MILITARY MEDICAL INSURANCE

Your Health

Our Concern

ANTI-FRAUD POLICY

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MILITARY MEDICAL INSURANCE -ANTI-FRAUD POLICY

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List of Abbreviations and Acronyms

BNR: Banque Nationale du Rwanda (Central Bank of Rwanda)

BOD: Board of Directors

FMC: Fraud Monitoring Committee

GP: General practitioner

HC: Health Centre

MMI: Military Medical Insurance

RHIA: Rwanda Health Insurers Association

RMDC: Rwanda Medical and Dental Council

RSSB: Rwanda Social Security Board

Definition of terms used

1. **Abuse:** involves charging for services that are not medically necessary, do not conform to professionally recognized practice standards/manual, or are unfairly priced.
2. **Fraud:** is defined as an intentional deception, misappropriation or misrepresentation intended to result in an unauthorized benefit. An example would be billing for services that are not rendered.
3. **Antifraud policy**: is a plan of action adopted by MMI establishing mechanisms of detection, reporting systems, investigating frauds and measures taken to castigate definite cases. It also highlights protection processes to be undertaken to prevent fraud within MMI businesses.
4. **Beneficiary:** this term refers to any MMI affiliate or their immediate family members as stipulated by the law.
5. **Contributors:** are companies/institutions that subscribe to MMI insurance scheme
6. **Employers:** refers to institutions that subscribed their employees in MMI for health insurance.
7. **Member:** This is a subscriber
8. **Service provider:** this refers to any private or public Health center (HC), clinic, polyclinic or hospital offering health care services, partnering with MMI
9. **Stakeholders:** implementation of this policy requires an all-inclusive approach to be able to attain its objectives. Stakeholders to this antifraud policy include all organs or institutions involved in provision of medical care, financial transactions, criminal investigations and court case trials.
   Professional bodies like the Rwanda Medical and Dental Council, RMDC, and similar organs are indispensable to effectiveness of this policy.
10. **Suppliers:** this is a company or group of companies or individuals that procure logistics to MMI, mostly through the procurement processes provided in the law governing public institutions.

I. Background: Need of Anti-fraud policy in Military Medical Insurance

a. Introduction

The Military Medical Insurance (MMI) is a public institution established by the N^{0} Law 08/2012 of 29/01/2012 establishing Military Medical insurance determining its mission, organization and functioning.

The main purpose of the MMI is to uplift the welfare of its members by providing the medical insurance within the country to its beneficiaries and their eligible dependents. It has legal personality and financial autonomy. MMI is ambitious to ensure access to high quality health care services to its beneficiaries and ensure cost effectiveness of services provided by its partners. It strives to prevent malpractice onto its subscribers.

Since its establishment MMI has been subject to various types of fraudulent acts and malpractice; it lacked a defined capping and suing mechanism as well as a partnership with specialized legal bodies.

Part of MMI planned activities is a refining of the existing system to prevent possible fraud. This policy is designed to define and clear up all types of fraud either already detected or latent. It will enlighten and alert its partners of the costly mistakes being done and subsequent upshots.

Within its principles, MMI ensures cost-effectiveness of medical acts to its beneficiaries. It has "Zero Tolerance" to deceitful and dishonest acts.

MMI strives to maintain the highest standards of governance, personal and corporate ethics, compliance with all laws and regulations. MMI values integrity and honesty while dealing with all its employees, customers, suppliers and other stakeholders

MMI is committed to support government, law enforcement and medical ethics bodies to combat financial crimes.

b. Purpose

The purpose of this policy is to prevent fraud in Military Medical Insurance (MMI)

c. Objectives

This policy is intended to cap fraudulent cases and design a legal or professional body follow up of detected cases in order to protect MMI from financial and reputational risks. An internal framework has to be put in place to identify, investigate, measure, monitor and report occurrence of frauds in MMI. This document defines and categorizes different types of frauds.

d. Scope

The framework applies to any of the following; employees, beneficiaries, medical service providers, contributors, suppliers or any third party who has a business relationship with MMI.

e. Stakeholders

The fraud is not particular to MMI, but a national burden. Its management is complex and it cannot be dealt by a single institution. It requires different stakeholders' expertise and efforts to prevent, detect and punish where required. As medical insurance, MMI deals with different professionals therefore, it is paramount to partner with their respective professional bodies responsible for regulating the practice, professional ethics and conduct, so that if violated, different measures will be taken as per their processes and procedures.

