OFFICE OF THE ATTORNEY GENERAL

AND

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

JOINT ANNUAL INTERAGENCY COORDINATION REPORT

SEPTEMBER 1, 2012 THROUGH AUGUST 31, 2013

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INTRODUCTION

This joint report between the Health and Human Services Commission (HHSC), Office of Inspector General (OIG) and the Office of the Attorney General (OAG) is pursuant to §531.103 of the Texas Government Code, as amended by Senate Bill 59, 83rd Legislature, 2013. The report summarizes statistical data and other information relating to the joint efforts of HHSC OIG and OAG to uncover fraud, waste, and abuse in the state Medicaid program for the period of September 1, 2012, through August 31, 2013.

RECENT DEVELOPMENTS

OIG and OAG continue to build upon the success of their efforts in detecting and preventing fraud, waste, and abuse in the Medicaid program. Reinforced by legislative action, the two agencies are making timely and relevant referrals to each other, and cooperative efforts have resulted in a number of successful investigations of fraudulent providers.

OIG and the OAG Medicaid Fraud Control Unit (MFCU) recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. The activities in the latest annual reporting period continue to reflect progress and success in uncovering fraud, waste, and abuse. The following actions have occurred in the last 12 months.

- OIG and MFCU have increased communication with managed care organizations (MCOs) and have improved reporting procedures with the expansion of managed care in fiscal year 2013. OIG and MFCU have participated in quarterly meetings with the MCO Special Investigative Units to share information, best practices, and exchange information on cases of mutual interest.
- OIG and MFCU have worked jointly to improve communication, to share resources and information about providers under investigation, and to ensure parallel criminal and administrative actions result in the most successful case dispositions.
- OIG and MFCU have shared information developed through claims analysis, investigative findings, and prosecution analysis to address deficiencies in Medicaid policy that allow for exploitation and abuse of the Medicaid program.
- OIG and MFCU have continued to attend quarterly meetings with the Centers for Medicare and Medicaid Services (CMS) Medi-Medi contractor, law enforcement, and other stakeholders to discuss investigation leads and share case information. CMS is the federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program.
- Both agencies have continued to uphold their commitment to promptly send each other information about referrals and to act on them. Monthly meetings have continued between OIG and MFCU staff to discuss referrals of cases and other mutually beneficial projects that aid investigative activities by both organizations. Regular ongoing communication on cases at all staff levels has helped to ensure that OIG and MFCU share case resources and knowledge and avoid duplication of effort. Other states recognize the ensuing working relationship between the two agencies as highly effective.
- OIG's review of orthodontic billings continues, with a transition to litigation as the emphasis on developing new cases decreases. OIG is working closely with OAG-Civil Medicaid Fraud Division to develop a cohesive and concerted litigation approach for a large number of cases currently set for

payment hold or overpayment hearings. OIG has also increased and expanded its investigative activities on dentists who bill other dental procedures beyond orthodontia. There has been a significant increase in complaints related to over-utilization of services, medically unnecessary services, solicitation, and improper inducements to Medicaid recipients by dentists in the large metropolitan areas of the state. Many dental providers have been placed on payment holds based on credible allegations of fraud. Such fraud consists of falsification of prior authorization documentation, solicitation, improper inducements, medically unnecessary services, and billing for services not rendered. The payment holds are an important protection against future federal and state payments based on false claims. OIG and MFCU are presently sharing evidence and exchanging information to ensure both administrative and criminal investigations have successful conclusions.

