



NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF RIVERDALE MENTAL HEALTH ASSOCIATION
CLAIMS FOR OUTPATIENT MENTAL HEALTH SERVICES
PAID FROM
NOVEMBER 1, 2003 – DECEMBER 31, 2008

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

December 30, 2010



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
90 Church St, 14th Floor
New York, NY 12204

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

December 30, 2010

[REDACTED]
Riverdale Mental Health Association
5676 Riverdale Avenue
Bronx, NY 10471

Re: Final Audit Report
Audit #: 09-5202

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Riverdale Mental Health Association" (Riverdale) paid claims for outpatient mental health services covering the period November 1, 2003, through December 31, 2008.

In the attached final report, the OMIG has detailed our objectives and scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This audit report incorporates consideration of any additional documentation and information presented in response to the draft report dated August 23, 2010. The mean point estimate overpaid is \$600,587. The lower confidence limit of the amount overpaid is \$387,163. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$387,163.

[REDACTED]
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If Riverdale has any questions or comments concerning this report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 09-5202 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, New York City Office
Office of the Medicaid Inspector General

cc:

[REDACTED]

[REDACTED]
Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Outpatient Mental Health programs are offered at hospital-based, freestanding, or state operated Psychiatric Centers. The purpose of these programs is to diagnose and treat mentally ill adults and children on an ambulatory basis. There are four categories of outpatient programs: clinic treatment, continuing day treatment, intensive psychiatric rehabilitation treatment, and partial hospitalization. The specific standards and criteria for mental health clinics are outlined in Title 14 NYCRR Parts 579, 585, 587, 588, and Title 18 NYCRR Section 505.25. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for mental health clinic services.

OBJECTIVE AND SCOPE

The objective of our audit was to ensure the agency compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to outpatient mental health services, our audit covered services paid by Medicaid from November 1, 2003, through December 31, 2008.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$16,201.50 in Medicaid payments. Of the 100 services in our random sample, 21 services had at least one error and did not comply with state requirements. Of the 21 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Claims Submitted Over 90 Days From the Date of Service	8
Missing Progress Notes	5
Billing for Services Not Authorized by the Treatment Plan	4
No EOB for Medicare Covered Service	3
No Documentation of Medical Service	2
Incorrect Servicing Provider Number	1
No Documentation of Service	1

Based on the procedures performed, the OMIG has determined Riverdale was overpaid \$3,693.70 in sample overpayments with an extrapolated point estimate of \$600,587. The lower confidence limit of the amount overpaid is \$387,163.

Please note that the amount of the disallowances resulting from the OMIG's audit does not include any COPS/CSP related adjustments which may be recovered by the Office of Mental Health (OMH) (See Attachment B). Any applicable COPS/CPS related adjustments that may result in disallowances will be reviewed by OMH and may result in an additional recovery.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Outpatient Mental Health claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Outpatient Mental Health Program

Outpatient Mental Health programs are offered at hospital-based, freestanding, or state operated Psychiatric Centers. The purpose of these programs is to diagnose and treat mentally ill adults and children on an ambulatory basis. There are four categories of outpatient programs: clinic treatment, continuing day treatment, intensive psychiatric rehabilitation treatment, and partial hospitalization. The specific standards and criteria for mental health clinics are outlined in Title 14 NYCRR Parts 579, 585, 587, 588, and Title 18 NYCRR Section 505.25. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for mental health clinic services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to ensure Riverdale's compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,

- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to Riverdale for outpatient mental health services paid by Medicaid from November 1, 2003, through December 31, 2008. Our audit universe consisted of 64,733 claims totaling \$10,662,520.15.

During our audit, we did not review the overall internal control structure of Riverdale. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with Riverdale's management personnel to gain an understanding of the outpatient mental health program;
- ran computer programming application of claims in our data warehouse that identified 64,733 paid outpatient mental health claims, totaling \$10,662,520.15;
- selected a random sample of 100 services from the population of 64,733 services; and,
- estimated the overpayment paid in the population of 64,733 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Medical Progress Notes
 - Rehabilitation Progress Notes
 - Written Orders for Rehabilitation Services
 - Plans of Care for Rehabilitation Services
 - Staff Credentials
 - Staff Time Cards
- Any additional documentation deemed by Riverdale necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

- Department of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, 14 NYCRR Part 587 and 588.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . ; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

18 NYCRR Section 540.7(a)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."
18 NYCRR Section 518.1(c)

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to Riverdale from November 1, 2003, through December 31, 2008, identified 21 claims with at least one error, for a total sample overpayment of \$3,693.70 (Attachment C).

Sample Selection

1. **Claims Submitted Over 90 Days From the Date of Service** 11, 14, 15, 48, 51, 53, 68, 82

Regulations state, "Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider.

The MMIS Provider Manual states: "Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider."

*18 NYCRR Section 540.6(a)(1)
MMIS Provider Manual Information for All
Providers General Billing, Page 6*

In 8 instances pertaining to 8 patients the claims were submitted more than 180 days after the date of service without the valid use of an exception code as the reason for late submission of claims. Regulations require a claim to be submitted within 90 days of the date of service; however, the OMIG disallowed claims submitted more than 180 days after the date of service without supporting documentation. This is in keeping with general industry standards.

Sample Selection

2. Missing Progress Note

1, 15, 30, 63, 97

Regulations state, "Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded within the following intervals: (1) clinic treatment programs—each visit and/or contact; (2) continuing day treatment programs—at least every two weeks; and (3) partial hospitalization programs—each visit and/or contact."

14 NYCRR 587.16(f)

In 5 instances pertaining to 5 patients, the required progress note was missing.

