, but no policy or political direction to move it forward.

How Can California Catch Up?

Peer Specialist Certification is a cross-cutting, inclusive, and cost-saving classification that has applications across all vulnerable and at-risk populations in the state – veterans, homeless, Transition Age Youth, elderly, and criminal justice populations to name a few - and has particular utility in integrated services for the dually diagnosed and co-morbid conditions in health care.

The California Mental Health Planning Council (CMHPC) recommends that the Legislature continue and solidify its mission to create a seamless, comprehensive, continuum of mental health services and care by:

- developing clarifying legislative language that MHSA and/or other funding may be used to establish an implementation and oversight body for statewide Peer Specialist Certification; and/or
- making Peer Certification a priority of the 2015-16 Legislative Session as a stand-alone issue ; and/or
- requiring the Certification of Peer Specialists in legislation pertaining to workforce expansion or expanded services for vulnerable populations: and/or
- identifying and including funding for the establishment of a Peer Specialist certifying and oversight body through the annual Budget Act.

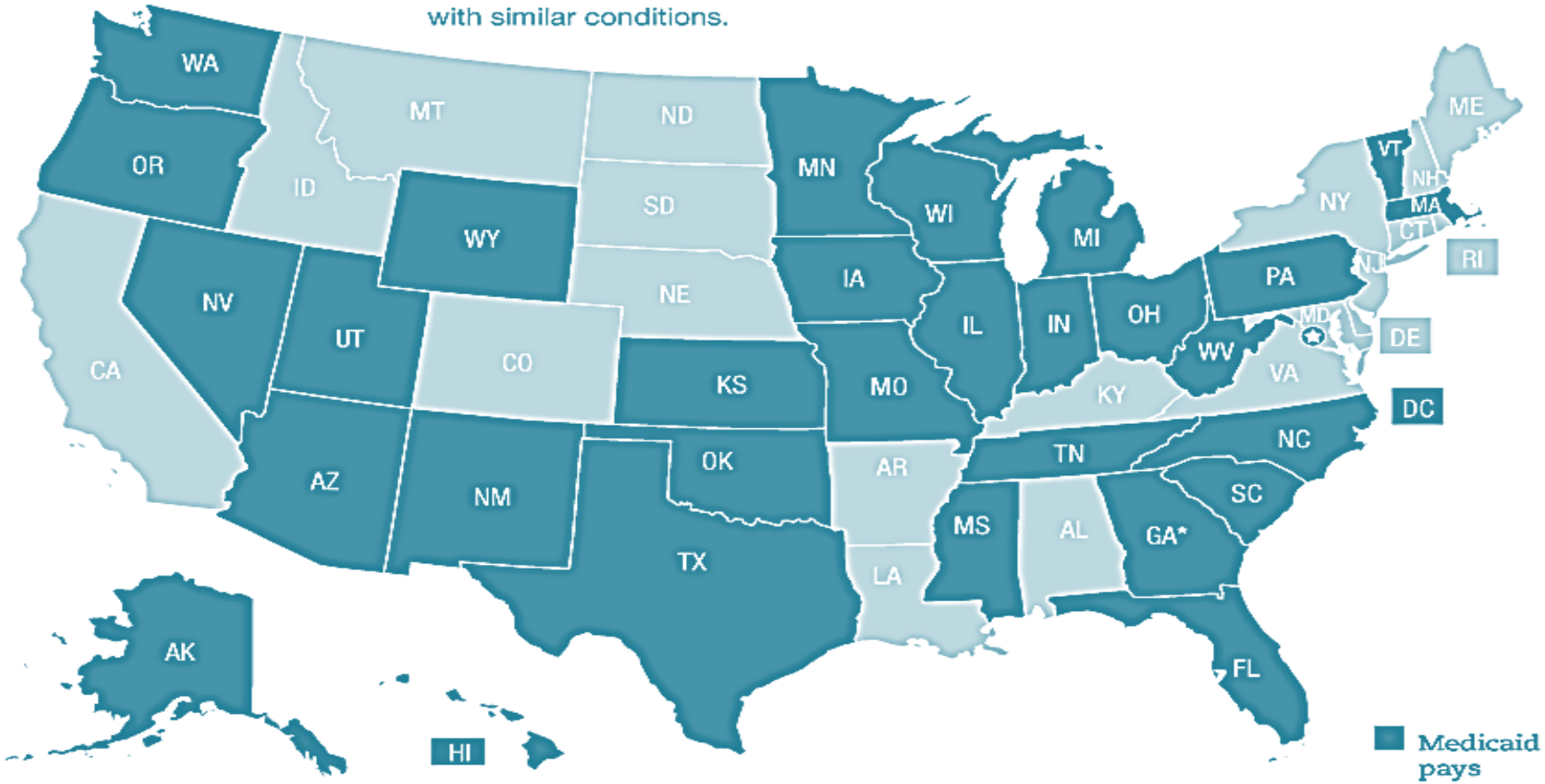
The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this issue to the forefront of mental health policy. These groups dedicated countless hours to investigating best practices, training models, potential curriculums, and workforce applications for Certified Peer Specialists and have generously shared their time and information to bring the CMHPC and others up to speed. Their work deserves attention and close consideration by anybody that might be in a position to support the implementation process. For detailed information on the background, issues, application, and potential processes, please visit: http://workingwelltogether.org/resources/recruiting-hiring-and-workforce-retention/wwt-toolkit-employing-individuals-lived or http://www.inspiredatwork.net/Resources.html,

