STATE PLAYBOOK
Medicaid Billing Policy Barriers for Professionals with Lived Experience

An Advocacy Framework for State and Federal Action

An Ecosystem of Exclusion

Individuals best equipped to guide people through recovery are often those who have walked that path themselves. Across federal and state behavioral health policy, agencies are actively recruiting people with lived experiences of incarceration and substance use into the workforce — as peer supporters, chemical dependency counselors, community health workers (CHWs), social workers, and more. At the same time, Medicaid's provider enrollment and exclusion rules screen on conviction history in ways that were built for a different population entirely: physicians, hospital owners, and large billing entities being assessed for fraud risk.

These credentialed professions are some of the most common economic on-ramps for professionals with lived experience (PwLE) in the criminal legal system. Each of these also intersect with Medicaid's provider exclusion apparatus in more discrete ways. When an individual overcomes licensure barriers and employment barriers, those entering the field of healthcare may encounter a third layer of carveouts when they attempt to obtain a National Provider Identifier as a covered health care provider. This is often after the PwLE has spent months and years training, interning, and advocating for their place in the workforce.

This is not a story of a single bad rule, but rather a fragmented *ecosystem* of federal statute, regulation created within the Centers for Medicaid and Medicare (CMS), and state implementation choices stacking on top of each other, with uneven and sometimes contradictory results depending on which state a person lives in and which career pathways they pursue.

This brief lays out how the Medicaid exclusionary screening policies actually work, where various impacted professions sit within them, and a set of state and federal advocacy opportunities scaled to what is realistically achievable by PwLEs, state-based coalitions and national partners.

How Medicaid Screening Excludes

Three distinct layers determine whether someone with a conviction history can bill Medicaid, each with a different source of authority.

1. Federal mandatory exclusion — Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7(a)). Congress, not an agency, wrote this layer.

> "The Secretary of HHS *shall* exclude anyone convicted of: program-related crimes against Medicare or Medicaid; patient abuse or neglect; felony health care fraud; or felony unlawful manufacture, distribution, prescription, or dispensing of a controlled substance."

No discretion applies once a conviction fits one of these four categories. Minimum exclusion is five years. Simple drug possession is notably absent from Section 1128(a)'s mandatory exclusion list (which includes manufacture, distribution, prescription, and dispensing), though it remains subject to permissive exclusion under Section 1128(b) and discretionary state-level screening.

2. CMS discretionary denial — 42 CFR 424.530/455.412. While 424.530 directly governs Medicare enrollment, state Medicaid programs must mirror or align with these discretionary baseline standards under

42 CFR § 455.412. A 2019 CMS final rule expanded agency discretionary authority to deny or revoke enrollment for any felony conviction within the preceding 10 years deemed “detrimental to program beneficiaries”, broadening beyond the historically enumerated list of offenses.

3. State Medicaid agency screening — 42 CFR Part 455, Subpart E. States must build risk-based screening tiers (limited, moderate, high) for provider categories, with high-risk categories subject to fingerprint-based criminal background checks. States have significant latitude in how they classify provider types, set exclusion periods, and what they screen for; this is why identical federal rules produce very different outcomes from state to state.

The practical effect: a conviction that is not a federal mandatory ban can still function as one, depending on how a state classifies a given role and how conservatively an employing agency interprets its own risk.

Different Pathways, Different Exposures

Peer supporters, chemical dependency counselors, social workers, and community health workers are often discussed as one workforce, but they sit at different points on the screening spectrum — and that variation is itself evidence that the barrier is a design choice, *not a fixed requirement*.

State variation in practice:

Role	Typical enrollment path	Screening exposure
Social workers (LSWs, LISWs, etc.)	State-licensed independent practitioners; required to individually enroll in Medicaid with an NPI across virtually all states.	Rigorous dual-layer screening via mandatory state licensing board background checks paired with federal/state Medicaid provider enrollment screening (42 CFR Part 455).
Chemical dependency counselors	Usually state-licensed; individually enrolled with Medicaid in most states	Similar to social work credentialing — dual-layer screening via state licensing board review and mandatory individual Medicaid provider enrollment
Community health workers (CHWs)	Newly being built into state Medicaid benefits; a growing number of states require individual national provider identified (NPI) enrollment	Fastest-growing exposure area — as more states introduce direct CHW Medicaid benefits, transition to individual NPI enrollment can create new screening bottlenecks.
Peer supporters	Historically billed under a supervising agency's NPI, not individually — but this varies widely by state	Most fragmented landscape — ranges from state-mandated individual Medicaid enrollment and screening to indirect supervisory billing with no state-level provider background checks.