- OIG has completed investigations of multiple hearing aid providers. OIG started this initiative in calendar year 2011 based on identified and systemic fraud, waste, and abuse by this type of provider. As with the dental providers, OIG has placed a number of hearing aid providers on payment hold to prevent future state and federal payments. These cases remain open in OIG with the Sanctions unit continuing the administrative enforcement process of recovering inappropriate overpayments, imposing civil monetary penalties, and pursuing possible exclusion. OIG is also working collaboratively with MFCU to share evidence and information to ensure successful outcomes in these investigations. These investigations have prompted a thorough review of Medicaid policy for hearing aid providers to help reduce future fraud, waste, and abuse. Additionally, HHSC is reviewing the Medicaid rates paid to hearing aid providers to ensure reimbursements do not create excessive or unanticipated costs to the Medicaid program.
- OIG is currently working on an investigative initiative that focuses on providers enrolled as Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Facilities (ORF). OIG targets these investigations to evaluate the high volumes of therapy provided to Medicaid children as well as allegations of improper solicitation and inducements. Given the large amount of data involved in these matters, OIG intends to contract through an RFP for the review of some of these matters for billing irregularities.
- MFCU is participating in Department of Justice Health Care Fraud Strike Forces in Houston and Dallas. The strike force in Dallas consists of investigators from United States Department of Health and Human Services OIG, Federal Bureau of Investigation, and MFCU. This strike force recently indicted a doctor for providing false certifications of medical necessity to home health agencies and durable medical equipment companies that resulted in $25 million in losses to Medicaid and $350 million to Medicare.
- OIG is actively analyzing and preparing for investigative initiatives into other historical abuses by provider types where Medicaid dollars are at risk.
- OIG executed a contract with 21st Century Technologies (21CT) to implement a comprehensive solution to identify suspected fraud, waste, and abuse through graph pattern analysis logic using 21CT's technology, called LYNXeon. LYNXeon is now fully deployed within the fee for service data set. Data loading from MCOs and third party data sources continues and will likely continue well into calendar year 2014. However, based on the more than 2 billion data points ingested and available for analysis at this point, LYNXeon has identified 167 potential cases of overpayments. OIG is currently evaluating each case for the appropriateness of a payment hold. OIG staff will continue to work with the vendor on the implementation of the next phase of the project, which includes expanding the data sets feeding into LYNXeon, development and implementation of a new investigative case management system and implementation of a data management solution.

- In fiscal year 2013, the Legislature authorized additional enforcement personnel, including nursing staff. MPI has posted for hire additional full-time nursing positions and has contracted with consultants to perform medical records reviews that are an essential part of provider investigations. Further, OIG has decreased the processing time it takes to complete cases. The target completion time is now 12 weeks. Although not all cases are completed in that time, the overall length of time to case completion has decreased dramatically and continues to decrease as additional staff join the agency. When OIG identifes provider fraud, waste, and abuse schemes as systemic or endemic to a certain provider type, MPI uses new federal legislation to place payment holds on providers when investigators can verify a credible allegation of fraud. At the same time, OIG has worked to ensure the integrity of the enforcement process by instituing multiple layers of internal review, along with meetings with providers, to avoid improper imposition of payment holds.
- OIG, in conjunction with the CMS Medicaid Integrity Group (MIG) auditors, facilitated six hospice audits. Questioned costs in the area of eligibility totaled $7,709,671; an additional $124,860 in pharmacy questioned costs have been identified. All six of the audits have been referred by the MIG auditors to the federal HHS OIG for possible fraud.
- OIG Compliance Division is in the final reporting stage of its audit of 34 Women's Health Program providers in the areas of operations, medical records, finances, and Titles V, X, XIX and XX. The Compliance Division audited centers for disease detection, laboratories, community oriented care centers, family planning facilities, and county hospital districts. OIG has identified approximately $1.8 million for potential recovery, and reports have been issued on $1.3 million of that. Of the $1.3 million reported, $510,261 has been recovered, with the remaining amount in the appeal process.
- During fiscal year 2013, the OIG Compliance Division completed 255 nursing facility reviews, comprising 23.2 percent of the total participating nursing facilities. Since September 1, 2012 (initiation of fiscal year 2013 retrospective reviews), $3,128,176.65 in actual dollars in error have been identified in these reviews. The identified amounts are subject to "reconsideration and appeal" by each nursing facility.
- The Quality Review Department within the Compliance Division completed 687 hospital reviews during fiscal year 2013. It has identified $28,021,936.82 in net overpayments for potential recovery.
- During 2013, the Limited Program revised 1 TAC 354 rules to change the name of the program to the Lock-In Program, add definitions for "lock-in" and "lock-in period" consistent with terminology in 42 CFR §431.54(e), clarify certain definitions, and delete others that were unnecessary. The changes clarified the federal authority for the Lock-In Program and simplified requirements relating to HHSC OIG lock-in reviews. The changes also clarified HHSC OIG processes related to: restricting a recipient to a designated primary care or pharmacy provider; providing notice of intent to restrict; and recipient rights to a fair hearing and access to services, including timeliness requirements governing HHSC OIG and the recipient. The Lock-In Program holds routine monthly meetings with MCOs, and is receiving a record number of referrals from MCOs. For the quarter ending August 31, 2013, the Lock-in Program received an average of 88 referrals per month. As of August 31, 2013, the Lock-In Program had 447 people locked into a single pharmacy or primary care physician.