STATELINE INFOGRAPHIC

Mental Health Peer Specialists

States where Medicaid pays for them

In 31 states, Medicaid pays for licensed peer specialists, counselors recovering from severe mental illness or substance addiction who are trained to help others with similar conditions.



Source: OptumHealth and Appalachian Consulting Group
NOTE: In Georgia, Medicaid pays peer specialists to provide "whole health" counseling.

Stateline infographic by Adam Rotmil and Christine Vestal
September 11, 2013

http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage#map

American Journal of
Preventive Medicine

RESEARCH ARTICLE

Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders

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Introduction: The purpose of this study was to identify and assess states with best practices in peer provider workforce development and employment. A growing body of research demonstrates that peer providers with lived experience contribute positively to the treatment and recovery of individuals with behavioral health needs. Increased employment opportunities have led to policy concerns about training, certification, roles, and reimbursement for peer provider services.

Methods: A case study approach included a national panel of subject matter experts who suggested best practice states. Researchers conducted 3- to 5-day site visits in four states: Arizona, Georgia, Texas, and Pennsylvania. Data collection included document review and interviews with state policymakers, directors of training and certification bodies, peer providers, and other staff in mental health and substance use treatment and recovery organizations. Data collection and analysis were performed in 2015.

Results: Peer providers work in a variety of settings, including psychiatric hospitals, clinics, jails and prisons, and supportive housing. A favorable policy environment along with individual champions and consumer advocacy organizations were positively associated with robust programs. Medicaid billing for peer services was an essential source of revenue in both Medicaid expansion and non-expansion states. States' peer provider training and certification requirements varied. Issues of stigma remain. Peer providers are low-wage workers with limited opportunity for career growth and may require workplace accommodations to maintain their recovery.

Conclusions: Peer providers are a rapidly growing workforce with considerable promise to help alleviate behavioral health workforce shortages by supporting consumers in attaining and maintaining long-term recovery.

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INTRODUCTION

Peer providers are individuals who provide services in behavioral health settings—both mental health and substance use disorders (SUDs) treatment—based on their own experience of recovery from mental illness or addiction and skills obtained from formal peer provider training.[1] They are part of the transformation of behavioral health care into a "recovery-oriented" model of care. Traditional mental health care focuses on treatment and control of symptoms of mental illness and

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addiction with services primarily provided by licensed professionals. By contrast, the recovery model focuses on maintaining long-term recovery past acute crises.[2] Key components of this model include empowering and involving consumers of behavioral health services in shaping their own care and the integration of peer providers into the workforce supporting recovery and resilience.[3,4]

In 1999, Georgia was the first state in the nation to include mental health peer providers in its Medicaid plan as a billable provider type.[5] In 2007, the Centers for Medicare & Medicaid Services issued a letter to state Medicaid directors authorizing them to bill Medicaid for peer provider services under particular conditions, including the establishment of statewide training and certification and supervision of peer providers by "competent mental health professional(s)."[6] By 2016, a total of 42 states and the District of Columbia had adopted statewide certification and training for peer providers and Medicaid reimbursement for mental health peer support.[7] Only 11 states have provisions for Medicaid billing for SUD peer support.[8] In 2015, there were an estimated 25,417 certified mental health peer support specialists in the U.S.[9] There are no similar nationwide numbers available for SUD peer providers.

The Centers for Medicare & Medicaid Services rationale for authorizing Medicaid billing for peer support cited studies that established peer support as "an evidence-based mental health model of care."[6] Peer providers are thought to be effective because their lived experience allows them to establish a rapport with consumers. This rapport includes promoting belief in the recovery process and demonstrated success in self-efficacy and management of one's own recovery.[10] Findings from numerous RCTs suggested the potential for peer providers to improve outcomes, including reducing hospitalizations, enhancing self-efficacy and quality of life, and increasing patient activation.[10–16]

Despite the spread of peer provider programs, the integration of peer providers into traditional settings still faces challenges of poorly defined roles, client–staff boundary issues, lack of workplace accommodations, variation in training and work experience, and workplace stigma.[17–23] Peer providers often receive lower pay than comparable non-peer staff and experience limited career mobility.[24–26]

This paper contributes to the literature on peer providers with in-depth research and identification of best practices in utilization of the peer provider workforce based on 194 interviews conducted in four states. The authors make policy recommendations for future employment of peer providers in behavioral health settings.

