RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 30, 2014

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

Dear Secretary Dudek,

Enclosed is a six-month status report on the Auditor General's *State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards*, Report Number 2014-173, issued March 2014. 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: Six-Month Status Report of AG Report# 2014-173
cc/enc: Kathy DuBose, Joint Legislative Auditing Committee
Melinda Miguel, Chief Inspector General, EOG
Justin Senior, Deputy Secretary, Division of Medicaid
Tonya Kidd, Deputy Secretary, Division of Operations
Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance

Florida Agency for Health Care Administration
AG 12-13 Federal Awards Audit (Report# 2014-173)
Six-Month Status Report as of September 30, 2014

Finding# 2013-001	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) did not appropriately record in the correct funds the receivables resulting from Medicaid overpayments.	We recommend that the Bureau establish written fiscal year-end reporting procedures to better ensure that receivables resulting from Medicaid overpayments are appropriately recorded in the correct funds.	The Agency staff reviewing year-end requirements was new last year. However, current staff, even though new to the Agency, is very familiar with financial statement requirements and will ensure future compliance. The Bureau is working to properly document this process to ensure that appropriate consideration is given to the unique financial statement requirements of each fund.	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Florida Agency for Health Care Administration
AG 12-13 Federal Awards Audit (Report# 2014-173)
Six-Month Status Report as of September 30, 2014

Finding# 2013-002	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) did not correctly identify, calculate, and record all Disproportionate Share Program receivables, revenues, and deferred revenues.	We recommend that the Bureau strengthen fiscal year-end reporting procedures to ensure that, among other things, the applicable spreadsheet includes correct calculations for receivables and appropriate consideration is given to the 60-day collection period when recognizing deferred revenues and revenues.	The Bureau has developed a process to reconcile the data received from the program office on a quarterly basis. This quarterly reconciliation process will identify errors earlier in the process allowing more time for research and resolution. The Bureau is working on a written procedure for this process. The Agency staff reviewing year-end requirements was new last year. However, current staff, even though new to the Agency, is very familiar with financial statement requirements and will ensure future compliance. The Bureau is working to properly document this process to ensure that appropriate consideration is given to the unique financial statement requirements of each fund.	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Florida Agency for Health Care Administration
AG 12-13 Federal Awards Audit (Report# 2014-173)
Six-Month Status Report as of September 30, 2014

Finding# 2013-008	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) did not record all year-end accounts payable (liabilities) and expenditures in the period the transactions occurred.	We recommend that the Bureau establish written fiscal year-end reporting procedures to better ensure that all year-end liabilities and related expenditures are recorded in the period in which the transactions occurred.	Certified accounts payables were established by the Bureau of Financial Services; however, payables were inadvertently deleted once it was determined that sufficient certified forward budget was not available to pay the invoices presented. The appropriate way to handle this situation would have been to remove the certified indicator from the payables that exceeded the available balance. This issue will be addressed with staff during accounts payable training. Also, current supervisory staff is very knowledgeable of the certified forward process and will implement a review process that will ensure this will not happen in the future.	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Finding# 2013-045	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
Refugee Medical Assistance (RMA) claim payments made to providers were not always paid in accordance with established Medicaid policy.	We recommend that the FAHCA ensure that appropriate controls are in place and operating effectively to ensure that RMA claims are accurately and properly processed and paid.	In response to the 1st bullet: In coordination with multiple Bureaus and the General Counsel's Office, the Agency is in the process of reviewing procedures pertaining to the identification and recovery of amounts due to the Agency from retro-terminated providers. Upon completion of this review, procedures will be implemented to notify these providers of amounts due to the Agency for claims paid for services subsequent to the date for which the provider lost Medicaid eligibility. In response to the 2nd bullet: The physician service copayments not always applying correctly is a known FL MMIS system issue that has been previously documented. The Agency created a Change Order (CO) #36821 (Claim copayment not being deducted) to address this issue. This system modification is underway and will be completed by July 2014.	Fully Corrected	The Agency has completed its review of the procedures pertaining to the identification and recovery of amounts due to the Agency from retro-terminated providers, as proposed in the March 2014 response to the audit finding. Procedures are finalized and have been approved by Agency management and its legal staff with an implementation date of September 2014. Copayment issue: CSR 2250 including CO#36821 were implemented on April 17, 2014 to make this correction. Cheryl Travis - MCM (850) 412-3416