3. Billing for Services Not Authorized by the Treatment Plan

1, 25, 72, 73

Regulations state, "All services shall be delivered in accordance with a written individual treatment plan".

Regulations also require that: (1) Treatment plan shall be updated or revised as necessary to document changes in the recipient's condition or needs and the services and treatment provided. (2) A treatment plan for a child shall be developed by professional staff of the program with participation of the recipient, as appropriate. A description of such participation shall be documented. The recipient's family and/or collaterals shall participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan.

18 NYCRR 505.25(d)(2)

14 NYCRR Section 587.16(a) and (b)

In 4 instances pertaining to 4 patients, the services delivered were not in accordance with the treatment plan and/or treatment plan review.

Sample Selection

In 1 instance, the group service was not authorized by the treatment plan. In 1 instance, an individual session was held that was not authorized by the treatment plan. In 1 instance, more continuing day treatment services were provided in a week than were authorized by the treatment plan. In 1 instance, the treatment plan approved only 1 individual session per month.

4. No EOB for Medicare Covered Service

11, 32, 40

Regulations state, "The department ... will seek reimbursement for any payments for care and services it makes for which a third party is legally responsible."

The MMIS Manual requires that providers must bill all applicable insurance sources, including Medicare, before submitting claims to Medicaid. The Manual also requires that providers must maintain appropriate financial records supporting their receipt of funds and application of monies received. Such records must be readily accessible for audit purposes.

18 NYCRR Section 360-7.2

MMIS Provider Manual for Clinics, Section 2.1.9

In 3 instances pertaining to 3 patients, no Explanation of Medical Benefits (EOB) was found for a Medicare eligible patient who received services covered by Medicare.

5. No Documentation of Medical Service

8, 24

Regulations state, "Only covered services which are actually delivered to eligible recipients shall be reimbursed."

In addition, "All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client...."

18 NYCRR Section 505.25(f)(1)

18 NYCRR Section 505.25(e)(5)

In 2 instances pertaining to 2 patients medical records did not document a medical service.

6. Incorrect Servicing Provider Number 92

Regulations state, "By enrolling the provider agrees ... (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."

The Medicaid Update states, "Beginning in Summer 2002, the Office of Medicaid Management will activate a series of edits that require identification of servicing and referring practitioners. These edits will verify that the practitioner license or MMIS provider ID numbers reported on clinic claims are accurate and legitimate Facilities and freestanding clinics should consult their MMIS Provider Manuals for instructions on completing the servicing/referring ID field. The instructions describe the proper completion of the fields that identify the SED license number and license type of MMIS provider ID. These fields will be reviewed and edited for accuracy during claims processing."

*18 NYCRR Section 504.3
June 2002 Medicaid Update*

In 1 instance, the servicing provider was not accurately identified.

7. No Documentation of Service 28

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . ."

Regulations also require that bills for medical care services and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

*18 NYCRR Section 504.3(a)
18 NYCRR Section 540.7(a)(8) and Section 517.3*

In 1 instance, the records did not document a clinical service.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$387,163, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:


New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204


If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$600,587. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to [REDACTED] Esq., Office of Counsel, at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

[REDACTED]
Riverdale Mental Health Association
5676 Riverdale Avenue
Bronx, NY 10471

PROVIDER ID [REDACTED]

AUDIT #09-5202

	<input checked="" type="checkbox"/> PROVIDER
AUDIT	<input type="checkbox"/> RATE
	<input type="checkbox"/> PART B
TYPE	<input type="checkbox"/> OTHER:

AMOUNT DUE: \$387,163

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 1237
File #09-5202
Albany, New York 12237-0048

Thank you for your cooperation.

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- Universe - Medicaid claims for outpatient mental health services paid during the period November 1, 2003, through December 31, 2008.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Riverdale claims for outpatient mental health services paid during the period November 1, 2003, through December 31, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period November 1, 2003, through December 31, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.
- Source of Random Numbers – The source of the random numbers was the OMIG statistical software. We used a random number generator for selecting our random sampling items.
- Characteristics to be measured - Adequacy of documentation received supporting the sample claims.
- Treatment of Missing Sample Services - For purposes of appraising items, any sample service for which Riverdale could not produce sufficient supporting documentation was treated as an error.
- Estimation Methodology – Estimates are based on the sample data using per unit estimates.

SAMPLE RESULTS AND ESTIMATES

		<u>Non-Projected*</u>	<u>COPS/CSP Breakout</u>	<u>COPS/CSP Non-Projected**</u>
Universe Size	64,733			
Sample Size	100			
Sample Book Value	\$16,201.50			
Sample Overpayments	\$3,693.70	\$167.54	\$2,730.08	\$140.67
Net Financial Error rate	23%			
Mean Dollars in Error	\$35.2616		\$25.9841	
Standard Deviation	73.0169		53.1401	
Point Estimate of Total Dollars	\$2,282,757	\$168	\$1,682,170	\$141
Less COPS/CSP Point Estimate	<u>1,682,170</u>			\$141
Adjusted Point Estimate of Total Dollars	<u>\$600,587</u>	\$168		
Confidence Level	90%			
Lower Confidence Limit	\$1,498,747	\$168	\$1,111,584	\$141
Less COPS/CSP Lower Confidence Limit	<u>1,111,584</u>			\$141
Adjusted Lower Confidence Limit	<u>\$387,163</u>	\$168		

* The *Adjusted Point Estimate of Total Dollars* and the *Adjusted Lower Confidence Limit* both contain \$168 in non-projected overpayments.

** The *Point Estimate of Total Dollars* and the *Lower Confidence Limit* for the *COPS/CSP Breakout* both contain \$141 in non-projected overpayments.