MEMORANDUM OF UNDERSTANDING (MOU)

As required by HB 2292 of the 78th Texas Legislature, the MOU between MFCU and HHSC OIG was updated and expanded in November 2003. After extensive collaboration, the MOU was again updated in May 2012. The MOU ensures the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases and has proven beneficial to both agencies.

In addition, pursuant to the requirements of Senate Bill 8 of the 83rd Legislature (regular session), OIG entered into MOUs with both DPS and OAG for the coordination and support of law enforcement officers dedicated to Medicaid provider integrity.

THE HEALTH AND HUMAN SERVICES COMMISSION OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created OIG to strengthen HHSC's authority to combat fraud, waste, and abuse in health and human services programs. OIG provides program oversight of HHS activities, providers, and recipients through its Compliance, Chief Counsel, and Enforcement divisions,[1] which identify and reduce fraud, waste, and abuse, and improve HHS system efficiency and effectiveness.

The Compliance Division performs audits, reviews, and non-audit procedures of providers who contract with HHSC to administer programs. The division also includes a Managed Care Audit Unit in response to the implementation of statewide managed care.

The Chief Counsel and Enforcement divisions play an intricate role in coordinating with OAG as it relates to provider investigations and sanction actions.

Within the Enforcement Division, the Medicaid Provider Integrity (MPI) section performs the following duties:

- Investigates allegations of fraud, waste, and abuse involving Medicaid providers and other HHS programs.
- Refers cases to Sanctions, refers cases and investigative leads to law enforcement agencies, licensure boards, and regulatory agencies, and refers complaints to MFCU.
- Provides investigative support and technical assistance to other OIG divisions and outside agencies.

Under the Chief Counsel, the Sanctions section imposes administrative enforcement intervention and adverse actions on providers of various state health care programs found to have committed Medicaid fraud, waste, and abuse by violating state and federal statutes, regulations, rules or directives, and investigative findings. Sanctions monitors the recoupment of Medicaid overpayments, damages, and penalties, and may negotiate settlements and conduct informal reviews, as well as prepare agency cases and provide expert testimony and support at administrative hearings and other legal proceedings against Medicaid providers, when applicable. Sanctions works directly with MFCU in excluding convicted providers from the Medicaid program, collecting restitution in criminal cases, and imposing payment holds at the request of OAG. Sanctions also ensures proper accounting, reporting, and disbursement of funds awarded in litigation by the Civil Medicaid Fraud Division.

OIG has clear objectives, priorities, and performance standards that emphasize the following:

- Coordinating investigative efforts to aggressively recover Medicaid overpayments.
- Allocating resources to cases that have the strongest supporting evidence and the greatest potential for monetary recovery.
- Maximizing the opportunities for case referrals to MFCU.

[1] Information on specific organizational units within these Divisions may be found in OIG's Annual Report at https://oig.hhsc.state.tx.us/Reports/reports.aspx.

MEDICAID FRAUD AND ABUSE REFERRAL STATISTICS

HHSC OIG Fraud, Waste & Abuse Referrals Received FY 2013

Referral Source	Received
Anonymous	117
Attorney	3
HHSC Medicaid/CHIP	3
HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated	136
HHSC – OIG Compliance Division	8
HHSC - OIG Internal Affairs Division	1
HHSC – OIG Technology Analysis, Development and Support (TADS)	4
Managed Care Organization/Special Investigative Unit	88
Parent/Guardian	76
Provider	40
Provider Self-Reported	23
Public	149
Recipient	56
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	3
Texas Board of Dental Examiners	2
Texas Department of Aging & Disability Services (DADS)	31
Texas Department of Assistive and Rehabilitative Services (DARS)	1
Texas Department of Family and Protective Services (DFPS)	5
Texas Department of State Health Services (DSHS)	8
Texas Medicaid Healthcare Partnership (TMHP)	5
Texas State Legislator	2
Governor's Office	5
United States Department of Health and Human Services OIG (U.S. HHS OIG)	2
Total Received	**768**

