Susan W. Moore  
Health Policy and Third Party Payer Advocacy  
Medical Association of Georgia  
1849 The Exchange, Suite 200  
Atlanta, Georgia 30339

Dear Ms. Moore:

Thank you for your inquiry regarding Centers for Medicare & Medicaid Services’ (CMS) new automated provider screening and how CMS uses the credit report information, if at all, during the provider screening process.

CMS launched the Automated Provider Screening (APS) technology on December 31, 2011. APS technology was initially developed to conduct routine and automated screening checks of providers and suppliers against numerous private and public databases to more efficiently identify and remove ineligible providers and suppliers prior to their enrollment or revalidation in Medicare. CMS contracts directly with Turning Point to implement the APS system. Turning Point subcontracted with Equifax, in relevant part, to perform identity verifications of providers and suppliers in connection with the enrollment and screening process.

CMS did not perform credit checks of providers for purposes of identity verification. CMS hired Equifax as a data aggregator in order to conduct identity verifications in connection with the provider screening process. The provider screening process requires Equifax to check its database which consists of consumer files to verify information such as a provider’s name and address. That process, performed by Equifax, leverages two information technology tools to verify a provider’s identity. Each time Equifax performed identity verifications using these two tools, it resulted in a separate entry for each tool on a provider’s credit report. CMS does not use a provider’s credit score as part of identity verification of providers and suppliers in connection with the enrollment and screening process. CMS is currently changing the process for identity verification such that it will not involve the credit process so no provider should continue to see these inquiries in the future.

You expressed concern that CMS and the Office of inspector General (OIG) will make Medicare and Medicaid enrollment and revalidation decisions using credit report data elements as predictors of risk of fraud. As an initial matter, CMS and the OIG are not involved in individual Medicaid enrollment decisions. Similarly, the OIG is not involved in Medicare enrollment
determinations. CMS makes determinations regarding enrollment and revalidation in the Medicare program. In addition, CMS is not currently using credit report data elements as predictors of risk of fraud, waste, and abuse to the Medicare program in connection with enrollment determinations.

Finally, you inquired how screening measures such as on-site visits, fingerprinting and criminal background checks will impact the “typical” actively practicing solo and group practitioner. There are three levels of screening and associated risk: “limited,” “moderate,” or “high,” and each provider/supplier category is assigned to one of these three screening levels. Generally, physicians and physician groups or clinics fall into the “limited” risk category. Fingerprint-based criminal background checks are only applicable to providers and suppliers assigned to the high screening level. Accordingly, the level of screening activity is commensurate with the designated risk category to which the provider is assigned. We anticipate that providers and suppliers in the limited risk category, such as physicians, should be minimally impacted by the level of screening required for enrollment or revalidation in the Medicare program. Whereas providers and suppliers in higher risk levels may be subject to more rigorous screening because they pose a higher risk of fraud, waste, and abuse to the Medicare program.

Thank you for your support of CMS’ program integrity efforts.

Sincerely,

Ted Doolittle
Deputy for Policy