

STATE OF WISCONSIN,)

Plaintiff,)

v.)

ABBOTT LABORATORIES, INC., et. al.,)

Defendants.)

Case No.: 04 CV 1709

**DEFENDANTS' EIGHTH SET OF INTERROGATORIES
AND REQUESTS FOR PRODUCTION DIRECTED TO PLAINTIFF**

Pursuant to Wis. Stat. §§ 804.08 and 804.09, Defendants request that the State of Wisconsin ("Plaintiff") respond to the following Interrogatories and Requests for Production (the "Requests") no later than 30 days from date of service.

DEFINITIONS

The following terms used in these Requests, whether or not capitalized, are defined as follows:

1. "Claim Reference Files" refers to those files that identify what the claim numbers in the MMIS database represent. *See* March 25, 2008 deposition transcript of State designee, Carrie Gray ("Gray Tr.") at 43:5-18 (excerpt attached as Ex. A).
2. "Cross-Walks" refers to any documents, files or databases used to assist in matching a single NDC with a HCPCS code and vice versa.
3. "Dual-Eligible Claims" or "Crossover Claims" refer to claims covered by both Medicaid and Medicare. *See* Gray Tr. at 41:21-42:7 (Ex. A).

4. "HCPCS Historical Pricing Files" refers to any documents, files or databases containing the pricing information for HCPCS code and/or physician claims. *See Gray Tr. at 39:3-41:20; 65:17-66:7 (Ex. A).*

5. "Level I, Level II, and Level III fields" refers to fields in the MMIS database and described on Exhibits B and C, attached. *See also Gray Tr. at 46:11-48:12 (Ex. A).*

6. "Manual Pricing" refers to the reimbursement amount paid for certain physician-administered drugs and/or HCPCS codes. *See Gray Tr. at 39:9-41:5 (Ex. A).*

7. "MMIS Database" refers to the database which contains claims for reimbursement from Medicaid providers.

8. "PADs" or "Physician-Administered Drugs" refer to drugs administered by a physician or under the supervision of a physician.

9. "Pharmacy Claims Pricing Files" contain the pricing information for pharmacy and/or NDC claims, a portion of which was produced to Defendants on December 13, 2007 and January 2, 2008. *See Gray Tr. at 57:11-60:16 (Ex. A).*

10. "Quick Reference" refers to the file or document which identifies what the pricing action codes in the MMIS database represent. *See Gray Tr. at 64:14:-65:7; 66:8-67:4 (Ex. A).*

11. "Relevant Time Period" means January 1, 1993 until the present.

12. "You," "Your," "State," "Wisconsin," or "Plaintiff" refer collectively to Plaintiff State of Wisconsin, including the Department of Health & Family Services, and its fiscal agent, EDS.

GENERAL INSTRUCTIONS

1. To the extent that You consider any of the following Requests and/or Interrogatories objectionable, please respond to the remainder of the Request and/or Interrogatory, and separately state the part of each Request and/or Interrogatory to which

you object and each ground for objection with sufficient particularity and in sufficient detail to permit the court to determine whether information falls within the scope of such objections.

2. Each Request extends to all documents and data in the possession, custody, or control of You or anyone acting on Your behalf. Documents and data are to be deemed in Your possession, custody, or control if it is in Your physical custody, or if it is in the physical custody of any other Person and You (i) own such Document in whole or in part; (ii) have a right, by contract, statute, or otherwise, to use, inspect, examine, or copy such document or data on any terms; (iii) have an understanding, express or implied, that You may use, inspect, examine, or copy such document or data on any terms; or (iv) have, as a practical matter, been able to use, inspect, examine, or copy such document or data when You sought to do so.

3. If production is requested of a document or data that is no longer in Your possession, custody, or control, state when the document or data was most recently in Your possession, custody, or control, how the document or data was disposed of, and the identity of the Person, if any, presently in possession, custody, or control of such document or data. If the document or data has been destroyed, state the reason for its destruction.

4. Provide the following information for each document or data withheld on the grounds of privilege: (i) its date; (ii) its title; (iii) its author; (iv) its addressees; (v) all of its recipients; (vi) the specific privilege under which it is withheld; (vii) its general subject matter; and (viii) a description of it that You contend is adequate to support Your contention that it is privileged.

5. The singular is meant to include the plural, and vice versa.

6. The terms “and” and “or” have both conjunctive and disjunctive meanings, and the terms “each,” “any” and “all” mean “each and every.”

INTERROGATORIES

INTERROGATORY NO. 1:

Identify what HCPCS codes you contend are at issue in this case.

INTERROGATORY NO. 2:

Identify what criteria was used to select the HCPCS codes in the data produced to Defendants on September 6, 2006.

INTERROGATORY NO. 3:

For each HCPCS drug code claim, identify how You determined what price to use for reimbursement purposes, including but not limited to:

- a) Whether you used AWP to set the price used for each HCPCS drug code claim and, if not, what pricing information you used.
- b) What other pricing information (i.e. other than ingredient cost) you used to set the price used for each HCPCS drug code claim.
- c) The identity of the person and/or entity responsible for determining what price to use for a given HCPCS drug code.
- d) How You determined what price to use when there were multiple NDCs associated with a given HCPCS drug code.
- e) The identity of the person and/or entity responsible for determining what price to use when there were multiple NDCs associated with a given HCPCS drug code.

INTERROGATORY NO. 4:

Identify how the Manual Pricing amount was determined for PADs reimbursed under the Medicaid program during the Relevant Time Period, including but not limited to:

- a) Specific steps taken to designate that Manual Pricing should be used for a given PAD.
- b) Specific steps taken to determine the Manual Pricing amount for a given PAD.
- c) Circumstances under which a PAD would be reimbursed based on Manual Pricing.

- d) The identity of the person(s) and/or entities responsible for determining whether to apply Manual Pricing for a given PAD and/or the Manual Pricing amount for PADs.

INTERROGATORY NO. 5:

Identify how the MAC rate was determined for PADs during the Relevant Time

Period, including but not limited to:

- a) Specific steps taken to determine the MAC rate for a PAD, including how it was determined which NDC to use in calculating the reimbursement amount for a multi-source drug.
- b) The identity of the person and/or entity responsible for determining the MAC rate for PADs.

INTERROGATORY NO. 6:

Identify whether the Medicare claims data produced to Defendants on August 25, 2006 contain Wisconsin Medicare Part B beneficiaries' claims and/or Dual-Eligible Claims.

INTERROGATORY NO. 7:

Explain what the Level I, Level II, and Level III fields in the MMIS database represent, including but not limited to:

- a) whether the definitions set forth in Exhibits B and C, attached, for the Level I, Level II, and Level III fields are accurate;
- b) why the definitions for the Level I, Level II, and Level III fields set forth in Exhibit B differ from those set forth in Exhibit C; and
- c) what the specific terms in the definitions set forth in Exhibits B and C, attached, for the Level I, Level II, and Level III fields mean, including but not limited to the terms "locality" and "specialty specific rates."

SPECIFIC REQUESTS FOR PRODUCTION OF DOCUMENTS

REQUEST NO. 1:

Pharmacy address, provider address, and place of service fields in the MMIS database for both pharmacy and HCPCS claims for the Relevant Time Period. *See Gray Tr.* at 25:6-12; 25:13-19; 51:22-52:7 for references to these fields (Ex. A).

REQUEST NO. 2:

Complete HCPCS data containing all of the line numbers for each claim for the Relevant Time Period. *See Gray Tr. at 32:10-34:7* for references to the missing line numbers (Ex. A).

REQUEST NO. 3:

HCPCS Historical Pricing Files for the Relevant Time Period.

REQUEST NO. 4:

Pharmacy Claims Pricing Files for October 2004 through the present.

REQUEST NO. 5:

Claim Reference Files for the Relevant Time Period.

REQUEST NO. 6:

Quick Reference document which covers the Relevant Time Period.

REQUEST NO. 7:

Any documents constituting, reflecting or referring to Cross-Walks used to determine rebates or reimbursement rates for HCPCS claims for the Relevant Time Period.

REQUEST NO. 8:

Any documents used to answer the above Interrogatories.

Dated: May 20, 2008

/s/ Jennifer A. Walker

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CERTIFICATE OF SERVICE

I hereby certify that on May 20, 2008, a true and correct copy of the foregoing document was served upon all counsel of record via LexisNexis File & Serve.

/s/ Marc Marinaccio

Marc A. Marinaccio

EXHIBIT A

STATE OF WISCONSIN : CIRCUIT COURT : DANE COUNTY

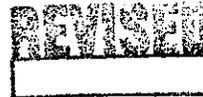
STATE OF WISCONSIN,

Plaintiff,

v.

Case No. 04-CV-1709

AMGEN, INC., et al.,



Defendants.

DEPOSITION of STATE OF WISCONSIN

(CARRIE GRAY), taken at the instance of the Defendants, under and pursuant to the provisions of Chapter 804.05 of the Wisconsin Statutes, and the acts amendatory thereof and supplementary thereto, before me, KIM M. PETERSON, CM, Registered Professional Reporter and Notary Public in and for the State of Wisconsin, at the Risser Federal Building, 17 West Main Street, Madison, Wisconsin, on the 25th day of March, 2008, commencing at 9:00 o'clock in the forenoon.

