CAPPS
CITIZENS ALLIANCE ON PRISONS & PUBLIC SPENDING

May 14, 2018

Margo Sharp
Bureau of Medicaid Policy and Health System Innovation
Medical Services Administration
P.O. Box 30479
Lansing, MI 48909-7979

RE: Provider Enrollment Fitness Criteria (Policy Number: 1635-PE (Revised))

Dear Ms. Sharp:

I am the Policy Director at the Citizens Alliance on Prisons and Public Spending (CAPPS), a criminal justice research and advocacy organization based in Lansing. I submitted comments on the first version of this policy last November, along with over 300 other concerned stakeholders, and I was pleased to see it withdrawn in response to the public comments submitted. I am equally disappointed to see the policy reissued with few meaningful changes. It continues to be a wholly misguided policy that should not be adopted.

1. Not a Reasonable Standard Relating to Provider Qualifications.

States are not free to impose any provider qualifications they want. Medicaid recipients have a right to "free choice of providers," and states can only limit this right with "reasonable standards relating to the qualifications of providers." 42 C.F.R. 431.51(c)(2). 1635-PE—which excludes providers (and agents thereof) from participation in Michigan's Medicaid program for periods of 5 or 10 years based on a broad range of criminal convictions—is *not* a reasonable standard relating to the qualification of providers.

First, 1635-PE starts from a false premise: MDHHS is under no obligation to issue these restrictions,[1] and the substance of them is inconsistent with the April 19, 2016 CMS guidance 1635-PE claims to implement. This guidance actually emphasizes that Medicaid beneficiaries have "free choice of providers" and that this means states should not create overbroad, exclusionary rules regarding Medicaid participation. Among other things, it states that:

- State provider eligibility standards must relate to the provider's "capability to perform the required services in a professionally competent, safe, legal, and ethical manner";

[1] I am not aware of any federal requirement to exclude providers based on criminal histories beyond those listed in 42 U.S.C. 1320a-7(a), and 1635-PE does not list any authority that does.

- States lack the authority to "target a provider or set of providers for reasons unrelated to their fitness to perform covered services";
- States may not exclude any provider "without evidence of evidence of fraud or criminal action,[2] material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them"; and
- Action against a provider without evidence that relates to the provider's fitness to perform covered services "would not be in compliance with the free choice of provider requirement."[3]

1635-PE is fundamentally inconsistent with these principles: it targets a set of providers with certain criminal histories for up to 10 years *without* any evidence that those histories relate to their *present* fitness to provide covered services. This is not a "reasonable standard relating to provider qualifications" as described by *SMD # 16-005*.

Second, the proposed policy defines "impacted providers" not only as CHAMPS-enrolled providers, but as Board members, managing employees, 5% owners, or *agents* of providers, which it defines as "any person who has been delegated the authority to obligate or act on behalf of a provider" (*see* pg. 1, "Impacted Providers"). As written, this definition sweeps in *all* employees and independent contractors of *any* facility that receives Medicaid funding – including janitorial and facilities staff, security and food service personnel, and the like. This is overbroad, and includes agents with no role in the provision of covered services. Plainly, that is not a reasonable standard relating to provider qualifications.

Third, it does so based on a broad range of crimes that is so vague and poorly-defined that it gives neither a potentially-impacted provider nor DHHS adequate guidance on how to apply it.[4] For example, it excludes all providers with a federal or state felony within the last 10 years "*including, but not limited to*, any criminal offense related to":

- "murder, rape, abuse or neglect, assault, *or other similar crimes against persons*";
- "extortion, embezzlement, income tax evasion, insurance fraud, *and other similar financial crimes*"; and
- "*any* felony that placed the Medicaid program or its beneficiaries at immediate risk" (Section II(5)) (emphasis added).

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[2] Read in light of the "free choice of providers" standard, exclusion based on a conviction is not a "reasonable standard" relating to the qualification of a provider unless it relates to their *present ability to do their job* "in a professionally competent, safe, legal, and ethical manner." Exclusions that do not take into account what job the person will do, or the specific facts of their conviction do not meet this standard.

[3] *See* Department of Health & Human Services, Centers for Medicare & Medicaid Services, *SMD # 16-005*, "Re: Clarifying 'Free Choice of Provider' Requirement in Conjunction with State Authority to Take Action Against Medicaid Providers (April 19, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf

[4] The vagueness of the scope of this regulation may raise issues under the Due Process Clause of the 14th Amendment—particularly with respect to providers (and agents thereof) who are currently employed and will be excluded from participation in Michigan's Medicaid program without notice and an opportunity to respond.

The policy creates similar exclusions for misdemeanors within 5 years of conviction, as well as "any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b)" (Section II(6)). This would establish a mandatory exclusion for a misdemeanor conviction for drug possession,[5] which in Michigan typically results in community supervision. In case it isn't obvious, imposing harsh additional employment-related penalties above and beyond what the legal system requires is bad public policy that will harm impacted communities.

2. Exclusions Are Inconsistent with Federal Exclusion Law

1635-PE is also inconsistent with Federal law on exclusions, which takes care to base exclusions on conduct that is directly related to one's fitness to provide covered services. MDDHS should follow this approach instead of imposing overbroad mandatory exclusions.

