



ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

**Office of the Attorney General
and
Texas Health and Human
Services Commission**

**Joint Semi-Annual Interagency
Coordination Report**

March 1, 2012 through August 31, 2012



Activities of the Health and Human Services Commission, Office of the Inspector General and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program

RECENT DEVELOPMENTS

The Health and Human Services Commission (HHSC) and the Office of the Attorney General (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.

The HHSC Office of Inspector General (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. Activities in the latest biannual reporting period continue to reflect progress and success in this area. For example, the following has occurred in the last six months:

- OIG and MFCU staff have worked proactively to increase communication with managed care organizations and improve reporting procedures with the expansion of managed care in FY2012.
- OIG and MFCU staff have worked jointly to improve communication, to share resources and information regarding 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 improve 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 and/or act upon referrals. The ensuing working relationship between the two agencies is recognized by other states as highly effective.
- Monthly meetings have continued between OIG and MFCU staff to discuss referrals of cases and other mutually beneficial projects that aide investigative activities by both entities.
- Communications on cases have remained consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge are shared and efforts are not duplicated.
- OIG continues to investigate allegations related to fraud, waste, and abuse by Texas Medicaid dentists of billing related to orthodontic services. A significant number of investigations have been completed and others are still in process. 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 attributable to falsification of prior authorization documentation submitted to the state for these services. -The payment holds are an important protection against future federal and state dollars being paid based on false claims. OIG and MFCU are presently sharing evidence and exchanging information to ensure both the administrative and criminal investigation have successful conclusions.
- OIG has completed its investigations on multiple hearing aid providers. This was an initiative started by OIG in calendar year 2011 based on identified and systemic fraud, waste, and abuse by this provider type. As with the dental providers, OIG has placed numerous hearing aid providers on payment hold to protect against future state and federal dollars being paid to unscrupulous providers. These cases remain open in OIG with the Sanctions unit to continue the administrative enforcement process of recovering inappropriate overpayments, imposing civil monetary penalties and possible

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- exclusion. OIG is also working collaboratively with MFCU to share evidence and information to ensure successful outcomes in these investigations.
- In addition to conducting on-sites for newly enrolling DMEs, OIG also initiated a sweep of existing DME providers during the 3rd and 4th quarters of FY2012. As part of this initiative, on-sites of existing DME providers were completed around the state to help ensure that those providers are in compliance with state and federal enrollment requirements. As a result of this initiative, OIG identified a number of suspicious DME providers and DME providers who are no longer operational at the addresses on record and is taking steps to terminate those providers' enrollment.
 - MFCU is participating in Department of Justice Health Care Fraud Strike Forces in Houston and Dallas. The strike force in Dallas, composed of investigators from HHS/OIG, the FBI and MFCU, 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 historically abused provider types where Medicaid dollars are at risk.
 - OIG will be working with vendors in the very near future who will provide state of the art predictive analytic technology to help identify fraud, waste and abuse trends within the Medicaid program. The new analytical tools will allow OIG to initiate investigations more expeditiously and protect more of the State's resources.
 - In FY 2012, OIG determined that more resources needed to be shifted to the Medicaid Provider Integrity Section (MPI) to focus on fraud, waste, and abuse investigations of Medicaid providers. This resulted in a transfer of 52 full-time employees from the General Investigations section of OIG to MPI. MPI increased the number of field investigators in the Dallas, San Antonio, Houston, and Pharr regional offices. MPI added additional full-time nurses and contracted with consultants to perform medical records reviews which are an essential part of provider investigations. OIG has decreased the processing time it takes to complete cases from approximately four years to approximately eight weeks, becoming more active and aggressive with investigations. When OIG identifies provider fraud, waste, and abuse schemes as systemic or endemic to a certain provider type, OIG now self-initiates cases to investigate and determine the extent of the program non-compliance and/or fraud. MPI has aggressively used new federal legislation in investigation to place payment holds on providers when investigators can verify a credible allegation of fraud. Accordingly, the number of providers on payment holds has increased significantly in FY 2012 compared to previous fiscal years.
 - OIG conducted an Agreed Upon Procedures (AUP) review of Evercare STAR and STAR+PLUS from August 1, 2007 to April 30, 2011. OIG reviewed 224 files and found errors in 143, which contained \$4,865,077 of questionable costs. OIG expects to recover \$4.8 million on behalf of the Medicaid program and approximately \$400,000 in investigation costs.
 - OIG Compliance Division is in the process of auditing 34 Women's Health Program facilities for operations, medical records, finances, and Title V, X, and XX. After an initial audit of 30 facilities, approximately \$1.8 million has been identified for recovery.
 - OIG conducted an invoice audit of 13 individual stores that were found to be associated with J&L Nutrition Centers, which has been disqualified from WIC sales for three years. The stores seemed to be purchasing products from a local wholesaler and selling the products to WIC participants with little or no markup. In addition to the pricing concerns, the stores did not have documentation to substantiate approximately \$600,000 in sales to the WIC program. OIG has recovered roughly \$300,000 of the \$600,000 identified for recovery. After the invoice audit was completed, OIG referred the case to the Attorney General for a criminal investigation.
 - The OIG Compliance Division has also completed 395 nursing facility reviews, comprising 36 percent of the total participating nursing facilities, from September 1, 2011 through August 31, 2012. Since September 1, 2011 (initiation of FY 2012 retrospective reviews), \$13,903,780 in overpayments have been identified via extrapolation and approximately \$4,846,818 in actual dollars in error have been identified in these reviews. The identified amounts are subject to "reconsideration and appeal" by each nursing facility. Reviews of 707 hospitals during the same time period have identified \$31,659,661 in net overpayments for recovery.