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<p>1 APPEARANCES</p> <p>2</p> <p>3 MR. FRANK REMINGTON, Assistant</p> <p>4 Attorney General, State of Wisconsin, Wisconsin</p> <p>5 Department of Justice, P.O. Box 7857, Madison,</p> <p>6 Wisconsin, 53707-7857, appeared on behalf of the</p> <p>7 State of Wisconsin.</p> <p>8</p> <p>9</p> <p>10</p> <p>11 HOGAN & HARTSON, LLP, 111 South</p> <p>12 Calvert Street, Suite 1600, Baltimore, Maryland,</p> <p>13 21202, by MS. JENNIFER WALKER, appeared on behalf of</p> <p>14 the Defendant Amgen, Inc.</p> <p>15</p> <p>16</p> <p>17</p> <p>18 von BRIESEN & ROPER, S.C., 411</p> <p>19 East Wisconsin Avenue, Milwaukee, Wisconsin, 53202,</p> <p>20 by MS. BETH J. KUSHNER, appeared via telephone, on</p> <p>21 behalf of the Defendants Pfizer, Inc. and Pharmacia</p> <p>22 Corporation.</p>	<p>1 INDEX</p> <p>2 WITNESS EXAMINATION PAGE</p> <p>3 CARRIE GRAY By Ms. Walker 5</p> <p>4 By Mr. Katz 72</p> <p>5</p> <p>6</p> <p>7 EXHIBITS</p> <p>8 EXHIBIT NO.: MARKED</p> <p>9 Exhibit Gray 037 - MMIS data - data sample 10</p> <p>10 Exhibit Gray 038 - Medicaid data elements</p> <p>11 and pricing methods 16</p> <p>12 Exhibit Gray 039 - HCPCS Refresh data - data</p> <p>13 sample 26</p> <p>14 Exhibit Gray 040A- HCPCS Refresh document 29</p> <p>15 Exhibit Gray 040B- May '06 HCPCS list for</p> <p>16 claims extract 29</p> <p>17 Exhibit Gray 041 - Medicaid data elements</p> <p>18 and pricing methods 44</p> <p>19 Exhibit Gray 042 - T19 rebates - data sample 52</p> <p>20 Exhibit Gray 043 - Pricing files- data sample 57</p> <p>21 Exhibit Gray 044 - Drug pricing screen (PK) 57</p> <p>22</p>
3	5
<p>1 APPEARANCES</p> <p>2</p> <p>3 KELLEY DRYE, 101 Park Avenue, New</p> <p>4 York, New York, 10178-0002, by MR. CLIFFORD KATZ,</p> <p>5 appeared via telephone on behalf of the Defendant Dey</p> <p>6 and Mylan Laboratories, Inc. and Mylan</p> <p>7 Pharmaceuticals, Inc.</p> <p>8</p> <p>9</p> <p>10</p> <p>11 DECHERT, LLP, 2440 West El Camio</p> <p>12 Real, Suite 700, Mountain View, California,</p> <p>13 94040-1499, by MR. RICHARD J. CUTLER, appeared via</p> <p>14 telephone on behalf of the Defendant GlaxoSmithKline.</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p>	<p>1 PROCEEDINGS</p> <p>2 CARRIE GRAY, called as a witness</p> <p>3 herein by the Defendants, after having been first</p> <p>4 duly sworn, was examined and testified as follows:</p> <p>5 EXAMINATION</p> <p>6 BY MS. WALKER:</p> <p>7 Q. Good morning, Ms. Gray. I know you've</p> <p>8 been deposed before in this case, so -- but I just</p> <p>9 want to remind you about some of the ground rules.</p> <p>10 If you ever need a break, just let me or</p> <p>11 Frank know and I'm happy to stop. I only ask that</p> <p>12 you wait to finish one of my questions so the</p> <p>13 record's complete before we break.</p> <p>14 Secondly, if you could provide a verbal</p> <p>15 response to my questions so the court reporter can</p> <p>16 accurately record it, I'd appreciate it.</p> <p>17 A. Sure.</p> <p>18 Q. Also, if you could let me finish my</p> <p>19 question before you answer just so we're not</p> <p>20 talking over each other, that would be helpful. And</p> <p>21 finally, if at any point you don't understand any</p> <p>22 of my questions, just let me know and I'll rephrase</p>

<p style="text-align: right;">6</p> <p>1 it because I want to make sure we're on the same</p> <p>2 page --</p> <p>3 A. Okay.</p> <p>4 Q. -- as far as is the questions. Sound</p> <p>5 okay?</p> <p>6 A. Sounds fine.</p> <p>7 Q. Do you understand that you've been</p> <p>8 designated by the State as someone who can speak on</p> <p>9 behalf of DHFS about the State's MMIS database?</p> <p>10 A. Yes, I am.</p> <p>11 Q. And about the HCPCS database?</p> <p>12 A. Yes.</p> <p>13 Q. And rebate and pricing files?</p> <p>14 A. Yes.</p> <p>15 Q. And are you prepared to testify about</p> <p>16 these?</p> <p>17 A. To the best of my ability, yes.</p> <p>18 Q. Do you work with any of these databases</p> <p>19 or files as part of your job?</p> <p>20 A. Yes, I do.</p> <p>21 Q. Which ones?</p> <p>22 A. I work primarily with the pricing data.</p>	<p style="text-align: right;">8</p> <p>1 Q. How often would you say that you access</p> <p>2 these databases? Every day?</p> <p>3 A. At least, if not every other.</p> <p>4 Q. Okay. Were you involved at all in</p> <p>5 helping the State collect the data to produce to</p> <p>6 the defendants in this case?</p> <p>7 A. This --</p> <p>8 MR. REMINGTON: Object to the form of the</p> <p>9 question.</p> <p>10 BY MS. WALKER:</p> <p>11 Q. You can answer.</p> <p>12 A. No, I -- No, not this set of data.</p> <p>13 Q. Okay. What did you do to prepare for</p> <p>14 today's deposition?</p> <p>15 A. I met with Frank and Jeff and we went</p> <p>16 over some information relating to the questions</p> <p>17 that you had presented to them.</p> <p>18 Q. And how many times did you meet with</p> <p>19 them?</p> <p>20 A. Twice.</p> <p>21 Q. And how long each time?</p> <p>22 A. Probably an hour the first time and</p>
<p style="text-align: right;">7</p> <p>1 I will spend time in the claims data. I spend time</p> <p>2 in the rebate data. I spend time in the HCPCS</p> <p>3 data.</p> <p>4 Q. When you refer to the claims data,</p> <p>5 that's the MMIS data?</p> <p>6 A. It's the pharmacy claims data and the</p> <p>7 HCPCS claims data --</p> <p>8 Q. Okay.</p> <p>9 A. -- that is stored in the MMIS.</p> <p>10 Q. And then when you refer to the pricing</p> <p>11 data, what are you referring to?</p> <p>12 A. We have a succession of screens that are</p> <p>13 used for pricing. So the pricing data is on the DS</p> <p>14 screen, and that's where I go to get that</p> <p>15 information, the pricing data in the MMIS.</p> <p>16 Q. It's in the MMIS?</p> <p>17 A. (Witness nods.)</p> <p>18 Q. And what kind of pricing is in the</p> <p>19 pricing data?</p> <p>20 A. There's NDC pricing. There's procedure</p> <p>21 code pricing, which would refer to HCPCS and CPT</p> <p>22 codes.</p>	<p style="text-align: right;">9</p> <p>1 yesterday it was two hours.</p> <p>2 Q. Okay. Did you speak with anyone besides</p> <p>3 Frank and Mr. Archibald?</p> <p>4 A. No, I did not.</p> <p>5 Q. Okay. Did you review any transcripts,</p> <p>6 like your prior deposition transcript or anyone</p> <p>7 else's transcripts?</p> <p>8 A. I reviewed an affidavit by Ted Collins.</p> <p>9 MS. WALKER: Okay. Frank, I'm just going</p> <p>10 to ask that the deposition be designated highly</p> <p>11 confidential because I'm going to be showing some</p> <p>12 extracts of the data that contain pricing</p> <p>13 information, defendants' pricing information. We</p> <p>14 can just designate those portions of the deposition</p> <p>15 that relate to that.</p> <p>16 MR. REMINGTON: Are you -- Are -- Is this</p> <p>17 data you got from us?</p> <p>18 MS. WALKER: Yes, yes, and we took</p> <p>19 samples of the data, but it has pricing information</p> <p>20 on it. So the exhibits will reflect pricing</p> <p>21 information of the defendants.</p> <p>22 MR. REMINGTON: I'm not sure I -- Did I</p>

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<p>1 --</p> <p>2 MS. WALKER: Yes. You designated it</p> <p>3 highly confidential when you produced it to us.</p> <p>4 MR. REMINGTON: Okay. I think I'd rather</p> <p>5 have those pages, do it page by page, rather than</p> <p>6 designate the whole deposition confidential. I</p> <p>7 think that's --</p> <p>8 MS. WALKER: That's fine. That's fine.</p> <p>9 MR. REMINGTON: Okay. How do we</p> <p>10 facilitate that?</p> <p>11 (Discussion off the record.)</p> <p>12 BY MS. WALKER:</p> <p>13 Q. Okay. Let's focus on the MMIS data</p> <p>14 first. I'm going to hand you what will be marked as</p> <p>15 Gray Exhibit 37.</p> <p>16 (Exhibit Gray 037 was marked for</p> <p>17 identification.)</p> <p>18 BY MS. WALKER:</p> <p>19 Q. This is a sample of the data that the</p> <p>20 State produced to us, and this document is marked</p> <p>21 highly confidential.</p> <p>22 First, some general questions about the</p>	<p>1 that's sent on the claim from the provider, the</p> <p>2 pharmacy, and populate the fields. So neither DHFS</p> <p>3 or EDS is responsible for populating. It's</p> <p>4 information that comes from the provider and is put</p> <p>5 in these fields as identified.</p> <p>6 Q. Okay. And just so I understand, MMIS</p> <p>7 data just reflects the pharmacy claims and not</p> <p>8 necessarily physician?</p> <p>9 A. No. It reflects both.</p> <p>10 Q. Both? Okay. And some of these claims</p> <p>11 could reflect both generics and brand drugs?</p> <p>12 A. No. An NDC only reflects either a</p> <p>13 generic or a brand.</p> <p>14 Q. Right. But there could be both types in</p> <p>15 the claims database?</p> <p>16 A. Yes, there could be. I'm sorry. I</p> <p>17 misunderstood your question.</p> <p>18 Q. No problem. And so if it's a generic,</p> <p>19 it could be reimbursed based on MAC?</p> <p>20 A. Yes.</p> <p>21 Q. And if it's a brand it's reimbursed on</p> <p>22 the AWP minus whatever percentage is in effect at</p>
11	13
<p>1 MMIS data. Is the data, where is it physically</p> <p>2 stored? Is it online? Is it here at the State? Is</p> <p>3 it at EDS? Where is it physically stored?</p> <p>4 A. I don't know. I have access to it on a</p> <p>5 computer that is EDS -- EDSnet. I don't know where</p> <p>6 the physical location of it is.</p> <p>7 Q. But you log in --</p> <p>8 A. I log into it, yes, like three log-ins</p> <p>9 to get to this information.</p> <p>10 Q. Okay. And so both DHFS and EDS have</p> <p>11 access to this data?</p> <p>12 A. The Bureau of Benefits Management has</p> <p>13 access to this data. There are other bureaus, but</p> <p>14 I know for sure that we do and that EDS does. I</p> <p>15 can't tell you who else within DHFS has access to</p> <p>16 this data.</p> <p>17 Q. Okay. Is EDS responsible for filling in</p> <p>18 the fields, or does DHFS do that?</p> <p>19 A. This is claims data. So this is what</p> <p>20 comes from the provider pharmacy to EDS, to the</p> <p>21 fiscal agent, through our point of sale system.</p> <p>22 The only thing we do is take the data</p>	<p>1 the time the claim is submitted?</p> <p>2 A. Yes.</p> <p>3 Q. Okay. Is there a field that indicates</p> <p>4 on here which -- whether or not MAC was applied, or</p> <p>5 the AWP minus, or usual and customary?</p> <p>6 A. No. There is no field on here that</p> <p>7 indicates that.</p> <p>8 Q. So how is it determined which one to</p> <p>9 apply?</p> <p>10 A. There's a process that happens when the</p> <p>11 claim is submitted to make that determination.</p> <p>12 There is a number of fields that are here that are</p> <p>13 used to determine how a claim is priced. Not a</p> <p>14 single field, but a -- a succession of fields that</p> <p>15 may determine how we price a claim.</p> <p>16 Q. Can we just do an example? Say there's</p> <p>17 a brand claim --</p> <p>18 A. Single source brand or --</p> <p>19 Q. Let's do single source for now.</p> <p>20 A. So a single source brand claim would</p> <p>21 come in. The system would look at the claim as it</p> <p>22 enters and says okay, it's a single source brand</p>

