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State of Alaska vs. Eli Lilly & Co

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DEFENDANTS:

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

v.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630 CI

APPEAL FROM ORDER OF THE DISCOVERY MASTER

Eli Lilly & Company ("Lilly") appeals from the Order of the Discovery Master, denying Lilly discovery of medical records and a complete production of the State's Medicaid database.[1] If the Discovery Master's Order is upheld, Lilly will be forced to contest the entire litigation within a framework of statistical evidence devised entirely by the State. The practical effect of this ruling is that "the method by which the State has chosen to prove its case will limit Lilly's method of defending against the State's claims," exactly what this Court ruled should not occur,[2] and Lilly and the Court will be denied essential facts not contained in the database.[3]

[1] Discovery Master Order: State's First Motion to Compel, Lilly's Motion to Compel and Lilly's Motion for Commission for Subpoena at 9. (herein after "Discovery Master Order").
[2] Order Re: Plaintiff's Claims of Proof at 5.
[3] Because the discovery at issue in this appeal is central to Lilly's ability to defend itself against the State's case, and the resolution of these issues will weigh heavily on the ultimate outcome of this action, Lilly requests relief from the five page limit for appeals of the Discovery Master's decisions set forth in the Supplemental Scheduling Order.

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I. ARGUMENT

A. Lilly Is Entitled to Make a Non-Statistical Defense Against the State's Tort Claims.

The State alleges improper promotion of Zyprexa and medical injuries caused by Zyprexa.[4] These claims require proof of misrepresentations, causation and damages.[5] The State does not contest that medical records contain information relevant to resolve such claims, but argues Lilly should be limited to whatever data is contained within its database.[6] Claims data, however, are only summaries of medical events, prepared for reimbursement purposes, not medical reasons. Whatever the Court ultimately concludes about the admissibility of such evidence to prove the State's case, Lilly should not be precluded from presenting evidence of medical events from medical records.

Medical records are crucial because the fundamental issues here: (1) whether Zyprexa causes diabetes, and (2) whether the doctor prescribed Zyprexa because of off label promotion and misrepresentations cannot be fairly evaluated without facts contained only in those records. The epidemiological approach of using claims data, by its very nature, has limitations, not present in medical records. Many risk factors that are confounding for diabetes, essential to the determination of whether the medication caused diabetes, are not

[4] Pl.'s Mem. Describing Its Claims and Proofs at 5.
[5] *Clary v. Fifth Ave. Chrysler Cntr.*, 454 P.2d 244, 247 (Alaska 1969) (strict liability); *Anchorage Chrysler Cntr., Inc. v. DaimlerChrysler Corp.*, 129 P.3d 905, 914 (Alaska 2006) (fraud); *Lexington Ins. Co. v. Lindahl Constr. and Eng'r, Inc.*, 47 P.3d 1081, 1088 n.19 (Alaska 2002) (negligence).
[6] *See, e.g., Doxsee v. Doxsee*, 80 P.3d 225, 228 (Alaska 2003) (discussing use of testimony of a physician in a personal injury case who discussed examining plaintiff's medical records).

captured in claims data, such as whether the patient had preexisting diabetes, diabetes diagnosed during periods where the claimant was not enrolled in Medicaid,[7] a family history of diabetes, and whether the patient was overweight, or led a sedentary lifestyle. The Court need look no further than the Guo article that the State has proffered as a template for its methodology,[8] or other literature relied upon by the State's endocrinology expert for these express limitations.[9]

[7] Affidavit of Beth A. Virnig ¶ E.3 (noting it is common for Medicaid recipients to come on and off the Medicaid rolls and that claims data will not account for medical events that occur while off the Medicaid rolls). (Attached as Exhibit B to Def.'s Reply Brief to its Mot. Regarding its Application for a Commission to Issue a Subpoena and Suppl. Brief in Support of its Mot. to Compel Discovery).

[8] Jeff J. Guo et al., Risk of Diabetes Mellitus Associated with Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder, Pharmacotherapy 27 (2007) ("It is unclear whether diabetes in the study population is due to the use of atypical antipsychotics versus the underlying condition of bipolar disorder versus characteristics of the Medicaid population, such as low socioeconomic status, poor overall physical health, unhealthy lifestyles, and poor access to health care services."). (Attached as an exhibit to Pl.'s Mem. Describing its Claims and Proofs).

[9] Plaintiff's epidemiology expert, Dr. Brancati, in his prior expert report, for example cites to Lambert, et al., Diabetes Risk Associated with use of Olanzapine, Quetiapine, and Risperidone in Veterans Health Administration Patients with Schizophrenia, Am. Journal of Epidemiology 2006 Oct. 1; 164(7): 672-81 Epub 2006 Aug. 30 (Aug. 30, 2007) (noting confounders could provide a possible explanation to results as the study lacked information on individual risk factors such as weight, caloric intake, existing hypertension or hypercholesterolemia and family history of diabetes); Moisan et al., Exploring the Risk of Diabetes Mellitus and dyslipidemia among ambulatory users of atypical antipsychotics, Pharmacoepidemiology and Drug Safety 2005; 14: 427-436 (Mar. 22, 2005) ("Another limitation involves our inability to take into account factors known to increase the risk of diabetes and dyslipidemia (e.g. family history, food habits, physical activity, etc.)."). (Exhibit A and Exhibit B respectively).

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The State claims that physicians prescribed Zyprexa because of misrepresentations and "off label" promotion. Claims records, however, reveal nothing about *why* a physician prescribed Zyprexa. Without medical records, Lilly is completely denied the ability to show that a patient was prescribed Zyprexa for a particular use only after the patient failed on other medications, or the physician considered and rejected other treatment options.

The only other court to address this precise issue has ruled "the claims and allegations contained in this action cannot fairly and properly be litigated unless Defendant has access to … medical records of Medicaid patients who were prescribed Risperdal and other anti-psychotic medications that Plaintiff contends are superior to Risperdal."[10] In light of this finding, the court ordered "the production of medical records and individual discovery of a representative sample of persons who received Medicaid-financed anti-psychotic medications."[11] Lilly explained to the Discovery Master that it would accept similar sampling in this case.[12] Such a result would be consistent with the Discovery Master's Order regarding call notes, where ten percent of Alaska Zyprexa call notes sought by the State are being produced by Lilly. As things currently stand, however, the State is allowed to discover evidence relating to its allegation that Lilly misled doctors, but Lilly is denied the opportunity to develop evidence from actual medical records to contest that evidence.

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[10] *Foti v. Janssen Pharmaceutical, Inc.*, No. 04-3967-D, Consent Judgment at 2 (La. Dist. Ct. Apr. 10, 2007). (attached as exhibit E to Def.'s Mot. to Compel Discovery).
[11] *Id.*
[12] *See* Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 46-47. (Exhibit C).

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B. The Discovery Master's Ruling Impedes Lilly's Ability To Challenge The State's Statistical Evidence.

In addition to denying Lilly access to proofs, the Discovery Master also took away Lilly's ability to cross examine summary data. This is a denial of basic due process. It is well settled as a matter of Alaska law to permit litigants to challenge the accuracy of summary data with underlying records.[13] The Discovery Master's ruling prevents Lilly from challenging the State's statistical evidence by showing that the coding in the database is inaccurate and incomplete. The Discovery Master's rationale was that "[w]hile Lilly is free to challenge [the] validity of the database, it is not clear to me that access to individual records is the appropriate scientific method of doing so."[14] This logic prejudges the analyses to be submitted by Lilly's experts before the State has even made a complete production of its Medicaid data (*see* accompanying Motion for Extension). The Discovery Master's assumptions about the proper way to challenge the database find no support in the record, as the State did not make this argument. Indeed, epidemiological studies such as the Guo article have concluded that causation of diabetes in a Medicaid population taking anti-psychotics could not be determined because of confounding risk factors that are not recorded in claims data.[15] The Discovery Master concluded that Lilly should be satisfied by pointing out to the

[13] *Liimatta v. Vest*, 45 P.3d 310, 319 and n.36 (Alaska 2002); *see also Deitchman v. E.R. Squibb & Sons, Inc.*, 740 F.2d 556, 561-62 (7th Cir. 1984) (holding records, including medical records, held by a University registry were the best evidence to cross examine expert witnesses on the issue of causation where those experts relied on studies based on those underlying records).

[14] Discovery Master Order at 5.

[15] *See* Guo, et al., at 27.

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Court and the jury that the State's statistical model is "inadequate."[16] But pointing out to the jury that the information may be missing is not a reasonable substitute for showing how much data is missing, or that the summary data contained in the database is just inaccurate.

The Discovery Master reasoned that because pre-1996 data is corrupted the State will not use that data in its model and therefore Lilly has no need for pre-1996 records, as there will be no pre-1996 model to challenge.[17] This missed the point of Lilly's need for this evidence. A patient's medical history – what risk factors he or she has for diabetes, what medications have been tried and failed are relevant here, and the State has never suggested otherwise. Also, pre-1996 evidence may show diabetes diagnoses that pre-date the launch of Zyprexa. The absence of pre-1996 data presents a compelling need for medical records. If, as the State represents, the claims data before 1996 is not usable, medical records are the ***only*** evidence of these facts.[18]

Lilly's need for this discovery is particularly important because of the deficiencies in the State's Medicaid database,[19] which, in addition to the absence of pre-1996 data,[20] include the fact that the database does not contain medical information for periods of time

[16] Discovery Master Order at 5.
[17] *Id.* at 7.
[18] *See, e.g.,* Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 14-15. (Ex. C).
[19] Press Release, Alaska Dept. of Health & Social Services, State Selects New Company to Replace Medicaid Claims System (July 26, 2007). (Attached as Exhibit J to Def.'s Reply in Support of its Mot. to Compel Discovery).
[20] *See, e.g.,* Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 14-15.

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where a recipient left Medicaid and then later rejoined the rolls,[21] and the fact that internal audits of the database indicate that high errors rates exist in the claims records.[22] The State's own policy is to investigate the reliability of the data in the claims system by reviewing medical and prescription records, which is one of the reasons that Lilly seeks discovery of medical records.[23]

C. Patient Privacy and Time for Discovery Do Not Justify Depriving Lilly of Relevant Discovery.

The Discovery Master found that privacy issues outweighed Lilly's need for these records.[24] In the Zyprexa personal injury litigation, Lilly has maintained the confidentiality of the records of thousands of Zyprexa patients in a manner that has respected their privacy. In the Janssen case, the privacy objection was overruled, because the State had put the medical condition of its Medicaid recipients at issue and the claims could not be litigated without access to medical records.[25] Here, the records could be produced pursuant to a protective order. If a protective order is inadequate, the State itself argued that patient confidentiality could be protected by the State de-identifying the records—a suggestion Lilly

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[21] Affidavit of Beth A. Virnig at ¶ E.3, *see also* Campana Dep. at 143-44. (Exhibit D).
[22] Campana Dep. at 322-32.
[23] *Id.* at 226, 319-20.
[24] Discovery Master Order at 7.
[25] *Foti*, Consent Judgment at 2; *see also Caines v. Addiction Research and Treatment Corp.*, No. 06 Civ. 3399 (PAC) (MHD), 2007 WL 895140, at *1 (S.D.N.Y. Mar. 20, 2007).