METHODS

Researchers used a comparative case study design to examine four states with best practices in peer provider employment, via comprehensive site visits to study peer providers in mental health and SUD settings.

An expert panel was convened telephonically in February 2015 to provide guidance in selecting states for the case studies. The expert panel consensus was that Arizona, Georgia, Texas, and Pennsylvania were among the leading states in the employment and training of peer providers and thus were selected for the case studies. Researchers contacted state officials, certification boards, training organizations, and provider organizations in these four states to gather preliminary information about their peer provider models. Some key informants and provider organizations were suggested by panelists whereas others were suggested by state behavioral health departments and web searches.

Three- to 5-day site visits were scheduled in 2015 with four to nine organizations per state. During site visits, teams of two to four researchers toured facilities and conducted semi-structured interviews with individuals in training and certification bodies, state agencies, and provider organizations. Interviewees included policymakers, training and certification specialists, peer providers, supervisors, and managers in peer-run, recovery-focused, and traditional treatment settings. In-person visits enhanced rapport with interviewees and allowed researchers to observe the sites and communities in which interviewees worked. A total of 194 individuals at 29 organizations were interviewed. At least two researchers attended each interview and took detailed notes. Background information, such as staffing counts, billing and reimbursement information, job descriptions, and program brochures, was also collected.

In 2015, interview notes were coded for key themes by state using Atlas.ti software, version 8. Themes were compared across the four states for similarities and differences. All members of the research team participated in the coding and development of the key themes.

The IRB at the University of California, San Francisco, approved this study. All research participants consented to participation.

RESULTS

Several key themes in the four study states have implications for the growth of peer provider employment nationwide: roles and job descriptions in various employment settings; training and certification approaches; billing and reimbursement for peer providers; workforce and career development; and maintaining recovery, addressing boundaries, and stigma.

Diverse Employment Settings and Roles

Across the four states, peer providers were employed in a variety of settings and sectors, including non- and for-profit organizations and government agencies. Some organizations were peer run and staffed. Clinical settings included mental health clinics, detox and rehabilitation centers, crisis stabilization units, and psychiatric

hospitals. Non-clinical settings included peer-run respites, community centers, supportive housing, and sobering houses. Many peer providers spent most of their time meeting with consumers in the community or at a facility, such as a jail, prison, or probation center; mental health, family, or drug court; or hospital or primary care clinic. Typical job duties included leading wellness groups, teaching classes, case management, and one-on-one services, including referrals to housing, jobs, and other resources; financial counseling; wellness coaching; accompanying consumers to appointments; and emotional support provided in-person or telephonically. Documentation accounted for a significant portion of time for peer providers in Medicaid-billable positions.

Examples from each of the states illustrate the variety of peer provider roles and settings. Pennsylvania had a number of forensic peer provider programs, including one deployed by a private organization providing peer support re-entry services in local Pennsylvania county jails. Texas had a robust peer provider program inside some of its state psychiatric hospitals, including support groups, art activities, and one-on-one peer support. Arizona had peer providers working with tribal organizations and on reservations with a focus on stigma reduction and outreach. Georgia created a certification for Whole Health and Wellness Coaches who assist mental health consumers in setting and maintaining health and wellness goals, accessing resources, and managing stress in coordination with a nurse or primary care provider.

Training and Certification Approaches

In order to include peer providers in a state Medicaid plan, there must be a state-approved training and certification program.[6] The four states chose different approaches to approving curricula and exams, certification, and selecting training vendors.

Georgia and Texas each selected a single training vendor for mental health peer providers and used a customized version of the Appalachian Consulting Group curriculum. Georgia had a single vendor for training SUD peer providers (Table 1). This approach provided statewide consistency in training and curricula, but sometimes limited access to training. By contrast, Pennsylvania designated two training vendors for mental health; Pennsylvania and Texas designated multiple vendors for SUD peer providers, specifying core competencies (Pennsylvania) or a single curriculum (Texas) for all vendors. Arizona had multiple authorized training vendors and did not distinguish between mental health and SUD peer providers in training and certification. However, each organization's curriculum, competency exam, and exam scoring methodology had to be reviewed and approved by the state. Some interviewees reported that multiple training vendors fostered healthy competition, innovation, and greater access, whereas others felt it created a lack of consistency in screening and training standards.