14	<p>1 because of the information contained in the pricing 2 fields, and there's no innovator indicator, which 3 is one of your fields, so we would price it at the 4 AWP minus 13. 5 Q. Okay. And is there a directive that's 6 sent to EDS so they'd know to price it at that? 7 A. That's how we've set up the claims 8 processing system. So the claims processing system 9 has all of this already put right into it to know 10 how to price a claim. 11 Q. Okay. 12 A. So when we billed and design, it's all 13 there. 14 Q. So if -- if you wanted to determine, 15 say, with the first -- let's use the first claim as 16 an example, if you wanted to determine whether that 17 was reimbursed based on AWP or MAC or usual and 18 customary, how would you determine that? 19 A. I would take the procedure code, I would 20 look at the no sub indicator and the -- no 21 substitution indicator field and the innovator 22 indicator field, and then we would know -- we would</p>	16	<p>1 What's billed. 2 Q. Do all of the cutbacks figure into the 3 allowed amount, or just some of them? 4 MR. REMINGTON: Object to the form of the 5 question. 6 THE WITNESS: They -- There -- In the 7 pharmacy claims there aren't a lot of cutbacks, but 8 it is -- it is a process that is used to determine 9 allowed amount in certain situations. 10 BY MS. WALKER: 11 Q. Okay. We'll come back to that. I'm 12 going to hand you what will be marked as Exhibit 13 38. 14 (Exhibit Gray 038 was marked for 15 identification.) 16 BY MS. WALKER: 17 Q. Do you recognize this document? 18 A. Yes. 19 Q. And what is it? 20 A. This is the pricing methodology for the 21 pharmacy claims data. 22 Q. So for the data that's reflected in</p>
15	<p>1 have some idea. We would also have to refer back 2 to the pricing fields. So it goes back to that 3 pricing information on the DS screen to help make 4 that determination. 5 Q. And just so you know, these are all the 6 fields, and we had to put them on two pages just 7 because there's so many of them. Okay. When we get 8 to the pricing file, maybe we could walk through 9 that again and figure it out. 10 A. Um-hum. 11 Q. I also want to walk through a couple of 12 these fields just so I make sure I understand what 13 they mean. What is the allowed amount? 14 A. That's the amount that Medicaid would -- 15 would pay the pharmacy on the claim. 16 Q. Okay. 17 A. That's the Medicaid allowed amount. 18 Q. And how is that amount determined? 19 A. It's based on the pricing screen and 20 whether there's any coordination of benefits, 21 third-party liability and cutbacks that need to be 22 made based on what's paid. What's billed, sorry.</p>	17	<p>1 Exhibit 37? 2 A. Correct. 3 Q. If you could look on page 4, under the 4 table it says the lesser of the system calculated 5 amount or billed amount becomes the allowed amount? 6 A. Um-hum. 7 Q. Is the system calculated amount 8 maintained in the MMIS database? 9 A. It's a pricing algorithm that's done 10 behind the scenes. There isn't a number that -- 11 that -- that -- It's an algorithm, so it's not 12 available to see here. 13 Q. Is it available somewhere else? 14 A. I don't know. I don't -- I don't know. 15 I would -- I'm going to have to say I don't know 16 right now. I know it -- Okay. Start over. Sorry. 17 Yes, it's available. I just don't know where it's 18 available at. 19 Q. Okay. 20 A. Sorry. 21 Q. Do you know who would know where -- 22 A. Kimberly Smithers.</p>

18	<p>1 Q. In the table above that sentence it says</p> <p>2 that the system calculated amount is the drug cost</p> <p>3 over the package size times the quantity allowed</p> <p>4 plus the dispensing fee minus 50 cents?</p> <p>5 A. That's it. There's the algorithm.</p> <p>6 Sorry. I didn't look up.</p> <p>7 Q. No, no problem. What does the 50 cents</p> <p>8</p> <p>9 A. In the -- In July of '95, as part of the</p> <p>10 budget bill 50 cents was removed from every claim</p> <p>11 that was processed through the Medicaid pharmacy</p> <p>12 system. So it's a 50 cent, we call it rate</p> <p>13 reduction.</p> <p>14 Q. And it looks like here it's taken off of</p> <p>15 the dispensing fee?</p> <p>16 MR. REMINGTON: Object to the form of the</p> <p>17 question.</p> <p>18 THE WITNESS: No. It's taken off the</p> <p>19 claim.</p> <p>20 BY MS. WALKER:</p> <p>21 Q. The total --</p> <p>22 A. The claim. Total price of the claim.</p>	20
19	<p>1 Q. Do you know how the system calculated</p> <p>2 amount was determined prior to September '02?</p> <p>3 A. I do not know that one, no.</p> <p>4 Q. Do you know who would?</p> <p>5 A. Kimberly Smithers.</p> <p>6 Q. Okay. If we could go back to Exhibit</p> <p>7 37, what amounts does the drug cost field</p> <p>8 represent?</p> <p>9 A. It is what's on the reference file, the</p> <p>10 pricing screen at the time the claim is processed.</p> <p>11 So whatever date of service is on the claim at that</p> <p>12 point in time, it goes to that DS screen, which is</p> <p>13 the pricing screen, and it -- that's what goes in</p> <p>14 that field.</p> <p>15 Q. And then what does the calculated drug</p> <p>16 cost represent?</p> <p>17 A. If I can look at this --</p> <p>18 Q. Yes.</p> <p>19 A. Is that okay?</p> <p>20 Q. Please.</p> <p>21 A. The data element describes it as the</p> <p>22 cost of the drug minus any dispensing fees.</p>	21
18	<p>1 Q. Well, how -- how, if you know, do the</p> <p>2 drug cost and the calculated drug cost differ?</p> <p>3 A. The drug cost doesn't contain the</p> <p>4 dispensing fee. It only contains the price of the</p> <p>5 drug at the time. The calculated drug cost would</p> <p>6 be minus any dispensing fees, according to the --</p> <p>7 to this data dictionary.</p> <p>8 Q. Well, if we look at this first example</p> <p>9 here, it appears that the drug cost is actually</p> <p>10 lower than the calculated drug cost.</p> <p>11 A. Yes, it does.</p> <p>12 Q. And if the calculated drug cost is minus</p> <p>13 the dispensing fee, I guess one would assume that</p> <p>14 it would be lower.</p> <p>15 A. Unless it's billed as usual and</p> <p>16 customary.</p> <p>17 Q. Okay. Do these fields, the drug cost</p> <p>18 and calculated drug cost fields, relate at all to</p> <p>19 the allowed amount?</p> <p>20 A. No.</p> <p>21 Q. And under what circumstances would the</p> <p>22 calculated drug cost contain no as opposed to a</p>	20
19	<p>1 value? You see there's a couple examples.</p> <p>2 A. I'm sorry. I don't know.</p> <p>3 Q. Do you know who would know?</p> <p>4 A. Kimberly Smithers.</p> <p>5 Q. If we can move to the no substitution</p> <p>6 indicator field.</p> <p>7 A. Um-hum.</p> <p>8 Q. What is that field?</p> <p>9 A. The no substitution indicator field is a</p> <p>10 field that the pharmacy provider will indicate on a</p> <p>11 claim when they are dispensing a brand medically</p> <p>12 necessary drug. So if they are dispensing Prozac,</p> <p>13 because there's a generic Fluoxetine, and they need</p> <p>14 to dispense a brand Prozac, they will use a no</p> <p>15 substitution indicator for that field.</p> <p>16 Q. Why would it say no?</p> <p>17 A. Because they can send a zero, meaning we</p> <p>18 want -- it's a MAC drug.</p> <p>19 Q. Okay. Then you see there's a number of</p> <p>20 cutback amount fields?</p> <p>21 A. Yes.</p> <p>22 Q. What do these fields represent,</p>	21

22	<p>1 generally?</p> <p>2 A. Generally, it just -- they mean that</p> <p>3 there would be instances where we would cut back</p> <p>4 their reimbursement for certain situations.</p> <p>5 Q. Taking the first one, which is the last</p> <p>6 column on page 1 of Exhibit 37, what does COB stand</p> <p>7 for?</p> <p>8 A. Coordination of benefits.</p> <p>9 Q. Does this reflect payments by</p> <p>10 third-payers or other payers?</p> <p>11 A. Other insurance or Medicare, yeah.</p> <p>12 Q. In what circumstances would Medicare be</p> <p>13 the other payer?</p> <p>14 A. There are drugs that are covered by</p> <p>15 Medicare, such as albuterol inhalers, that can be</p> <p>16 billed via NDC, and they then will cross over with</p> <p>17 an NDC with the Medicare paid amount on there. So</p> <p>18 the cutback for Medicare would be Medicare's</p> <p>19 payment.</p> <p>20 Q. So Medicaid's the second payer to</p> <p>21 Medicare in those circumstances?</p> <p>22 A. Medicaid is always the payer of last</p>	24	<p>1 the difference is in those fields.</p> <p>2 Q. Does the co-pay cutback amount reflect</p> <p>3 the amount that the end user pays in the co-pay?</p> <p>4 A. Yes.</p> <p>5 Q. And do you know if the recipient</p> <p>6 liability cutback amount reflects something other</p> <p>7 than the co-pay?</p> <p>8 A. Yes, it does. It reflects something</p> <p>9 other than the co-pay.</p> <p>10 Q. Do you know what it might reflect?</p> <p>11 A. I do not know.</p> <p>12 Q. Do you know what the manual medical</p> <p>13 cutback amount reflects? You see a couple of the</p> <p>14 claims have some values in them.</p> <p>15 A. I don't know.</p> <p>16 Q. Do you know who would know?</p> <p>17 A. Kimberly Smithers.</p> <p>18 Q. Back to the recipient liability cutback,</p> <p>19 do you know in what circumstances a recipient would</p> <p>20 be responsible for something other than a co-pay?</p> <p>21 A. No. They -- No, I don't. They wouldn't</p> <p>22 be.</p>
23	<p>1 resort.</p> <p>2 Q. What is the computer medical cutback</p> <p>3 amount?</p> <p>4 A. I do not know.</p> <p>5 Q. What about the computer pricing cutback</p> <p>6 amount?</p> <p>7 A. From my understanding, it's the</p> <p>8 difference between the billed amount and the</p> <p>9 allowed amount in many cases.</p> <p>10 Q. Does the manual medical cutback amount,</p> <p>11 the manual pricing cutback amount and the total</p> <p>12 deny cutback amount also reflect a difference</p> <p>13 between the billed amount and allowed amount?</p> <p>14 A. I don't know.</p> <p>15 Q. There's a field -- The next field's a</p> <p>16 co-pay cutback amount?</p> <p>17 A. Yep.</p> <p>18 Q. How does that differ from the recipient</p> <p>19 liability cutback amount, which is six rows down?</p> <p>20 Do you see it?</p> <p>21 A. Yeah. I'm just looking and seeing if I</p> <p>22 see anything interesting here. I don't know what</p>	25	<p>1 Q. So this 5.2 we see, you're not sure what</p> <p>2 that reflects?</p> <p>3 A. No, I'm not.</p> <p>4 Q. Would Ms. Smithers know?</p> <p>5 A. Yes.</p> <p>6 Q. Does the State maintain the pharmacy</p> <p>7 addresses anywhere?</p> <p>8 A. In the MMIS.</p> <p>9 Q. So there's another field that reflects</p> <p>10 that information?</p> <p>11 A. Not on the claims data, but yes, there</p> <p>12 is that field in the MMIS.</p> <p>13 Q. Okay. What about a code for facility</p> <p>14 type?</p> <p>15 A. That would be place of service. And</p> <p>16 yes, that is available.</p> <p>17 Q. It's referred to as place of service; is</p> <p>18 that correct?</p> <p>19 A. Um-hum. Yes.</p> <p>20 Q. What about the National Council for</p> <p>21 Prescription Drug Programs provider ID number,</p> <p>22 sometimes referred to as the NCPDP number?</p>