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agreed to do both prior to and during the argument.[26] Patient confidentiality can be resolved the same way that claims data is de-identified.[27]

Lastly, the Discovery Master gave considerable weight to the schedule in making his decision: "I can say with some confidence that if [production of medical records] is ordered, the March 2008 trial date will have come and gone before anyone sees an actual patient record."[28] Due process and Alaska's Rules of Civil Procedure do not permit denial of relevant discovery simply because a trial date has been scheduled.[29] In this case, Lilly requested these records in February, but its entitlement to records was part and parcel of the Proof of Claims briefing, so Lilly could not compel their production earlier. Then, after the Court's Order, the State continued to resist medical records discovery, requiring Lilly to seek the records through motion practice. Lilly should not be denied relevant discovery simply because of the time elapsed determining its entitlement to it. Moreover, as set forth in Lilly's

[26] Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 46.

[27] The Discovery Master noted that the collection of records would be costly and neither party volunteered to pay this expense. Discovery Master Order at 7. First, Lilly did offer to undertake all of the expense of record collection. Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 60. Only if the State wanted to redact the records, did Lilly not agree at the hearing to pay the State to undertake this effort – just as the State has not agreed to pay Lilly the cost of its voluminous production. Second, if the Court believes that the expense of production should be shifted, it could do so within its discretion.

[28] Discovery Master Order at 7.

[29] Alaska R. Civ. P. 26(b)(1); *Siggelkow v. Siggelkow*, 643 P.2d 985, 986 -87 (Alaska 1982) ("Denial of a motion for continuance constitutes an abuse of discretion 'when a party has been deprived of a substantial right or seriously prejudiced' ... [t]he trial court's legitimate concern for preventing delay should not prejudice the substantial rights of parties by forcing them to go to trial without being able to fairly present their case.") (quoting *Barrett v. Gagnon*, 516 P.2d 1202, 1203 (Alaska 1973)).

Motion for Extension of the Schedule, also filed today, there are independent grounds to extend the schedule, including the complexity of this case and delay in production of the State's complete Medicaid database, which is the source of all the State's statistical evidence.

D. The State Should Produce Its Entire Medicaid Database to Lilly.

Lilly also appeals from the Discovery Master's Order denying the Commission of a Subpoena for access to the First Health database, or other remedy that would provide Lilly with the State's full Medicaid database.[30] The Discovery Master denied Lilly's motion for these remedies based on the State agreeing to produce some, but not all of the data it had previously withheld, effectively allowing the State to define the scope of its own production obligations.[31] As set forth in the Motion for Extension, the State has not produced its Medicaid database, has not explained why it has not produced its database, and has presented absolutely no evidence, declaration or argument as to the burden of doing so. All that has been said is that "it's not like producing a basketball."[32] With respect, this statement does not provide a basis for failing to produce the full data set.

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[30] Discovery Master Order at 9.
[31] *Id.*
[32] Sept. 11, 2007, Motion Arguments Before the Discovery Master Transcript at 7.

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DATED this 2nd day of October, 2007.

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Original Contribution

Diabetes Risk Associated with Use of Olanzapine, Quetiapine, and Risperidone in Veterans Health Administration Patients with Schizophrenia

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To evaluate risk of new-onset type 2 diabetes associated with use of selected antipsychotic agents, the authors conducted a new-user cohort study in a national sample of US Veterans Health Administration patients with schizophrenia (and no preexisting diabetes). The authors studied 15,767 patients who initiated use of olanzapine, risperidone, quetiapine, or haloperidol in 1999–2001 after at least 3 months with no antipsychotic prescriptions. Patients were followed for just over 1 year. New-onset diabetes was identified through diagnostic codes and prescriptions for diabetes medication. In Cox proportional hazards regression adjusting for potential confounders, with patients initiating haloperidol use designated the reference group, diabetes risk was increased equally with new use of olanzapine (hazard ratio (HR) = 1.64, 95% confidence interval (CI): 1.22, 2.19), risperidone (HR = 1.60, 95% CI: 1.19, 2.14), or quetiapine (HR = 1.67, 95% CI: 1.01, 2.76). Diabetes risks were higher in patients under age 50 years. When data were reanalyzed with prevalent-user cohorts and matched case-control designs, results were similar, with slightly less elevated risk estimates. Assuming that the observed associations are causal, approximately one third of new cases of diabetes may be attributed to use of olanzapine, risperidone, and quetiapine in patients taking these medications. Prescribers should be mindful of diabetes risks when treating patients with schizophrenia.

antipsychotic agents; case-control studies; cohort studies; diabetes mellitus; pharmacoepidemiology; schizophrenia; veterans

Abbreviation: VHA, Veterans Health Administration.

The introduction of a new generation of antipsychotic drugs has been heralded as an important advance in the treatment of schizophrenia. The "atypical" or second-generation antipsychotic agents (e.g., olanzapine) are at least as effective as older drugs (e.g., haloperidol) in treating schizophrenia but are less likely to cause extrapyramidal side effects and tardive dyskinesia (1–11). However, some of the newer drugs have been associated with metabolic disturbances,

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including weight gain (12–17), hyperlipidemia (18–20), hyperglycemia, and new-onset diabetes mellitus (18, 21–25).

Evidence for a possible link between use of second-generation antipsychotic agents and diabetes has come from case reports (26–46), case-control studies (47), and cohort studies of ongoing users (23, 25, 48, 49). While most studies have reported an association, the magnitude of the risk and the differences in risk among agents in this class have varied between studies. This inconsistency is probably related to differences in the patient populations studied, reference groups, definitions of diabetes, exposure definitions, and control for potential confounding. Furthermore, most of the studies failed to restrict the exposure to new users or to persons using single agents, so confounding related to discontinuation or switching of medication may have biased the results (50).

We conducted a study to determine the risk of new-onset type 2 diabetes in relation to newly initiated use of single-agent antipsychotic medications among Veterans Health Administration (VHA) patients with schizophrenia. We attempted to improve exposure definition, reduce selection bias, adjust for multiple confounders, and minimize the influence of previous antipsychotic agents on the observed outcome. To facilitate comparisons with previous studies and to illustrate the impact of design choices on results of observational studies, we also describe the results obtained in a prevalent-user cohort analysis and a matched case-control analysis.

MATERIALS AND METHODS

Data sources

In this study, we used electronic data available for all VHA patients nationally (51). This includes information on all VHA medical encounters (outpatient, inpatient, and long-term-care) obtained from the Austin Automation Center, VHA outpatient and inpatient prescription data from the Pharmacy Benefits Management Strategic Healthcare Group, and death records from the Beneficiary Identification Records Locator Subsystem, a registry of all veterans who applied for VHA death benefits that is supplemented by data from Social Security records. This study was approved by the institutional review boards of the University of Illinois at Chicago and the Hines Veterans Health Administration (Hines, Illinois).

Sample selection

We identified VHA patients with schizophrenia and constructed a series of new-user cohorts of patients who began receiving antipsychotic medication after 12 or more weeks without an antipsychotic prescription. Schizophrenia patients were identified on the basis of *International Classification of Diseases, Ninth Revision, Clinical Modification*, codes for schizophrenia (295.xx) in records of inpatient stays or outpatient visits on at least two separate days from October 1, 1996, through September 30, 2001. Study subjects were restricted to those who had filled at least one prescription for an antipsychotic drug from January 1, 1999, through September 30, 2001. To study new users only, we further excluded those patients who had been prescribed antipsychotic medication during the first 12 weeks of collection of national prescription data, from October 1, 1998, through December 31, 1998. To study new-onset diabetes only, we also excluded patients who had any sign of diabetes prior to their first exposure to antipsychotic agents (a diabetes diagnostic code (250.xx) going back to October 1, 1996, or a prescription for a diabetes medication going back to October 1, 1998). We also excluded all patients whose first contact with the VHA system (based on the presence of any prescription, procedure, or diagnostic record in inpatient or outpatient data) was fewer than 12 weeks prior to their first antipsychotic drug exposure. In this way, we could be reasonably sure that patients were using the VHA on an ongoing basis and were unlikely to be receiving antipsychotic agents from other sources.

Definition of diabetes

Patients were considered to have new-onset diabetes if they were given diabetes diagnostic codes (250.xx) on at least two separate days or if they filled a prescription for an antidiabetic drug (insulin, sulfonylureas, biguanides, thiazolidinediones, α-glucosidase inhibitors, or meglitinides). This definition has been shown to be reliable and valid in the VHA system (52). The date of diabetes was defined as the earliest sign of diabetes (the first diagnosis or prescription) for a subsequently confirmed case.

Analysis

Analyses were conducted using SAS, version 8.2 (53). Four new-user cohorts were constructed consisting of schizophrenic patients newly initiating use of one of three selected second-generation antipsychotic medications (olanzapine, quetiapine, or risperidone) or haloperidol, the most commonly used conventional antipsychotic agent. There were insufficient numbers of new users of clozapine, ziprasidone, and aripiprazole for these persons to be included in the new-user cohort analysis.

Cohort samples were characterized and compared in terms of demographic factors and other study variables. Cox proportional hazards regression was used to estimate hazard ratios with 95 percent confidence intervals for new-onset diabetes developing over the course of follow-up (54). Observation began on the day a patient received his or her first prescription for an antipsychotic agent (after January 1, 1999) and continued until the first occurrence of diabetes, death, initiation of use of a second antipsychotic agent, or last contact with the VHA system prior to September 30, 2001. The proportional hazards assumption was confirmed using "log-log" plots (55).

Multivariate regression models were constructed to adjust for potential confounders, including sex, age, race/ethnicity, marital status, exposure to other medications that may cause diabetes (beta-blockers, thiazide diuretics, lithium, phenytoin, corticosteroids) (56), and number of basic or comprehensive metabolic panels that included glucose testing performed during follow-up. The last factor was included to adjust for potential bias related to intensity of screening

for diabetes that may have varied among patients using different antipsychotic medications.

In this analysis, we present hazards for initiating use of each second-generation antipsychotic medication, with persons initiating haloperidol as the reference category. To facilitate comparison with other studies, we also present some results of parallel analyses that used patients initiating any conventional antipsychotic agent (chlorpromazine, etc.) as the reference group.

This is a study of patients on single-agent antipsychotic drug therapy, since we censored patients when they switched to another antipsychotic drug. It is possible that some patients may have been switched from one drug to another after showing signs of glucose dysregulation. If such patients developed diabetes after switching medications, our initial analysis would have missed these cases when perhaps they should have been attributed to the preswitch drug. To examine this possibility, we reran our analyses including in the models any cases of diabetes that were diagnosed 30, 60, or 90 days after switching medications.

Hazard ratios for the various second-generation antipsychotic agents were compared and differences were evaluated using the Wald test (the TEST statement in PROC PHREG in SAS). Effect modification by age and other factors was evaluated using interaction terms in the overall models and conducting separate analyses in each stratum of age. Linear trends in hazard ratios by age were evaluated using an ordinal term. Estimates of attributable risk percentage were calculated using hazard ratios obtained from proportional hazards modeling (57).

Additional analyses: prevalent-user cohorts and case-control designs

We conducted two additional analyses. In the first, we implemented a prevalent-user cohort design, which was identical to that for the new-user cohorts except that we did not exclude patients who had been exposed to antipsychotic agents during the prior 12-week period. These cohorts were larger and consisted mostly of schizophrenia patients on continuing antipsychotic drug therapy. Observation began with the first antipsychotic prescription, regardless of prior prescriptions, and continued as in the new-user cohort design, with proportional hazards regression being employed in the analysis.