- **Ohio** — Since a 2018 Medicaid billing rule change, everyone providing behavioral health and addiction services, including peer recovery workers, must individually register as a Medicaid provider and pass a criminal background check. Previously, employers billed on workers' behalf. Ohio advocates raised concern at the time that people in recovery providing peer services — widely seen

as effective precisely because of their lived experience — could lose their jobs or be barred from entering the field.[1]

- **West Virginia** — Peer recovery support specialists are listed as a directly enrollable Medicaid provider type alongside licensed clinicians.[2]
- **California** — Medi-Cal peer support specialists have no fee-for-service enrollment pathway, so the state does not require individual criminal background checks for them; counties may still impose their own requirements.[3]
- **Colorado** — Peer support services are billed under the NPI of a supervising provider, which limits individual-level screening exposure for the peer themselves.[4]
- **Indiana** — State law generally bars health care facilities from hiring people with certain recent felony convictions, including controlled-substance felonies within five years. A 2025 legislative proposal would carve out a specific exception for peer recovery coaches certified through the state's Division of Mental Health and Addiction.[5]

National data underscores the stakes: research cited by SAMHSA-adjacent sources estimates that as many as 44% of peer recovery support specialists have some history of criminal justice involvement — meaning background screening policy impacts not just a small section of this workforce, but a substantial share of it.[6]

HHS Priorities Across Agencies and Bureaus

Across the U.S. Department of Health and Human Services (HHS), several divisions are actively driving initiatives to expand, empower, and integrate professionals with lived experience (PwLE) into the behavioral health and public health systems[7]:

- **HHS Center for Faith and Opportunity Initiatives:** Led by individuals who speak publicly about lived expertise in behavioral health, criminal legal involvement, workforce development, and higher education, the Center serves as a credible, nonpartisan venue for raising leadership on second-chance employment and community reintegration.[8]
- **HRSA Bureau of Health Workforce:** Through the Behavioral Health Workforce Education and Training (BHWET) Program, HRSA allocates dedicated federal funding to build a robust paraprofessional pipeline, directly training peer support specialists and community health workers.[9]
- **SAMHSA (Substance Abuse and Mental Health Services Administration):** SAMHSA continuously elevates peer support, successful recovery stories, and lived experience as essential pillars of recovery-oriented care, establishing national peer standards and convening sessions on workforce integration.
- **NIDA (National Institute on Drug Abuse):** Through research networks such as JCOIN 2.0 (Justice Community Opioid Innovation Network), NIDA funds community-advised research and implementation

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[1] Health Policy Institute of Ohio (HPIO). (2018, September 21). *State OKs Medicaid rule change for addiction treatment staff with criminal records*.
[2] West Virginia Department of Human Services (DoHS) / Bureau for Medical Services Provider Enrollment Instructions (*WV MMIS Provider Taxonomy and Enrollment Manual*).
[3] California Welfare and Institutions Code (WIC) § 14045.15 (*Medi-Cal Peer Support Specialist Services Act*).
[4] https://hcpf.colorado.gov/peerservices
[5] Indiana Code § 16-28-13 (*Employment of Persons with Certain Convictions in Health Care Facilities*)
[6] https://library.samhsa.gov/sites/default/files/peer-support-mh-addictions-workforce-pep24-08-005.pdf
[7] https://www.c-span.org/program/public-affairs-event/sec-robert-f-kennedy-jr-and-iowa-gov-on-peer-support-services-for-addiction/684175
[8] HHS Center for Faith and Opportunity Initiatives — staff
[9] HRSA Behavioral Health Workforce Education and Training Program for Paraprofessionals

science that rely directly on justice-involved individuals, peer navigators, and community members to improve health outcomes at the intersection of public health and justice systems.[10]

The Need for Government Alignment and Coherence

While many HHS components actively fund, research, and champion a healthcare workforce with lived expertise, parallel efforts around Medicaid program integrity introduce conflicting administrative incentives. A recent letter from the Centers for Medicare & Medicaid Services (CMS) shines a light on peer support services as an area of growing vulnerability for improper billing and healthcare fraud. In response, CMS has reinforced state authority to apply stringent provider screening, broad look-back periods, and discretionary enrollment denials to reshape the environment through vigorous fraud prevention efforts. A January 2026 letter from CMS to California called recovery peer support a “high-risk service” and demanded an answer to how oversight was administered.[11] Already this agency oversight approach has led to multiple states increasing strict screening procedures, imposing new carveouts and rewriting state licensing requirements.[12]

This dynamic creates an unintended policy friction: on one hand, federal investments actively recruit, train, and validate PwLEs as essential care providers, while on the other hand, traditional Medicaid screening mechanisms (intensified by heightened anti-fraud scrutiny) can result in broad exclusions that block these same individuals from obtaining billing credentials or maintaining employment - even after they complete their training and obtain their license

Rather than taking a critical stance toward fraud prevention, policy discussions must center on interagency effectiveness to ensure that federal initiatives work in alignment rather than in opposition. By adopting a whole-of-government approach, HHS leadership can establish formal cross-agency coordination mechanisms between CMS, SAMHSA, HRSA, NIDA, and the Faith Center, preventing one agency's fraud-prevention baseline from inadvertently invalidating another office’s investment in best practices.