26	<p>1 A. We don't maintain that number. We</p> <p>2 maintain our proprietary Medicaid ID number, which</p> <p>3 is found in the pharmacy billing provider ID</p> <p>4 column.</p> <p>5 Q. And what does this number reflect?</p> <p>6 A. It is the Medicaid pharmacy provider ID</p> <p>7 number. It's our -- It's the number that when they</p> <p>8 register to become a certified pharmacy that we</p> <p>9 assign them.</p> <p>10 Q. Okay. That's all the questions I have</p> <p>11 for the MMIS data for now, so you can set that</p> <p>12 aside.</p> <p>13 A. Both exhibits, Jennifer?</p> <p>14 Q. Yeah. We're going to move on to HCPCS</p> <p>15 data. I'm going to hand you what's been marked as</p> <p>16 Exhibit 39.</p> <p>17 (Exhibit Gray 039 was marked for</p> <p>18 identification.)</p> <p>19 BY MS. WALKER:</p> <p>20 Q. Again, I ask that this exhibit be marked</p> <p>21 highly confidential. Again, Ms. Gray, this is a</p> <p>22 sample of the data that was produced by the State</p>	28	<p>1 tell you that once you do this, there are some</p> <p>2 things that we do once we receive the data at -- in</p> <p>3 the -- in the claims processing system, such as the</p> <p>4 cutbacks and things like that.</p> <p>5 So the information comes in on the claim</p> <p>6 from the provider, we populate everything they send</p> <p>7 in, and there may be cutbacks or other information</p> <p>8 that we do as we process the claim.</p> <p>9 Q. And by we, do you mean the State or EDS?</p> <p>10 A. EDS on behalf of the State.</p> <p>11 Q. Okay.</p> <p>12 A. So just to clarify because -- I'm sorry,</p> <p>13 because I was looking at the cover sheet here and</p> <p>14 thinking that's all there was.</p> <p>15 Q. That's no problem.</p> <p>16 A. So just to clarify that yes, we populate</p> <p>17 what comes in on the claim from the provider and</p> <p>18 then process it. And so the rest of that data is</p> <p>19 what happens when EDS processes the claim on behalf</p> <p>20 of the State.</p> <p>21 Q. Okay. Thank you for the clarification.</p> <p>22 And I assume EDS does that at the direction of --</p>
27	<p>1 to the defendants in this litigation. Is this data</p> <p>2 also contained within MMIS?</p> <p>3 A. Yes, it is.</p> <p>4 Q. So you would access it the same way that</p> <p>5 you would access the dataset that we just looked</p> <p>6 at?</p> <p>7 A. Yes, I would.</p> <p>8 Q. And again, the provider sends this</p> <p>9 information and the fields are populated based on</p> <p>10 their claim?</p> <p>11 A. Based on the information on the claim,</p> <p>12 yes.</p> <p>13 Q. I'm going to hand you a couple more</p> <p>14 exhibits so we can refer to all three of them. Can</p> <p>15 we have these marked 40A and 40B?</p> <p>16 A. Can I go back to that question you just</p> <p>17 asked me?</p> <p>18 Q. Yes.</p> <p>19 A. When we started, the data was like this</p> <p>20 and I was looking at the top page on the pharmacy</p> <p>21 claims data and thinking that it was only this</p> <p>22 piece of data. My answers don't change, but I will</p>	29	<p>1 of the State?</p> <p>2 A. Exactly.</p> <p>3 (Exhibit Gray 040A and Exhibit Gray 040B</p> <p>4 were marked for identification.)</p> <p>5 BY MS. WALKER:</p> <p>6 Q. Court reporter has handed you what's</p> <p>7 been marked as Gray Exhibit 40A and 40B?</p> <p>8 A. Yep.</p> <p>9 Q. Do you recognize 40A?</p> <p>10 MR. REMINGTON: Do you want to ask who</p> <p>11 came on the phone?</p> <p>12 MS. WALKER: Who just joined us?</p> <p>13 MR. REMINGTON: Or someone hung up.</p> <p>14 BY MS. WALKER:</p> <p>15 Q. I'm sorry. Do you recognize Exhibit</p> <p>16 40A?</p> <p>17 A. Yes.</p> <p>18 Q. And what is it?</p> <p>19 A. It is the data -- It is descriptions of</p> <p>20 the information contained within the HCPCS Refresh</p> <p>21 data.</p> <p>22 Q. Actually, I think it --</p>

30	<p>1 A. It's not the data dictionary, but it 2 reflects information contained -- Sorry. Go ahead. 3 Q. Just some -- Just to give you some 4 background, we sent Mr. Remington some questions 5 about the data, and these are some of the responses 6 that we received back from the data -- 7 A. Okay. 8 Q. -- about those questions. If we could 9 just look at question number 1, which states please 10 describe these data. In particular, what types of 11 claims are included in these data. And again, it's 12 referring to the HCPCS data. 13 The response indicates that the HCPCS 14 data contains claims information that details 15 utilization, expenditure, pricing and cutback 16 information for every HCPCS code as listed in 17 attachment WI-HCPCS May 2006, XLS. 18 If you look at 40B, this is what was 19 provided to us. Do you know if 40B reflects all 20 the HCPCS codes that are contained within the HCPCS 21 database? 22 A. No, it does not.</p>	32	<p>1 Q. And WW? 2 A. Yes. 3 Q. Okay. 4 A. The WW code based on -- was a -- Yeah, 5 they're HCPCS codes. 6 Q. Are claims for procedure codes for drug 7 administration and other medical services reflected 8 in the HCPCS database? 9 A. Yes. 10 Q. If we could look at an example, if we 11 could look at the first -- on Exhibit 39, the first 12 five? 13 A. The first five rows? 14 Q. Yes. It appears that they are all the 15 same claim; is that correct? 16 A. They all have the same claim ICN, but 17 they're all different line numbers on that claim. 18 They're all different details. 19 Q. And what do the line numbers represent? 20 A. Details. 21 Q. Such as? 22 A. There could be up to nine claims, nine</p>
31	<p>1 Q. It does not? 2 A. Ugh-ugh. 3 Q. Do you know what criteria were used to 4 select these? 5 A. No, I don't. 6 Q. Do you know who would? 7 A. I don't know. I don't know who would. 8 Q. If you take a look at Exhibit 40B, it 9 appears that there are HCPCS codes at least that 10 I've never recognized before. Like, for example, 11 if you turn to page 8 -- 12 A. Um-hum. 13 Q. -- there's a K and there's a field 14 called none and there's a P. 15 A. Yes. 16 Q. Do you know what these codes reflect? 17 A. I can't tell you what the description 18 is, but they are HCPCS codes. The none, I don't 19 know where that falls, but the P codes and the K 20 codes are HCPCS codes. 21 Q. And same with S? 22 A. Yes.</p>	33	<p>1 details on a claim. 2 Q. So, for example, one could represent the 3 drug administration, one could represent the drug, 4 one could represent the office visit? 5 A. Yes. Exactly. 6 Q. Here if we look at the first five rows 7 there's line numbers 3 through 7? 8 A. Um-hum. 9 Q. Do you know why the line numbers 1 and 2 10 are missing? 11 MR. REMINGTON: Object to the form of the 12 question. 13 THE WITNESS: No. No, I don't. I wasn't 14 involved in gathering the data. No, I don't. 15 BY MS. WALKER: 16 Q. Is it possible that they could reflect 17 some of the examples that we talked about, such as 18 an office visit or the drug administration? 19 A. Yes, that could be true. 20 Q. Would it ever be the case where line 21 number 1 and 2 would not be filled out and only 3 22 through 7 --</p>

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1 A. Not that I'm aware of, no.

2 Q. Okay.

3 A. But you also say -- But the data here is

4 only this set of HCPCS codes, and the set of HCPCS

5 code is wide. So it could also be that 1 and 2

6 contain codes that were not contained or requested

7 on this list.

8 Q. Okay. And if you look in the procedure

9 NDC code column it appears to have HCPCS codes?

10 A. Physician-administered drug codes, yes.

11 Q. Does it also -- Does the HCPCS database

12 also have the NDC's?

13 A. No, it does not.

14 Q. So if it's a multi-source that shares

15 the same HCPCS code, how do you determine which AWP

16 -- which NDC's AWP to use for reimbursement

17 purposes?

18 A. I don't understand that question.

19 Q. Okay. Let me try it again. Let's say

20 -- Let's use a brand name drug for an example, and

21 let's say two therapeutically equivalent brands

22 share the same J code.

35

1 A. Okay.

2 Q. Which -- And the brands are reimbursed

3 -- prior to going to ASP they're reimbursed based

4 on AWP minus whatever the percentage is. How does

5 EDS or the State know which brands -- which AWP

6 associated with which brand drug to use for

7 reimbursement purposes without the NDC?

8 MR. REMINGTON: I'm going to object to

9 the form of the question.

10 THE WITNESS: I can't currently think of

11 a situation based on the description of this -- of

12 one of these codes where that might be at issue. I

13 mean, based on the description and the strength you

14 would use the description and the strength to

15 determine which NDC pricing to use.

16 BY MS. WALKER:

17 Q. So the physician provides the strength?

18 A. The strength is included in the

19 description of the HCPCS provided by the AMA.

20 Q. Let me -- Let me use an example coming

21 from my client. My client's Amgen and they have a

22 drug called Epogen.