Federal law has a narrow set of mandatory exclusions: conviction of a program-related crime, conviction of a crime related to patient abuse, conviction of a felony for health care fraud, and conviction of a felony for the unlawful "manufacture, distribution, prescription, or dispensing" of a controlled substance." *See* 42 U.S.C. 1320a-7(a). All of these mandatory exclusions are based on past misconduct that is directly related to one's qualifications as a health care provider or participant in Federal health care programs.[6]

The permissive exclusions, in contrast, are a long list of scenarios where the HHS Secretary "*may*" exclude a person from participation based on an individualized evaluation of whether their conduct demonstrates a future risk to patients or program funds.

1635-PE does not undertake this analysis: all of its exclusions are mandatory, and unlike the federal statute, its mandatory exclusions are not limited to crimes that directly relate to abuse of patients, program-related misconduct, or relevant past misconduct related to controlled substances. Because of this it is not reasonable and related to provider qualifications.

3. Title VII of the Civil Rights Act.

Title VII requires employers to show that an exclusion based on criminal conduct is job related and consistent with business necessity. To make this showing, an employer must demonstrate that the exclusion is reasonable based on (1) the nature and gravity of the offense, (2) the time elapsed since the offense, and (3) the nature of the job held or sought.[7]

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[5] *See* 42 U.S.C. 1320a-7(b)(3).

[6] While 42 U.S.C. 1320a-(7)(a)(4) refers generally to controlled substance felonies, it is limited to drug felonies that relate to one's fitness to provide health care services, such as drug manufacture and distribution, and improper prescribing and dispensing.

[7] *See Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e et seq.*, No. 915.002 (April 25, 2012), *citing Green v. Missouri Pacific Railroad*, 523 F.2d 1290 (8th Cir. 1975), available at https://www.eeoc.gov/laws/guidance/arrest_conviction.cfm.

1635-PE makes no effort to demonstrate that providers with a criminal history are not qualified to provide medical services to Medicaid recipients,[8] and in fact, many providers that could be impacted by this policy have *already* been independently licensed to do so by the State of Michigan, and hired after a mandatory criminal history screening by their employers.

4. Arbitrary Exercise of Administrative Authority.

If the policy were interested in addressing specific public safety concerns, I would expect the administrative record to contain (1) documentation of those specific concerns, (2) evidence of the administrative decision-making process about those concerns, and (3) evidence that DHHS narrowly tailored 1635-PE to minimize impacts to providers that do not demonstrably pose such a risk. However, I am aware of no evidence that DHHS considered any of these issues, and the sweep of 1635-PE suggests that DHHS failed to undertake this analysis. Indeed, it appears that DHHS simply looked at the criminal code and developed these exclusions out of whole cloth based on their own preconceptions of those crimes. If so, the proposed policy is an arbitrary exercise of administrative authority that is unlawful. *See Dykstra v. Department of Natural Resources*, 198 Mich. App. 482, 491 (1993) ("A rule is arbitrary if it was fixed or arrived at through an exercise of will or by caprice, *without consideration or adjustment with reference to principles, circumstances, or significance*.") (emphasis added).

5. Public Health Impacts.

Many of the best providers of critical health care services—such as substance abuse counselors and peer coaches—are qualified to do so *because of* their experience with substance abuse, and unsurprisingly many of these individuals have criminal histories related to that experience, including misdemeanors and felonies related to controlled substances.

In light of this, it is counterproductive to arbitrarily exclude these providers from the workforce, and doing so is likely to have negative public health effects in our state—both by limiting the number of providers available to provide treatment and by taking some of the most effective providers out of the field. Amidst an opioid crisis of unprecedented proportions, it is baffling that DHHS is actively seeking to do so.

6. Public Safety Impacts.

Finally, the exclusions proposed by this policy are likely to have negative public safety impacts apart from blunting our response to the opioid crisis. It is well-established that stable employment is a key factor in post-conviction success for those with criminal-

[8] Evidence suggests that many individuals with criminal histories are no more likely to be arrested than members of the general public. Alfred Blumstein and Kimonori Nakamura, *Redemption in an Era of Widespread Criminal Background Checks*, NIJ Journal (No. 263) at 13.

justice involvement,[9] and this policy would not only cut off access to potentially life-changing jobs in health care for people with criminal histories, it would take those jobs away from the many people that already have such jobs and who are models of successful reentry into society—including current substance abuse counselors and peer coaches. Not only is this a needless change to Medicaid policy, it is likely to negatively impact public safety by limiting access to employment for people with criminal records, and by taking away the livelihoods of numerous current providers (and their agents).

For all of these reasons, please rescind this policy immediately.

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If DHHS is unwilling to abandon the proposed approach, 1635-PE should be substantially revised. At a minimum, DHHS should:

1. Restrict the definition of "provider" to individuals that are actually involved in the provision of covered services (instead of sweeping in all "agents" of providers);
2. Specifically define what convictions justify exclusion (without catch-alls and reservations of rights about the scope of the exclusions);
3. Limit the list of convictions that justify exclusion to crimes that demonstrably impact a provider's current qualification to provide covered services;
4. Provide evidence that the conviction-based exclusions selected are justified by objective risk to Medicaid funds or beneficiaries; and
5. Give impacted providers notice and an opportunity to respond *prior to exclusion*.

Please feel free to contact me if you would like to discuss these matters further.

Sincerely yours,

_____/s/_____
John S. Cooper, J.D., M.A.

[9] *See, e.g.,* Berg, M. T., & Huebner, B. M. (2011). Reentry and the ties that bind: An examination of social ties, employment, and recidivism. *Justice Quarterly*, 28(1), at 398 (finding unemployed offenders are 18% more likely to be rearrested than employed offenders within 600 days of release).