In the second additional analysis, we conducted a matched case-control analysis nested in the prevalent-user cohorts. Among persons initiating use of antipsychotic agents, new-onset cases of diabetes were matched on sex, age (±5 years), and location of VHA care with up to six controls who showed no evidence of diabetes over the course of the study. Medication exposures prior to diabetes diagnosis in the case and during the same time period for matched controls were examined, without restriction to newly initiated use. Patients in the case-control study had to have been taking one and only one antipsychotic medication during the retrospective exposure period. Because there is little consensus on the timing of the putative effects of antipsychotic agents on diabetes risk, we used three different retrospective exposure periods: 12, 24, and 52 weeks prior to the development of diabetes in the case. Conditional logistic regression was used in the analysis to compute odds ratios and 95 percent confidence intervals for each of the second-generation antipsychotic medications, with haloperidol as the reference category (58). These models included terms for covariates identical to those entered in the proportional hazards regression models utilized in the new-user cohort design as described above, except for sex, since it was used in matching.

In conducting these additional analyses, we found sufficient numbers of patients prescribed clozapine to evaluate diabetes risk associated with this second-generation antipsychotic agent. Findings from parallel prevalent-user cohort and case-control analyses of this medication using similar methods are presented separately.

RESULTS

We observed 15,767 patients in the four cohorts of antipsychotic initiators studied (table 1). Patients in these cohorts were broadly similar in terms of age, sex, race/ethnicity, marital status, use of other potentially diabetogenic medications, and number of diabetes screening tests. There were slightly more women and fewer racial minority patients among the quetiapine users, and more never-married and African-American patients among those prescribed haloperidol. Otherwise, frequency distributions varied by no more than a few percentage points across the four cohorts. Average length of follow-up was also similar (just over 1 year), except for quetiapine, which was only approved for use during the study. The annual incidence (unadjusted) of new-onset diabetes over the course of follow-up ranged from 2.0 per 100 person-years of exposure in users of haloperidol to 3.6 per 100 person-years in quetiapine users.

Table 2 gives the hazard ratios and 95 percent confidence intervals for initiation of olanzapine, risperidone, and quetiapine, with patients initiating haloperidol used as the reference group. For all three second-generation antipsychotic agents, the hazard ratio was 1.6–1.7, and adjustment for potential confounders had little effect on the estimates. There were no significant differences in effects among the three second-generation antipsychotic agents. When 30, 60, or 90 days were added to follow-up in patients switching to another antipsychotic agent, the results were similar but with slightly narrower confidence intervals. There appeared to be effect modification by age, with generally higher odds ratios being seen in younger patients, at least for olanzapine and risperidone ($p = 0.05$ and $p = 0.03$, respectively, in tests of homogeneity of hazards between persons aged ≥50 years and <50 years). Estimates of attributable risk percentage were 33.3 percent, 32.0 percent, and 35.0 percent for olanzapine, risperidone, and quetiapine, respectively.

Table 3 summarizes results from the new-user cohort design in comparison with those from the two additional analyses implementing prevalent-user cohort and case-control designs. The more expanded sample of patients studied in these analyses (see table 4) was compared with patients in the new-user cohort design; except for a slightly smaller percentage of racial minority patients, there were no differences

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TABLE 1. Characteristics of four cohorts of new users of antipsychotic medication (n = 15,767) among US veterans with schizophrenia, 1999–2001

Variable	Antipsychotic agent			
	Olanzapine (n = 5,987)	Risperidone (n = 5,901)	Quetiapine (n = 877)	Haloperidol (n = 3,008)
Mean age (years)	50.3 (11.2)*	51.1 (12.2)	50.6 (11.7)	52.0 (12.1)
Sex (%)				
Male	94.1	93.2	91.7	95.1
Female	5.9	6.8	8.3	4.9
Race/ethnicity (%)				
White	48.4	47.7	58.3	44.0
African-American	28.8	30.8	21.2	39.4
Hispanic	6.8	4.8	4.1	5.4
Other	0.8	0.6	0.6	0.6
Unknown	15.2	16.2	15.8	10.6
Marital status (%)				
Married	22.3	22.4	21.3	16.9
Never married	40.5	40.0	39.2	48.5
Divorced, separated	32.6	32.1	33.7	30.0
Widowed	2.8	4.6	3.8	3.4
Unknown	1.8	1.4	1.9	2.1
Use of medications potentially inducing diabetes (%)				
Beta-blockers/thiazide diuretics	16.0	16.5	17.8	14.8
Lithium	5.9	5.2	5.9	5.1
Corticosteroids	1.6	1.5	0.8	1.8
Phenytoin	1.9	2.0	1.4	2.2
No. of metabolic panels per patient	0.18 (0.74)	0.18 (0.73)	0.15 (0.64)	0.19 (0.83)
Mean duration of follow-up (days)	367.4 (299.6)	371.6 (300.5)	244.3 (246.8)	364.5 (325.7)
Mean time to event (days)	240.8 (196.1)	267.3 (228.9)	214.1 (175.3)	304.1 (260.8)
No. of new cases of diabetes diagnosed during study period	200	193	21	60
Diabetes incidence per 100 person-years of exposure	3.3	3.2	3.6	2.0

* Numbers in parentheses, standard deviation.

of more than a few percentage points in the distributions of demographic factors, other medications, or laboratory tests. Except for quetiapine in the prevalent-user cohorts, the relative risk of diabetes was increased with use of all three second-generation antipsychotic agents, regardless of design. Estimates ranged from 1.2 to 1.8. In the prevalent-user cohorts, risk was elevated for both olanzapine and risperidone, but risk associated with olanzapine was significantly greater than that associated with risperidone ($p = 0.02$). Otherwise, there were no significant differences in diabetes-related risks for the three medications in any of the analyses.

When the reference group was changed from patients exposed to haloperidol to patients exposed to any conventional antipsychotic agent, the pattern of results was essentially unchanged, with somewhat lower estimates of effect. The hazard ratios were between 1.4 and 1.5 in the new-user cohorts and between 1.1 and 1.3 in the prevalent-user cohorts.

In parallel analyses, there were 1,293 patients in the clozapine cohort (110 without a prescription in the first 12-week period), and 106 developed new-onset diabetes during follow-up. Clozapine patients tended to be younger, and fewer of them were married or members of racial/ethnic

TABLE 2. Risk of developing diabetes according to initiation of use of second-generation antipsychotic medication among US veterans with schizophrenia, 1999–2001*

Analysis	Second-generation antipsychotic agent					
	Olanzapine (n = 5,961)		Risperidone (n = 5,901)		Quetiapine (n = 877)	
	HR†	95% CI†	HR	95% CI	HR	95% CI
Unadjusted (all ages)	1.63	1.22, 2.18	1.58	1.18, 2.11	1.66	1.01, 2.73
Adjusted						
All ages‡	1.64	1.22, 2.19	1.60	1.19, 2.14	1.67	1.01, 2.76
All ages + 30 days to follow-up§	1.57	1.19, 2.08	1.55	1.17, 2.05	1.67	1.04, 2.70
By age group (years)						
<45 (n = 4,928)	3.06	1.41, 6.63	3.40	1.56, 7.42	2.98	0.95, 9.31
45–54 (n = 6,312)	1.54	0.99, 2.39	1.38	0.88, 2.16	1.04	0.44, 2.41
55–64 (n = 2,177)	0.84	0.44, 1.60	1.15	0.63, 2.10	1.11	0.36, 3.44
65–74 (n = 1,329)	1.22	0.55, 2.72	1.14	0.49, 2.65	2.59	0.74, 8.97
≥75 (n = 1,021)	3.15	0.66, 15.21	2.46	0.52, 11.51	3.21	0.26, 39.23

* Cox proportional hazards regression analysis of new-user cohorts. Users of haloperidol were the reference category.

† HR, hazard ratio; CI, confidence interval.

‡ Models included terms for sex, age, race/ethnicity, marital status, use of other potentially diabetes-inducing medications (beta-blockers, thiazide diuretics, lithium, phenytoin, and corticosteroids), and number of basic or comprehensive metabolic panels performed during follow-up.

§ Follow-up extended to 30 days after discontinuing medication and switching to a new antipsychotic agent.

minority groups. The hazard ratio for clozapine from the prevalent-user cohort analysis was 2.15 (95 percent confidence interval: 1.74, 2.66) and was significantly higher than the hazard ratios for olanzapine, risperidone, and quetiapine ($p < 0.001$). From the case-control analyses, the odds ratio was 1.34 (95 percent confidence interval: 0.98, 1.82) for the 12-week exposure period, and it increased to 1.41 and 1.60 for the 24- and 52-week periods, respectively.

DISCUSSION

Second-generation antipsychotic agents are widely used as first-line therapy for psychotic illnesses, accounting for 80 percent of all antipsychotic medications prescribed in the United States in 2002 (59). Conventional antipsychotic drugs such as haloperidol may cause movement disorders and tardive dyskinesia—stigmatizing and sometimes debilitating side effects that harm patients' functioning and well-being (60). Some second-generation antipsychotic drugs may cause these side effects, but at a lower rate, while offering efficacy equal to or better than that of the older drugs (11, 61).

There is growing evidence of metabolic side effects, such as hyperglycemia and weight gain, following the use of certain second-generation antipsychotic agents. This complicates the comparison between newer and older antipsychotic drugs (59, 61, 62). Prescribing choices must now be based on an assessment of each drug's efficacy as well as its potential to cause movement disorders or metabolic side effects. Apart from clozapine, the evidence is equivocal as to whether or not second-generation antipsychotic drugs differ from one another in effectiveness, and it is not certain that they are more effective than their older counterparts (11, 59, 61–64). If and when additional benefits of second-generation agents are confirmed, they must be weighed against the risk of metabolic problems and their higher acquisition costs.

The association between second-generation antipsychotic agents and diabetes risk first came to light in case reports. In most of these, observers reported diabetic ketoacidosis, new-onset diabetes, or hyperglycemia among patients initiating either clozapine (26–33, 65) or olanzapine, the two second-generation antipsychotic agents that have been on the market for the longest time and have most often been associated with weight gain (66). Subsequently, there appeared reports of diabetes occurring in patients taking one of the other second-generation antipsychotic agents, risperidone (32, 43–46) or quetiapine (32, 41, 42), leading to uncertainty about which agents in this class carry the highest risk of diabetes. While the weight gain associated with use of these agents may contribute to the increased risk of diabetes, the mechanism appears to be complex, possibly involving direct effects of the agents on insulin sensitivity and serotonin receptor activity (22, 32, 67).

Epidemiologic studies have largely confirmed the association of new-onset diabetes with use of second-generation antipsychotic agents. However, the increase in risk is relatively small, and there are inconsistencies in the findings, particularly with respect to variation in risk among individual agents (23, 25, 47–49, 68). Compared with conventional antipsychotic agents, clozapine has been associated with more than a twofold increased risk of diabetes in younger

TABLE 5. Results from cohort and case-control analyses of diabetes risk according to use of second-generation antipsychotic medication among US veterans with schizophrenia, 1999–2001*

Second-generation antipsychotic agent	Cohort study design								Case-control study design							
	New-user cohorts			Prevalent-user cohort		12-week exposure period†			24-week exposure period‡			52-week exposure period§				
	No. of cases	HR#	95% CI#	No. of cases	HR	95% CI	No. of cases	OR#	95% CI	No. of cases	OR	95% CI	No. of cases	OR	95% CI	
Olanzapine	5,981	1.64	1.22, 2.19	19,780	1.39	1.26, 1.54	1,302	3,270	1.37	1.16, 1.58	1,138	2,898	1.39	1.20, 1.62	951	2,147	1.32	1.11, 1.58
Risperidone	5,601	1.60	1.19, 2.14	18,369	1.26	1.14, 1.40	1,001	2,808	1.20	1.03, 1.38	869	2,494	1.21	1.04, 1.42	666	1,793	1.35	1.12, 1.62
Quetiapine	877	1.67	1.01, 2.76	1,578	1.19	0.93, 1.39	147	348	1.46	1.14, 1.87	124	293	1.47	1.13, 1.92	85	186	1.62	1.32, 2.49

* In all analyses, patients exposed to haloperidol were the reference group.
† In the prevalent-user cohort analysis, the hazard ratios for olanzapine and risperidone were significantly different from each other at $p < 0.05$. There were no other significant differences between second-generation drugs within each design.
‡ The 12-week case-control study included 541 haloperidol cases and 1,578 controls.
§ The 24-week case-control study included 393 haloperidol cases and 1,180 controls.
¶ The 52-week case-control study included 244 haloperidol cases and 621 controls.
# HR, hazard ratio; CI, confidence interval; OR, odds ratio.

patients (ages 20–34 years) with schizophrenia. This was reported from a cohort analysis of Iowa Medicaid claims data (49) and subsequently confirmed in a larger study of VHA patients with schizophrenia (48). In most studies, more modest risk increases of 20–80 percent have been reported for the other, newer second-generation antipsychotic agents.