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- The Limited Program or Lock-in Program (LP) works by limiting certain recipients to a single primary care provider, a single pharmacy, or both. This can occur if a recipient engages in “doctor shopping” or “pharmacy shopping” for misusing benefits. Currently, LP has 313 people locked into a single pharmacy and/or primary 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. It continues to ensure the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases and has proven beneficial to both agencies.

THE HEALTH AND HUMAN SERVICES COMMISSION OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created OIG to strengthen HHSC’s authority to combat waste, abuse, and fraud in health and human services programs. OIG provides program oversight of Health and Human Service (HHS) activities, providers, and recipients through its Compliance, Chief Counsel, and Enforcement Divisions,¹ which are designed to identify and reduce waste, abuse, or fraud, and improve HHS system efficiency and effectiveness. Specifically, the Chief Counsel and Enforcement Divisions play an intricate role in coordinating with the OAG as it relates to provider investigations and sanction actions.

Within the Enforcement Division, the Medicaid Provider Integrity (MPI) section investigates allegations of waste, fraud, and abuse involving Medicaid providers and other health and human services programs; refers cases to Sanctions; refers cases and investigative leads to law enforcement agencies, licensure boards, and regulatory agencies; refers complaints to MFCU; and 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/or adverse actions on providers of various state health care programs found to have committed Medicaid fraud, waste, or 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/or 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 the 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:

- 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; and
- 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>.

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Medicaid Fraud and Abuse Referral Statistics

HHSC OIG Waste, Abuse & Fraud Referrals FY2012 (3rd & 4th Quarters) Received From:

Referral Source	Received
Anonymous	98
Attorney	1
US HHS OIG	3
HHSC – OIG General Investigations	1
HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated	19
HHSC – OIG Utilization Review Division (UR)	4
HHSC - Ombudsman	1
HHSC – Vendor Drug	1
Managed Care Organization/Special Investigation Unit	50
Parent/Guardian	56
Provider	53
Provider Self-Reported	9
Public	58
Recipient	51
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	2
Texas Department of Aging & Disability Services (DADS)	7
Texas Department of Family and Protective Services (DFPS)	1
Texas Department of State Health Services (DSHS)	6
Texas Medicaid Healthcare Partnership (TMHP)	1
Total Cases Received:	422