36

1 A. Yes.

2 Q. And Johnson & Johnson has a drug called

3 Procrit, and they share the same J code. Trust me.

4 A. Okay.

5 Q. Assume that that's correct for the time

6 being.

7 A. Okay.

8 Q. How would the State know whether to

9 reimburse for that J code based on the AWP

10 associated with Procrit versus the AWP associated

11 with Epogen?

12 A. The way I did it, I can only speak to

13 the way I applied the pricing, the manual pricing

14 to those codes, was that I would, you know, look at

15 both of them and get as close to the, you know,

16 strength and quantity and -- strength based on the

17 description as I could and choose the appropriate

18 price.

19 It varied. I mean, these are claims

20 going back to '93, so -- at that time there was no

21 easy way to do it. So you would look at both and

22 make a determination.

37

1 Q. Do the physicians on their claim forms,

2 do they provide the NDC, or just the --

3 A. Not today. Just the HCPCS.

4 Q. Did they ever provide --

5 A. Not yet.

6 Q. Related to those questions, how does the

7 State determine utilization for rebates?

8 A. The State created a one-to-one J code to

9 NDC match. So Remicade, for example, has a single

10 J code and a single NDC. We will rebate for those.

11 If they have, in your example, Procrit and Epogen,

12 those are not on the table because there is no

13 one-to-one correspondence. The table we set up is

14 one-to-one. One J code, one NDC.

15 Q. So what you would you do for the example

16 of Epogen?

17 A. It wouldn't be on our table and we've

18 contracted with HWT, a vendor, to pursue that. They

19 go and send letters to providers who have billed

20 those codes based on claims data and ask them to

21 provide the NDC of the drug they dispensed.

22 Q. And I'm sorry, what was the vendor's

38	<p>1 name?</p> <p>2 A. HWT, Incorporated.</p> <p>3 Q. And how long have they been doing that</p> <p>4 for the State?</p> <p>5 A. I'm sorry. I don't know. I don't know</p> <p>6 off the top of my head.</p> <p>7 Q. At least since you've been at the State?</p> <p>8 A. Oh, yes, because I was involved in</p> <p>9 setting it up, so yes. It was after 2002.</p> <p>10 Q. Do you know what the State did prior to</p> <p>11 2000?</p> <p>12 A. We didn't do anything. We only used the</p> <p>13 one-to-one table. If there was one NDC and one J</p> <p>14 code, that's what we went after.</p> <p>15 Q. Okay. Prior to going to the ASP-based</p> <p>16 reimbursement for physician-administered drugs it's</p> <p>17 my understanding that they were reimbursed similar</p> <p>18 to how pharmacy-dispensed drugs are reimbursed</p> <p>19 based on the AWP minus whatever the percentage that</p> <p>20 was in effect at the time?</p> <p>21 A. Um-hum.</p> <p>22 Q. The lower of the AWP or the usual and</p>	40	<p>1 A. Correct.</p> <p>2 Q. And how -- which types of drugs are</p> <p>3 manually done -- changed that way?</p> <p>4 A. Honestly, before I came on I don't know</p> <p>5 how that was determined. Many of the</p> <p>6 physician-administered drugs were done that way</p> <p>7 because they just didn't know how to price them.</p> <p>8 They didn't understand the strength and -- and</p> <p>9 description could help you determine a price, and</p> <p>10 so -- that's my understanding.</p> <p>11 Q. And who did this process?</p> <p>12 A. The pharmacy consultants or the medical</p> <p>13 consultants. So a pharmacist or a doctor that is</p> <p>14 working at EDS.</p> <p>15 Q. Someone like Ted Collins?</p> <p>16 A. No.</p> <p>17 Q. No?</p> <p>18 A. No.</p> <p>19 Q. He just does pharmacy?</p> <p>20 A. He just does the MAC, yes.</p> <p>21 Q. Do you know the names of any of the</p> <p>22 pharmacy consultants or doctors working at EDS who</p>
39	<p>1 customary.</p> <p>2 A. Um-hum.</p> <p>3 Q. Similar to the question I asked about</p> <p>4 the MMIS data, is there a field here that reflects</p> <p>5 whether these drugs were reimbursed based on the</p> <p>6 AWP minus or the usual and customary?</p> <p>7 A. No, there's not.</p> <p>8 Q. And how would one determine that?</p> <p>9 A. The HCPCS reimbursement is different</p> <p>10 than NDC reimbursement. There is a price on file</p> <p>11 that is put there, like you explained, either the</p> <p>12 usual and customary or the MAC, or there's a manual</p> <p>13 pricing segment. And then if it's that manual</p> <p>14 pricing segment, it's priced by the pharmacy</p> <p>15 consultant using different resources. So it's a</p> <p>16 different sort of reimbursement than NDC's. It's</p> <p>17 just done a different way. There's a fee schedule</p> <p>18 posted to our Web site where all of the MAC's fees</p> <p>19 are for these types of codes.</p> <p>20 Q. When you say manual, does that mean</p> <p>21 someone goes in and manually decides for this drug</p> <p>22 it will be reimbursed at whatever rate?</p>	41	<p>1 might have done this?</p> <p>2 A. The only one I knew that was present at</p> <p>3 -- Alice Fung.</p> <p>4 Q. Do you know how to spell her last name?</p> <p>5 A. F-U-N-G.</p> <p>6 Q. So is it possible that for some</p> <p>7 physician-administered drugs the pricing is</p> <p>8 completely unrelated to the AWP?</p> <p>9 MR. REMINGTON: Object to the form of the</p> <p>10 question.</p> <p>11 THE WITNESS: Not generally, no. They</p> <p>12 would use resources that contain that information</p> <p>13 to help them determine the price.</p> <p>14 BY MS. WALKER:</p> <p>15 Q. And again, there's nothing in the HCPCS</p> <p>16 database or the MMIS database that shows whether or</p> <p>17 not it was done by a manual pricing versus the</p> <p>18 usual and customary AWP?</p> <p>19 A. No. That would be shown on the pricing</p> <p>20 screens.</p> <p>21 Q. Are you familiar with dual eligible</p> <p>22 claims?</p>

42

1 A. Crossovers?

2 Q. Claims that are covered both by Medicaid

3 and Medicare.

4 A. Yes.

5 Q. Okay. You refer to them as crossover

6 claims?

7 A. Yes.

8 Q. Okay. Does -- On page 2 of this -- of

9 Exhibit 39 --

10 A. Yep.

11 Q. -- do you see a field called Medicare

12 cutback amount?

13 A. Yes, I do.

14 Q. Does a positive number in this field

15 indicate a crossover claim?

16 A. The crossover claims are indicated by

17 the claim type found in the claim ICN field.

18 Q. And how --

19 A. 30's are crossover. So any claim, ICN

20 that starts with a 30, is a crossover.

21 Q. Okay.

22 A. There are others, but based on what you

43

1 have here 30 is what would be considered -- 24. So

2 based on what you've got here 30's and 24's are

3 crossovers. There may be others, but those are the

4 ones I'm familiar with.

5 Q. Is there some type of document that

6 identifies what all the crossover -- what numbers

7 would be -- Let me start over. Is there a document

8 that reflects what numbers would represent the

9 crossover claims?

10 A. Yep.

11 Q. And what is that document?

12 A. I don't know the title of it, but -- I

13 don't know what it's called, but it -- it's --

14 claim type would be my -- it's referenced as claim

15 type.

16 Q. And do you have a copy of that?

17 A. I could get it. It's on -- I can get

18 one, yes.

19 Q. What does the Medicare cutback amount

20 represent then?

21 A. Medicare cutback amount would represent

22 -- I just need to refresh my memory quick here. My

44

1 understanding is it's the amount that Medicare paid

2 that Medicaid is not responsible for.

3 Q. So would it reflect the 80 percent?

4 A. Generally, yeah. Yes. Yes.

5 MR. REMINGTON: You were looking for a --

6 BY MS. WALKER:

7 Q. I have a document that might help you.

8 Let's go ahead and --

9 A. Says see explanation below.

10 Q. Let's have this marked as --

11 A. Medicare Part B. There it is. Okay.

12 Thank you.

13 Q. Let's have this marked as Exhibit 41.

14 (Exhibit Gray 041 was marked for

15 identification.)

16 BY MS. WALKER:

17 Q. Ms. Gray, do you recognize this

18 document?

19 A. Do I recognize it? No, I don't.

20 Q. It is my understanding that this was

21 produced to us --

22 MR. REMINGTON: May I see a copy?

45

1 MS. WALKER: Oh, I'm sorry, Frank.

2 Q. -- as the data dictionary or

3 documentation for the HCPCS data. Perhaps it could

4 help you.

5 A. Thanks. Yes. Comparing the Medicare

6 paid amount to the calculated Medicaid allowed

7 amount. So we would cut back that amount to arrive

8 at what we would allow. So this would be what I

9 explained. We cut back that amount to arrive at

10 what our allowed amount will be for payment on the

11 claim.

12 Q. And this would be for dual eligible

13 claims?

14 A. Yes.

15 Q. Okay. Does Wisconsin Medicaid simply

16 pay the 20 percent of the allowed amount for

17 Medicare, or do they calculate their own allowed

18 amount independently?

19 A. We calculate our own allowed amount

20 independently.