Training hours varied across states, ranging from 40 to 75 hours. In Texas, SUD peer provider certification curricula and examinations are aligned with standards developed by the International Certification & Reciprocity Consortium, which provides limited reciprocity across states and greater oversight and accountability within states.

Peer providers were enthusiastic about the training they had received and the networking opportunities it provided, but felt they needed ongoing training in documentation.

Funding Mechanisms for Peer Support

Funding mechanisms for peer support evolved from a reliance on grant funding to increasing use of Medicaid billing and Medicaid managed care contracts. Medicaid reimbursement created a new funding stream to support peer support services and helped expand the workforce in organizations eligible to bill Medicaid for peer providers. In Medicaid expansion states, Medicaid payments were reported to cover much of the cost of employing peer providers. In non-Medicaid expansion states, funding for peer support was more reliant on state general revenues and state and federal grants.

There was state variation in billing for SUD peer provider services. Georgia and Arizona billed Medicaid for SUD peer providers. Neither Pennsylvania nor Texas could do so because SUD peer providers were not included in their state Medicaid plans. Interviewees in Pennsylvania and Texas credited the lack of growth in their SUD peer provider workforce to this non-inclusion, although some Medicaid MCOs in these states contracted with employers of peer providers, providing a payment mechanism for SUD peer support.

Interviewees reported that Medicaid billing requires extensive documentation. Many reported difficulties, with some peer providers' lack of computer experience and knowledge of billing terminology with incorrect documentation leading to negative financial ramifications. Peer providers reported concerns about the impact of time-consuming documentation on their relationships with consumers. Some peer-run organizations chose not to bill Medicaid for peer support because of concerns that documentation and clinical supervision requirements might compromise their philosophy of peer support, which is rooted in mutuality.

Workforce and Career Development

All four states had some type of policy mandating the hiring of peer providers. In Arizona and Georgia, this was

Table 1. State Comparison: Training and Certification

Category	Arizona	Georgia	Pennsylvania	Texas
Mental health				
Title	Peer Support Specialist	Certified Peer Specialist	Certified Peer Support Specialists	Certified Peer Specialist
Year statewide certification instituted	2012	2001	2007	2009–2010
No. of peer providers certified 2016[a]	2,524[b]	1,700	4,389	750
No. of authorized training vendors	16[b,c]	1	2	1
Training hours	Varies	40	75	43
Substance use disorders				
Title	Peer Recovery Specialist	Certified Addiction Recovery Empowerment Specialists	Certified Recovery Specialist	Peer Recovery Support Specialists
Year statewide certification instituted	2012	2011	2008	2012
No. of peer providers certified 2015	2,524[b]	310	535	460
No. of authorized training vendors	21[b,c]	1	6	180
Training hours	Varies	40	54	46

[a]Because accurate data were not available from state sources, authors utilized information from Wolf J, Jones N, Rosen C. The national peer career development project state certification survey results. September 2016.
[b]Arizona does not differentiate between mental health and substance use disorder in training and certification.
[c]Arizona now has 21 vendors. Updated information on number of vendors can be found in Kaufman L, Kuhn W, Stevens Manser S. University of Texas at Austin. Peer specialist training and certification programs: a national overview. 2016.
No., number.

the result of class action lawsuits; in Texas and Pennsylvania it was a policy developed through a behavioral health care transformation initiative (Table 2). Interviewees reported that hiring mandates increased peer provider employment in traditional behavioral health settings, but that these organizations needed to prepare staff and supervisors to integrate peer support successfully. For example, Pennsylvania's Office of Mental Health and Substance Abuse Services provided outreach and technical assistance in order to help organizations develop a welcoming environment for peer providers.

Peer providers' wages were reported to be low in all of the states. As the demand for peer providers increased, some organizations were adjusting pay and benefits in order to retain staff. Low wages were compounded by the part-time nature of much peer provider employment. Peer providers reported working part-time for the following reasons: (1) out of choice because of their own recovery issues; (2) to not exceed thresholds for disability benefits; (3) the perception that employers did not want to pay benefits available to full-time workers; and (4) lack of available full-time positions.

Career advancement opportunities for peer providers were generally limited to advancement to supervisor. One large Arizona organization and Texas state psychiatric hospitals had multistep career ladders, but these were exceptions. A few employers supported career advancement by providing tuition support for degree programs. State policies played a role in promoting career advancement for peer providers. Pennsylvania added the certified peer specialist category as a civil service classification, developed a certified peer specialist supervisor category that recognized different combinations of experience and education, and provided supervisor training. Texas's three-tiered peer specialist classification in its state hospital system was expected to be adopted by local Mental Health Authorities in the future. The Arizona Department of Health Services/Division of Behavioral Health funded Arizona State University to develop a Peer Career Advancement Academy to provide additional training to advance certified peer providers' careers.