Two previous studies of VHA patients have provided much of the published evidence on this issue (23, 48). In a prevalent-user cohort analysis of VHA patients with schizophrenia, persons taking second-generation antipsychotic agents were just 9 percent more likely to have diabetes than persons taking conventional antipsychotic medications (48), with relative risks ranging from 1.1 to 1.3 for clozapine, olanzapine, quetiapine, and risperidone. Risk increases were greater in younger patients (age <50 years). This study was limited by its mixing of new and ongoing users of one or more of these agents, its failure to differentiate between new and existing cases of diabetes, and limited adjustment for potential confounders. In a second study of VHA patients from Ohio, a prevalent-user cohort analysis was performed that included all patients prescribed antipsychotic agents, not just those with schizophrenia. Compared with haloperidol, olanzapine (but not risperidone) was associated with an approximately 50 percent increased risk of diabetes (23). While the investigators attempted to address the effect of medication-switching in the analysis, they did not examine the potential influence of the pattern of switching (i.e., whether different drugs were taken simultaneously or sequentially and, if so, in what sequence), nor did they consider potential bias related to the functional form of their time-dependent covariates (69).

Findings bearing on this question have been reported from two other studies. In a nested case-control analysis of the United Kingdom General Practice Research Database, high odds ratios for diabetes were found for use of olanzapine (odds ratio = 4.2) and risperidone (odds ratio = 1.6) relative to conventional antipsychotic medication ($p > 0.05$) (47). In a second study (25), a follow-up analysis of a large prescription claims database, risk of diabetes was increased with use of any antipsychotic medication as compared with the general (nonpsychiatric) population. Compared with haloperidol, diabetes risk was greater with use of risperidone (hazard ratio = 1.23) but not with olanzapine or quetiapine use. These investigators also restricted their sample to new users and evaluated risks for patients using single antipsychotic agents. However, the sample was not limited to patients with schizophrenia, diagnosis of diabetes was based solely on prescription data, and there was more limited adjustment for confounders.

In the present study, there were negligible differences in diabetes risk associated with use of olanzapine, risperidone, and quetiapine. Each appeared to increase risk by 60–70 percent in comparison with haloperidol. Elevations in risk were higher among younger patients with schizophrenia. However, since the incidence of diabetes climbs steeply with age, a greater number of diabetes cases may be attributable to second-generation antipsychotic agents in older users as compared with younger users, and switching to lower-risk agents may actually prevent more cases of diabetes among older patients.

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TABLE 4. Characteristics of five cohorts of prevalent users of antipsychotic medication (n = 55,808) among US veterans with schizophrenia, 1999–2001

Variable	Antipsychotic agent				
	Olanzapine (n = 19,760)	Risperidone (n = 19,030)	Quetiapine (n = 1,578)	Clozapine (n = 1,293)	Haloperidol (n = 13,518)
Mean age (years)	50.0 (11.5)*	51.1 (12.4)	49.8 (11.6)	47.6 (8.7)	53.0 (12.3)
Sex (%)					
Male	93.7	93.2	90.4	95.1	95.6
Female	6.3	6.8	9.6	4.9	4.4
Race/ethnicity (%)					
White	53.2	52.2	58.5	75.8	49.0
African-American	24.4	26.4	20.3	14.1	33.2
Hispanic	6.8	5.0	3.3	2.9	5.8
Other	1.0	0.9	1.0	1.2	1.0
Unknown	14.6	15.5	18.9	5.9	11.2
Marital status (%)					
Married	23.0	23.1	22.0	9.5	19.2
Never married	43.2	42.6	40.2	60.4	48.0
Divorced, separated	29.1	29.1	33.0	21.0	26.7
Widowed	2.7	3.6	2.9	1.2	3.3
Unknown	2.0	1.6	2.0	2.0	2.6
Use of medications potentially inducing diabetes (%)					
Beta-blockers/thiazide diuretics	14.0	13.7	15.5	15.5	14.9
Lithium	6.6	5.8	7.2	4.4	6.6
Corticosteroids	1.6	1.6	1.1	0.6	1.6
Phenytoin	1.6	1.7	1.2	0.5	2.0
No. of metabolic panels per patient	0.24 (0.92)	0.22 (0.86)	0.18 (0.81)	0.22 (0.91)	0.24 (0.92)
Mean duration of follow-up (days)	495.5 (391.8)	522.5 (389.5)	270.9 (288.1)	609.5 (441.7)	505.5 (399.1)
Mean time to event (days)	290.3 (280.8)	301.1 (286.5)	137.5 (151.6)	350.6 (349.0)	295.8 (285.2)
No. of new cases of diabetes diagnosed during study period	1,098	1,026	50	106	571
Diabetes incidence per 100 person-years of exposure	4.1	3.9	4.3	4.9	3.0

* Numbers in parentheses, standard deviation.

We believe that the risk of diabetes can be attributed confidently to each agent evaluated in this study because of the new-user cohort design and because each study patient was exposed to one and only one drug during the follow-up period. Without this design, there may be important confounding related to discontinuation or switching of medications, and the effects of the agent under study may be biased by other prior or concurrent medications used (50). To our knowledge, all previous studies but one (25) either have not addressed these potential problems or have accounted for them using other methods (23, 48, 49, 68, 70). The estimates from our study suggest that, in patients with schizophrenia using olanzapine, quetiapine, or risperidone, approximately one case per 100 patients per year or one third of new-onset diabetes is attributable to use of these agents as compared with use of haloperidol.

Differences in study design may explain why our results are partially at variance with those of other studies. We evaluated this by analyzing our data using alternative study designs. Results from the prevalent-user cohort analysis are comparable to those that have been reported for studies of this kind, in that the relative risk estimates are somewhat closer to 1.0 and diabetes risk is higher with use of olanzapine compared with risperidone (23, 48). The other

finding from this analysis is a higher risk of diabetes associated with clozapine use—about a doubling of risk—and this is also consistent with previous reports (48, 49). Risk estimates from the case-control analysis are similar to those from our new-user cohort analysis. Indeed, while there are some differences in risk estimates coming from the analyses using different designs, they are similar and are statistically consistent with one another in suggesting a modestly increased risk of diabetes with use of clozapine, olanzapine, quetiapine, and risperidone. In making these comparisons, caution is warranted in using large study samples to evaluate such small differences in risk estimates—differences that may be the result of unexplained bias.

In comparison with the new-user cohort analysis, more modest associations with diabetes risk were found in the prevalent-user cohort design. This sampling strategy is more likely to include patients who were long-term users and tolerated their drugs well, since patients who gained more weight or had other metabolic problems may have had their medications discontinued or changed prior to the time of our study. Their underrepresentation in the sample may have resulted in the somewhat weaker associations observed with the prevalent-user cohort design. It is important to recognize that potential confounding or problems of differences between switchers and long-term users cannot be resolved entirely through the use of a cohort design. Nevertheless, we believe that the new-user cohort design is preferable as a method of reducing these potential problems (50).

Other considerations warrant caution in interpreting these findings. The pharmacy or diagnostic data may have been inaccurate or incomplete, and there may have been misclassification in the identification of schizophrenia and diabetes, although conservative definitions were used (52). Confounding by contraindication remains a possible explanation for our results, particularly since we lacked critical information with which to adjust for baseline diabetes risk, such as data on initial weight, change in weight, caloric intake, existing hypertension or hypercholesterolemia, and family history of diabetes. Prescribers who believed that some drugs (e.g., clozapine or olanzapine) caused more weight gain than others may have steered patients with high diabetes risk away from these agents. If this did occur, the risk for these drugs may have been underestimated, while risk for more weight-neutral drugs (e.g., risperidone or quetiapine) may have been overestimated. Concern about this potential source of confounding is mitigated by our finding of only minute differences in the intensity of diagnostic screening between users of the different drugs. Nevertheless, confounding by contraindication remains a possible source of bias in this study and in previously conducted observational studies of antipsychotic agents and diabetes, none of which controlled for baseline diabetes risk.

There are other limitations to our research. Medications taken prior to the 3-month period used to identify patients for the new-user cohort analysis may have influenced subsequent risk, and we had no information on those prescriptions. Restricting our study to patients exposed to only one antipsychotic agent limited our ability to assess the potential diabetogenic effects of simultaneous or sequential exposures to more than one antipsychotic drug—patterns that may be common in clinical practice. Since we did not study ziprasidone or aripiprazole, the newest second-generation antipsychotic agents, no conclusions should be drawn from our study about their potential for causing diabetes.

Some caution in generalizing the results of our study to users of other antipsychotic agents is also warranted. We studied patients with schizophrenia, and effects may be different in patients taking antipsychotic drugs for other indications. Patients in our new-user cohorts who did not receive antipsychotic medication at the VHA for at least 3 months may have been different from the larger population of VHA patients with schizophrenia. Although some of these patients may have used non-VHA services during that time, they were unlikely to obtain outpatient medications from non-VHA sources, where costs are higher and access is more limited (71, 72). Poor adherence to treatment is a significant issue in schizophrenia (73–75), and substantial time periods without treatment are not unusual. The lack of differences in patient characteristics between the new-user cohorts and the prevalent-user cohorts partially mitigates these concerns. Generalizing these results beyond the VHA population should be done with caution, especially since there were so few women in the sample.

The evidence presented here for an association between selected second-generation antipsychotic medications and metabolic problems should be placed in a broad context. Decisions concerning selection of specific antipsychotic medications should be based on safety, efficacy, tolerability, and cost (61, 63). The relative weights assigned to these factors will depend on the clinical and financial context of treatment (76, 77).

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ORIGINAL REPORT

Exploring the risk of diabetes mellitus and dyslipidemia among ambulatory users of atypical antipsychotics: a population-based comparison of risperidone and olanzapine†

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SUMMARY

Purpose To compare the incidence rates of diabetes mellitus and dyslipidemia in ambulatory first-time users of risperidone and olanzapine.

Methods The database for the Prescription Drug Insurance Plan in the province of Quebec was used as the data source for a population-based cohort study. Deidentified data were extracted for all ambulatory patients who first received an atypical antipsychotic between 1 January 1997 and 31 August 1999. Eligible patients were categorized as taking: no antidiabetic medication; no lipid reducing medication; neither type of medication. Those who started to use an outcome drug (an antidiabetic or lipid-lowering medication) before the end of the follow-up period (31 August 2000) were considered to have developed the corresponding outcome disease. Incidence rate ratios (IRR) (and 95% confidence intervals) for initiating antihyperglycemic or lipid-lowering drug treatment, or both were calculated. Outcomes on risperidone were compared to those on olanzapine.