21 Q. If -- So if the amount differs from what

22 Medicare thinks the allowed amount is versus what

46	<p>1 Wisconsin Medicaid thinks the allowed amount is,</p> <p>2 the allowed amount field here will reflect</p> <p>3 Wisconsin Medicaid's calculation? Start over?</p> <p>4 A. Yes, please. Yes, please.</p> <p>5 Q. If the amount that Medicaid determines</p> <p>6 is the allowed amount for dual eligible differs</p> <p>7 from the amount that Medicare determines, which one</p> <p>8 trumps?</p> <p>9 A. Medicaid. It's a calculated allowed</p> <p>10 amount.</p> <p>11 Q. On Exhibit 39 there are three fields</p> <p>12 that are described as level 1 pricing, level 2</p> <p>13 pricing and level 3 pricing. And if you look at</p> <p>14 Exhibit 41, it appears that these fields relate to</p> <p>15 Medicare. Level 1 pricing is Medicare co-insurance</p> <p>16 amount, level 2 is the Medicare allowed amount, and</p> <p>17 level 3 is the Medicare paid amount on a claim</p> <p>18 detail record.</p> <p>19 A. Yep.</p> <p>20 Q. Is that your understanding --</p> <p>21 A. Yes, it is.</p> <p>22 Q. -- of those fields?</p>	48	<p>1 procedure code reimbursement. So there's a</p> <p>2 different type of service as it relates to the</p> <p>3 procedure code, and so what -- that could impact</p> <p>4 reimbursement in these levels.</p> <p>5 BY MS. WALKER:</p> <p>6 Q. Okay. So do both definitions apply to</p> <p>7 -- to a given claim?</p> <p>8 MR. REMINGTON: Object to foundation.</p> <p>9 THE WITNESS: Honestly, I don't know.</p> <p>10 BY MS. WALKER:</p> <p>11 Q. If you know.</p> <p>12 A. Don't know.</p> <p>13 Q. Well, if we could look at Exhibit --</p> <p>14 A. Which exhibit? Sorry.</p> <p>15 Q. Back to this one.</p> <p>16 A. Okay.</p> <p>17 Q. If we could just look at some of these</p> <p>18 answers and if you know, if you could kind of</p> <p>19 explain to me what some of this means. What does</p> <p>20 type of service refer to?</p> <p>21 A. Different provider types, such as family</p> <p>22 planning, have a different type of service on a</p>
47	<p>1 A. Yep.</p> <p>2 Q. And then if you look back at Exhibit</p> <p>3 40B.</p> <p>4 A. B?</p> <p>5 Q. I'm sorry, A. This one.</p> <p>6 A. Okay.</p> <p>7 Q. And you look at the last page, question</p> <p>8 number 8 asks please define the following fields</p> <p>9 and explain the high number of entries with values</p> <p>10 of zeros. And here again it's referring to those</p> <p>11 same fields; the level 1 pricing, the level 2</p> <p>12 pricing and the level 3 pricing, but here it</p> <p>13 appears to be providing a different definition. Is</p> <p>14 it possible that both definitions apply in</p> <p>15 different circumstances?</p> <p>16 A. Just give me a second. I need to read</p> <p>17 these.</p> <p>18 Q. Take your time.</p> <p>19 A. Okay.</p> <p>20 MR. REMINGTON: Object to foundation.</p> <p>21 THE WITNESS: Based on Exhibit 40A, it's</p> <p>22 referring to the combination of type of service and</p>	49	<p>1 specific procedure code that they cover so that we</p> <p>2 know it's allowed for family planning clinics to</p> <p>3 bill and receive a different reimbursement rate,</p> <p>4 for example.</p> <p>5 So there may be a type of service 1, and</p> <p>6 that's for all physician-administered drug claims</p> <p>7 administered by physicians. There may be a type of</p> <p>8 service V, and that represents -- This is examples.</p> <p>9 Don't -- That's all I'm trying to do here.</p> <p>10 Q. That's fine.</p> <p>11 A. So type of service V may be for family</p> <p>12 planning clinics, and there may be a different rate</p> <p>13 of reimbursement on the pricing screen for that</p> <p>14 procedure code with that type of service for that</p> <p>15 particular provider type.</p> <p>16 Q. So it's not -- The difference is --</p> <p>17 comes in the different type -- physicians versus</p> <p>18 clinics?</p> <p>19 A. For example, yes. If you -- Yes,</p> <p>20 different types of service. So different providers</p> <p>21 using different types of service. It allows us to</p> <p>22 establish rates.</p>

50

1 Q. And how are these rates determined?

2 A. Based on our previous conversation, most

3 of them are the AWP minus 13 prior to the ASP or

4 MAC or the manual pricing. Sometimes based on the

5 family planning waiver that we have we have to set

6 rates differently, or if we have a vaccine that is

7 through the Vaccines for Children Program up to

8 somebody that's 18 years old, but then we also need

9 to cover it from 18 over. Then we need a different

10 type of service so we can establish a different

11 rate for those people. Those are examples.

12 Q. Okay. And then the procedure code, what

13 does that refer to?

14 A. The HCPCS code.

15 Q. Okay. Looking at the response to sub

16 part B, it says level 2 prices are provider

17 locality and pricing specialty specific rates for a

18 type of service and procedure code combination.

19 What does locality refer to, if you know?

20 A. I don't know in this situation.

21 Q. Do you know what pricing specialty

22 refers to?

51

1 A. Not in this situation, no.

2 Q. Are the -- When the prices are

3 determined for the type of service procedure code

4 combination, are they negotiated on an individual

5 basis or clinic basis or --

6 A. No. There's no negotiation that goes

7 into it. The -- The -- No. There's no negotiation

8 that happens for that.

9 Q. So Wisconsin Medicaid just says this is

10 the reimbursement for this type of service?

11 A. Correct.

12 Q. And if you sign up, this is what you'll

13 get.

14 A. Based on your terms of reimbursement,

15 yes.

16 Q. Is there something that -- a document or

17 database or something that indicates what those

18 different rates are for the different combinations

19 of --

20 A. The fee schedule that I referenced

21 earlier.

22 Q. Does the State maintain data on the

52

1 provider address?

2 A. Yes.

3 Q. And that's also in the MMIS database?

4 A. Yes.

5 Q. What about place of service?

6 A. Yes. That's available, also. Yes, it's

7 available.

8 Q. Okay. We can set aside those for --

9 A. Can we break then if we're going to move

10 on to something else?

11 Q. Yeah, absolutely.

12 A. Okay. Thanks.

13 (Recess taken.)

14 (Exhibit Gray 042 was marked for

15 identification.)

16 BY MS. WALKER:

17 Q. I've handed you what's been marked as

18 Exhibit 42, and ask that this be designated highly

19 confidential on the transcript.

20 This reflects three samples of three

21 different data that we received from the State. One

22 was referred to as T19, one was referred to as SC1,

53

1 and the last one is referred to SC2.

2 A. Okay.

3 Q. Does SC stand for SeniorCare?

4 A. Yes, it does.

5 Q. Do you know if the T19 data also

6 contains the SeniorCare 1 and SeniorCare 2 data?

7 A. No, it does not.

8 Q. So they're three distinct different

9 databases each with different information?

10 MR. REMINGTON: Object to the form of the

11 question.

12 THE WITNESS: Can you clarify databases?

13 I'm not sure what you want me --

14 BY MS. WALKER:

15 Q. The -- What does the T19 rebate database

16 represent -- reflect? What type of information?

17 A. This is the Medicaid invoice.

18 Q. And what does the SeniorCare 1 database

19 reflect?

20 A. It's the SeniorCare levels 1 and 2A

21 rebates, invoices.

22 Q. And what are levels 1 and 2A?

54	<p>1 A. It refers to the Federal poverty level.</p> <p>2 Level 1 is under 160 percent, and level 2 is 160 to</p> <p>3 200 percent Federal poverty level.</p> <p>4 Q. And what does the SeniorCare 2 rebate</p> <p>5 database reflect?</p> <p>6 A. That would be the nonwaiver portion of</p> <p>7 SeniorCare and it would represent people in level</p> <p>8 2B and 3. And I know what your question is, so</p> <p>9 level 2B is people between 200 and 240 percent of</p> <p>10 the Federal poverty level, and level 3 is people</p> <p>11 over 200 percent, 240 percent of the Federal</p> <p>12 poverty level.</p> <p>13 Q. Does the T19 also include BadgerCare?</p> <p>14 A. If they're in fee for service. If</p> <p>15 they're in an HMO, no.</p> <p>16 Q. What happens if they're in a HMO?</p> <p>17 A. Everything is paid for through the HMO.</p> <p>18 Q. What type of rebates are represented</p> <p>19 here? Is it just the rebates that manufacturers</p> <p>20 agree to pay in order to participate in Medicaid?</p> <p>21 MR. REMINGTON: Object to the form of the</p> <p>22 question.</p>	56	<p>1 A. If you're going back to '93, then we</p> <p>2 didn't have supplemental rebates. If you're in</p> <p>3 after 2004, we did. I can't answer that question</p> <p>4 without timeframe.</p> <p>5 Q. Okay. 2004 to the present, where would</p> <p>6 the supplemental rebate invoice information be</p> <p>7 reflected? In a separate database?</p> <p>8 A. Yes.</p> <p>9 Q. And is that -- is there a name for that</p> <p>10 database?</p> <p>11 A. I'm sure there is. I just know where to</p> <p>12 go find it. I don't know what the specific name of</p> <p>13 the database is.</p> <p>14 Q. What's reflected -- Generally, what's</p> <p>15 reflected in that database?</p> <p>16 A. What the supplement -- The agreed upon</p> <p>17 supplemental rebate agreement between the State and</p> <p>18 the manufacturer through Provider Synergies</p> <p>19 negotiations.</p> <p>20 Q. Does it reflect the amount billed to the</p> <p>21 manufacturer, the invoice amount?</p> <p>22 A. Which invoice amount?</p>
55	<p>1 THE WITNESS: I'm going to -- Do we have</p> <p>2 a timeframe, do we know? I mean --</p> <p>3 BY MS. WALKER:</p> <p>4 Q. Well, we asked for data back to 1993. I</p> <p>5 don't specifically recall what the timeframe is for</p> <p>6 this data, but let's assume just for purposes of my</p> <p>7 question that it goes back to 1993.</p> <p>8 A. Okay. This would be what the -- the CMS</p> <p>9 Federal rebate agreement would represent, what they</p> <p>10 would pay. The rebate amount agreement would</p> <p>11 reflect what -- the CMS rebate agreement.</p> <p>12 Q. So what manufacturers would pay under</p> <p>13 the CMS rebate agreement?</p> <p>14 A. Correct.</p> <p>15 Q. Does it reflect supplemental rebates?</p> <p>16 A. No. Those are invoiced separately.</p> <p>17 Q. By Provider Synergies?</p> <p>18 A. They provide the data. We do the</p> <p>19 invoicing, yes.</p> <p>20 Q. Okay. And where would that -- is there</p> <p>21 a separate database where that information is</p> <p>22 reflected?</p>	57	<p>1 Q. For the supplemental rebate.</p> <p>2 A. Yes. Yes.</p> <p>3 Q. Other than the CMS rebates, does this</p> <p>4 reflect any other rebate?</p> <p>5 A. No, it does not.</p> <p>6 Q. Okay. We can set these aside.</p> <p>7 (Exhibit Gray 043 and Exhibit Gray 044</p> <p>8 were marked for identification.)</p> <p>9 THE WITNESS: Thank you.</p> <p>10 BY MS. WALKER:</p> <p>11 Q. Court reporter has handed you what's</p> <p>12 been marked as Gray Exhibit 43?</p> <p>13 A. Um-hum.</p> <p>14 Q. Do you recognize this document?</p> <p>15 A. I recognize the data in the document.</p> <p>16 Q. And what is it?</p> <p>17 A. It is the pricing information found on</p> <p>18 our reference file.</p> <p>19 Q. And is this the information that you</p> <p>20 referred to earlier when we were talking about the</p> <p>21 MMIS data?</p> <p>22 A. Yes. This is stored in the MMIS.</p>