HHSC OIG Fraud, Waste & Abuse Referrals Made FY 2013

Referral Source	Referred
Claims Administrator – Educational Contact	18
Managed Care Organization/Special Investigative Unit	57
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	47
Texas Attorney General Consumer Protection Unit	1
Texas State Board of Dental Examiners	10
Texas Medical Board	4
Texas State Board of Pharmacy	2
Texas Board of Nursing	1
Texas Board of Orthotics and Prosthetics	1
Texas Department of Aging & Disability Services (DADS)	11

Texas Department of State Health Services (DSHS)	1
United States Department of Health and Human Services OIG (U.S. HHS OIG)	6
United States Department of Labor	1
United Stated Drug Enforcement Agency (DEA)	1
Vendor Drug Program	3
Total Referred	**164**

Medicaid Fraud, Waste & Abuse Workload Statistics and Recoupments – FY 2013

Action	1st & 2nd Quarters FY 2013	3rd & 4th Quarters FY 2013	Total FY 2013
Cases Opened	200	568	768
Cases Closed	154	261	415
Referrals to MFCU	39	9	48
Referrals to Other Entities	59	58	117
MPI Cases Completed & Transferred to Sanctions	17	56	73
MPI CAF Holds Referred to Sanctions	11	0	11
On-site DME Provider Verifications	51	141	192
Sanctions Recoupments[2]	$10,292,179	$2,283,374	$12,575,553
Providers Excluded	68	241	309

Medicaid Fraud & Abuse Detection System[3]

Action	1st & 2nd Quarters FY 2013	3rd & 4th Quarters FY 2013	Total FY 2013
Cases Opened	2,431	1,189	3,620
Cases Closed	1,741	2,098	3,839

[2] May include OAG identified amounts and Medicaid global settlements. Amounts listed in OAG's statistics may also include potential overpayments identified by OIG. The amount reported includes recoveries and civil monetary penalties.

[3] Medicaid Fraud & Abuse Detection System (MFADS) is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.

OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

The Office of the Attorney General Medicaid Fraud Control Unit (MFCU) is charged with investigating fraud, waste, and abuse in the Medicaid program. In order to fulfill its mission, MFCU relies on referrals from OIG, state nursing home regulators, and local law enforcement agencies. MFCU conducts referral-based investigations, in part, because the federal grant that funds 75 percent of its operations specifies that OIG will conduct data mining of Medicaid claims providers submit, and refer potential fraud cases to MFCU for criminal investigation. In addition to OIG referrals, MFCU also investigates allegations of abuse and embezzlement at Medicaid-funded nursing homes from state agencies that oversee nursing homes and local law enforcement agencies that investigate patient abuse.

Since 2002, MFCU has identified more than $945 million in suspected Medicaid overpayments and has obtained more than 970 criminal convictions. The unit has a staff of 196 commissioned peace officers, forensic accountants, prosecutors, and other officials dedicated to pursuing Medicaid fraud. With field offices in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio, and Tyler, MFCU maintains an on-site presence across the state. Because the legislature has not authorized OAG to independently prosecute Medicaid fraud, MFCU's prosecutors must be cross-designated as Special Assistant U.S. Attorneys (SAUSAs) allowing OAG prosecutors to prosecute Medicaid fraud in federal court under the supervision of the U.S. Attorneys offices or as special assistant district attorneys. MFCU prosecutors have received cross-designation in all four U.S. Attorneys' districts and local district attorneys deputize them as needed on a case-by-case basis.

REFERRAL SOURCES

MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, HHSC OIG, other state agencies, and federal agencies. MFCU staff review every referral the unit receives, including 16,202 complaints and intake reports received from the DADS Client Assessment, Review and Evaluation System in FY 2013. Referrals that have a substantial potential for criminal prosecution are investigated. The current addition of staff and field offices has enabled the unit to respond quickly and efficiently to the referrals investigated. The following chart provides a breakdown of referral sources for this reporting period.