Results A total of 19 582 eligible patients were included in the analysis. Relative to risperidone, olanzapine was associated with a higher risk of initiating a pharmacologic treatment for diabetes [IRR: 1.33 (1.03–1.74)], dyslipidemia [IRR: 1.49 (1.22–1.83)], or either condition [1.47 (1.23–1.76)].

Conclusions Olanzapine seems to be associated with a higher risk of developing diabetes and/or dyslipidemia than risperidone. Further prospective studies are needed to rigorously assess the safety of olanzapine. Copyright © 2005 John Wiley & Sons, Ltd.

KEY WORDS — diabetes mellitus; dyslipidemia; atypical antipsychotics; population-based; cohort study

INTRODUCTION

Schizophrenia is a major psychotic disorder that can be highly debilitating. The disease most commonly manifests itself in late adolescence or early adulthood, and has a worldwide lifetime prevalence of about 1%.[1] Schizophrenia is frequently characterized by a chronic recurrent course that leads to significant costs associated with health care utilization and productivity loss.[1,2] The economic burden of schizophrenia in Canada in 1999 was estimated at 4.3 billion CAD (2.3 billion in direct health care costs, plus 2 billion in indirect costs for support services).[3]

Typical (conventional) antipsychotics such as chlorpromazine and haloperidol revolutionized the treatment of schizophrenia and contributed substantially to the process of de-institutionalization in the past 30 years.[4] Unfortunately, their effectiveness in managing schizophrenia is compromised by a high incidence of

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drug-related side effects—especially extra-pyramidal symptoms—that often lead to treatment non-compliance and discontinuation.[5,6] The new atypical antipsychotics (i.e., clozapine, olanzapine, quetiapine, and risperidone) exhibit different pharmacological profiles,[1,7] and have demonstrated superior efficacy against negative symptoms. They have also been associated with a lower risk of extra-pyramidal symptoms.[7]

On the other hand, atypical antipsychotics (olanzapine and clozapine, in particular) appear to cause weight gain to a higher proportion of patients than do most conventional antipsychotics.[8] Four recent reviews of case reports[8–12] and one meta-analysis[13] suggest that risperidone causes less weight gain than clozapine, olanzapine, and quetiapine. Moreover, Crabot *et al.*[14] observed in a recent clinical trial that clozapine, olanzapine and to a lesser degree, risperidone produced an increase in body weight. It has been suggested that these apparent differences in potential for causing weight gain are associated with differences in drug affinity for different neurotransmitter receptors.[10]

It is well established that obesity predisposes or exacerbates a number of diseases, including type II diabetes mellitus[15] and dyslipidemia.[16] Indeed, evidence is emerging that atypical antipsychotics may increase the risk of diabetes mellitus and dyslipidemia—especially hypertriglyceridemia. Recent observational studies support the evidence of an increased risk of diabetes for users of atypical antipsychotics,[17,18] in particular for those using olanzapine,[19–21] clozapine or quetiapine[21] as opposed to risperidone. On the other hand, differences in risk between olanzapine and risperidone have not been observed in other studies.[17,22] With regard to the risk of developing dyslipidemia, Koro *et al.*[22] have observed a strong association between olanzapine and hyperlipidemia when compared to risperidone. Nevertheless, in one[17] of the studies, there were too few users of each of the atypical antipsychotic to allow for appropriate head-to-head comparisons. Moreover, the duration of antipsychotic treatment may not have been taken into account in two of the studies[20,23] while diabetes diagnosis may have preceded the initiation of the antipsychotic treatment in another one[21] making causality assessment difficult. Therefore, the extent to which individual atypical antipsychotics are associated with diabetes or dyslipidemia is not well established.

We aimed to determine whether olanzapine is associated with a relative increase in the incidence of these diseases. More specifically—since risperidone induces less weight gain than olanzapine and seems to be associated to a lesser degree to diabetes and dyslipidemia—are patients treated with risperidone at lower risk of developing diabetes or dyslipidemia? To address this question, we conducted a population-based cohort study that compared the incidence rates of diabetes and dyslipidemia (alone or in combination) in a population of ambulatory first-time users of olanzapine or risperidone.

METHOD

Study population

We used the database from the Prescription Drug Insurance Plan administered by the Quebec Health Insurance Board [Régie de l'Assurance-maladie du Québec (RAMQ)] to conduct a population-based cohort study. This insurance plan covers the province of Quebec's non-institutionalized seniors (age 65 years or over), welfare recipients, and members of the general population who are not beneficiaries of a private drug plan. In 2000, over 3.2 million of a population of 7.2 million inhabitants were RAMQ beneficiaries.

To select study participants, we asked the RAMQ to identify all drug plan beneficiaries who had received at least one prescription of an atypical antipsychotic drug (i.e., clozapine, olanzapine, quetiapine, or risperidone) between 1 January 1997 and 31 August 1999. For each of the beneficiaries who met our screening criteria, the RAMQ sent us data on all drugs dispensed and on all physician visits between 1 July 1996 and 31 August 2000 and on all periods of eligibility for the drug plan. To preserve anonymity, the RAMQ sent us denominalized data. Using the information provided, we excluded all beneficiaries who: (1) were 65 years or older since antipsychotics can be prescribed for dementia in this age group; (2) had received any atypical antipsychotic during the 180 days preceding the index date (i.e., first prescription fill date for the index drug) (risperidone or olanzapine); (3) had received two atypical antipsychotics at the index date; (4) were initiated on clozapine or quetiapine; or (5) had not been eligible for the drug plan for all 180 days preceding the index date.

From the remaining patients, we identified three subpopulations. The 'diabetes-free study population' included only patients who had not received a drug from the 'drugs used in diabetes' class of the anatomical therapeutic and chemical classification (ATC)[24] (class A10) during the 180 days preceding the index date. The 'dyslipidemia-free study population' comprised patients who had not received a drug from the ATC class of serum lipid reducing agents (class C10)

during the same period. Finally, the 'both diseases-free study population' excluded all patients who had received a drug from either class A10 or C10.

Variables

By using unique encrypted health insurance numbers, we linked the RAMQ beneficiary database, and the pharmacists' and physicians' billing databases at the patient level. The physicians' billing database provides data on medical consultations. The pharmacy database contains information on dispensed drugs (prescription fill date; drug name, dose, and dosage form; quantity of drug dispensed; treatment duration), and is considered both reliable and valid.[25] The beneficiary database provides data on age, sex, drug plan eligibility, and (when applicable) death.

The outcome variable was defined as a first prescription of: any antidiabetic drug, for the diabetes-free study population; any serum lipid reducing agent, for the dyslipidemia-free study population; a first prescription of either of these drug classes, for the both diseases-free study population. Beneficiaries who were prescribed an outcome drug were considered to have the disease usually treated with the drug. Person-months of follow-up were calculated as the interval between the prescription date of the first index drug and the prescription date of the first outcome drug. Patients who discontinued the index drug became ineligible for the drug plan, died, or reached the end of the follow-up period (31 August 2000) were censored at that event date. A patient was deemed to have discontinued the index drug if the prescription was not refilled 60 days after the end of its duration (e.g., at day 90, relative to a 30-day prescription). The discontinuation date was defined as the date of the last refill plus its duration.

Analyses

We used frequency distributions to describe the baseline (i.e., at the index date) characteristics of each of the three study sub-populations. We then used Cox's proportional hazards model to compute incidence rate ratios (IRR) of having diabetes, dyslipidemia or either disease among olanzapine users compared with risperidone users. We employed the same procedure to build all three models. We first tested the interaction between sex and index drug use and the interaction between age group and index drug use. As we did not find any interaction, age, sex, use of a typical antipsychotic during the 180 days preceding the index date, type of beneficiaries, number of physician visits per day of follow-up, and concomitant use of any drug considered to potentially cause weight gain, or predispose to diabetes or dyslipidemia (Appendix A) were included in the models as potential confounding variables. We computed 95% confidence intervals (CI) for each IRR. We tested the interaction between the drug and the log of follow-up in days. The proportionality assumption for the proportional hazards model was met for each of the three outcome models. All analyses were performed using version 8.1 of the SAS software package.[28]

RESULTS

In all, 38 043 RAMQ beneficiaries received an atypical antipsychotic between 1 January 1997 and 31 August 1999. Of these, 19 582 (51%) were eligible for at least one of the three study sub-populations (Figure 1). The diabetes-free, dyslipidemia-free, and both diseases-free sub-populations consisted of 18 891 (Table 1), 18 675 (Table 2), and 18 134 (Table 3) patients, respectively. In each of these sub-populations, around 54 and 46% of individuals were first prescribed olanzapine and risperidone, respectively.

The risk of initiating an antidiabetic drug treatment was higher among people prescribed olanzapine than among those prescribed risperidone (IRR: 1.33; 95%CI: 1.03–1.73) (Table 4). People taking olanzapine had a higher risk of initiating a lipid-lowering drug treatment than those taking risperidone (IRR: 1.49; 95%CI: 1.22–1.83). The risk of initiating either antidiabetic or lipid-lowering agents was higher among patients on olanzapine (IRR: 1.47; 95%CI: 1.23–1.76). Survival probabilities of treatment initiation for diabetes, dyslipidemia, or both are illustrated in Figures 2–4.

DISCUSSION

All but 3% of these ambulatory patients received either risperidone or olanzapine as their first atypical antipsychotic treatment. Not surprisingly, the number of clozapine and quetiapine users was low. Quetiapine was listed on the RAMQ formulary in April 1998, 51 and 14 months after risperidone and olanzapine, respectively, and 16 months into the 44-month study period. Because there were few quetiapine users and since clozapine is reserved for refractory cases because it increases the risk of agranulocytosis and requires close monitoring, we decided not to include quetiapine and clozapine users in this risk assessment.

An important finding emerged from this study. In our population, olanzapine users were at higher risk of

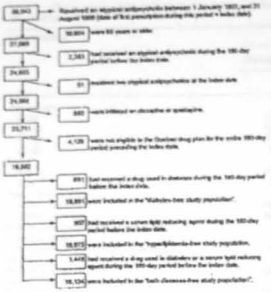

Figure 1. Selection of study subjects

initiating antidiabetic or lipid-lowering drug treatments than patients treated with risperidone. This finding is relevant to public health, given that diabetes and dyslipidemia are both known to increase cardiovascular morbidity and mortality,[27–33] as well as health care costs.[34]

Our findings add to the evidence that individuals exposed to olanzapine are at increased risk for diabetes or dyslipidemia than those exposed to risperidone. Our results are in agreement with recent observational studies.[20,23] In these studies, it is, however, unclear whether individuals exposed to olanzapine or risperidone were new users of these drugs, and thus, it is not well established whether duration of exposure to antipsychotic treatment was taken into account. In our study, we minimized the effect of prior treatment by including only new users of atypical antipsychotics. Indeed, the inclusion of prior users might have biased incidence estimates: prior use of atypical antipsychotics might already have affected patient weight and metabolism, and hastened the apparent onset of the outcome disease. Despite potential differences in methodology, results were similar.