58	<p>1 Q. Court reporter's also handed you what's 2 been marked as Gray Exhibit 44? 3 A. Yep. 4 Q. Do you recognize this document? 5 A. Yes. 6 Q. And what is it? 7 A. It describes the fields that are 8 contained in Exhibit 43. 9 Q. How are these pricing files used in the 10 normal course of business? 11 A. These would be when the -- We reference 12 these when a claim is processed. It will look at 13 what, you know, our allowed amount would be based 14 on the pricing here. It's used every day just to 15 go out and look up information to respond to 16 provider or manufacturer questions. It is used -- 17 It is updated weekly by First DataBank through a 18 process. 19 Q. Does First DataBank update all of the 20 fields or just some of these fields? 21 A. Some of them. The pricing fields -- The 22 First DataBank information comes in and then there</p>	60	<p>1 two separate fields so we could delineate between 2 the two. Now they're both the same. 3 Q. Which one was the unit dose? 4 A. 694. 5 Q. So the refill would reflect the unit 6 dose? 7 A. When it was effective, yeah. 8 Q. If we could look at this in connection 9 with the -- Exhibit 37, which is the sample from 10 the MMIS -- 11 A. Yep. 12 Q. -- database, I believe you testified 13 earlier that the pricing file is used to fill in 14 the drug cost -- 15 A. Yes. 16 Q. -- column? 17 A. Um-hum. 18 Q. If we could take an example, and this is 19 where you might need the ruler, row 19, which is a 20 claim number that ends in 5760. It's got a claim 21 pay-date of July 25th, 1999. Maybe that's easier 22 to find. It's about a third of the way down, half</p>
59	<p>1 is a Blue Book, which we call First DataBank, 2 that's our internal jargon, Blue Book terminology. 3 There's a process that Blue Book uses to update the 4 appropriate fields from First DataBank and go out 5 and read tables to complete the updating of these 6 pricing fields. 7 Q. Can you identify on Exhibit 43 which 8 fields First DataBank updates? 9 A. FFPUL/AWP, NDC, description, package, 10 effective date, no sub in some instances. 11 Q. Where does MAC come from? 12 A. That's our MAC table. 13 Q. The one that Ted Collins works on? 14 A. Yes. 15 Q. And what does prof refer to? 16 A. Professional fee. It's the dispensing 17 fee. 18 Q. What about refill? 19 A. It's the dispensing fee. They're both 20 the same. At one point in time, as you can see, 21 there are two different values in that field. We 22 reimbursed a unit dose dispensing fee, so we had</p>	61	<p>1 the way down. 2 A. Sorry guys. Oh, here. I was too far 3 down. Got it. 4 Q. This example has an NDC code of 5 00070077700. 6 A. Yes, it does. 7 Q. And if you look back at the pricing 8 file, the first NDC we see is the same NDC. 9 A. Okay. 10 Q. Is that right? 11 A. Yes, it is. 12 Q. This claim had an begin service date in 13 June of -- 8, 1999; is that correct? 14 A. Yes. 15 Q. So if you could walk me through it, 16 which price would be applied for this claim to the 17 drug cost field? 18 A. The pricing file stores the original -- 19 stores 10 rows. The row for 99 is here. Somebody 20 have a pen I can borrow? Thank you. 21 MR. REMINGTON: I'm sorry to interrupt. 22 Do you know what the dates are on Exhibit 43 as to</p>

62	<p>1 what the pricing file represents?</p> <p>2 MS. WALKER: The answer to your question</p> <p>3 is no. This is just a sample, a snapshot from some</p> <p>4 of the data.</p> <p>5 MR. REMINGTON: I guess then I object to</p> <p>6 the -- I guess I object to the form of the question</p> <p>7 to the extent that it's represented that this is</p> <p>8 the -- that Exhibit 43 is the correct pricing file</p> <p>9 for the claim that we've identified on Exhibit 37.</p> <p>10 MS. WALKER: Well, there are -- there are</p> <p>11 some effective dates in the right-hand column that</p> <p>12 relate to pricing for the NDC.</p> <p>13 MR. REMINGTON: Okay.</p> <p>14 THE WITNESS: Okay. Can you please ask</p> <p>15 me your question again?</p> <p>16 BY MS. WALKER:</p> <p>17 Q. Sure. For that NDC that had a service</p> <p>18 date of June 8th, 1999, what field would be applied</p> <p>19 to the drug cost? It looks like 17 was applied.</p> <p>20 A. Yeah, the MAC.</p> <p>21 Q. And we look at the effective date of --</p> <p>22 A. We're looking at the line that has an</p>	64	<p>1 A. The federal upper limit for generic is</p> <p>2 contained in that field.</p> <p>3 Q. So the definition is -- is it wrong?</p> <p>4 A. It's incomplete. It's not wrong. It's</p> <p>5 just incomplete.</p> <p>6 Q. Okay. So it applies to both brands and</p> <p>7 generics, that field, FFPUL.</p> <p>8 A. If there's an FFPUL that is present on</p> <p>9 the First DataBank tape for a generic drug, that</p> <p>10 field is populated. If there is no FFPUL on a</p> <p>11 generic drug, then that field is full of zeros. If</p> <p>12 it's a brand name drug, then this definition is</p> <p>13 correct.</p> <p>14 Q. Okay. Thank you. The PAC field, what</p> <p>15 do these codes represent?</p> <p>16 A. Pricing action codes represent a reason</p> <p>17 a drug is reimbursable or not reimbursable. So a</p> <p>18 775, which is what you see in that line we just</p> <p>19 looked at with the 9/1/98 effective date, tells you</p> <p>20 that this drug is reimbursable for that -- for</p> <p>21 those dates of service.</p> <p>22 Q. Is there something that explains what</p>
63	<p>1 effective date of 9/1/98.</p> <p>2 Q. Okay. And it was MAC'd because</p> <p>3 presumably it's a generic?</p> <p>4 A. Correct.</p> <p>5 Q. Okay. Do the FFPUL/AWP, no sub and MAC</p> <p>6 fields have any relationship to the cutback fields</p> <p>7 in the MMIS database?</p> <p>8 A. Not that I'm aware of.</p> <p>9 Q. What does FFPUL stand for?</p> <p>10 A. Federal financial participation upper</p> <p>11 limit.</p> <p>12 Q. Okay. If we look at Exhibit 44 on page</p> <p>13 2 --</p> <p>14 A. Um-hum.</p> <p>15 Q. -- you see the paragraph beginning with</p> <p>16 FFPUL/AWP, average wholesale price, it says that</p> <p>17 it's a six bite numeric field that determines the</p> <p>18 rate the brand name NDC would pay?</p> <p>19 A. Correct.</p> <p>20 Q. Since this indicates that it relates to</p> <p>21 brand, would -- would the federal upper limit ever</p> <p>22 be contained in this field?</p>	65	<p>1 each of the codes mean?</p> <p>2 A. Yeah, there is. Yes, there is.</p> <p>3 Q. Is it called a quick reference?</p> <p>4 A. Yes, it is.</p> <p>5 Q. And do you have a copy of the quick</p> <p>6 reference?</p> <p>7 A. Yes, I do.</p> <p>8 Q. Is the PAC used to determine the</p> <p>9 dispensing fee for a claim? Is it related to that</p> <p>10 at all?</p> <p>11 A. In certain situations there are pricing</p> <p>12 action codes that would allow a dispensing fee and</p> <p>13 not allow one. We don't -- We don't use those on</p> <p>14 our pricing file. Those are just -- We have them</p> <p>15 available to us, but they're not anything that we</p> <p>16 use on the pricing file.</p> <p>17 Q. Okay. You might have said this before,</p> <p>18 but just so I'm clear on it, is the pricing file</p> <p>19 used also to determine payment for</p> <p>20 physician-administered drugs?</p> <p>21 A. Yes, but there's a -- this -- this is</p> <p>22 the NDC's. There is a different file similar to</p>

66	<p>1 this for the HCPCS codes.</p> <p>2 Q. And is that different than the fee</p> <p>3 schedule?</p> <p>4 A. Actually, the fee schedule is a current</p> <p>5 snapshot of what's on there. What you're</p> <p>6 referencing in the MMIS would have the history like</p> <p>7 this does.</p> <p>8 Q. Now, on -- if you look back at Exhibit</p> <p>9 44 --</p> <p>10 A. Um-hum.</p> <p>11 Q. -- under field description, the first</p> <p>12 one, CT claim type, the last sentence says valid</p> <p>13 values and the descriptions can be found in the</p> <p>14 quick reference?</p> <p>15 A. Yes.</p> <p>16 Q. Do you see that?</p> <p>17 A. Yes.</p> <p>18 Q. Is -- Is that the same quick reference</p> <p>19 as we saw under the PAC?</p> <p>20 A. Yes, it is.</p> <p>21 Q. Same document?</p> <p>22 A. Same document.</p>	68	<p>1 MS. WALKER: Thanks.</p> <p>2 MR. REMINGTON: Okay.</p> <p>3 BY MS. WALKER:</p> <p>4 Q. What is the no sub field?</p> <p>5 A. If the -- If the drug is the innovator</p> <p>6 drug, brand innovator drug, the no sub field would</p> <p>7 contain the AWP minus 13 percent price because</p> <p>8 there is a generic and it's MAC'd. So no sub</p> <p>9 contains the AWP minus 13 price. If the provider</p> <p>10 gets a prior authorization, has a prescription that</p> <p>11 says brand medically necessary on it and submits</p> <p>12 the claim with the no sub -- no substitution</p> <p>13 indicator on it, which is on your Exhibit 37, then</p> <p>14 we will pay at that no substitution price for that</p> <p>15 brand name drug.</p> <p>16 Q. At the brand drug innovator price?</p> <p>17 A. If -- If it's the brand innovator and</p> <p>18 they submit the PA and the no substitution</p> <p>19 indicator, they will get the AWP minus 13 price.</p> <p>20 Q. Okay. The FFPUL/AWP field, if we look</p> <p>21 at this first NDC example that we have here, I</p> <p>22 believe you testified that if there is an FFPUL</p>
67	<p>1 Q. Okay.</p> <p>2 A. And many of the other place of service</p> <p>3 and all of those will also -- are also in the quick</p> <p>4 reference.</p> <p>5 MS. WALKER: Frank, I think that might be</p> <p>6 all the questions I have, if I could just take five</p> <p>7 minutes to look at my notes.</p> <p>8 MR. REMINGTON: Sure. Yeah.</p> <p>9 (Recess taken.)</p> <p>10 BY MS. WALKER:</p> <p>11 Q. Okay. I just had a couple more</p> <p>12 questions and then I'm going to hand it over to</p> <p>13 Cliff Katz, who has a couple questions, too.</p> <p>14 A. Oh, okay.</p> <p>15 Q. And I also forgot to mention that the</p> <p>16 pricing file dictionary, Exhibit 44, if we can mark</p> <p>17 that one as highly confidential also. My question</p> <p>18 --</p> <p>19 MR. REMINGTON: Well, excuse me. Now,</p> <p>20 isn't this pricing --</p> <p>21 MS. WALKER: I'm sorry. Exhibit 43.</p> <p>22 MR. REMINGTON: Oh, all right.</p>	69	<p>1 field it will be the FFPUL. If there isn't, it</p> <p>2 will just be a zero?</p> <p>3 A. If it's a generic drug, yes.</p> <p>4 Q. Here for this NDC we have some zeros and</p> <p>5 some values.</p> <p>6 A. Which field are we looking at? Still</p> <p>7 the FFPUL field?</p> <p>8 Q. Yes.</p> <p>9 A. Okay.</p> <p>10 Q. Do you know why that would be? In some</p> <p>11 cases there would be zeros and some cases we'd have</p> <p>12 a --</p> <p>13 A. This is no longer a valid NDC according</p> <p>14 to CMS. The manufacturer terminated this NDC on</p> <p>15 August 31st, 2002. So what happens when they do</p> <p>16 that is our system automatically puts zeros in all</p> <p>17 the pricing fields, zero in the indicator field so</p> <p>18 that claims cannot process against it. That's what</p> <p>19 that 710 indicates.</p> <p>20 Q. What about on 7/1/97? There appears to</p> <p>21 be a zero in the FFPUL/AWP field.</p> <p>22 A. They may not have established one</p>