Secondly, organs like police, prosecution and courts will be involved in investigating and punishing fraud if qualified for their respective competences.

II. Fraud Categories and Definitions

Fraud in medical insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties. This may, for example, be achieved by means of: misappropriating assets, deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurer's status; abusing responsibility, a position of trust or a fiduciary relationship

In simple terms, insurance fraud can be defined as: The act of making a statement known to be false and used to induce another party to issue a contract or pay a claim. This act must be willful and deliberate, involve financial gain, done under false pretenses and is illegal.

For practical purpose of the application of this policy, fraud may be defined as the use of deception with the intention of:

a) Gaining an advantage, financial or otherwise, personally and for family or friends; or

b) Avoiding an obligation; or

c) Causing a financial loss to the MMI

This policy defines two broad categories; there are common fraud to any organization and particular risk of fraud associated with company's products and/or services, medical insurances in our case.

Broadly, Medical Insurance frauds fall into the following categories:

2.1. Common fraud cases

Common fraud includes, payroll frauds, inventory, and conspiracy with other parties.

2.1.1. Misrepresentation of assets

Employees with access to cash may be tempted to steal it. A prime example is theft from petty cash. Small amounts taken at intervals may easily go unnoticed.

In this type of fraud, we also count stealing or disappearing MMI documents with attached values of money or not (e.g.: bank checks, payment slips, contracts, etc.). Divulging or selling a piece of information deemed secret is not only lack of professionalism but also in many cases a punishable fraudulent act.

2.1.2. Inventory fraud

Similarly, employees may prefer items of inventory. The most trivial example of this employees taking office stationery, also larger items may be taken. These types of fraud, are generally undetected because of their immateriality. On the whole, such fraud will tend to be too insignificant to have a serious impact on results or long term performance.

2.1.3. Manipulation of the payroll for contributors

For contributor payroll is a particularly attractive area for management wishing to understate salaries artificially. At this point the payroll declared is manipulated by understating the salaries of their employees, adding or removing individuals on payroll intentionally for benefitting from insurance.

2.1.4. Paying for goods not received

Staff may collude with suppliers, who issues invoices for larger quantities of goods than actually delivered. The additional payments made by the company are split between the two parties.

2.1.5. Disposal of the assets to employees

It may be possible for an employee to arrange to buy the company assets (e.g. a car) for personal use. In this situation, there may be scope to manipulate the book value of the asset so that the employee pays below market value. This could be achieved by over depreciating and undervaluation of the relevant asset.

2.1.6. Computer hacking:

Organizations are becoming increasingly dependent on computers for operational systems as well as accounting and management information. With this dependency comes and increases exposure to fraud. The computer is frequently the vehicle through which fraudulent activities are carried out.

This includes also the illicit invasion and manipulation of electronic files of the company by an employee or any related person to access data, prototypes or guarded information so as to benefit an advantage or disclose it for either a personal / third party gain or MMI fall back (loss).

2.2. Medical services related abuse and fraud

Medical services are often abused or forged. Differentiating both of these require critical investigations to enlighten the grounds of the acts.

Fraud is willful and deliberate, involves financial gain, done under false pretense. Abuse generally fails to meet one or more of these criteria, hence the subtle difference. Needless to say that the main purpose of both fraud and abuse is financial gain.

Abuse can be defined as practices that are inconsistent with medical ethics or practice guidelines and result in an unnecessary cost to claims.

The billing of services that may not be fraudulent, are intended for the financial gain of a particular individual or corporate are classified as abuse.

Few examples of common health insurance abuse/fraud would be - excessive diagnostic tests, extended hospital stay, conversion of day procedure to overnight admission, admission limited to diagnostic investigations, overbilling of services/items, double billing of same services, etc.

III. Parties involved in health insurance fraud and types of fraud committed by each:

Following is a list of possible parties, although not limited to, that play part in initiating or implementing fraud.

a) Policyholder Fraud and /or Claims Fraud

Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim. This is one of the major frauds incurring big losses to companies; in this type, one or more staff of the management team either cooperates with a third party to make false or abusive claims or support them when identified by subordinates.

b) Intermediary Fraud

Fraud perpetuated by an intermediary/agent /broker against the insurer and/or policyholders.

a) Providing fake policy to customer and siphoning off premium,
b) Manipulating pre-policy health check-up records,
c) Guiding customer to hide material fact to obtain cover or to file claim,
d) Participating in fraud rings and facilitating policies in fictitious names,
e) Forging data in group health covers

c) Internal Fraud

Fraud / Misappropriation against the insurer by a staff member.