Finding# 2013-050	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
Medical service claim payments made to providers of Medicaid services were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, some payments were for improper amounts or for unallowable services.	We recommend that the FAHCA ensure that appropriate electronic and manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	The FL MMIS modifications to update the identified Medicaid/Medicare crossover issue have been partially completed. The required additional developmental resources were unavailable due to other Federal mandates and were not available to complete this task by the original target of December 2013. Work has restarted on this task and completion is planned to be finished by April 2014. Regarding the pharmacy claim in question, pricing updates are occasionally received from manufacturers and are downloaded in the Agency's pharmacy system by First Data Bank with retroactive dates. Any claim paid during the interim would be reimbursed at the price in the system on the adjudication date. This was the condition for the claim noted. The claim was adjudicated December 20, 2012; a price increase was received January 5, 2013 retroactive to December 28, 2012. The provider has been advised that they may void and rebill the claim to receive the updated reimbursement.	Partially Corrected Fully Corrected Fully Corrected Fully Corrected	The Agency has pulled all the claims for the reprocessing and has finalized the letter template that will be sent to inform providers. The next steps are to produce individualized data for the providers, send the data with the letters, and wait 21 days for any appeals to be filed. For those cases where appeals are not filed, recoupment will begin shortly thereafter. Pharmacy Claim with Underpayment: The claim in the finding was submitted and paid on December 30, 2012. The claim paid correctly at the rate on file at the time of adjudication. It was the responsibility of the pharmacy to void and reprocess the claim once the new rate was loaded. This issue is closed. Copayment issue: CSR 2250 was implemented April 17, 2014 to make this correction. Inpatient stays greater than 45 days: CSR 2052 (Balanced Budget Act of 1997 (BBA) Claims Edits) was implemented in multiple stages beginning on 06/02/2011. The final portion of this CSR was

Finding# 2013-050	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		The issue identified with copayments not correctly applying for each service provided is a previously documented system issue and is currently being researched. FL MMIS was updated previously with partial fixes that have been implemented. The Agency created CO #36821 (Claim copayment not being deducted) to further review and address this issue. The Hospital Services 45 day limit issue was documented by CSR #2052-Balanced Budget Act of 1997 (BBA) Claims. There were 15 COs originally opened for this CSR and 14 are complete with only one outstanding. Additional research using the examples from this finding are being performed on this issue and once the research is completed, a projected completion date will be determined. In coordination with multiple Bureaus and the General Counsel's Office, the Agency is in the process of reviewing procedures pertaining to the identification and recovery of amounts due to the Agency from retro-terminated providers. Upon completion of this review, procedures will be implemented	Fully Corrected	implemented on 05/23/2013. Currently CMS is reviewing documentation provided by the Agency, for each of the 98 identified claims, which shows that the claims correctly paid in accordance with Agency policy. The reviewers who originally determined that the claims were paid in error did not take into consideration that the claims are allowed, if they have an approved Prior Authorization associated with them. The Agency has completed its review of the procedures pertaining to the identification and recovery of amounts due to the Agency from retro-terminated providers, as proposed in the March 2014 response to the audit finding. Procedures are finalized and have been approved by Agency management and its legal staff with an implementation date of September 2014. Cheryl Travis - MCM (850) 412-3416

Finding# 2013-050	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		to notify these providers of amounts due to the Agency for claims paid for services subsequent to the date for which the provider lost Medicaid eligibility.		

Finding# 2013-051	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in the State's accounting records.	We recommend that the FAHCA strengthen procedures for the accurate recording of medical assistance related payments in the State's accounting records. We also recommend that the FAHCA consider revising the methodology used for recording payments to the correct medical services appropriation categories to reduce the need for subsequent journal transfers.	The Agency submitted a budget amendment, which was approved on February 5, 2014, to realign the Medicaid Services budget to match the latest estimating conference (December 4, 2013). The approval of this budget amendment is the first step toward ensuring budget authority is available by category to ensure medical assistance related payments are paid and posted in the correct appropriation categories at fiscal year-end. The Agency is in the process of developing the necessary processes and procedures to ensure measures are in place by fiscal year-end to ensure medical assistance payments are initially paid or subsequently transferred to the correct medical services appropriation categories.	Fully Corrected	The Agency has taken all possible steps available to ensure medical assistance related payments are paid from the correct appropriation category. The Agency will submit budget amendments to realign its Medicaid Services appropriations with the results of the Social Services Estimating Conference for Medicaid Expenditures. If necessary and if time permits, the Agency will submit a budget amendment to request additional budget authority for a particular category to ensure expenditures can be recorded correctly by category. During the certified forward process, the Agency has been directed to maximize its general revenue funds. Therefore, priority has always been placed on recording the expenditures in the correct fiscal year rather than the correct appropriation categories. Anita Hicks - Financial Services (850) 412-3815

