FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 16, 2011

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek,

Please find enclosed our six-month status report on the Auditor General's *State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards,* Report Number 2011-167, issued March 2011. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the Auditor General's recommendations six months from the report date.

If you have any questions about this status report, please contact Mary Beth Sheffield at 412-3978.

Sincerely,

Eric W. Miller
Inspector General

EWM/szg
Enclosure

cc: Kathy DuBose, Legislative Auditing Committee
Justin Senior, Acting Deputy Secretary, Division of Medicaid
Tonya Kidd, Deputy Secretary, Division of Operations
Molly McKinstry, Deputy Secretary, HQA

Agency for Health Care Administration
AG 09-10 Federal Awards Audit (Report#2011-167)
Six-Month Status Report as of September 16, 2011

Finding# FA 10-052	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA did not appropriately allocate salary and benefit costs for an employee who worked on multiple Federal awards.	We recommend FAHCA ensure that salary and benefit costs are allocated appropriately between multiple programs when applicable. FAHCA should maintain personnel activity reports or equivalent documentation to support the allocation to multiple Federal programs.	We concur with the findings and recommendation. Supervisors are aware that a position funded by Title XXI must be dedicated to those related functions. If a situation occurs that requires the position to assist in another area, activity reports will be kept for proper funding and reporting.	The position's responsibilities have been revised to be related only to Title XXI.	Fully Completed Paula Shirley (850) 412-3820

Agency for Health Care Administration
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Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
Payments made to providers on behalf of clients for medical service claims were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, the payments were for improper amounts or for unallowable services.	We recommend that FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed, including ensuring that FMMIS is updated timely with current information. Furthermore, we recommend that FAHCA discontinue its practice of instructing Medicaid waiver providers to submit claims that do not accurately reflect the nature or location of services rendered or comply with applicable regulations.	HOME HEALTH – Personal care services provided through the DD waiver (through APD) are currently being transferred to the state plan; the funds previously allocated to APD to provide personal care services under the waiver have been shifted and are now available to AHCA to provide personal care services to these recipients under the Medicaid state plan. The independent unlicensed providers of personal care services were allowed to enroll as Medicaid providers of personal care services. These unlicensed providers were unable to bill for visits, so AHCA decided to change policy to allow home health services providers to be reimbursed for personal care services that are provided in less than two hours. This has no	<u>Home Health -</u> The recoupments efforts for this overpayment should be completed by December 2011. At that time, this item will be closed.	December 31, 2011 Claire Davis (850) 412-4264

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		significant fiscal impact. Hence there are FY 09-10 expenditures associated with S9122, but minimal utilization at this 1-hour level. By amending the handbook and instructing the QIO to allow home health providers to bill 1 hour of continuous care only as personal care services for Medicaid recipients under 21, the fiscal impact will not be significant given the current utilization. After reviewing a sample of the claims provided on CD, the Agency has determined that the claims paid inappropriately and should have been denied. FMMIS does have edits in place to prevent private duty nursing and personal care services claims from paying without a prior authorization number. It is not clear why the claims		

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		identified were able to bypass the prior authorization system requirements. However, we are working with staff in the Bureau of Medicaid Contract Management (MCM) to determine why the claims paid inappropriately. MCM has confirmed that this problem is fixed, and these claims would not be able to bypass this edit if they were processed for payment today. Medicaid services will work with the Bureau of Medicaid Program Integrity to recoup the funds from any claims that paid without a prior authorization number. The plan is to cross reference the claims through the QIO to determine if they actually didn't receive prior authorization. The results of the cross reference will determine the providers		

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		that require recoupment of claims. DD WAIVER SERVICES - We will change FMMIS to allow place of service codes for DD waiver services to be adjustable, other than the only choice "99", to reflect specific places of service.	<u>DD Waiver Services</u> - This item has been fully corrected. Because Special Medical Home Care Services is a specific residential service under the DD waivers, the place of service is a required element and identified based on the coding. The DD rate table in rule specifies a maximum limit of 365 days per year. This limit is verified through the APD Gatekeeper Matrix system and billed through FMMIS according to these specific codes and prior authorized rates. Special Medical Home Care Services is a DD waiver service in FAC rule. The service specific procedure code	Complete Leigh Meadows (850) 412-4258