Maintaining Recovery and Addressing Boundaries and Stigma

A critical component of the peer provider role is having adequate time and resources to maintain one's own recovery. Peer support requires a balance of empathy and self-disclosure while maintaining professional boundaries with consumers. This requires skillful negotiation by individuals who are themselves in recovery and may experience relapse. This component was highly emphasized in all the training programs. Some employers

Table 2. State Comparison: Factors Impacting Billing and Hiring

Category	Arizona	Georgia	Pennsylvania	Texas
Medicaid expansion state	Yes	No	Yes	No
Year CMS authorized billing for MH peer providers	2007	1999	2007	NA
Year CMS authorized billing for SUD peer providers	2007	2012	–	–
Average peer specialist salary by HHS/SAMHSA region 2015[a]	$15.27	$14.83	$14.72	$15.69
Common billing codes	H0038[b] H0038 HQ[c] H2016[d]	H0038[b] H0038 HQ[c] H0025[e]	H0038[b] H0038 GT[f]	H2017[g] H2014[h]
Source of peer hiring mandate	Lawsuit: *Arnold v. Sarn*	Lawsuit: The Civil Rights of Institutionalized Persons Act (CRIPA) of 1980	Pennsylvania Office of Mental Health and Substance Abuse Services: BH transformation initiatives	Texas State Department of Health Services: Texas Recovery Initiative
Description of hiring mandate	State must provide peer and family support services	Most state-funded behavioral health agencies required to hire at least 2 FTE peer providers	Each county is required to make peer support available as part of its mental health services	22 SUD recovery agencies receiving grants must hire peer providers

[a]Daniels A, Ashenden P, Goodale L, Stevens T. National survey of compensation among peer support specialists. www.leaders4health.org. The College for Behavioral Health Leadership. Published January 2016.
[b]Peer support, one-on-one.
[c]Peer support, group.
[d]Comprehensive community support services (peer support)—3 or more hours in duration.
[e]Behavioral health prevention education service (whole health and wellness coaching).
[f]Peer support, telephonic.
[g]Psychosocial rehabilitation services.
[h]Skills training and development.
BH, behavioral health; FTE, full-time equivalent; CMS, Centers for Medicare & Medicaid Services; FTE, full-time equivalent; HHS, Department of Health and Human Services; MH, mental health; NA, not applicable; SAMHSA, Substance Abuse and Mental Health Services Administration; SUD, substance use disorder.

responded to this need for accommodations in leave of absence policies and the peer supervision process. One-to-one or group supervision was provided to peer providers in all of the sites visited. It included checking in on one's recovery, additional training such as documentation, and client updates. However, several human resources interviewees reported that peer support staff required no more accommodations than any other staff.

The perception of stigma is an important issue in the peer provider role according to many interviewees. Peer providers in peer-run organizations reported less difficulty with stigma. Stigma may include labeling, stereotyping, and discrimination internalized or experienced.[27] Problems with acceptance and stigma were reportedly more common when peer providers needed to interact with non-peer staff in clinical and forensic settings. Some non–peer-run organizations required staff and leadership to attend training on the peer provider role in order to address issues of stigma before introducing peers.

DISCUSSION

The growth of peer provider employment is related to increased acceptance of the recovery model of care and enhanced focus on empowering consumers to manage their own recovery. Job growth in the four case study states was driven by a number of factors, including strong consumer advocacy groups and champions within state government; increased insurance coverage because of Medicaid expansion under the Affordable Care Act (in Pennsylvania and Arizona); behavioral health workforce shortages; Substance Abuse and Mental Health Services Administration grant programs[8]; class action lawsuits; and hiring mandates.

The relationship between certification, training, and employment growth is unclear. Although a recent study estimated that the number of mental health peer provider certifications grew in the U.S.,[9] there is little research on how many are employed. Better tracking of the employment of peer providers would assist in workforce planning across states. Tracking could be done through licensing boards, by state agencies, or in partnership with external research organizations, such as universities.

Certification encourages standardization and professionalism that may enhance peer provider status and wages and ensure higher quality care. However, some peer provider advocates have concerns that certification and professionalization might harm the essence of peer provision and limit entry into the field. This concern is discussed in previous research.[19,28]

Differing training and certification standards across states mean that peer providers cannot easily transfer their credentials to another state. Twenty-five states offer reciprocity through the International Certification & Reciprocity Consortium, which is largely used for SUD peer providers. Mental Health America has recently announced a National Certified Peer Specialist Certification designed to exceed standards in public behavioral health and open career pathways in the private sector.[29]

Medicaid payment plays a large role in peer provider employment. Only three U.S. states have not yet adopted the statewide certification and training protocols necessary to bill Medicaid for peer support.[7,9] Medicaid expansion was reported as a factor in increasing peer provider employment in Pennsylvania and Arizona. The uncertain future of state Medicaid programs likely has an important impact on the employment of peer providers.

