Alliance of Community Medical & Rehabilitation Providers

Response to Anti-Fraud Task Force Interim Report, July 2012

August 16, 2012

We have reviewed the proposed Regulatory Model for Healthcare and Assessment Facilities in Ontario, prepared by Mr. Willie Handler on July 19, 2012, as well as the analysis and comments prepared by the Anti-Fraud Task Force in their recent report.

The Alliance supports the spirit and principles behind a regulatory system whose goal is to prevent, detect and punish fraudulent behaviour. We are therefore in agreement with Mr. Handler's and the Anti -Fraud Task Force's recommended objectives in instituting a regulatory model:

- Transparency in ownership, costs and conflicts of interest
- Accountability for facilities, owners and practitioners
- Verification of practices
- Sanctions for fraudulent behaviour

We are also strongly in support of active collaboration between a new regulatory entity focused on fraud and the existing College system focused on clinical practices.

Finally, we agree that all private facilities should be covered under the same umbrella, whether providing assessment and treatment at the client's request or assessments at the insurer's request, whether small or large, and whether comprised of regulated or unregulated providers. We do note, however, that fraudulent billing to government and insurers is not limited to the auto insurance sector and have therefore factored that into our commentary.

Who Would Be the Regulator?

Mr. Handler has recommended that this function be filled by FSCO. We believe, however, that there would be considerable value in involving other public sector entities such as the Ministry of Health, OHIP, the Ministry of Community and Social Services, the Ministry of Education, Veterans Affairs Canada, and the Workplace Safety and Insurance Board, some of which were referenced in the recent Anti- Fraud Task Force report. We also believe that insurers who provide extended health insurance coverage would be interested in participating (indeed, they offered a seminar via the regulatory Colleges earlier this year on the topic of fraud in the private health sector). **Given that the government's emphasis is on eliminating fraud by health care providers (versus other suppliers to the the insurance system where fraud can occur) and the fact that fraud is occurring in numerous other sectors beyond just auto, we believe that anti-fraud regulation should be a joint responsibility shared between FSCO and the Ministry of Health (via the existing regulatory College system).** This would better reflect the emphasis on health care providers and that the particular 3rd party payer who may be at risk due to fraud crosses a range of jurisdictions beyond just FSCO.

In addition to the regulatory body itself being established jointly by Health and Finance, we believe that a multi-stakeholder advisory board will be crucial to this venture's success. It is our opinion that a large part of the efficacy of the Anti- Fraud Task Force has been related to the synergies resulting from various Ministries, Departments and key stakeholders sharing information. Bringing this diversity of knowledge and experience together is a critical success factor for the Anti- Fraud Task Force – and we believe would be equally so in the development of an effective regulatory entity.

We note that some consideration to the involvement of the Ministry of Consumer and Commercial Relations may be warranted, given their work on consumer-level fraud in the province.

In the regulatory College system, a proportion of each College's Board is comprised of representatives of the frontline individuals who are being regulated. This is an important aspect of ensuring the College is in tune with frontline service provision issues. We therefore strongly recommend that frontline providers in the auto sector be included in FSCO's regulatory entity via the advisory board concept. Given that the Alliance is the only multi-disciplinary association comprised of only frontline providers who work directly in the system, we would be pleased to assume this role in the regulatory entity.

While the initial work completed by this entity would be focused on the auto sector given the current emphasis in this area, we believe it could then be organically extended to other health care environments where funding is provided on a 3rd party basis. The auto sector could be the "pilot project" for broader anti-fraud regulation of all private health practices in Ontario.

Categories of Licenses

Mr. Handler has suggested three categories of licensing related to volume of billing in the auto sector and the regulated or unregulated nature of work being conducted. While we believe that such a division is essentially arbitrary, we are not opposed to it. It is our understanding that the "Restricted License" would refer to a restriction placed on the facility to only provide services in the specific license category applied for. Mr. Handler provided some examples of such service categories. We know this is simply a list of examples, but we wish to ensure that several other important providers of unregulated goods and services would be covered, notably rehabilitation support workers, personal support workers and equipment vendors. We will support a Restricted License category if it includes all unregulated providers. We support that such facilities would still be required to have a Clinical Director role, but the role would not necessarily be filled by a regulated health professional. Sole practitioners in any license category would themselves fill the role of Clinical Director.

License Application Process

We recommend that all facilities, regardless of license category, follow the same application process, which would include submission of:

- **Facility basic information (e.g., name, operating address(es) and other contact information, year operations began, prior operating name(s) if they have changed)**
- **Overview of services to be provided**
- **Ownership structure (e.g., sole proprietor, partnership, incorporation)**

- **Articles of incorporation (if applicable)**
- **List of related healthcare companies (through common shareholder ownership)**
- **Personal shareholder information (for non-publicly traded entities) including names, addresses and attestation regarding any past felony conviction in any jurisdiction**
- **Consent for background check on owners and management in any jurisdiction**
- **Attestation that facility will comply with regulator's requests to verify invoices**
- **Statutory declaration of no conflicts of interest with respect to ownership and services provided (e.g., an insurer, adjusting company or lawyer/paralegal cannot own a health facility)**
- **Name(s) and resume(s) of Clinical Director(s) with prerequisite minimum 5 years' experience, with no Clinical Director having had a felony conviction or license revocation in the past 5 years in any jurisdiction**
- **Clinical Director must attest to being on-site for a minimum of 50% of the facility's operating hours (recognizing that this time may be divided across more than one site if the company operates at more than one location or time is split between clinic/office and client locations in the community)**
- **Clinical Director must attest to having unrestricted access to the company's financial information**
- **For companies providing Insurer Examinations, Clinical Director must attest that all assessors have a minimum set of qualifications, including at least 5 years' experience in the specific area(s) they assess**

We note that Mr. Handler made recommendations for the Clinical Director to be a bank account signatory. We do not believe that this requirement will have any impact on the ability to perpetrate fraud given how easily it can be manipulated. We therefore recommended requiring the Clinical Director to have unrestricted access to the company's financial information as we believe this is the more crucial element. Mr. Handler also made note of liability policies, however there are no "signatories" on liability policies, these policies are simply purchased for individuals and corporations.