HHSC OIG Waste, Abuse & Fraud Referrals FY2012 (3rd and 4th Quarters) Referred To:

Referral Source	Referred
Claims Administrator – Educational Contact	25
Managed Care Organization/Special Investigation Unit	40
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	55
Texas Board of Dental Examiners	7
Texas Board of Medical Examiners	6
Texas Board of Nursing	2
Texas Board of Pharmacy	2
Texas Department of Aging & Disability Services (DADS)	26
Texas Department of Family and Protective Services (DFPS)	2
Texas Department of State Health Services (DSHS)	2
United States Department of Health and Human Services OIG (HHS-OIG)	13
Vendor Drug Program	2
Total:	182

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Medicaid Fraud, Abuse & Waste Workload Statistics and Recoupments – FY 2012

Action	1st Quarter FY 2012	2nd Quarter FY 2012	3rd Quarter FY2012	4th Quarter FY2012	Total FY2012
Cases Opened	217	201	1,357	1,035	2,810
Cases Closed	174	120	1,691	1,933	3,918
Referrals to MFCU	42	39	39	16	136
Referrals to Other Entities	62	45	74	53	234
MPI Cases Referred to Sanctions	1	11	48	50	110
On-site DME Provider Verifications	51	44	40	47	182

Medicaid Fraud & Abuse Detection System²

Cases Opened	1,485	1,451	1,199	987	5,122
Cases Closed	985	943	1,552	1,740	5,220
Sanctions Recoupments³	\$462,189	\$21,031,006	\$11,163,757	\$1,663,797	\$34,320,749
Providers Excluded	208	204	177	80	669

² MFADS is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.

³ 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.

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OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

The Medicaid Fraud Control Unit (MFCU) is charged with investigating waste, fraud, and abuse in the Medicaid program. In order to fulfill its mission, MFCU relies on referrals from HHSC's Office of Inspector General (OIG), state nursing home regulators, and local law enforcement agencies. MFCU conducts referral-based investigations, in part, because the federal grant that funds 75% of its operations specifies that OIG will conduct data mining of Medicaid claims submitted by providers 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 \$800 million in suspected Medicaid overpayments and has obtained more than 860 criminal convictions. The unit has a staff of 193 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 the Office of the Attorney General to independently prosecute Medicaid fraud, MFCU's prosecutors must be cross-designated as Special Assistant United States Attorneys – which allows OAG prosecutors to prosecute Medicaid fraud in federal court under the supervision of the U.S. Attorneys' offices – or special assistant district attorneys. MFCU prosecutors have received cross-designation in all four U.S. Attorneys' districts and are deputized by local district attorneys on an as-needed 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 received. MFCU then investigates referrals that have a substantial potential for criminal prosecution. 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	Received
Department of Aging and Disability Services	74
Health & Human Services Commission - Office of Inspector General	67
Law Enforcement	10
Managed Care Organizations	38
Medicaid Fraud Control Unit Self-Initiated	19
Medicaid Providers	25
Medicare Contractors	3
National Association of Medicaid Fraud Control Units	3
Public	124
State and Federal Agencies	21
U.S. Department of Health and Human Services, Office of Inspector General	13
Other	55
TOTAL	452

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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 the Unit's investigations. Instead, fraudulent overpayments identified by MFCU investigators are generally recovered by HHSC-OIG.

During this reporting period, MFCU prosecutors have been deputized by various district attorneys to prosecute 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 proven to be especially beneficial in increasing the number of Medicaid fraud cases prosecuted through the federal system. Under this arrangement, MFCU Assistant Attorneys General have been cross-designated as Special Assistant U.S. Attorneys (SAUSAs). They are housed primarily in the federal district offices. As SAUSAs, they are authorized to prosecute Medicaid fraud cases in federal court through the authority of the U.S. Attorney's Office. 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

MFCU statistics for the third and fourth quarters of fiscal year 2012 are as follows.

