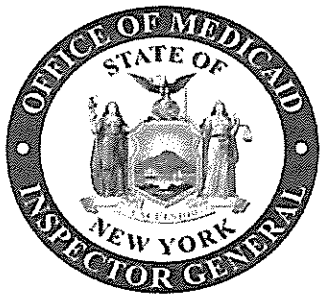

NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF PUERTO RICAN FAMILY INSTITUTE, INC. CLAIMS FOR OUTPATIENT MENTAL HEALTH SERVICES PAID FROM APRIL 1, 2003 – DECEMBER 31, 2007

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

November 23, 2010

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
90 Church Street, 14th Floor
New York, NY 10007

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

November 23, 2010

[redacted]
Puerto Rican Family Institute, Inc.
145 West 15th Street
New York, NY 10011

Re: Final Audit Report
Audit #: 09-1910

Dear [redacted]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Puerto Rican Family Institute" (PRFI) paid claims for outpatient mental health services covering the period April 1, 2003, through December 31, 2007.

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 July 19, 2010. The adjusted mean point estimate overpaid is $2,607,513. The adjusted lower confidence limit of the amount overpaid is $2,022,212. 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 $2,022,212.

If PRFI has any questions or comments concerning this report, please contact [redacted] at [redacted] or through email at [redacted] Please refer to report number 09-1910 in all correspondence.

Sincerely,

[redacted]

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

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 PRFI 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 April 1, 2003, through December 31, 2007.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with $15,422.94 in Medicaid payments. Of the 100 services in our random sample, 30 services had at least one error and did not comply with state requirements. Of the 30 noncompliant services, most contained more than one deficiency. Specifics are as follows:

Error Description	Number of Errors
Failure to Meet Group Visit Duration Requirements	12
No Documentation of Service	4
Insufficient Duration for Collateral Billings	4
Missing Treatment Plan for Clinic Treatment Program	3
Group Patient Limit Exceeded	3
Billing for Unauthorized Services	2
Duration of Visit Not Documented	1
Missing Progress Note	1
No EOB for Medicare Covered Service	1
Missing Treatment Plan for Day Treatment Programs Serving Children	1
No Documented Medical Service	1

Based on the procedures performed, the OMIG has determined PRFI was overpaid $4,558.00 in sample overpayments with an extrapolated adjusted point estimate of $2,607,513. The lower adjusted confidence limit of the amount overpaid is $2,022,212.

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 PRFI 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 PRFI for outpatient mental health services paid by Medicaid from April 1, 2003, through December 31, 2007. Our audit universe consisted of 131,098 claims totaling $20,722,891.36.

During our audit, we did not review the overall internal control structure of PRFI. 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 PRFI management personnel to gain an understanding of the outpatient mental health program;
- ran computer programming application of claims in our data warehouse that identified 131,098 paid outpatient mental health claims, totaling $20,722,891.36;
- selected a random sample of 100 services from the population of 131,098 services; and, estimated the overpayment paid in the population of 131,098 services.

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

- Medicaid electronic claim information

- Patient record, including, but not limited to:
  - Progress Notes / Service Notes
  - Rehabilitation Progress Notes
  - Treatment Plans and Treatment Plan Reviews
  - Attendance Sheets / Sign-in Sheets
  - Staff Credentials
  - Staff Time Cards

- Any additional documentation deemed by PRFI 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 PRFI from April 1, 2003, through December 31, 2007, identified 30 claims with at least one error, for a total sample overpayment of $4,558.00 (Attachment C).

		Sample Selection
1.	**Failure to Meet Group Visit Duration Requirements** Regulations state, "Group therapy visits: Shall be reimbursed for services of at least 60 minutes in duration provided to from 2 to 12 recipients and one therapist." 14 NYCRR Section 588.6(a)(4) In 12 instances pertaining to 12 patients, clinic group therapy visits of less than 60 minutes were billed.	4, 11, 12, 18, 30, 32, 37, 38, 55, 73, 79, 92
2.	**No Documentation of Service** 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 504.3(a)* and *18 NYCRR 540.7(a)(8) and 517.3* In 4 instances pertaining to 4 patients, patient records did not document a clinical service.	5, 15, 37, 43