Referral Source	1st & 2nd Quarters FY 2013	3rd & 4th Quarters FY 2013	Total FY 2013
Federal Agencies and Entities	27	36	63
HHSC OIG	29	39	68
HHSC – Other than OIG	97	60	157
Hot Line / Ombudsman	0	3	3
Local Law Enforcement	5	9	14
Other	11	12	23
Provider Related	73	55	128
Pubic	151	136	287
Self-Initiated	12	23	35
State Boards and Agencies	9	16	25
Total Received	**414**	**389**	**803**

CRIMINAL INVESTIGATIONS

MFCU conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid healthcare providers. The provider types cover a broad range of disciplines and include physicians, dentists, home health agencies, physical therapists, licensed professional counselors, ambulance companies, case management companies, laboratories, podiatrists, nursing home administrators and staff, and medical equipment companies.

Common investigations include assaults and criminal neglect of patients in Medicaid-funded facilities, fraudulent overbilling for products and services that were not actually rendered, misappropriation of patients' trust funds by nursing home staff, theft of patients' prescription drugs by care givers, and filing of false information by Medicaid providers. MFCU investigators often work cases with other state and federal law enforcement agencies. Because MFCU's investigations are criminal, the penalties assessed against providers can include imprisonment, fines, court-ordered restitution, and exclusion from the Medicaid program. The provider is also subject to disciplinary action by his or her professional licensing board. Unlike the Civil Medicaid Fraud Division, MFCU is not authorized to seek recovery of fraudulent overpayments that are uncovered during its investigations. Instead, HHSC OIG generally recovers fraudulent overpayments that MFCU investigators identify.

During this reporting period, various district attorneys deputized MFCU prosecutors to pursue Medicaid fraud cases. As the unit continues to offer its expertise to assist local district attorneys with Medicaid fraud prosecutions, this trend is expected to continue. MFCU's partnership with the four federal judicial districts has been especially helpful to prosecution in increasing the number of Medicaid fraud cases through the federal system. Under this arrangement, MFCU Assistant Attorneys General have been cross-designated as SAUSAs. They reside primarily in the federal district offices. As SAUSAs, they have U.S. Attorney's Office's authority to prosecute Medicaid fraud cases in federal court. The unit also has two Assistant Attorneys General who work in the Harris County District Attorney's Office in Houston.

MEDICAID FRAUD AND ABUSE REFERRAL STATISTICS

Action	1st & 2nd Quarters FY 2013	3rd & 4th Quarters FY 2013	Total FY 2013
Cases Opened	250	305	555
Cases Closed	0262	246	508
Cases Presented	140	143	283
Criminal Charges Obtained	73	41	114
Convictions	56	49	105
Potential Overpayments Identified	$32,552,869.95	$106,604,930.46	$139,157,800.41
Misappropriations Identified	$16,695.42	0	$16,695.42
Cases Pending	1,208	1,267	2,475

OFFICE OF THE ATTORNEY GENERAL CIVIL MEDICAID FRAUD DIVISION

. Under Chapter 36 of the Texas Human Resources Code (the Texas Medicaid Fraud Prevention Act), the Civil Medicaid Fraud Division (CMF) is charged with taking legal action to recover fraudulent overpayments to Medicaid providers. These often lengthy and complex cases require a substantial investment of time and resources but have yielded more than $460 million for the state treasury. With an annual budget of $6.2 million, CMF's recovery of $61.7 million for the state[4] treasury in fiscal year 2013 was more than ten times the cost of operating the division.

To fulfill its fraud prevention duties, CMF issues civil investigative demands, requires providers to answer sworn responses to written questions, and conducts sworn examinations under oath prior to litigation. The remedies available under the Act are extensive and include treble damages plus interest, the imposition of civil penalties per violation, the recovery of costs and attorneys' fees, as well as the automatic suspension or revocation of the Medicaid provider agreement and/or license of certain providers.