The use of peer support in forensic settings is particularly promising as many incarcerated individuals also have mental illness or SUDs or both. Innovative partnerships like that between Pennsylvania's Office of Mental Health and Substance Abuse Services and the Department of Corrections, in which prison inmates are trained and certified as peer providers eligible for civil service employment on release,[30] and the private program visited that utilized peer providers to work with inmates in Pennsylvania county jails, should be explored by other states. State and county regulations barring employment of those with criminal records and that disallow ex-offenders from entering jails and prisons make it difficult to implement forensic programs. States that have found a successful model of hiring individuals with a history of criminal convictions may be helpful to other states that experience barriers.

Although employment is part of recovery for many with lived experience, the quality of peer provider positions is diminished by low wages,[31] workplace stigma, and few career advancement opportunities. Some employers are actively addressing these issues by developing career ladders and dedicating resources to staff and leadership training on the role of peer providers. In states that were early adopters of peer provider programs, state-level organizations led trainings on organizational transformation prior to the introduction of peer providers into traditional behavioral healthcare workplaces. Despite these efforts, researchers heard from many interviewees that stigma in the peer provider role continues. This may be partially because of a misunderstanding of the peer provider role and partially fear of encroachment of traditional provider roles. These encroachment concerns are similar to those reported for other growing non-licensed roles, such as community health workers[32] and medical assistants.[33]

Although there are studies of the efficacy of peer providers, much of this research has been limited by small sample sizes and other methodologic issues.[34–37] There is even less research on SUD peer providers.[8] Additional research may be helpful to better understand both workforce issues and peer provider impact on behavioral health outcomes.

Limitations

This study focuses on four states that are frontrunners in peer provider employment. Each state has a different cultural and policy environment and some findings may not be generalizable. Data on states and organizations is self-reported and could not always be independently verified. Peer providers working in states with less developed peer provider policies may have different experiences than those in these four states.

CONCLUSIONS

Peer provision is a rapidly growing occupation with considerable promise to help alleviate the behavioral healthcare workforce shortage by supporting consumers in maintaining long-term recovery. Peer providers can aid organizations in establishing rapport with consumers, sensitizing treatment staff to consumer needs, and encouraging a recovery-oriented culture that allows for self-disclosure and self-care for all staff. Growth of the peer provider profession can be facilitated by continued improvement of training and certification, addressing wages and benefits, tracking of long-term employment outcomes, facilitation of documentation skills, revision of regulations that create barriers to practice, and education of behavioral health leaders in the capacity of peer providers to help those with mental health and SUD treatment needs.

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Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note 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.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing
Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers 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. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

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AMENDED IN ASSEMBLY JULY 27, 2020

AMENDED IN SENATE JUNE 18, 2020

AMENDED IN SENATE MARCH 26, 2020

SENATE BILL No. 803

Introduced by Senator Beall
(Principal coauthor: Assembly Member Waldron)
(Coauthors: Senators Mitchell, Wiener, and Wilk)
(Coauthors: Assembly Members Aguiar-Curry, Arambula, *Carrillo,* Cristina Garcia, Grayson, Ramos, Reyes, Weber, and Wicks)

January 8, 2020

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

legislative counsel's digest

SB 803, as amended, Beall. Mental health services: peer support specialist certification.

(1) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers.

This bill would establish a peer support specialist certification program administered by the department.

This bill would require the department to conduct specified activities relating to the certification of peer support specialists, including establishing a certifying body to provide for a statewide certification for peer support specialists and determining curriculum and core competencies, as specified, required for certification of an individual as a peer support specialist. The bill would require the department to ~~amend the Medicaid state plan to include a certified peer support specialist as a provider type for purposes of the Medi-Cal program and to include~~ *seek any federal waivers or other state plan amendments to achieve specified objectives, such as including* peer support specialist services as a distinct service type under the Medi-Cal program. The bill would authorize the department to establish a certification fee schedule and to require remittance of fees as contained in that schedule to support the department's activities related to the ongoing administration of the peer support specialist certification program. The bill would require Medi-Cal reimbursement for peer support specialist services to be implemented only if, and to the extent that, federal financial participation is available and the department obtains all necessary federal approvals. The bill would authorize the department to implement, interpret, or make specific its provisions by various means, including plan letters, without taking regulatory action, until regulations are adopted, and would require the department to adopt regulations by January 1, 2022.