Our results are also in agreement with those reported by Gianfrancesco *et al.*[35] In this study however, new users of atypical antipsychotic drugs

Table 1. Characteristics of the diabetes-free study population, number (%) per censoring event, and mean duration of follow-up ($N = 18\,891$)

Characteristics	Study drug		
	Olanzapine ($N = 10\,106$)	Risperidone ($N = 8785$)	Total ($N = 18\,891$)
	n (%)	*n* (%)	*n* (%)
Age in years			
0–29	1768 (17.5)	2088 (23.8)	3856 (20.4)
30–44	4660 (46.1)	3605 (41.0)	8265 (43.8)
45–59	3133 (31.0)	2513 (28.6)	5646 (29.9)
60–64	545 (5.4)	579 (6.6)	1124 (6.0)
Sex			
Female	4771 (47.2)	4394 (50.0)	9165 (48.5)
Male	5335 (52.8)	4391 (50.0)	9726 (51.5)
Type of beneficiarien			
General clientele	2144 (21.2)	2317 (26.4)	4461 (23.6)
Welfare recipients	7962 (78.8)	6468 (73.6)	14 430 (76.4)
Number of physician visits per year of follow-up, median	16.2	17.7	16.8
Censoring events			
Prescription of a drug used in diabetes[a]	170 (1.7)	87 (1.0)	257 (1.4)
Death	93 (0.9)	56 (0.6)	149 (0.8)
Study drug discontinuation	6670 (66.0)	6573 (74.8)	13 243 (70.1)
Loss of eligibility to drug program	133 (1.3)	127 (1.5)	260 (1.4)
End of follow-up period	3040 (30.1)	1942 (22.1)	4982 (26.4)
Incidence rates ($\times 10^{-2}$/days)	4.45	3.14	3.90

[a]Drugs listed in class A10 of the ATC classification.

Table 2. Characteristics of the dyslipidemia-free study population, number (%) per censoring event, and mean duration of follow-up ($N = 18\,675$)

Characteristics	Study drug		
	Olanzapine ($N = 9928$)	Risperidone ($N = 8747$)	Total ($N = 18\,675$)
	n (%)	n (%)	n (%)
Age in years			
0–29	1771 (17.8)	2096 (24.0)	3867 (20.7)
30–44	4589 (46.2)	3588 (41.0)	8177 (43.8)
45–59	3040 (30.6)	2477 (28.3)	5517 (29.5)
60–64	528 (5.3)	586 (6.7)	1114 (6.0)
Sex			
Female	4695 (47.3)	4387 (50.2)	9082 (48.6)
Male	5233 (52.7)	4360 (50.8)	9593 (51.4)
Type of beneficiaries			
General clientele	2095 (21.1)	2296 (26.3)	4391 (23.5)
Welfare recipients	7833 (78.9)	6451 (73.7)	14 284 (76.5)
Number of physician visits per year of follow-up, median	16.2	17.7	16.8
Censoring events			
Prescription of a serum lipid reducing agent[†]	294 (3.0)	140 (1.6)	434 (2.3)
Death	93 (0.9)	57 (0.7)	150 (0.8)
Study drug discontinuation	6540 (65.9)	6524 (74.6)	13 064 (70.0)
Loss of eligibility to drug program	130 (1.3)	130 (1.5)	260 (1.4)
End of follow-up period	2871 (28.9)	1896 (21.7)	4767 (25.5)
Incidence rates ($\times 10^{-5}$/days)	7.94	5.10	6.73

[†]Drugs listed in class C10 of the ATC classification.

Table 3. Characteristics of both diseases-free study population, number (%) per censoring event, and mean duration of follow-up ($N = 18\,134$)

Characteristics	Study drug		
	Olanzapine ($N = 9657$)	Risperidone ($N = 8467$)	Total ($N = 18\,134$)
	n (%)	n (%)	n (%)
Age in years			
0–29	1761 (18.2)	2082 (24.6)	3843 (21.2)
30–44	4522 (46.8)	3523 (41.6)	8045 (44.4)
45–59	2899 (30.0)	2336 (27.6)	5235 (28.9)
60–64	485 (5.0)	526 (6.2)	1011 (5.6)
Sex			
Female	4555 (47.1)	4221 (49.9)	8776 (48.4)
Male	5112 (52.9)	4246 (50.1)	9358 (51.6)
Type of beneficiaries			
General clientele	2043 (21.1)	2231 (26.4)	4274 (23.6)
Welfare recipients	7624 (78.9)	6236 (73.6)	13 860 (76.4)
Number of physician visits per year of follow-up, median	16.0	17.5	16.6
Censoring events			
Prescription of a drug used in diabetes or of a serum lipid reducing agent[†]	370 (3.8)	178 (2.1)	548 (3.0)
Death	87 (0.9)	53 (0.6)	140 (0.8)
Study drug discontinuation	6348 (65.7)	6319 (74.6)	12 667 (69.9)
Loss of eligibility to drug program	130 (1.3)	125 (1.5)	255 (1.4)
End of follow-up period	2732 (28.3)	1792 (21.1)	4524 (25.0)
Incidence rates ($\times 10^{-5}$/days)	10.4	6.77	8.85

[†]Drugs listed in class A10 or C10 of the ATC classification.

Table 4. Incidence rate ratios (IRR) [and confidence intervals (95%CI)] of diabetes, dyslipidemia, or either of conditions among atypical antipsychotic users

Initiation of treatment for	Atypical antipsychotic	*n*	Crude IRR	95%CI	*p*-value	Adjusted IRR*	95%CI	*p*-value
Diabetes	Risperidone	8785	1.00			1.00		
	Olanzapine	10 106	1.40	1.08–1.81	0.01	1.33	1.03–1.73	0.03
Dyslipidemia	Risperidone	8747	1.00			1.00		
	Olanzapine	9928	1.53	1.23–1.88	<0.001	1.49	1.22–1.83	<0.001
Either of conditions	Risperidone	8467	1.00			1.00		
	Olanzapine	9667	1.52	1.27–1.81	<0.001	1.47	1.23–1.76	<0.001

*Adjusted for age, sex, type of beneficiaries, number of physician visits per day of follow-up, concomitant use of any drug considered to potentially cause weight gain, or predispose to diabetes or dyslipidemia, and for use of any typical antipsychotic during the 180 days preceding the index date.

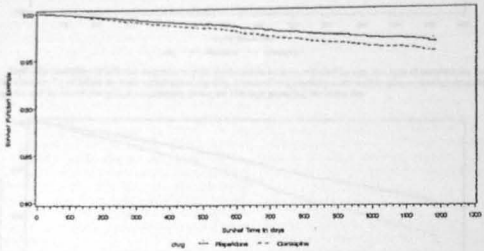

Figure 2. Survival probabilities of initiating drug treatment for diabetes, by drug, adjusted for age, sex, type of beneficiaries, number of physician visits per day of follow-up, concomitant use of any drug considered to potentially cause weight gain, or predispose to diabetes or dyslipidemia, and for use of any typical antipsychotic during the 180 days preceding the index date

were defined as the absence of a prescription for that antipsychotic for at least 90 days before the study index prescription, and the period of follow-up was limited to a maximum of 12 months. In our study, we defined new users of antipsychotic drugs as those who had not had a prescription for any atypical antipsychotic drugs in the 180 days preceding the index date. Next, by using Cox's proportional hazards model to estimate the risks ratios, we took into account a follow-up duration as long as 44 months for these drugs. Furthermore, we took into account the concomitant use of drugs that could have contributed to weight gain, diabetes, or dyslipidemia which was not done in the aforementioned study.

By contrast, our findings are not concordant with those reported in two other studies exploring the association between atypical antipsychotics and diabetes.[21,22] In the former[21] however, the design was cross-sectional which makes causality difficult to establish. In the latter study, Ettinnan *et al.*[22] did not report a statistically significant difference between risperidone and olanzapine in the proportion of new users prescribed an antibiabetic drug during the study period. However, there was no attempt to estimate the relative risk adjusting for potential confounding variables.

Our findings are also in agreement with evidence emerging from case studies. Melkersson *et al.*[36] observed that 10 of 14 patients treated with olanzapine had insulin levels above the normal limit (although pretreatment values were not known). In a recent review, Liebzeit *et al.*[37] retrieved 15 published cases of diabetes induced by olanzapine. One study, reported in a letter, compared the total cholesterol, triglyceride

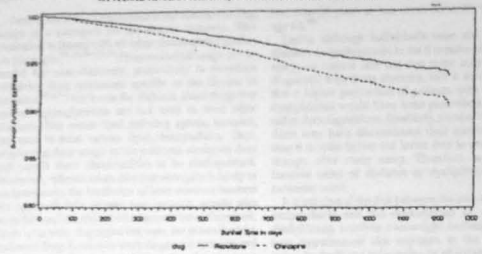

Figure 3. Survival probabilities of initiating drug treatment for dyslipidemia, by drug, adjusted for age, sex, type of beneficiaries, number of physician visits per day of follow-up, concomitant use of any drug considered to potentially cause weight gain, or predispose to diabetes or dyslipidemia, and for use of any typical antipsychotic during the 180 days preceding the index date

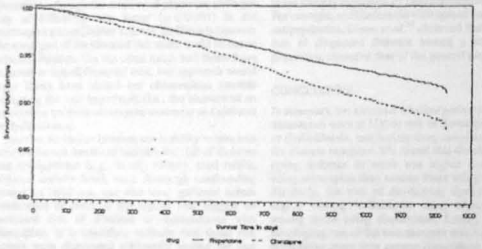

Figure 4. Survival probabilities of initiating drug treatment for either diabetes or dyslipidemia, by drug, adjusted for age, sex, type of beneficiaries, number of physician visits per day of follow-up, concomitant use of any drug considered to potentially cause weight gain, or predispose to diabetes or dyslipidemia, and for use of any typical antipsychotic during the 180 days preceding the index date

levels, and lipoprotein fractions of men treated with olanzapine or risperidone (22 subjects per group) for a mean of 17 months[38]: olanzapine-treated patients had significantly higher levels of plasma triglyceride and very low-density lipoprotein cholesterol. Baseline values were not, however, taken into account. Osser *et al.*[39] also observed an increase in fasting triglycerides levels after 12 weeks of olanzapine treatment.

More recently, Lindenmayer *et al.*[40] examined clinical trial data for changes in glucose and cholesterol levels during treatment with antipsychotics. They found that olanzapine was associated with a statistically significant increase in glucose and cholesterol levels after 14 weeks of treatment. There was no significant elevation in glucose or cholesterol levels with risperidone.

Among the study's limitations is our need to use drug usage as a surrogate for the disease outcome. This limitation is shared with all other observational studies on this topic.[17,18,20–22,35] Pharmaceutical usage can be useful for case discovery, particularly in situations involving drug treatments specific to the disease in question.[41,42] This is true for diabetes, since drugs that control hyperglycemia are not used to treat other diseases. The serum lipid reducing agents, however, are used to treat various lipid abnormalities. Thus, employing drug usage as the outcome surrogate does not permit these abnormalities to be distinguished. Moreover, reliance on an outcome surrogate is likely to underestimate the incidence of both diseases because the approach fails to take into account: people who have the condition(s) but who have not been diagnosed; those who were diagnosed but were not prescribed the outcome drug; those who were diagnosed and received but did not fill a prescription for the outcome medication. It is not known whether patients on olanzapine were screened and treated for diabetes and dyslipidemia more intensively than patients on risperidone though the number of physician visits per day of follow-up was lower ($p < 0.001$) in the olanzapine group (Tables 1, 2, and 3). If this is however the case, part of the elevated risk ratios could be due to misclassification. On the other hand, had these flaws resulted in non-differential bias, our approach would most likely have biased our observations towards accepting the null hypothesis (i.e., the absence of an association between olanzapine treatment and diabetes or dyslipidemia).