Beyond Regulation: The Essential Role of Insurance

While CMS rules and state Medicaid policies establish the regulatory framework, the practical shift toward a fair-chance behavioral health workforce ultimately relies on a risk-averse ecosystem. Re-insurers and stop-loss carriers act as financial gatekeepers, often setting underwriting criteria that dictate whether managed care organizations and agencies can absorb the liability (and potential increase of insurance rates) of hiring professionals with past convictions. Insurance brokers serve a crucial bridging role by structuring tailored Errors & Omissions policies, fidelity bonds, and fair-chance coverage riders for employing organizations. When reinsurers and brokers shift from viewing past criminal history as an automatic liability to evaluating an agency’s actual operational and supervisory compliance, they unlock the financial foundation required for sustainable, billable employment.

Program integrity, risk mitigation, and fair-chance employment for PwLEs are not mutually exclusive goals; clear sub-regulatory guidance can assist states in establishing narrowly defined supervisory oversight and employer compliance standards to combat fraud without relying on legacy criminal history as a default proxy for program risk. Ultimately, delivering clear, unified direction across HHS gives healthcare facilities, state Medicaid agencies, and professionals with lived experience a consistent pathway, guaranteeing public investments in workforce expansion translate into sustainable, billable, and secure career opportunities.

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[10] https://www.jcoinctc.org/

[11] https://leadingage.org/wp-content/uploads/2026/01/HHS-Letter-012726-Gov-Newsom.pdf

[12] https://governor.ohio.gov/media/news-and-media/governor-dewine-signs-executive-order-announces-dbh-to-assume-recovery-housing-certification-and-oversight

State-Level Advocacy Asks

State Medicaid agencies control the screening tiers and much of the practical barrier- we ask all states to have:

1. Published, transparent screening criteria. Ask the state Medicaid agency to publish clear, written criteria for how background checks apply to behavioral health, peer, and CHW roles specifically. Much of the current effect comes from ambiguity — employing agencies, uncertain what is actually disqualifying, default to blanket exclusion out of caution. Transparency does not change the substance of the rule, which makes this one of the lowest-cost, least burdensome asks.

2. A look-back period and offense-relevance limit. Modeled on Indiana's 2025 peer recovery coach exception, ask the state to limit disqualification to recent, role-relevant offenses rather than any felony conviction ever incurred — extended explicitly to CHWs and chemical dependency counselors, not just peer specialists. Other states are following suit (cite).

3. An individualized waiver or reinstatement pathway. Creating a mechanism to allow someone previously screened out to petition for an individualized determination, rather than facing a flat bar. This mirrors waiver concepts CMS already uses elsewhere (for example, for sole-source or sole-community providers) and gives advocates a longer-term target even where it is not immediately winnable.

Federal-Level Advocacy Asks

1. Support and broaden the PEER Support Act (H.R. 2741). This bill already directs HHS, in coordination with the Department of Justice, to study state criminal background check barriers for peer support specialists and issue recommendations to states and CMS. The role of the advocate is to add visibility and urgency, and to push for its scope to explicitly include CHWs and chemical dependency counselors — not peer specialists alone — since both are increasingly exposed to the same individual-enrollment barriers.

2. CMS sub-regulatory guidance clarifying the detrimental standard for lived-experience roles. CMS can act here without Congress, the way it did with its 2007 and 2013 peer services guidance letters. The ask: updated guidance clarifying that the detrimental-felony standard under 42 CFR 424.530, offering states clear standards for supervisory oversight to maintain program effectiveness without relying on personal conviction history as a direct proxy for program risk or fraud.

3. A statutory waiver or rehabilitation pathway in Section 1128 itself. Amending the federal exclusion statute to build in an explicit waiver process for peer support, CHWs, and more, weighing time since conviction and relevance to the role rather than applying a flat bar. This is a multi-year legislative goal, appropriate for a national coalition's longer agenda rather than an immediate ask.

The Urgent Need for Action

Federal and state agencies are already investing public dollars in recruiting people with lived experience into behavioral health roles, while a separate, older screening apparatus limits how much of that labor can actually be billed and sustained. The ask across every level is coherence between the two and the recognition that the answer to many healthcare workforce gaps rests with the people closest to the problem.

To learn more about the sweeping changes made to Medicaid, SNAP and other assistance programs, please visit the JustUS Coordinating Council's policy resource library.