Finding# 2013-052	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA did not ensure that refunds, including those for drug rebates, were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS). In addition, the FAHCA did not always reduce Federal cash draws by the Federal share of drug rebates received.	We recommend that the FAHCA ensure that CMIA report data submitted to the FDFS is accurate and complete and that cash draws are appropriately reduced for drug rebates received.	Understated Refund Transactions: The Bureau is developing a process to compile, reconcile, and enter the data used in the CMIA report on a quarterly basis. This quarterly reconciliation process will identify errors earlier in the process allowing more time for research and resolution. The Bureau is working to properly update the written procedure for this process. Cash Draws in Excess of Medicaid Program Needs As a result of a provision of the Patient Protection and Affordable Care Act (PPACA), the rebate sharing arrangement with states and the federal government was changed, retroactive to January 1, 2010, requiring states to remit a higher percentage of rebate revenue to CMS. In addition, PPACA requires drug manufacturers that participate in the Medicaid Drug Rebate program to pay rebates for drugs dispensed to individuals enrolled in a Medicaid managed care organization (MCO), if the MCO is responsible for coverage of such	Fully Corrected	In the event that drug rebate collections exceed our appropriation for the Prescribed Medicine/Drugs category, the Agency will submit a budget amendment requesting additional budget authority. The normal process of transferring the state and federal share of expenditures to the Grants and Donations Trust Fund to utilize the revenue received from rebates will be suspended until additional budget authority is approved. As an interim plan, the Agency will request non-operating budget authority to transfer the federal share of the drug rebate revenue to the Medical Care Trust Fund. Anita Hicks - Financial Services (850) 412-3815

Finding# 2013-052	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		drugs. The rebate revenue from MCOs is a new source of revenue not previously collected. In November 2012 and February 2013, drug manufacturers were invoiced for outpatient prescription drugs dispensed to Medicaid patients by MCOs for January 2010 through December 2012. The Agency received $1,213,544,586 in drug rebate revenue during Fiscal Year 2012-2013; however, the Agency was appropriated $730,555,925 in the Grants and Donations Trust Fund in the Prescribed Medicine/Drugs category to transfer the expenditures from the General Revenue Fund and the Medical Care Trust Fund. Expenditures for outpatient prescription drugs are initially paid from the General Revenue Fund (state share) and the Medical Care Trust Fund (federal share). The Agency transfers the state and the federal share of expenditures to the Grants and Donations Trust Fund to utilize the revenue received from rebates because rebate revenue is deposited in the Grants and Donations Trust Fund. The Agency reduces its federal draw in the amount of the federal share of the rebate as the mechanism of returning the		

Finding# 2013-052	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		federal share to CMS. The Agency exhausted its Grants and Donations Trust Fund budget authority due to the receipt of manufacturer rebates invoiced for the period retroactive to 2010, and had to suspend its standard process of returning the federal share of the rebate revenue to the federal government. As an interim solution, the Agency submitted a non-operating budget amendment in accordance with chapter 216.181 (12), F.S. This amendment requested an increase in transfer authority in the Grants and Donations Trust Fund in order to transfer the federal share of the rebate revenue to the Medical Care Trust Fund, which allows the federal share of the rebate to be returned to CMS and prevents the assessment of interest payments and/or other penalties. This amendment was approved on June 11, 2013, and $283,960,417.29 in drug rebate revenue was transferred to the Medical Care Trust Fund. The amount transferred is the amount of drug rebate revenue (federal share) that we should have reduced the federal draw by during the period of March 18, 2013 through June 24, 2013, but were unable to due to the		

Finding# 2013-052	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		lack of budget authority to implement our standard process.		