Another limitation involves our inability to take into account factors known to increase the risk of diabetes and dyslipidemia (e.g., family history, food habits, physical activity level, etc.). Although confounding cannot be ruled out, our data were gathered before publication of most of the reports that suggest an increased risk of diabetes or dyslipidemia with olanzapine. It is therefore unlikely that those risk factors were distributed differently among the two index drug groups.

Similarly, we lacked information about the actual indication for which an atypical antipsychotic was prescribed. Since risperidone is the only atypical antipsychotic indicated (since 1999/2000) in Canada for the treatment of symptoms associated with serious dementia,[43] risperidone users could have differed from those on olanzapine. As schizophrenia may be a risk factor for diabetes,[24] a higher proportion of schizophrenic patients in the olanzapine group could explain at least part of the elevated risk ratios. To minimize this potential bias, we restricted the analysis to people aged less than 65 years as late onset dementia occurs after age 65.[44]

Lastly, although individuals were not treated for diabetes or dyslipidemia in the 6 months prior to study entry, we cannot rule out that some may have been diagnosed with these diseases, still it seems unlikely that a higher proportion of patients with diabetes or dyslipidemia would have been prescribed olanzapine rather than risperidone. Similarly, some of these individuals may have discontinued their medication more than 6 months before the index date to come back on therapy after study entry. Therefore, some of the incident cases of diabetes or dyslipidemia may be recurrent cases.

It is not clear if the link between the use of an atypical antipsychotic and the development of diabetes or dyslipidemia involves overweight exclusively. Some have hypothesized that exposure to the medication may—by itself and independently of weight—be associated with the onset of diabetes or dyslipidemia.[10,45] Moreover, schizophrenia may be associated with an increased prevalence of diabetes and dyslipidemia that is not entirely explained by pharmacological treatment. For example, well before the widespread use of atypical antipsychotics, Dixon *et al.*[24] observed that the proportion of diagnosed diabetes among a schizophrenic population exceeded that of the general population.

CONCLUSION

In summary, we assessed whether patients initiated on olanzapine were at higher risk of developing diabetes or dyslipidemia, employing drug usage as a surrogate for disease outcome. We found that the risk of developing diabetes de novo was higher among people using olanzapine than among those using risperidone. Similarly, the risk of developing dyslipidemia was higher among individuals using olanzapine than among those using risperidone. Lastly, the risk of developing one of the two diseases was higher among olanzapine users than among risperidone users.

When they choose a drug, clinicians ought to consider a range of factors related to effectiveness, side effects, quality of life, adherence to treatment, and health care costs. Our data suggest that the differences in risks of diabetes and dyslipidemia associated with the various atypical antipsychotics should also be taken into account. As type II diabetes and dyslipidemia increase cardiovascular morbidity and mortality, our findings raise concerns about the long-term safety of olanzapine. Further prospective studies are needed to rigorously assess the cardiovascular safety of this drug.

KEY POINTS

- The risk of developing diabetes was higher among people using olanzapine than among those using risperidone.
- The risk of developing dyslipidemia was higher among individuals using olanzapine than among those using risperidone.
- As diabetes and dyslipidemia increase cardiovascular morbidity and mortality, our findings raise concerns about the long-term safety of olanzapine.

ACKNOWLEDGEMENTS

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Appendix A

DRUGS CONSIDERED TO POTENTIALLY CAUSE WEIGHT GAIN, OR PREDISPOSE TO DIABETES OR HYPERGLYCEMIA AS LISTED IN MEYLER'S SIDE EFFECTS OF DRUGS.[48]

- Androgens: danazol, fluoxymesterone, methyltestosterone, nandrolone, testosterone.
- Anticonvulsants: gabapentin, valproic acid, vigabatrin.
- Beta-adrenergics blockers: acebutolol, atenolol, metoprolol, nadolol, pindolol, propranolol, sotalol, timolol.
- Corticosteroids.
- Estrogens: clomiphen, conjugated estrogens, diethylstilbestrol, esterified estrogens, estradiol, estrone, estropipate, ethinyl estradiol, raloxifen.
- Ketotifen.
- Lithium.
- Megestrol.
- Monoamine oxydase inhibitors: moclobemide, phenelzine, tranylcypromine.
- Pizotifen.
- Progestagens: levonorgestrel, medroxyprogesterone, norethindrone, progesterone.
- Tamoxifen.
- Tricyclic antidepressants: amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nortripyline, trimipramine.

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630 CI

MOTION ARGUMENTS BEFORE THE DISCOVERY MASTER

Pages 1 - 168
Tuesday, September 11, 2007
11:00 A.M.

at
LANE POWELL
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

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MR. SUGGS: Would you prefer that we address the issue regarding medical records first?
DISCOVERY MASTER: Early. You can do it first. Early.
MR. SUGGS: Do you want to --
MR. STEELE: Can I switch with you, David, because I'm going to talk about that?
MR. SUGGS: Oh, certainly. Absolutely.
DISCOVERY MASTER: Leave aside in your initial round of arguments the length of the 30(b)(6) motion and the newly filed motion to postpone the Taurel deposition. We'll take care of that after we've taken care of everything else.
So we'll start with -- are you going to do it, Mr. Steele?
MR. STEELE: That would be me.
DISCOVERY MASTER: Okay. Make sure everybody can hear Mr. Steele. Mr. Rothschild, Mr. Lehner, are you able to hear Mr. Steele?
MR. ROTHSCHILD: This is Eric. I can hear fine. Thank you.
MR. LEHNER: George Lehner. Yes. Thank you.
DISCOVERY MASTER: Okay. If you can't or we cut out, let us know, please.

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MR. STEELE: All right. Let me start with the things that I think we can agree on. Counsel, helpful to us and helpful to the process is the affidavit of your expert, whose name I'm going to mispronounce, Beth Veerig?
MR. BOISE: Virnig.
MR. STEELE: Virnig. The difficulty we were having was the difficulty in addressing the question of how somebody could give anybody all of the Medicaid database. It's not like a basketball where it's in our possession, wrapped up neatly and nicely, and we can just hand it to you.
So fortunately, I guess, we have this affidavit by your expert, and I think that I can address some of the things that she addresses there, because I take what she is saying to be a description by her of what else you need in addition to what we have given you thus far. So let me see if I can go through that one at a time.
Does the Court have the affidavit?
DISCOVERY MASTER: I don't think so.
MR. STEELE: It would have been part of the lengthy response that was filed.
DISCOVERY MASTER: Then I do have it. Okay. I have it. Number? Exhibit number.

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MR. BOISE: B.
MR. STEELE: Maybe get on the same page with me.
DISCOVERY MASTER: Got it.
MR. STEELE: Can you turn to page 3? Because that's what we're going to discuss.
DISCOVERY MASTER: Um-hum.
MR. STEELE: Okay. I take what is being said here to be this. Beginning at page 3, the good doctor is saying what else it is that you need in order to do what it is that you intend to do with the data. Dave Campana, who is the Medicaid person most knowledgeable about what exists and how hard it is to get it, is in a meeting out of state until the 13th. Since we just got this yesterday and I was flying, I didn't see it till this morning. So I have not been able to confer with him, but I have gotten Matt Garretson and his people on the line.
Mr. Garretson would be one of our co-counsel and also somebody who is knowledgeable in general about what kind of things exist in the Medicaid database.
To confer with him to see what of these things we think ought to be there or ought to be available and how hard it would be to get it. So I

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am prepared to go through those one at a time and say what it is that we have to say about it. I think it will probably solve some of our problems because I think we can accommodate you on some of these things.
She begins on No. 1, but No. 2 is really where we start talking about things that you want, underneath enrollment data. On No. 2, to the extent that it is available and can be de-identified - by de-identified I mean take out patient-specific information, like name and Social Security number - we're willing to produce this information.
MR. JAMIESON: Excuse me. Is that paragraph 2?
MR. STEELE: That's 2 on page 3. And again, I'm saying this on behalf of Dave Campana, who I have not been able to speak with, but speaking in general with Mr. Garretson, we believe this sort of thing is available. If it is available and it can be produced, that is, if it exists and we can get it, we will give it to you in a de-identified form.
I think we've refined our approach to de-identifying information, knowing that what you all are interested in, as are we, is being able to identify discrete patients within the database. In other words, knowing information that will be able to

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for the same thing really as No. 10, and again you can have it if it is available and if it exists.

I would suggest to you that maybe the good doctor hasn't looked at all of the things that we have given you. Maybe she's having trouble accessing it in a database, but I know, based on our statistical analysis, that some of the things that she's talking about in 10, 11, 12 and 13, all of which relate to medications, I believe that almost all of that is in there.

For example, I do believe that beta blockers are in there because that is a potential confounder, and so I believe that it is there. I believe that information is there with respect to diabetic medications because that is the measure that we are using to determine whether somebody has diabetes or not.

So maybe she's having trouble figuring out where these things are, but it is apparent to me from reading this that she doesn't know everything that is in there. But if there is more with respect to 10, 11, 12 and 13, we'll give it to you.

With respect to pre-96 data, we understand it to be corrupted for whatever reasons it is corrupted. If it can be assembled in a form that can

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be transmitted to you, and I don't know how difficult that is, but barring some unreasonable amount of expense or effort that would burden the State system, you can look at the fouled-up and corrupted 1996 data and make your own judgments. And again, I haven't been able to talk to Dave Campana about how difficult it is to bundle this up and send it to you. If it does turn out to be extraordinarily difficult, I'm sure we can work something out, pay for people's time if they have it, or we'll figure something out. But if you want to look at corrupted data, you are welcome to it.

That covers the database, and I think that that pretty much covers everything that needs to be said about it unless you guys have any other questions about -- like could we have this or could we have that.

DISCOVERY MASTER: How about if you all respond to the discrete database issue.

MR. BOISE: Sure.

DISCOVERY MASTER: If you're ready to do that.

MR. BOISE: Absolutely.

DISCOVERY MASTER: Okay.

MR. BOISE: Thank you. Much of what Mr.

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Steele has articulated, we certainly have had discussions about it, indeed on-the-record discussions about where similar types of, if not agreements, willingness to look for documents and look for data have been offered. And the response has largely been: If we have it, we'll try to provide it to you, and the like. Yet we still sit here without the data, and that's what prompted, in large part, our desire to go right to the source.

We don't doubt a word that Mr. Steele has said that this is complex. We don't doubt that there is more digging that needs to be done and there is experts that need to be involved in doing that digging. And that is why what we have asked for is to go to the data source itself maintained by the agent of the State, First Health, and have our experts go in and extract the data that needs to be extracted from the database.

The first example that Mr. Steele addressed was under enrollment data, and what I understood him to say was we will get all enrollment data, but in addition to that, you're going to look for additional information on race and gender. We certainly want that as well, but that was an example of data that we're seeking in a database. What we don't know is

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what we don't know.

We just received at the end of last week a listing of all the fields in the database, and there is hundreds and hundreds and hundreds of fields that are attached, I think as the last exhibit to that large pleading -- it's not there. I'll get a reference for you. Exhibit F, which we received late last week, which gives hundreds of fields of additional data items which we're just learning about.

So what happened here was we got a selective cut of data instead of the whole database. We're told it's burdensome to package it like a basketball and sort of hand it to us, and we appreciate that, but we haven't understood or heard what that burden is in any way, shape or form. We've offered to have our own experts go in and extract what we need from this database, and that's what we're really asking for here.