		Sample Selection
3.	**Insufficient Duration for Collateral Billings** Regulations state, "Collateral visit: Shall be reimbursed for clinical support services of at least 30 minutes in duration of face-to-face interaction between one or more collaterals and one therapist with or without a recipient." *14 NYCRR Section 588.6(a)(2) and (5)* In 4 instances pertaining to 4 patients, the duration of the collateral session was less than 30 minutes.	51, 66, 76, 77
4.	**Missing Treatment Plan for Clinic Treatment Program** Regulations state, "All services shall be delivered in accordance with a written individual treatment plan." In addition, regulations require that for clinic treatment programs, the treatment plan schedule is as follows: "The treatment plan...shall be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Review of the treatment plan shall be every three months...." *18 NYCRR Section 505.25(d)(2)* and *14 NYCRR Section 588.6(g)* In 3 instances pertaining to 3 patients, the medical record did not contain a treatment plan or required treatment plan review.	60, 64, 74
5.	**Group Patient Limit Exceeded** Regulations state, "Clinic treatment programs shall receive reimbursement for the following types of visits: (4) Group therapy visits: Shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 recipients and a therapist(s);..." *14 NYCRR Section 588.6(a)* In 3 instances pertaining to 3 patients, the maximum number of patients allowed for grouping counseling services was exceeded. The size of the group exceeded the maximum size by 8 patients.	59, 60, 65

6. Billing for Unauthorized Services 44, 55

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

In addition, regulations require that:: for outpatient mental health programs, the 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. Additionally, "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 indentified in the plan."

18 NYCRR Section 505.25(d)(2) and
14 NYCRR Section 587.16(a) and (d)

In 2 instances pertaining to 2 patients, services were billed that were not authorized by the treatment plan and/or the treatment plan review.

7. Duration of Visit Not Documented 90

Regulations state, "Clinic treatment programs shall receive reimbursement for the following types of visits: (1) Brief visit: Shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one recipient and one therapist. (2) Regular visit: Shall be reimbursed for services of at least 30 minutes in duration of face to face interaction between one recipient and one therapist."

Regulations require that case records include the record and date of all on-site and off-site face to face contacts with the recipient, the type of service provided and the duration of the contact.

14 NYCRR Section 588.6(a)(1) and (2) and
14 NYCRR Section 587.18(b)(7)

In 1 instance, the record did not indicate the duration of the visit.

8. Missing Progress Note 72

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 1 instance, the required progress note was missing.

9 No EOB for Medicare Covered Service 84

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 and
MMIS Provider Manual for Clinics, Section 2.1.9

In 1 instance, no Explanation of Medical Benefits (EOB) was found for a Medicare eligible patient who received services covered by Medicare.

10 Missing Treatment Plan for Day Treatment Programs Serving Children 10

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

In addition, regulations require that for day treatment programs serving children, the treatment

plan schedule is as follows: "The treatment plan...shall be completed within 30 days of admission. Review of the treatment plan shall be every three months..."

18 NYCRR Section 505.25(d)(2) and
14 NYCRR Section 588.7(d)

In 1 instance, the medical record did not contain a treatment plan or required treatment plan reviews.

11 No Documented Medical Service 7

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) and
18 NYCRR Section 505.25(e)(5)

In 1 instance, medical records did not document a medical 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 adjusted lower confidence limit amount of $2,022,212, 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:

[redacted]
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
[redacted]

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.

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 adjusted point estimate of $2,607,513. 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] 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]

Puerto Rican Family Institute, Inc.
145 West 15th Street
New York, NY 10011

AMOUNT DUE: $2,022,212

PROVIDER ID [redacted]

AUDIT #09-1910

AUDIT TYPE
[X] PROVIDER
[ ] RATE
[ ] PART B
[ ] OTHER:

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 #09-1910
Albany, New York 12237-0048

Thank you for your cooperation.

Attachment "A"

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- Universe - Medicaid claims for outpatient mental health services paid during the period April 1, 2003, through December 31, 2007.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid PRFI claims for outpatient mental health services paid during the period April 1, 2003, through December 31, 2007.
- Sample Unit - The sample unit is a Medicaid claim paid during the period April 1, 2003, through December 31, 2007.
- 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 PRFI could not produce sufficient supporting documentation was treated as an error.
- Estimation Methodology – Estimates are based on the sample data using per unit estimates.

Attachment "B"

SAMPLE RESULTS AND ESTIMATES

		Non-Projected*	COPS/CSP Breakout	COPS/CSP Non-Projected*
Universe Size	131,098			
Sample Size	100			
Sample Book Value	$15,422.94			
Sample Overpayments	$4,558.00	$135.87	$2,569.02	$135.87
Net Financial Error Rate	30%			
Mean Dollars in Error	$44.2213		$24.3315	
Standard Deviation	72.3958		45.4903	
Point Estimate	$5,797,459	$136	$3,189,946	$136
Less COPS/CSP Point Estimate	3,189,946			$136
Adjusted Point Estimate	$2,607,513	$136		
Confidence Level	90%			
Lower Confidence Limit	$4,222,564	$136	$2,200,352	$136
Less COPS/CSP Point Estimate	2,200,352			$136
Adjusted Lower Confidence Limit	$2,022,212	$136		

* The *Adjusted Point Estimate of Total Dollars* and the *Adjusted Lower Confidence Limit* both contain $136 in non-projected overpayments.