Finding# 2013-054	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA made payments to an ineligible provider.	We recommend that the FAHCA ensure that payments are made only to providers with Medicaid Provider Agreements in effect.	The Agency along with the Medicaid fiscal agent operations and system staff reviewed MMIS coding and operational guidelines and determined a vulnerability which, under extreme circumstances, would cause a provider to miss renewal. As a result, the Agency has implemented an automated job which will run periodically to identify any provider who has missed renewal. The MMIS will restrict claims for the delinquent provider and generate a renewal notice to the provider. Upon submission of a successful renewal packet, the provider agreement end date will be extended and the restricted claims will be released.	Fully Corrected	The Agency began manually running a job which will identify any provider who has missed renewal on September 8, 2014. The job will start running automatically during the November production release. The Agency has begun working on the September report and providing outreach to the delinquent providers. Shawn McCauley - MCM (850) 412-3428

Finding# 2013-055	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.	We recommend that the FAHCA increase its efforts to ensure that Life Safety Surveys and follow-up surveys are conducted within the established time frames.	During the audit period of 7/1/2012-6/30/2013 the auditors identified seven hospitals in which the annual Life Safety Code (LSC) inspections were conducted late. All seven of these hospitals were in the South Florida area which would be inspected by the Agency's Delray Beach and Miami Offices. During this past year, all vacant LSC positions in Delray Beach and Miami Offices have been filled. However, the surveyors still had to complete training and orientation prior to being able to survey independently, which will assist the offices in the future for the timely completion of the surveys. Also, the LSC lead for the Bureau of Field Operations, along with other life safety surveyors in the state, has assisted the field offices to timely complete the surveys. The Survey & Certification Support Branch is responsible for monitoring the timely completion of survey activity and reporting of any issues that fail to meet the established annual, recertification and revisit survey timeframes to the Bureau Chief of Field Operations.	Partially Corrected	The Division of Health Quality Assurance (HQA) Bureau of Field Operations continues to ensure LSC inspections are conducted annually, but no later than 15.9 months from the previous annual licensure and/or recertification survey. Also, if it is determined that an onsite revisit is necessary, the onsite revisit will be conducted a minimum of 45 days, however; a revisit can be conducted earlier than the 45th day if the provider alleges an earlier correction date, but not later than 90 days following the survey for which noncompliance was determined. There are times in which exceptions to the revisit timeframes may be appropriate, such as a waiver and/or if a provider fails to submit a timely plan of correction. The field offices would maintain the documentation in these instances. Survey & Certification Support Branch continues to monitor compliance. This process is currently being incorporated into the Licensure & Certification Standard Operating Procedures, which will be in place by 10/1/2014.

Finding# 2013-055	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		The Bureau of Field Operations reassessed their workload and developed overall priority levels to assist Field Office Management in scheduling their workload. Level 1 includes the Centers for Medicare & Medicaid Services (CMS) Tier 1 and Tier 2, Priority 1 State complaints, state statutory required inspections and initial licensure surveys. Level 2 includes CMS Tier 3 work, Priority 2 State Complaints, state health follow-up inspections and Rule required inspections. In October 2013, the Bureau of Field Operations updated their policy for conducting LSC inspections. Inspections are conducted annually, but no later than 15.9 months from the previous annual licensure and/or recertification survey. The Bureau's policy for conducting revisits has also been updated. Each field office is responsible to ensure the surveys are conducted in accordance with state and federal timeframes. If a revisit is needed based on the initial visit, the field office manager would determine, based on the survey findings, if an onsite revisit will be conducted. If it is determined an onsite revisit is		Kim Smoak - HQA (850) 412-4516

Finding# 2013-055	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		necessary, the onsite revisit will be conducted a minimum of 45 days, but no later than 90 days following the survey for which noncompliance was determined. Exceptions to the scheduling timeframes may be approved by the Chief of Field Operations. Documentation of the approval will be maintained by the field office and Quality Assurance lead.		