Like that of the MFCU, the CMF caseload is largely attributable to third-party referrals. The TMFPA permits private parties, sometimes called "whistleblowers," to file lawsuits alleging TMFPA violations on behalf of themselves and of the State of Texas. This authority is similar to that given to private parties under the federal False Claims Act. These cases are filed under seal and are commonly referred to as *qui tam* actions. Once filed, the OAG is responsible for determining whether or not to intervene as a party and prosecute the action on behalf of the state. When this authority was added to the TMFPA in 1997, the statute required dismissal of a case if the State did not intervene. In May 2007, the Act was amended to permit the private party, known as the "relator," to continue to pursue the lawsuit even if the OAG does not intervene. In either circumstance, the Act provides that the relator is entitled to a share of the recovery, but the recovery cap is less when the State intervenes. The 2007 amendments brought the TMFPA into conformity with federal law to permit Texas to retain an additional 10 percentage points of Medicaid recoveries that are shared with the federal government. After recent amendments to the TMFPA in 2013 that addressed changes in federal law, the TMFPA was re-certified as qualifying for the additional 10 percentage points

CIVIL MEDICAID FRAUD STATISTICS

CMF Docket	1st & 2nd Quarters FY 2013	3rd & 4th Quarters FY 2013	Total FY 2013
Pending CMF Cases/Investigations[5]	380	404	784
Cases Closed	57	36	93
Cases Opened	63	59	122

During the third and fourth quarters of this reporting period, CMF settled and recovered funds in 16 matters, 7 of which were payments or recoveries of $1 million or higher[6]:

[4] This is the amount that went to Texas taxpayers only, and does not include amounts sent to the federal government, relators, and the attorney fees of the Office of the Attorney General.

[5] There are an additional 14 cases that relate to non-Medicaid matters handled by CMF.

[6] Significant recoveries for the first two quarters of FY13 were reported previously.

1. *State of Texas ex rel Ramadoss v. Caremark* (multiple cases) -- Total recovery including state, federal, and relator's portions was $15,000,000.00.
2. *United States and Texas ex rel Heiden et al v. Boehringer*[7] -- Total recovery including state, federal, and relator's portions was $3,148,266.32.
3. *United States and Texas ex rel Conrad v. Healthpoint (part of Abbott/Conrad)*[8]-- Total recovery including state, federal, and relator's portions was $4,119,597.00.
4. *United States and Texas ex rel Thakur v*. *Ranbaxy* -- Total recovery including state, federal, and relator's portions was $31,757,708.00.
5. *United States and Texas ex rel Kulwicki v. Driscoll and Radiology* -- Total recovery including state, federal, and relator's portions will be $2,300,000.00 after all payments are made.
6. *State of Texas ex rel Trabulsi v. Chana* -- Total recovery including state, federal, and relator's portions will be $1,000,000.00 after all payments are made.
7. *United States and Texas ex rel Sandler v. Wyeth*-- Total recovery including state, federal, and relator's portions was $3,676,252.45.

CMF continues to pursue significant cases against the following defendants:

1. Carlos Mego M.D., Subbarao Yarra, M.D., each individually and d/b/a/ Valley Heart Consultants, P.A., and Valley Heart Consultants, P.A, for false and fraudulent billing for medical services requiring a state license that were in fact performed by unlicensed personnel, false and fraudulent billing for medical services that were "substantially inadequate" when compared to generally recognized medical standards, and conspiracy to defraud the Texas Medicaid program.
2. Richard Malouf, D.D.S., All Smiles Dental Center, Inc., et al for misrepresentations in the provision of dental/orthodontic services.
3. Ranbaxy, an India-based generic drug manufacturer, for falsely reporting prices to Texas Medicaid used to calculate reimbursement to pharmacies.
4. Multiple administrative matters being prosecuted jointly with HHSC's Office of Inspector General against the following dental and orthodontia providers: Trueblood Dental, M&M Orthodontics, National Orthodontix, Westmoreland Dental, Harlingen Family Dental, and Antoine Dental.

The Dental Fraud Task Force headed by the Deputy Attorney General for Civil Litigation is comprised of senior officials from CMF, MFCU, HHSC, and OIG. The task force investigation and review of fraudulent billing by orthodontic and dental providers is ongoing. Further details about the investigation cannot be included in this public report at this time. CMF also continues to investigate multiple other matters that are under seal and cannot be described in detail in this public report at this time.

[7] These funds were received November 8, 2012, and inadvertently omitted from the previous semi-annual report for FY 2013.

[8] These funds were received February 26, 2013, and inadvertently omitted from the previous semi-annual report for FY 2013.