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
			is S9122 U6. This procedure code is verified as a waiver services fee schedule called: "The Developmental Disabilities Home and Community-Based Services Waiver Billing Code Matrix for use with the Developmental Disabilities Home and Community Based services Waiver Provider Rate Table January 1, 2008."	
		DENTAL - State Agency Response and Corrective Action Plan A quadrant indicator must be submitted with procedure codes D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, D7310, and D7320. Medicaid has completed file	<u>Dental</u> – File maintenance is complete. Claims submitted with certain procedure codes will deny if: • A quadrant indicator is not on the line item; • The line item has a quadrant indicator other than 10, 20,	Complete Mary Cerasoli (850) 412-4228

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		maintenance to remove all indicators of quadrants except 10, 20, 30, 40, UR, UL, LL, and LR. This prevents same quadrant billing of certain procedure codes that are not allowed on the same date of service, same quadrant, and same recipient. The system now denies as a duplicate quadrant when one of the procedure codes listed above is billed another procedure code listed above for the same quadrant, same recipient, same date of service. CHIROPRACTIC - Re: Chiropractic visits paid in excess of 24 per calendar year: A Batch File Maintenance request (Tracking #KS09201001) was	30, or 40; or • If a duplicate quadrant indicator is present. Chiropractic: The Change Order has not yet been implemented. It is being prioritized for programming; at that time we will receive an estimate of when programming will be completed.	Completion date not yet known. Kathryn Stephens (850) 412-4235

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		completed October 14, 2010, to update the contract billing and reimbursement rules regarding Medicaid policy regarding limitation of visit codes to 24 per calendar year. Reprocessing instructions for the visit claims with dates of service July 1, 2008 (the date of contract implementation for the current Medicaid fiscal agent) through the file maintenance implementation date was also included in the File Maintenance request. The reprocessing procedure (CO 21607) will recoup chiropractic visits that were claimed in excess of the 24 per calendar year maximum, without prior authorization from Medicaid. Re: Reimbursements for chiropractic services		

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		provided in exceptional places of service: A Batch File Maintenance Request (Tracking # KS09201005) was submitted in September 2010, with instructions for updating the contract billing and reimbursement rules regarding Medicaid policy regarding the appropriate place of service location codes and places of service considered exceptions to policy. Instructions were given to require referral information on line item 17 of the CMS claim form for all chiropractic claims with an exceptional place of service location code. Instructions include denial of all claims billed with an exceptional place of services location code that do not have the appropriate referral information. The FMMIS		

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		file update regarding appropriate and exceptional places of service is progressing but has not been scheduled for implementation. Reprocessing instructions regarding all claims with dates of service January 1, 2010 (the date of adoption for the current Chiropractic Coverage and Limitations Handbook) through the file maintenance implementation date with exceptional places of services and without the required referral information were also included in the File Maintenance Request. The reprocessing procedure will recoup chiropractic visits that were provided in an exceptional place of service, without the appropriate referral required by policy.		

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		INPATIENT – All claims are reviewed by FAHCA's Balanced Budget Act coordinator or physician consultant. Details of the referenced claims were reviewed to ensure adherence to policy related to Balanced Budget Act approved exceptions. In the first instance, a billing error by the provider resulted in the entire 47 days of a claim originating on June 4 2009 being charged to 2008-2009 fiscal year, however 20 of these days should have been charged to 2009 - 2010 fiscal year. The recipient was then transferred to a different hospital on July 21, 2009 for an additional 27 days. The FMMIS system paid the claim for 27 days in the 2009 - 2010 fiscal year. Policy for 45 day limit in one fiscal year was exceeded. FAHCA	<u>Inpatient</u> – We are working with AHCA Area offices and providers to void two claims that resulted in overpayment. Providers are voiding the claims and resubmitting for the correct number of days.	September 15, 2011 Pam Kyllenon (850) 412-4211

Finding# FA 10-057	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		will recoup the additional two days reimbursement from provider. In the second instance, the Medicaid policy unit approved the claim through the BBA process, Code 20 (patient died) is indicated in status field 17 of the claim form. FAHCA policy is to pay claims in such circumstances. However, claim type 3 should not be approved through the BBA process. New staff member has been trained on the BBA process. FAHCA will recoup 12 days reimbursement paid in error.		