(2) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act provides that it may be amended by the Legislature by a ~~2 / 3~~ *⅔* vote of each house as long as the amendment is consistent with, and furthers the intent of, the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

~~This~~

For the 2020–21 and 2021–22 fiscal years, this bill would authorize the department to use funding provided through the MHSA, upon appropriation and to the extent authorized by the MHSA, to fund state administrative costs related to developing and administering the peer support specialist certification program, and would require those MHSA funds to be available for purposes of claiming federal financial participation under the Medicaid program. The bill would provide that this provision does not constitute a change in the MHSA, but is a

clarification of a funding purpose that is consistent with the intent of the MHSA.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Peer Support Specialist Certification Program Act of 2020.

SEC. 2. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer Support Specialist Certification Program

14045.10. The Legislature finds and declares all of the following:

(a) With the enactment of the Mental Health Services Act in 2004, support has been on the rise to include peer providers, identified as consumers, parents, and family members, for the provision of services.

(b) Peer providers in California provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorders in a variety of settings. Yet, no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(c) The United States Department of Veterans Affairs and at least 48 states utilize standardized curricula and certification protocols for peer support services.

(d) The federal Centers for Medicare and Medicaid Services (CMS) recognizes that the experiences of peer support specialists, as part of an evidence-based model of care, can be an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer comprehensive programs.

(e) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce homelessness, reduce hospitalizations and

hospital days, increase client activation, and enhance client self-advocacy.

(f) Certification can increase the diversity and effectiveness of the behavioral health workforce through the use of peers with lived experience.

14045.11. It is the intent of the Legislature that the peer support specialist certification program, established under this article, achieve all of the following:

(a) Support the ongoing provision of services for beneficiaries experiencing mental health care needs, substance use disorder needs, or both, by certified peer support specialists.

(b) Support coaching, linkage, and skill building of beneficiaries with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Increase family support by building on the strengths of families and helping them achieve a better understanding of mental illness in order to help beneficiaries achieve desired outcomes.

(d) Provide part of a continuum of services, in conjunction with other community mental health services and other substance use disorder treatment.

(e) Collaborate with others providing care or support to the beneficiary or family.

(f) Assist parents, families, and beneficiaries in developing coping mechanisms and problem-solving skills in order to help beneficiaries achieve desired outcomes.

(g) Promote skill building for beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

(h) Encourage employment under the peer support specialist certification to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the people whom they serve.

14045.12. For purposes of this article, the following definitions apply:

(a) "Certification" means the activities of the certifying body related to the verification that an individual has met all of the requirements under this article and that the individual may provide mental health services and substance use disorder treatment pursuant to this article.

(b) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(c) "Code of ethics" means the standards to which a peer support specialist is required to adhere.

(d) "Core competencies" means the foundational and essential knowledge, skills, and abilities required for peer specialists.

(e) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(f) "Department" means the State Department of Health Care Services.

(g) "Peer support specialist" means a person who is 18 years of age or older and who is a person who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer.

(h) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of skills learned in other support services. Peer support specialist services include, but are not limited to, support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified peer support specialist.

(i) "Recovery" means a process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and their cultural community.

14045.13. By July 1, 2021, the department shall do all of the following:

(a) Establish a certifying body, either through contract or through an interagency agreement, to provide for the certification activities described in this article.

(b) Provide for a statewide certification for peer support specialists, as contained in federal guidance in State Medicaid Director Letter No. 07-011, issued by the federal Centers for Medicare and Medicaid Services on August 15, 2007.

(c) Define the range of responsibilities, practice guidelines, and supervision standards for peer support specialists by utilizing best practice materials published by the federal Substance Abuse and Mental Health Services Administration, the United States Department of Veterans Affairs, and related notable experts in the field as a basis for development.

(d) Determine curriculum and core competencies required for certification of an individual as a peer support specialist, including curriculum that may be offered in areas of specialization, including, but not limited to, transition-age youth, veterans, gender identity, sexual orientation, and any other areas of specialization identified by the department. Core-competencies-based curriculum shall include, at a minimum, training related to all of the following elements:

(1) The concepts of hope, recovery, and wellness.

(2) The role of advocacy.

(3) The role of consumers and family members.

(4) Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.

(5) Cultural competence training.

(6) Trauma-informed care.

(7) Group facilitation skills.

(8) Self-awareness and self-care.

(9) Cooccurring disorders of mental health and substance use.

(10) Conflict resolution.

(11) Professional boundaries and ethics.

(12) Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.

(13) Safety and crisis planning.

(14) Navigation of, and referral to, other services.

(15) Documentation skills and standards.