Action	3rd & 4th Quarters FY2012
Cases Opened	239
Cases Closed	276
Cases Presented	114
Criminal Charges Obtained	60
Convictions	59
Potential Overpayments Identified	\$192,624,512.84
Misappropriations Identified	\$64,583.78
Cases Pending	1,218

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 \$400 million for the state treasury. With an annual budget of just \$6.2 million, CMF's recovery of \$130 million for the state treasury in FY 2012 was more than twenty 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. Texas received notice from the federal government in March 2011 that recent amendments to the Federal False Claims Act required amendments to the Act. Several of those changes to the Act were made in 2011 and the OAG is in the process of reviewing potential additional amendments in order to continue to be eligible for the additional 10 percentage points of Medicaid recoveries.

Civil Medicaid Fraud Statistics

CMF Docket	3 rd & 4 th Quarters FY2012
Pending CMF Cases/Investigations	364
Cases Closed	52
Cases Opened	85

During this reporting period, CMF settled and recovered funds in 12 matters:

1. *State of Texas ex rel Jones v. Janssen* -- CMF went to trial in this case in Travis County District Court on January 9, 2012. After seven days of testimony in the plaintiff's case, Janssen agreed to settle with Texas for a total recovery including state, federal, and relator's portions of \$158,000,000.00, the highest Texas settlement to date.
2. *State of Texas v. All Smiles* -- Total recovery including state, federal, and relator's portions was \$1,200,000.00.
3. *State of Texas et al v. Merck (Vioux)* -- Total recovery including state and federal portions was \$27,935,442.34.
4. *State of Texas ex rel Ven-A-Care v. Amgen* -- Total recovery including state, federal, and relator's portions was \$1,200,000.00.

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5. *State of Texas ex rel Conrad v. KV/Ethex* -- Total recovery including state, federal, and relator's portions will be \$656,756.64. This settlement is being paid out over five years and the defendant has filed for bankruptcy protection.
6. *State of Texas ex rel Conrad v. Dava* -- Total recovery including state, federal, and relator's portions will be \$2,853,650.32. This settlement is being paid out over five years.
7. *State of Texas ex rel Schroeder v. Medtronic* -- Total recovery including state, federal, and relator's portions is \$92,863.30.
8. *State of Texas ex rel Grubbs v. Kanneganti* -- This partial settlement represents a total recovery of \$9,000.00 for the state portion.
9. *State of Texas ex rel Grainger v. NextCare* -- Total recovery including state, federal, and relator's portions will be \$14,016.36. This settlement is being paid out over five years.
10. *State of Texas ex rel Chin v. Walgreens*-- Total recovery including state, federal, and relator's portions was \$44,898.68.
11. *State of Texas ex rel Morgan v. Express (McKesson)* -- Total recovery including state, and relator's portions was \$8,799,597.51.
12. *State of Texas ex rel Gerhaty (several) v. Glaxo* -- Total recovery including state, federal, and relator's portions was \$61,340,922.77.

CMF continues to pursue significant cases against the following defendants:

1. Caremark for failure to reimburse Medicaid for pharmacy benefits paid on behalf of dual eligible Medicaid recipients.
2. Carlos Mego M.D., Pedro Mego, M.D., Subbarao Yarra, M.D., Yamil W. Aude, 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.
3. Caremark for falsely rejecting reimbursement requests from Texas Medicaid sent by Texas Medicaid in December 2006.
4. Richard Malouf, D.D.S., All Smiles Dental Center, Inc., et al for misrepresentations in the provision of dental/orthodontic services.
5. Ranbaxy, an India-based generic drug manufacturer, for falsely reporting prices to Texas Medicaid used to calculate reimbursement to pharmacies.

Finally, 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 continues its 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.