The employees of insurance company could also be involved in committing fraud by expecting to receive favors/kickbacks, colluding with other fraudsters / fraud rings, siphoning premium etc.

The frauds within MMI can be committed by one staff or a cooperation of more staffs and/or with connivance with a third party.

These internally plotted frauds are, but not limited to,

a) Facilitating an illegitimate person to access Membership card, Data, healthcare services, etc.
b) Connivance with service provider to make false claims/invoice manipulation
c) Inappropriate approvals (Medical related, invoices, other transactions, etc.
d) Omission and negligence of duties (Improper identification, registration, verifications, etc.
e) Concealing of noticed errors (Financial, administrative errors, medical, supplies, et.
f) Divulgation of sensitive/confidential information
g) Disappearing supporting documents or files
h) noncompliance to insurance policies and internal rules/regulations

d) Beneficiary of health insurance

a) Fake / fabricated documents to meet policy terms conditions,
b) Declarations of fake medical conditions/ fake diseases for other interest
c) Connivance with service provider to fake and inflate bills, dishonesty,
d) Misuse and misplacement of membership card
e) Misleading prescribers for inexistent medical conditions
f) Exchanging prescribed medical products into other products (cosmetics, cash, eatables…)
g) Non declared professional diseases/ occupational hazards(Intentional)
h) RSSB patients (100%) healed but keep benefiting insurer's healthcare services

i) Forging or altering a prescription

j) Forging membership cards or any other MMI documents

k) Allowing others to use a MMI membership card to get service

l) Collusion with providers in order to get services or supplies

f) Service Provider

a) Overcharging, inflated billing, billing for services not provided
b) Unnecessary procedures,
c) Over prescription (excessive unnecessary investigations, expensive medicines …)
d) Unbundling and un coding
e) Extended length of hospital stay without medical indication
f) Fudging/falsifying bills, records, patient history
g) Irrational costing of consumables/devices not listed on the tariff
h) Interchanging tariff items (Day/night/weekend/GP/Specialists ….)
i) Charging consultations of part-time Doctors into full time/permanent consultations
j) Outpatients billed as inpatients while they weren't hospitalized (charged room, inpatient's follow ups, medications, etc.)
k) Charging to a beneficiary extra payment /fees on top of legitimate co-payment
l) Double billing or other illegal billing practices
m) Submitting false medical diplomas or licenses in order to qualify as MMI partner
n) Rebating or accepting a fee or a portion of a fee for a MMI patient referral

IV. Fraud/abuse prevention

4.1 Triggers

One of the ways to control fraud is to establish triggers / red alerts for early detection and corresponding action. A list of commonly used triggers and alerts for health insurance claims are presented regularly. These can be managed automatically through systems capabilities or manually detected through inspection of a physical file. It should be noted that the presence of a risk management trigger only warrants special attention and further investigation of the claim to collect evidence is required. The exercising of a trigger is not proof of fraudulent claim, only an indication of possible fraud.

4.2 Internal control

➢ Segregation of duties

Staff who have responsibility for a range of tasks have more scope for committing and concealing fraud. Therefore, the obvious way to control the risk is the segregation of duties. Management should identify certain functions that must be kept separate, for example separating the initiation of expenses from the authorization of payments.

Segregating responsibility for incurring expenses and authorization of payments tasks would also help to minimize the risk of fraud and increase the likelihood of detection.

- ➢ Appropriate documentation should be required for all transactions
- ➢ Limitation controls, authorizations and signature
  Each employee within MMI organization is limited to tasks, requiring written authorization by a direct supervisor of staff is good preventive tools. It increases accountability and also makes it harder to conceal a fraudulent transaction.
- ➢ Internal audits and inspections work should be concentrate on these areas (prevention and detection of fraud)

4.3 Beneficiaries

The rules require that MMI beneficiaries take steps to prevent fraud and abuse committed against the scheme as mentioned below;

- Keeping their Membership identification card in a safe place
- Not selling, loaning or altering their Membership card in order to obtain services for others
- Following the rules for MMI and the doctor's/clinic's office
- Informing MMI of any suspected fraudulent tendencies/practices
- Approving and signing on MMI medical claim forms for procedures done

All cases of suspected fraud, abuse or misuse by beneficiaries are investigated by the MMI fraud monitoring committee(FMC). Beneficiaries who are proven to have abused or misused the MMI services may be "locked in" to one doctor and one drug store, be required to re-pay for misspent funds and/or sued within competent courts of Rwanda.