(16) Confidentiality.

(e) Specify training requirements, including core-competencies-based training and specialized training necessary to become certified under this article, allowing for multiple qualified training entities, and requiring training to include people with lived experience as consumers and family members.

(f) Establish a code of ethics.

(g) Determine continuing education requirements for biennial certification renewal.

(h) Determine the process for biennial certification renewal.

(i) Determine a process for investigation of complaints and corrective action, including suspension and revocation of certification.

(j) Determine a process for an individual employed as a peer support specialist on January 1, 2021, to obtain certification under this article.

14045.14. (a) An applicant for certification under this article shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Possess a high school diploma or equivalent degree.

(3) Be self-identified as having experience with the process of recovery from mental illness or substance use disorder treatment either as a consumer of these services or as the parent or family member of the consumer.

(4) Be willing to share their experience.

(5) Demonstrate leadership and advocacy skills.

(6) Have a strong dedication to recovery.

(7) Agree, in writing, to adhere to a code of ethics.

(8) Successfully complete the curriculum and training requirements for a peer support specialist.

(9) Pass a certification examination approved by the department for a peer support specialist.

(b) To maintain certification under this article, a peer support specialist shall meet both of the following requirements:

(1) Adhere to the code of ethics and biennially sign an affirmation.

(2) Complete any required continuing education, training, and recertification requirements.

14045.15. (a) This article does not imply that an individual who is certified pursuant to this article is qualified to, or authorized to, diagnose an illness, prescribe medication, or provide clinical services.

(b) This article does not alter the scope of practice for a health care professional or authorize the delivery of health care services in a setting or manner that is not authorized pursuant to the Business and Professions Code or the Health and Safety Code.

14045.16. The department shall consult with the Office of Statewide Health Planning and Development, peer support and family organizations, mental health services and substance use disorder treatment providers and organizations, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council in implementing this article. Consultation shall include, at a minimum, quarterly stakeholder meetings. The department may additionally conduct technical workgroups upon the request of stakeholders.

14045.17. To facilitate early intervention for mental health services, community health workers may partner with peer support specialists to improve linkage to services for beneficiaries.

14045.18. The department may establish a certification fee schedule and may require remittance as contained in the certification fee schedule for the purpose of supporting the activities associated with the ongoing administration of the peer support specialist certification program. Certification fees charged by the department shall reasonably reflect the expenditures directly applicable to the ongoing administration of the peer support specialist certification program.

14045.19. ~~(a)~~ The department shall ~~amend its Medicaid state plan to do both of the following:~~ *seek any federal waivers or other state plan amendments, as necessary, to do all of the following:*

~~(1)~~

(a) Include a peer support specialist certified pursuant to this article as a provider type for purposes of this chapter.

~~(2)~~

(b) Include peer support specialist services as a distinct service type for purposes of this chapter, which may be provided to eligible Medi-Cal beneficiaries who ~~are enrolled in a Medi-Cal managed care plan or a mental health plan.~~ *receive specialty mental health services or Drug Medi-Cal services in any county, including any*

county that has implemented a Drug Medi-Cal organized delivery system, or both, if that county elects to do both of the following:

~~(b) The department may seek any federal waivers or other state plan amendments as necessary to implement the certification program provided for under this article.~~

(1) Opt in to provide peer support specialist services.

(2) Fund the nonfederal share of those services.

(c) Develop and implement one or more billing codes, reimbursement rates, and claiming requirements for peer support specialist services.

14045.20. Medi-Cal reimbursement for peer support specialist services shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

14045.21. For the purpose of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance.

14045.22. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific ~~Section~~ *Sections 14045.13, 14045.14, 14045.18, and* 14045.20 by means of informal notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. The department shall adopt regulations by January 1, 2022, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

14045.23. ~~Subject to an express appropriation in the annual Budget Act, and to~~ *To* the extent authorized by the Mental Health Services Act pursuant to subdivision (d) of Section 5892, *and if authorized under the annual Budget Act, in the 2020–21 fiscal year,* the department may fund state administrative costs related to developing and administering the peer support specialist certification program, as described under Section 14045.13. *Subject to an express appropriation in the Budget Act of 2021 for the 2021–22 fiscal year, and to the extent authorized by the Mental Health Services Act pursuant to subdivision (d) of Section 5892, the department may fund state administrative costs related to*

developing and administering the peer support specialist certification program, as described under Section 14045.13. To the extent permissible, those funds shall be available for purposes of claiming federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

SEC. 3. Section 14045.23 of the Welfare and Institutions Code, as added by Section 2 of this measure, does not constitute a change in the Mental Health Services Act, but is a clarification of a funding purpose under existing law that is consistent with the intent of the act.

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