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Finding# FA 10-058	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
Controls were not sufficient to ensure that amounts paid by FAHCA to the Commission for Transportation Disadvantaged (CTD) or amounts paid by CTD to transportation providers under a Medicaid transportation program were reasonable.	We recommend that current transportation costs be summarized and used to evaluate the reasonableness of the total contract amount as well as the amounts allocated to STPs and to the CTD for administrative costs. FAHCA should also conduct appropriate monitoring to evaluate CTD and STP compliance with governing laws, regulations, and contract terms.	The Agency will receive administrative costs audit for FY 2009/2010 to determine reasonableness of administrative costs for future contracting purposes. The Agency will receive audits for FY 2009/2010 and FY 2010/2011 in accordance with OMB Circular A-133 and the Florida Single Audit Act. The audits will allow the Agency to determine the reasonableness of funding and if the allocation is sufficient for providing services. On site survey of two transportation providers conducted in July 2010 and an on-site survey of the CTD and selected transportation providers to be conducted in the near future.	The Agency has followed up with the CTD on numerous occasions regarding completion of policies and procedure that would help the CTD meet its contractual obligation to the Agency. Agency staff chose this course with the belief that appropriate operating policies and procedures needed to be in place to ensure the CTD understands what the Agency would be looking for on monitoring visits. During this time the Agency issued two corrective action plans in response to repeated failure on the part of the CTD to complete the operating policies and procedures. In part due to the lack of completed operating policies and procedures the CTD has also not produced the	September 30, 2011 G. Douglas Harper (850) 412-4210

			annual audited financial reports required to answer this audit finding. The CTD does not dispute that it is required to produce the required reports, but it maintains that it hasn't had the manpower or leadership, until recently, to begin development of the report. The Agency has amended the contract twice since the previous response. The first was to decrease the dollar amount of the contract and the second was to extend the contract and make major revisions that would hold the CTD more accountable. The Agency is taking additional steps to work with the CTD to ensure that it meets all contractual obligations and audit requirements.	

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Finding# FA 10-060	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
Contrary to Federal and State requirements, FAHCA funded some current year expenditure obligations using 2008-09 certified forward appropriations. Additionally, expenditures were not always recorded to the correct appropriation categories in the State's accounting records.	We recommend that FAHCA ensure that the expenditures are made from the proper funding source and that unspent certified forward funds be allowed to revert as required by law. We also recommend that FAHCA accurately record expenditures in the State's accounting records.	Due to miscommunications, the certified forward appropriations were fully expended. Staff are aware that certified forward expenditures must be supported by the weekly claims financial reports. Unspent certified forward appropriations will be allowed revert. Regarding questioned recording of expenditures to the correct appropriation category (payments April 14, 2010 cited as example), our process is to pay from a few appropriation categories, then a journal transfer is processed to allocate the charges to the appropriate categories. For the payment referenced, a journal transfer was processed	Procedures have been established to ensure carry forward budget is not used to pay for current year expenditures. The status of expenditures to correct appropriations is still in process. The agency has no control over what claims are submitted against which appropriation code. The agency is in the process of seeking Legislative authority to align appropriations to expenditures at year end to help resolve the finding.	July 2012 Tonya Kidd (850) 412-3602

Finding# FA 10-060	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		to move expenditures to the appropriation category under which the claims were paid. The Journal Transfer voucher number is 010149, Statewide Document #D00-0057-8094.		

Finding# 10-061	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA could not always properly support salaries and wages charged to the Medicaid Program.	FAHCA staff indicated that starting with the September 2010 quarter the position will be included in the time and effort records. We recommend that FAHCA strengthen its procedures to ensure that time and effort records are used for all applicable HQA employees whose job	Florida AHCA staff with multiple duties from multiple funding sources have been educated regarding particular funding sources for their duties. Florida AHCA staff worked with Department of Management Services and Peoples First staff to set up coding time placed on timesheets to	Fully corrected - Affected employees have received training as to the proper coding and validating of time for Medicaid programs and are currently inputting their time appropriately. This is being monitored on an ongoing basis to ensure compliance.	6/30/11 Kimberly Smoak (850) 412-4516 Molly McKinstry (850) 412-4334

Finding# 10-061	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
	duties involve multiple programs.	attribute that time according to activity and funding source. Florida AHCA office staff are now entering their time into the Florida People's First Time Validation system paying attention to their activities with regard to funding sources.		