4.4 Service Providers

The rules require that MMI service providers take steps to prevent fraud and abuse. These include but not limited to;

- Billing MMI correctly for services actually provided to beneficiaries
- Advising MMI regarding changes in status, such as when a doctor leaves a provider group or clinic

- Ensuring that the care provided to beneficiaries is medically necessary and rendered in a manner that is consistent with current medical practice
- Informing MMI of any suspected fraudulent tendencies/practices

Cases of suspected provider fraud and patient abuse are referred to the MMI Fraud monitoring committee. Providers in violation of MMI rules and regulations will receive administrative or other legal sanctions, suspension of payments, limits on participation in the MMI activities, termination of the contract or be taken to competent courts.

4.5 Insurances role

All insurance companies under RHIA are required to have in place an Anti-Fraud Policy duly approved by their BODs. As fraud can be perpetrated by collusion involving more than one party, insurer should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly and collectively; lay down appropriate risk management policies and procedures across the organizations.

Set-up a Fraud Monitoring Committee (FMC) with well-defined procedures to identify, detect, investigate and report the fraud.

4.6 Other measures necessary for fighting against fraud:

a) Avail staff 24h/7 at the facility level where required

b) Establishment of an antifraud committee

c) Training of staff on fraud investigation

d) Continual education program to promote fraud awareness among beneficiaries and service providers

e) Report to competent organs and publish in public the confirmed cases of fraud and people/institution involved

f) Reinforce supervision of MMI staff on branches to ensure their permanent availability at their position

g) Framework for Exchange of Information: Lay down procedures for exchange of necessary information on fraud, amongst all insurers through respective councils.

h) Regular Communication Channels: Generate fraud mitigation communication within the organization at periodic intervals and lay down appropriate framework for a strong whistle blower policy. The insurer shall formalize the information flow from/amongst the various operating departments

V. Fraud Monitoring Committee, FMC

a) FMC Role and Functions:

The FMC shall have in place reporting procedures from the various departments like underwriting, claims, information technology, investments, accounts, internal audit and intermediary/agent's departments. All personnel shall be encouraged to report suspicious instances/ fraud to the FMC. The FMC shall carry out preliminary investigations and prepare reports for the MMI management for further decisions. Also this committee will lay down the policy framework for the training of personnel and intermediaries to sensitize them on prevention, detection, and mitigation of fraud. Suitable clause should be included in the terms of appointment of employees/intermediaries that clarifies the implications of fraud and penal provisions thereon. The head of the FMC shall be responsible for furnishing various reports on fraud to the Authority.

b) **Composition of the FMC**:

Internal auditor(Head)

Legal Advisor,

Security officer,

Compliance officer and other personnel upon request with required expertise depending on the case.

VI. Fraud awareness and training:

The Insurer shall inform both potential clients and existing clients about their anti-fraud policies. The Insurer shall appropriately include necessary caution in the insurance contracts/

relevant documents, duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholder, claimant and the beneficiary

VII. Fraud Response plan

The purpose of this plan is to define authority levels, reporting channel and actions taken at each level in the event of suspected or detected fraud. This plan is strictly established to deal with only fraud related cases and the flow is outlined below.

1. Every suspected or detected fraud related incidents by MMI personnel shall be reported without any delay to their direct supervisor (Director), who also in writing reports the case(s) to the FMC.

2. MMI beneficiary, business partner or any other concerned individual or organ who suspects or detects fraud shall report to MMI head office by using any available means of communication.

3. The management shall handover the cases reported to the Fraud monitoring committee (FMC) for further investigations.

4. On the completion of investigation by FMC, a written report shall be submitted to the management containing a description of incident, including the value of any loss, the people involved, the means of perpetrating the fraud; the measures to be taken to prevent recurrence; and any action needed to strengthen future responses to fraud.

5. After management review and approval, management will take timely and appropriate actions

This report will guide management on how to orient the cases; either by taking administrative measures or to be handed over to other competent authorities for further management (professional bodies, Police, courts, line ministries and other relevant stakeholders)

6. The management will report to the BOD the actions taken on termly basis

7. On the occasion where a BOD or senior management member is involved in fraudulent acts, the FMC will report the case to the line ministry and BNR for administrative action.

Commencement:

This anti-fraud policy shall come into force from the date of its signature.

Done at Kigali, on ...02/.05/.../2018

Dr King RUGAGI KAYONDO

Lt Col

Director General

Approved by:

NIYIGENA ALPHONSINE

BOD Chair person