License Issuing Process

Mr. Handler has suggested that applications must meet a "fit and proper" test. It is unclear to us what this means and until this is clarified, we object to it. It is our recommendation that licensing should be subject to proper application as outlined above. Licensing should be a process based on meeting clearly stated requirements that are not subject to interpretation. **Any facilities currently operating in the system who demonstrate adherence to the application requirements set out above should be issued licenses**. If a document exists which describes the "fit and proper" test, we would like to review it and have opportunity to provide commentary.

License Renewal Process

Facilities will complete and submit an Annual Information Return where they supply descriptions of how they ensured compliance with the various requirements noted in the application process above. We note that Mr. Handler additionally recommended quarterly attestations regarding accuracy and

appropriateness of bills submitted through HCAI. We believe that this is an unnecessary and non-beneficial requirement, given the other recommendations made.

Mr. Handler has suggested that facilities must notify the regulator of a change in Clinical Directors within 15 days. Knowing the complexities that often occur with a change in staff, we believe that 30 days is a more reasonable expectation without putting insurers at undue risk. We also believe that a similar notification should be provided if there is any substantive change in the licensing information (e.g., ownership, business name and address, etc.).

Monitoring, Investigation & Sanction Processes

We believe that considerable work needs to go into developing these systems and that the existing Colleges are best able to provide guidance into how to structure them. The Alliance would be happy to participate in discussions to this end, as we uniquely bring the "frontline provider and health practice owner" perspective to the table.

Considerations for the risk- and complaints-based investigation process should include the following requirements:

- **Complainant must submit evidence of a pattern of behavior**
- **Complaint must be specific in nature and related to fraud or a pattern of abusive actions; all other complaints should be referred to the regulatory College**
- **Regulatory Colleges must inform FSCO when a license is revoked (recognizing that a clinical restriction in practicing may or may not be relevant to anti-fraud regulation, so the College should specify its reason for restricting or revoking a license)**
- **Criteria must objectively specify what level of evidence will trigger an investigation**
- **Investigations may include audits of invoices submitted to confirm with actual clients (subject to permissions granted by the regulatory Colleges), review and follow up on information provided in license application (e.g., criminal background check on an owner or manager), review with College (if applicable) if any complaints or investigations are underway there, site visits to review facilities and financial procedures in place**
- **Investigations must be respectful and limited to the anti-fraud scope of regulation**
- **Sanctions must fit the nature and severity of the infraction, ranging from a warning (e.g., for failing to inform regulator of a change in Clinical Director, billing within less than 30 days, etc.) to license suspension (e.g., when fraud is confirmed)**
- **Process for reinstatement of license must be specified**

Other Anti- Fraud Measures

In its Interim Report, the Anti- Fraud Task Force included a number of areas for recommendation and input in addition to the implementation of a regulator for private health clinics in Ontario. We would like to offer our comments on some of these additional recommendations.

In the last reforms, many UDAPs that referred to insurer behaviour were removed. We would like to see a return to a balance of accountabilities in this realm between both providers and insurers.

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We support the use of Crime Stoppers as described in the Anti- Fraud Task Force report.

We support the implementation of a Professional Credential Tracker system where individual providers can verify directly how their name and regulatory number is being used.

We also support the recommendations to inform consumers of expected business practices.

We support requiring clients to sign an attendance log any time they attend for assessment or treatment sessions.

We support requiring clients to sign that they have received goods provided (e.g., orthotics, back rest, grab bar, etc.) and requiring that providers keep copies of all invoices for goods purchased on the client's behalf.

We believe additional clarification is required regarding charging clients $500 if they do not show up for an insurer examination. This is a complicated issue that warrants additional discussion and we are not sure how it relates to fraudulent activity.

We do not see the need for additional examinations under oath. This is a very stressful process for clients to go through and the insurer has many other ways of gathering the information they require, including via insurer examinations and simple requests for information.

We do not support the blanket civil immunity proposal. Insurers need to be held accountable for their behaviour, just as all other stakeholders are held accountable. Insurers already regularly accuse many legitimately seriously injured clients of being malingerers. If civil immunity is given, we are concerned there may be additional abuse of this power which will result in serious hardship for victims.

We support referencing the Cost of Goods Guideline in the SABS.

We support prohibiting clients from signing blank OCF forms by making this act an unfair and deceptive act or practice.

We support requiring insurers to provide an itemized breakdown of specific expenses incurred every 2 months.

We support insurers having to disclose information pertaining to preferred providers and their claims management processes to help consumers make informed choices of carrier beyond just price. However, we do not see this as an anti-fraud measure.

In conclusion, we see benefits to clients and the system as a whole in much of what Mr. Handler has proposed. However, we believe that consideration of our recommendations will further enhance the benefits and make for a system that best reflects the needs and realities of this sector and the health care system in general.