Finding# 10-062	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
In some instances, FAHCA drew funds based on projections that were not supported by a methodology and documentation showing that the funds were for immediate cash needs.	We recommend FAHCA develop an appropriate methodology for projecting cash needs. Documentation should be maintained to support the calculated cash need.	FAHCA has developed steps that are routinely followed in determining amounts for projected draws. Instructions have been written and worksheets are being maintained.	When a federal holiday falls on a Monday, the federal draw has to be projected based on the previous week in order for all time requirements to be met. A procedure has been developed whereas the projected draw is calculated by averaging the amounts	Completed. Paula Shirley (850) 412-3820

Finding# 10-062	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
			for the same week of the previous four months. The projected draw is adjusted to actual needs the following week.	

Finding# 10-063	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA did not ensure that amounts were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS).	We recommend FAHCA develop and implement written procedures for the preparation, review, and submission of the CMIA data to FDFS, including procedures for ensuring that the amounts reported are accurate and complete.	We concur with the recommendation. FAHCA is developing written procedures for the preparation, review, and submission of the CMIA data to FDFS.	Written procedures have been put in place to reconcile the draw worksheet to the Payment Management System and to identify refunds to be reported in the CMIA annual report.	Completed. Paula Shirley (850) 412-3820

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Finding# 10-065	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
Contrary to Federal requirements, FAHCA reported on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program reports expenditures that were not supported by provider claims.	We recommend that FAHCA report on the quarterly CMS-64 report only expenditures that are supported by actual claims.	A complete review of Emergency Payments made since July 2008 was made and any payment not supported by claims were reversed in an adjustment to the CMS 64 Report for the quarter ended September 2010. There have been no Emergency Assistance Payments made without claims support since then.	Written procedures have been put in place to ensure that all expenditures are supported by provider claims.	Completed. Paula Shirley (850) 412-3820

Finding# 10-066	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA procedures were not sufficient to ensure that expenditures reported on the CMS-64, Quarterly Medicaid Statement of Expenditures for the	We recommend that FAHCA correct the CMS-64 reports for all subsequent quarters where the expenditures were reported in the incorrect period. We also recommend	The prior period adjustments to move claims paid under check date 10/1/2008 from the quarter ending September 30, 2008 to the quarter ending December 31,2008 was	Adjustments for check date 4/1/2009 and 7/1/2009 were not done in the reports for quarters ending March 31, 2011 and June 30, 2011, however will be done in reports for	October 30, 2011 Paula Shirley (850) 412-3820

Finding# 10-066	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
Medical Assistance Program, included only activity pertaining to the applicable reporting period.	FAHCA continue its efforts to ensure that expenditures reported on the quarterly CMS-64 report include only payments made to providers during the applicable reporting period.	filed in the CMS 64 for the quarter ending September 2010. Adjustments for check date 4/1/2009 and 7/1/2009 will be done in the reports for quarter ending March 31, 2011 and June 30, 2011.	quarter ending September 2011.	

Finding# 10-067	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA procedures were not sufficient to ensure that Medicaid providers receiving payments had a current provider agreement in effect.	We recommend that FAHCA ensure that payments are made only to providers with current Provider Agreements in effect. Given that the transition to a new fiscal agent occurred two years ago, FAHCA should work with the fiscal agent to ensure that providers have current provider	The Agency completed installation of an automated reenrollment process in the MMIS in January of 2010 which required over 1200 hours of coding and testing. This automated process runs daily and identifies any provider with a provider agreement end date ninety (90) days in the	The final set of "Dear Provider" letters for reenrolling (and obtaining a current Provider Agreement) was sent in early August 2011. This final mailing (approximately 15,000) will close out all the required initial letters mailed to obtain reenrollment information along with new provider	December 31, 2011 Alan Strowd (850) 412-3450 Shawn McCauley (850) 412-3428