Finding# 2013-056	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
The FAHCA's established policies and procedures did not provide for the timely issuance of cost report audits of nursing homes and intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Additionally, the FAHCA had not performed monitoring of the vendor contracted to perform hospital cost report audits.	We recommend that the FAHCA enhance policies and procedures to provide for the timely issuance of cost report audits. We also recommend that the FAHCA ensure that the performance of the hospital cost report auditor (Medicare intermediary) be timely monitored.	Nursing Home Audits: According to the State Reimbursement Plan, Section I.A, cost reports are to be submitted five months after the fiscal year end of the cost report, but are not late until the January or July rate setting deadline, which is April 30 and October 31 of that year. Feasibly, a cost report with a fiscal year end of September 30 is not due until February, and then is not late until April 30th. That is over seven months, not taking into consideration the time taken to review the cost report, set rates, etc. Therefore, the policies in place are already using all the available time for cost report review, rate setting and then auditing. Currently, the Audit Services unit is attempting to take timing into consideration, so that we audit cost reports only going back two years in order to fit into the timeline of expediting the audit process. However, cost reports still have the five month FYE deadline, and the rate setting deadline to meet before they can even be reviewed. Going forward, the Audit Service unit will attempt to identify cost reports for audit and assign, given adequate budget and staffing, in a more timely fashion, in	Partially Corrected	NH/ICF-DD Audits: Effective June, 2014, the Agency assigned 115 additional nursing home cost reports for audit. Most of these maintained a fiscal year end of no earlier than 2010, with the majority of them having a fiscal year end in 2012. In order to maintain timeliness and monitoring procedures, the CPA firms continue to submit monthly reports to update the status of the audits. Additional ICF audits will also be assigned, as limited by budget, by September 30, 2014.

Finding# 2013-056	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		accordance with State and Federal guidelines. Hospital Audits: The current policies and procedures that are in place do provide for an adequate number of cost reports to be audited annually. The cost report is a combination of Medicare Title XVIII & V and Medicaid Title XIX. The Medicaid portion of the audit process cannot begin until the audit is completed for the Medicare program. The completion of the Medicare audit may take more than a year depending on the scope of the audit. In addition, the scope of the Medicaid audit may take a year or longer to finalize. At the beginning of each federal fiscal year, the Agency and the Medicare intermediary perform a reconciliation of pending audits to ensure audits are completed within a reasonable timeframe. Also, there are legislative budget restraints which only allow for a certain number of audit hours to be performed each state fiscal year. Moving forward, the Agency is in the process of contracting with a new vendor to perform Hospital audits. It is anticipated that the contract will be executed within the next month. The contract mandates a certain		Hospital Audits: The Agency, under the contract with Myers and Stauffer, LLC allows a periodic review of pending audit work performed by the vendor. This electronic process allows the Agency to review the audit work at any given time. This status report includes Net workload, number of received, completed packages, missing items and not submitted.

Finding# 2013-056	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		number of audits be completed each state fiscal year. Hospital Monitoring: For the hospital cost report audits completed by the Medicare intermediary, the FAHCA's procedure was to select and review a sample of audit working papers during the monitoring of the Medicare intermediary. The most recent First Coast Service Options, Inc. (FCSO) monitoring field review was performed for the time period of July 1, 2010 through December 31, 2011. Since the submission of that report, three events have occurred which have delayed the completion of a more current monitoring report. First, the individual responsible for the completion of the report is no longer with the Agency and the position is still vacant. Secondly, this position's duties and responsibilities for managing the Audit contract have been moved to another Agency staff. The new Contract Manager was unaware of the existence of this report. Finally, effective January 1, 2014 FCSO is no longer the		Hospital Monitoring: The Agency, under the contract with Myers and Stauffer, LLC allows a periodic review of pending audit work performed by the vendor. This electronic process allows the Agency to review the audit work at any given time. This status report includes Net workload, number of received, completed packages, missing items and not submitted. Zainab Day - MPF (850) 412-4080

Finding# 2013-056	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		Medicare intermediary for the audit work for the Medicaid portion of the cost report. Meyers and Stauffer is the new Medicaid vendor for the Medicaid audit work. The Agency will continue under the new contract with Meyers and Stauffer to have the vendor submit a periodic audit status report, which will reflect the status of audit work for each hospital. In addition, we will have the new vendor provide documentation and information required in the monthly monitor report, which will allow for an annual monitoring report to be completed at any given time. The current contract monitoring for the new vendor will be for the time period of March 1, 2014 until June 30, 2014. This limited report will be completed by September 30, 2014. ICF-DD Audits: The Audit Services unit will attempt to identify cost reports for audit and assignment, given the state fiscal year budget and current staffing, in a more timely fashion, in accordance with State and Federal guidelines. Currently, there are 10 ICF-DD home offices that make up 77 ICF providers and 12 providers		

Finding# 2013-056	Recommendation	Management Response as of March 5, 2014	Status of Finding as of September 30, 2014	Comments and Agency Contact
		without a home office. The Audit Services unit will attempt to ensure that an audit is assigned and completed for at least one provider in each of the home offices and the 12 providers without a home office for a total of 22 audits every two years.		