EXHIBIT B

HCPCS Refresh

1. Please describe these data. In particular, what types of claims are included in these data?

Response:

The HCPCS data contains claims information that details utilization, expenditure, pricing and cutback information for every HCPCS code as listed in attachment wi_hcpcs_may2006.xls

The following criteria was used to extract the HCPCS data

- They include all claim types with a PAID, or a partially paid status.
- The dates of service indicated on the claim are between January 1, 1992 and December 31, 2005 (both days inclusive).
- Only those claims were included where the procedure code indicated on the claim matched the HCPCS codes as listed in the attachment wi_hcpcs_may2006.xls

2. Please explain the differences between these data and the "WI Medicare Claims data 1998-2004" data, which also appear to contain physician-administered drug claims.

Response:

WI Medicare Claims data 1998-2004 was not included in the DVD produced in August 2006.

3. Please confirm that the file HCPCS Data Dictionary_Kim.doc contains the documentation for the HCPCS Refresh data.

Response:

The HCPCS Data Dictionary_Kim.doc is the documentation for the HCPCS Refresh data.

4. For each of the following cut-back fields, please explain the methodology used to determine the amount of the cut-back:

Response:

Computer Pricing:

Dollar cutback as described in the data dictionary.

Manual Pricing_Cutback_Amount:

Dollar cutback as described in the data dictionary.

Manual_Medical_Cutback_Amount:

Dollar cutback as described in the data dictionary.

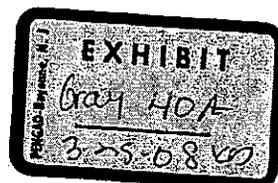
5. Do the cut-back fields contained in the data explain all differences between the "Allowed_Amount," "Billed_Amount," and "Detail_Paid_Amount?"

Response:

Cutbacks can result in either a reduction of the billed amount to arrive at the Medicaid allowed amount, or reduction of the Medicaid allowed amount to arrive at the Medicaid paid amount. Cutback fields are used to balance claims during processing.

6. Explain why differences would appear that are not explained by the cut-back fields.

Response:



Cutbacks can result in either a reduction of the billed amount to arrive at the Medicaid allowed amount, or reduction of the Medicaid allowed amount to arrive at the Medicaid paid amount. Cutback fields are used to balance claims during processing.

7. Please confirm the following: Ninety-nine percent of transactions have "Copay_Cutback_Amount" equal to \$0.00. Under what circumstances would cost-sharing be required of beneficiaries? How is the cost-sharing amount determined?

Response:

For most services, copayment amounts are based on Medicaid's reimbursement amount for each procedure code. Medicaid's reimbursement amounts for procedure codes are listed in service-specific maximum allowable fee schedules which are on the Medicaid Web site.

The following copayment amounts apply for most services; however, providers are instructed to refer to service-specific publications for specific copayment requirements, including copayment amounts.

Medicaid Reimbursement (per procedure code)	Copayment
Up to \$10.00	\$0.50
From \$10.01 to \$25.00	\$1.00
From \$25.01 to \$50.00	\$2.00
Over \$50.00	\$3.00

In addition, providers are told to verify that they are collecting the correct copayment for services, as some services have monthly or annual copayment limits. Providers may not collect recipient copayment in amounts that exceed Medicaid copayment limits. Providers are instructed to refer to service-specific publications for copayment limits.

According to HFS 104.01(12), Wisconsin Administrative Code, providers are prohibited from collecting copayment from the following recipient groups:

- Recipients under 18 years old. (For HealthCheck service, recipient under 19 years old are exempt).
- Recipients in nursing homes.
- Recipients in state-contracted managed care organizations receiving managed care-covered services. Refer to the Managed Care section of this handbook for more information.
- Pregnant women who receive medical services related to their pregnancy or to another medical condition that may complicate their pregnancy.

The following services do not require copayment:

- Case management services.
- Community support program services.
- Crisis intervention services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- Private duty nursing and respiratory care services.
- School-based services.

- Substance abuse day treatment services.
- Surgical assistance.

8. Please define the following fields and explain the high number of entries with values of zero:

a. Field "Level_1_Pricing_Amount" contains 73% of claims equal to \$0.00

Level I prices are provider-specific rates for a type of service (TOS) and procedure code combination. The same TOS/procedure code combination may have different rates for each provider.

b. Field "Level_II_Pricing_Amount" contains 72% of claims equal to \$0.00

Level II prices are provider locality and pricing specialty specific rates for a type of service (TOS) and procedure code combination. The same TOS/procedure code combination may have different rates for each locality and pricing specialty.

c. Field "Level_III_Pricing_Amount" contains 6% of claims equal to \$0.00

Level III pricing is used when a provider is to be paid a specific rate per service. Note: provider-specific rates, provider locality or pricing specialty specific rates do not apply.

9. Please provide decodes for and explain the field "Med_Stat_Code."

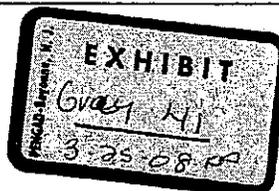
Response:

See attached document med_stat_code.xls for a description of each Medical Status Code.

EXHIBIT C

Medicaid Data Elements and Pricing Methodologies

HCPCS Claims			
Field Name	Field Length	Description	Notes
Claim ICN	Varchar2(15)	The unique 15-digit Medicaid Management Information System (MMIS) internal control number	
Line Number	Varchar2(2)	The specific detail of a claim record.	Values are: 01 - 28.
Claim Paid Date	Date	The date that the claim finalized and reported to a provider's Remittance and Status Report.	
Detail Paid Amount	Number(9,2)	The dollar amount paid for a service on a claim detail record.	
Begin Service Date	Date	The date that the recipient received services for the procedure code being billed on a specific claim line number.	
Procedure/NDC Code	Varchar2(11)	The code defining the services performed and billed on a claim detail.	Restricted to the HCPCS List that was supplied
Quantity Billed	Number(7,2)	The number of units billed by a provider for a service on a claim detail record.	
Quantity Allowed	Number(7,2)	The number of services (units) allowed on a claim detail record.	
Level I Pricing Amount	Number(9,2)	The Medicare coinsurance amount on a claim detail record for Medicare crossover claims.	
Level II Pricing Amount	Number(9,2)	The Medicare allowed amount on a claim detail record for Medicare crossover claims.	
Level III Pricing Amount	Number(9,2)	The Medicare paid amount on a claim detail record for Medicare crossover claims. The maximum allowed fee or percentage amount on non-Medicare claims.	
Allowed Amount	Number(9,2)	The dollar amount allowed by Medicaid for a service on a claim detail record	See Table below
Billed Amount	Number(9,2)	The dollar amount billed by a provider for a service on a claim detail record.	
Med Stat Code	Varchar2(2)	A code value that identifies the program that a recipient is enrolled in at the time the claim was processed.	See file labeled 'Medical Status Codes' for a listing of valid codes and descriptions.
COB Cutback Amount	Number(9,2)	The total dollar amount on a claim detail record that has been cutback for payment by other insurance.	
Computer Medical Cutback Amount	Number(9,2)		See Explanation Below
Computer Pricing	Number(9,2)		See Explanation



Medicaid Data Elements and Pricing Methodologies

Cutback Amount			Below
Copay Cutback Amount	Number(9,2)		See Explanation Below
HCPCS Claims			
Field Name	Field Length	Description	Notes
Manual Medical Cutback Amount	Number(9,2)		See Explanation Below
Manual Pricing Cutback Amount	Number(9,2)		See Explanation Below
Medicare Cutback Amount	Number(9,2)		See Explanation Below
Pay Percent Cutback Amount	Number(9,2)		See Explanation Below
Per Diem Cutback Amount	Number(9,2)		See Explanation Below
Procedural Cutback Amount	Number(9,2)		See Explanation Below
Recipient Liability Cutback Amount	Number(9,2)		See Explanation Below
Reimbursement Rate Cutback Amount	Number(9,2)		See Explanation Below
Spenddown Cutback Amount	Number(9,2)		See Explanation Below
Tax cutback Amount	Number(9,2)		See Explanation Below
Total Deny Cutback Amount	Number(9,2)		See Explanation Below
Pharmacy Billing Provider ID	Varchar2(8)	The provider number that has been assigned to the provider for billing purposes.	
Pharmacy Name	Varchar2(60)	The full name of the billing provider.	

Claim Cutbacks

During claim processing the MMIS performs various pricing functions to arrive at the final payment result for each service billed on a claim. One such pricing function is to 'cut back' either the dollar amount or the quantity amount. The type of cut-back that occurs is determined by the pricing methodology applicable to the service. Common cut-backs include the following:

- Medicare Part-B cutback: This is a method of limiting Medicaid's financial liability for Medicare coinsurance and is based on comparing detail Medicare paid amounts to the calculated Medicaid allowed amount. This method results in a reduction ('cutting-back') of the provider's billed amount to arrive at the Medicaid allowed amount.

Medicaid Data Elements and Pricing Methodologies

- Dollar cutback: Dollar cutbacks also occur in various pricing methodologies and can result in either a reduction of the provider's billed amount to arrive at the Medicaid allowed amount, or a reduction of the Medicaid allowed amount to arrive at the Medicaid paid amount. A *manual pricing* or *max fee pricing* cutback would be an example of a reduction of the provider's billed amount to arrive at the Medicaid allowed amount. An *other insurance* cutback or a *recipient copay cutback* would be an example of a reduction of the Medicaid allowed amount to arrive at the Medicaid paid amount.

- Quantity cutback: Quantity cutbacks can occur in various pricing methodologies and result in a reduction ('cutting back') of the provider's billed quantity to arrive at the Medicaid allowed quantity. Quantity cutbacks can occur on pharmacy claims, for example, based on a comparison of the provider's billed quantity to the package size on file for the specified drug (refer to the Pricing Manual for more detail). Quantity cutbacks may also occur during adjudication of detail edits or audits when the billed services exceed the services allowed by the applicable policy.