Finding# 10-067	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
	agreements in place or assess appropriate penalties for nonperformance against the fiscal agent.	future; flags the file as needing to reenroll; creates a report for tracking purposes; and sends the reenrollment packet to the provider. The provider has 90 days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window are suspended in the system to prevent claims with dates of service after the agreement end date from processing. This process has been running since February 1, 2010 and guarantees that no provider with a valid agreement will expire and still have claims process and pay. As an automated process, provider	agreements. Suspend actions have already been initiated against providers involved in the earlier mailings (i.e. those who failed to respond timely or at all). The final activities (terminating providers who did not respond to the re-enrollment notice) of this effort should be completed by the close of the 2011 calendar year.	

Finding# 10-067	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		reenrollment no longer has to shut down during fiscal agent transitions as in the past. The status for this finding remains partially corrected because the Agency is currently in the process of installing an additional automated job to identify providers with agreement end dates less than the current date; flag the file as needing to reenroll; create a report for tracking purposes; and send the reenrollment packet to the provider. The provider will have 90-days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window will be suspended in the system to prevent		

Finding# 10-067	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
		claims with dates of service after the agreement end date from processing. Senior management will then make a determination if the provider should be terminated. This job will be a one-time clean up of older provider files and encompasses the providers who were not reenrolled during the fiscal agent transition. Completion of this job will result in a fully corrected status for this finding.		

Finding# 10-068	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FAHCA had not developed policies and procedures to provide for the timely review and release of cost report	Subsequent to our inquiry, FAHCA completed the development of written policies and procedures	FAHCA has developed written policies and procedures pertaining to the release of cost reports. FAHCA will	FAHCA has developed written policies and procedures pertaining to the release of cost reports. FAHCA will	Completed. Lisa Milton (850) 412-4080

Finding# 10-068	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and nursing homes. Additionally, FAHCA had not resolved issues relating to the cost reports of the ICF-DD facilities for which independent auditors disclaimed an opinion for the 2004-05 fiscal year.	pertaining to the release of cost reports. We recommend that FAHCA continue to maintain and enhance written policies and procedures to assist in the review and release of nursing home and ICF-DD audit reports, including time frames for the timely selection of facilities and the timely review and release of the audit reports.	continue to maintain and revise all written policies and procedures as necessary to assist in the review and release of nursing home and ICF-DD audit reports to ensure timely selection of facilities and timely review and release of audit reports.	continue to maintain and revise all written policies and procedures as necessary to assist in the review and release of nursing home and ICF-DD audit reports to ensure timely selection of facilities and timely review and release of audit reports.	

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Finding# 10-071	Recommendation	Management Response as of March 16, 2011	Status as of September 16, 2011	Anticipated Completion Date and Agency Contact
FDCFS did not meet the CMHS maintenance of effort (MOE) requirement for the 2009-10 fiscal year due to the lack of sufficient availability of MOE funds. Additionally, FAHCA did not provide summary records or reports to support the amount of Medicaid expenditures used in the MOE calculation.	We recommend that FDCFS continue to correspond with SAMHSA regarding the efforts that may be made to comply with the MOE requirements. Additionally, we recommend that FAHCA periodically provide FDCFS with reports of actual expenditures to allow FDCFS to monitor total expenditures incurred and timely identify instances where expenditures may not be sufficient to meet the MOE requirement.	FAHCA will continue to respond to FDCFS requests for actual expenditures to allow FDCFS to monitor total expenditures incurred. The FDCFS typically makes requests to FAHCA via email on an annual basis. Once requests are received from FDCFS, FAHCA provides FDCFS with an extract of actual expenditure data. FAHCA will continue to respond to FDCFS requests in a timely manner.	AHCA will continue to respond to FDCFS requests for actual expenditures allowing FDCFS to monitor total expenditures incurred. FDCFS has decided to make requests to FAHCA via email after each Social Services Estimating Conference (SSEC). Once requests are received from FDCFS, FAHCA will provide FDCFS with an extract of actual expenditure data. FAHCA will continue to respond to the requests in a timely manner.	Completed. Tom Wallace (850) 412-4117