I mean, you have, you know, the position of the State having to go back to the one person who has the information concerning this data which was unable to answer now for a period of months, and I think it's time for us to be able to see what is in that database in its totality and be able to extract

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enrollees to obtain medical records. And if the State wants to go through the burden of de-identifying to protect its interests, that Lilly is in favor of that process. And we went further and said, to meet the doomsday scenario painted by Mr. Steele that we're going to take 700 plaintiffs' depositions, we said before we take a single deposition of a person who is suffering from mental illness, we're going to come back to you and say here is the type of people we need to depose.

But before we can even begin to make the judgment as to depositions of prescribers or plaintiffs, we need, A, a fuller database so we can make the assessment of medical records that we absolutely need, and we need additional medical records.

And there is only one other case I'm aware of that's proceeded in this fashion. The State of Louisiana has sued an atypical antipsychotic manufacturer, Jansen, Johnson and Johnson, over a Lilly competitor product, Risperdal, espousing similar theories, and we attached the court's order in that case.

There was a dispute as to whether medical records are obtainable in that litigation, and HIPAA

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concerns and privacy concerns were raised, and the court entered an order, said yes, you're entitled to at least a sampling of medical records, and ordered a sampling of 6,000 parties. Ultimately resolved on 6,000 medical records to be produced in that litigation.

And at a minimum, we would see a sampling of those medical records to begin with. As it's going to take time to collect all of them anyway, let's get started on a sampling of those that -- on Zyprexa, those not on Zyprexa, so we can start to unpeel what is really going on here and start to look at specific people, whether it be by name or number, and understand what this case is all about.

We think we are entitled to the medical records for each enrollee here ultimately to test it, but this has to be done in some incremental fashion. There is only so many that can be collected in a period of time, and we need to start this process so we can start to get this going.

I mean, even what we find from our experiences in the personal injury litigation, what we find is that a person -- medical records reveal preexisting diabetes. We see a patient that doesn't have schizophrenia by a coding mechanism, we go into

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the medical records, and we realize they do have schizophrenia. It gives much insight into what is really needed to be done here. And we have, you know, proof of terrific efficacy of this product that is important for, we think, a jury to see here.

Now, while the State may want to ultimately try their case in some sort of mathematical model, epidemiological model, Lilly should be free to defend itself by showing the jury what this medication is and how it works and hear from perhaps recipients if later deemed appropriate, hear from doctors who actually prescribed the medication. Or, at a minimum, let's look at the medical records and let the records start to speak for themselves on these issues that are really at issue here.

So from Lilly's perspective, we see a compelling need in order to, A, be able to test the accuracy of the data we're getting; B, to tell the full story, as we're told there is corrupt data prior to 1996. So if a patient had diabetes prior to 1996, we're never going to know that. They may have entered the system, and someone didn't check that box. And C, we want to be able to show on a case-by-case basis why this causation theory of epidemiology just doesn't hold water when it's put to

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the challenge of actually being tested by medical records and the real-life facts that exist in this patient population.

The State is undoubtedly seeking millions, tens of millions, hundreds of millions. I don't know what the ultimate claim here is going to look like. And there is certainly some cost to this litigation, undoubtedly. Certainly the product liability litigation has gone forth where we looked and received medical records and were able to make assessments based on those. And from Lilly's defense perspective, it's essential that we have the same opportunity here.

DISCOVERY MASTER: I have a question about the Los Angeles -- L.A. I wrote.

MR. BOISE: Louisiana.

DISCOVERY MASTER: That's Louisiana?

MR. BOISE: Yes, sir.

DISCOVERY MASTER: Maybe I'm missing something, but my impression from reading that material was that, 1, it was -- the court issued a consent decree; and 2, at best it was based on a fairly brief decision by a judge or magistrate without -- I didn't see the background material on that that analyzed the arguments you all are making.

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need, you know, for medical records. We have argument and briefing in addition to the affidavit which lays it out in fuller detail as well.

So the issue really is will Lilly be denied the right to present its case in a manner which will show the medical issues in a way other than epidemiology, or is Lilly forced to defend its case in the sole theory that plaintiffs have chosen to present their case.

And I'd submit it's fundamentally unfair to say that Lilly is limited to the manner in which the State has decided to pursue its claims; that ultimately this may be -- there is some burden associated with that that I think is -- certainly should be considered. And if the burden is it's costly for the State to collect the medical records, well, then in that situation, give us the names, and we'll go out and subpoena them.

If the issue is, well, that's not satisfactory because we want to protect the privacy interests and we need to do the de-identifying and that's the burden, well, that's the burden. I mean, we're prepared to collect the medical records on our own, at our expense, have them subject to a protective order, take all effort and respect with

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those records and not contact a single person about their medical history without coming back to this Court.

We're willing to take every step necessary to make this not a burden on the individuals, and not a burden on the State, for that matter, and address the needs in any way that will allow us to get the records that we think are just essential to defending ourselves.

MR. STEELE: Let me just address that last point.

DISCOVERY MASTER: Okay. Address the last one, and have one last word as well. Go ahead.

MR. STEELE: Sure. The burden of getting the medical records, Lilly wants the medical records. If the medical records are to be gotten, they should bear the burden of it. The way that it is done is -- the way that it should be done is the way that it is always done. There are many services that go out and are in the business of collecting medical records. They can do that in electronic format.

The way to do it is to give that service, as an escrow holder, the names of the people so that only they will have them, and we can all be assured they won't go somewhere that they shouldn't, and then

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they can collect and de-identify the records. That's how it should be done.

MR. BOISE: We made that proposal.

DISCOVERY MASTER: Is the beef who's going to pay for it if you go that way?

MR. STEELE: Sure. They should pay for it.

MR. BOISE: For the process of collecting? We're perfectly well to go out and hire a medical collection service and go out for the burden of collecting those records. Whether -- you know, who pays for the de-identifying process, if the State is going to pay for the process of document collection and those issues and there is going to be fee sharing along the way, I think it should be subject to discussion as to how the burden of production ultimately is done, or further order from the Court.

DISCOVERY MASTER: You want to take 10, 15 and then we'll move on to other issues?

(Recess held.)

DISCOVERY MASTER: On the record. And we have -- on the phone, who do we have?

MR. LEHNER: This is George Lehner.

MR. ROTHSCHILD: And this is Eric Rothschild.

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DISCOVERY MASTER: Okay. Go ahead, Mr. Steele.

MR. STEELE: One thing that our side wanted to point out as sort of a general frame around all of this discussion is that one of the things that Judge Rindner has very clearly ruled on is that we have a March trial date. And a concern that we have, I think, with respect to all of the things that we're discussing here today is that we proceed consistent with the wishes of Judge Rindner and that we fashion our approach to completing the discovery in a way when it -- so that it can be accomplished within those time frames. I think that that's -- I know that that's very important to us, that we remain on schedule, and we are willing to, at least within our power, to expedite that which we can do to move things forward. So I just wanted to put that frame around our discussion.

DISCOVERY MASTER: Would you like to respond or add to the frame there, Mr. Boise?

MR. BOISE: Just to add to it, you're familiar with the history here of the Judge's desire and then declination to cut to the chase on what the proofs would look like. And really in earnest discovery began when the Judge ruled on August 1 as

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IN THE SUPERIOR COURT OF THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630

VIDEOTAPED 30(b)(6) DEPOSITION OF
STATE OF ALASKA
DESIGNEE: DAVID CAMPANA

Tuesday, September 18, 2007
10:00 a.m.
Volume I

Taken by Counsel for Defendant
at
Lane Powell, LLC
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

A-P-P-E-A-R-A-N-C-E-S

For Plaintiff:
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For Defendant:

Eric J. Rothschild
Barry Boise (via speaker phone)

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inputted into the MMIS?
A. It's first input into the EIS, Eligibility Information System, at the Division of Public Assistance. That is placed on a tape twice a week and at the end of month file and provided for the MMIS system.
Q. I take it the EIS probably includes both people who have been determined to be eligible and those who have not?
A. Yes.
Q. What goes to MMIS, just the eligibles?
A. That I don't know.
Q. Certainly, in the MMIS form there is an

0143

indication that this person is eligible, correct?
A. Correct.
Q. Now, for people who become eligible for Medicaid, some of them become ineligible, correct?
A. Correct.
Q. Based on changing financial situations?
A. Correct.
Q. Any other reasons?
A. Move out of state.
Q. Anything else?
A. Die.
Q. Anything else?
A. Get married.
Q. How does the state find out that someone is no longer eligible?
A. Sometimes they don't find out for a while, for a period of time. At times, they get direct communication with the recipient.
Q. If a person becomes ineligible and the state finds out, that fact would be recorded in the MMIS, correct?
A. Correct.
Q. And it could happen for some people that they are on the rolls and then they are off the rolls and then they are back on again?

0144

A. Correct.
Q. All of that information should be captured in the MMIS?
A. Correct.
Q. In the enrollment reference file?
A. Correct.
Q. When a person goes on the rolls and then off the rolls and then back on the rolls, do they maintain the same recipient number that they did the first time around?
A. Yes.
Q. Has it been your experience that sometimes that isn't maintained, that someone reapplies and they get a new recipient number?
A. If there has been a name change, they could end up with a new recipient number.
Q. With no name change, do you feel that kind of error doesn't occur?
A. I have no confirmation that it occurs.
Q. Is it sometimes the case that a person starts with their Medicaid eligibility as a result of being the child of someone who is Medicaid eligible and then later become Medicaid eligible themselves?

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A. That could happen.
Q. In that case, is it the -- well, in that case,

0145

when a child is eligible for Medicaid, they would actually be operating under the recipient number of their parent; is that right?
A. No. Each person has their own ID number, except in the case of mother and newborn.
Q. Okay.
A. But very shortly after newborn goes home, they have their own ID number.
Q. Have you found it to be the case that sometimes adult applicants who have been on Medicaid as children end up getting different recipient numbers?
A. That's not my experience.
Q. How does the Alaska Medicaid program use eligibility information?
A. That's one of the first edits on claims processing.
Q. Meaning when that claim comes in, you are entering the recipient's number and --
A. And the recipient better be eligible if you want a payable claim.
Q. What -- do you know what form hospitals use to submit their Medicaid claims?
A. They have used what's called a UB. There was a UB, I believe, 96, and then there is a UB04 that's currently being used.

0146

Q. If I said it was UB92 --
A. Or UB92, yeah.
Q. So am I correct in understanding that the hospitals in the state have switched from UB92 to UB4 relatively recently?
A. I don't know the chronology of that event.
Q. Do you know at all what time periods the UB92 was used?
A. No, I don't.
Q. Do you believe that the UB92 was used during some periods that are at issue in this litigation, that 1996 to 2006 period?
A. Please restate that question.
Q. Was the UB92 form in effect at any time between 1996 and 2006?
A. That I don't know.
MR. ROTHSCHILD: Can we just take a short break?
VIDEOGRAPHER: Off record. The time is 4:09.
(There was a short break.)
VIDEOGRAPHER: Back on the record. The time is 4:18.
(Exhibits No. 10 and No. 11 marked.)
Q. Mr. Campana, I have marked two exhibits, Exhibit

0147

No. 10 and No. 11. Do you recognize that to be the provider manual for hospitals issued by First Health?
A. Yes, I do.
Q. And that's dated March 2006, correct?
A. Correct.
Q. I'll represent to you that we pulled that right from the website, so that's the most current version I was able to put my hands on.

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IN THE SUPERIOR COURT OF THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630

VIDEOTAPED 30(b)(6) DEPOSITION OF
STATE OF ALASKA
DESIGNEE: DAVID CAMPANA

Wednesday, September 19, 2007
9:30 a.m.
Volume II

Taken by Counsel for Defendant
at
Lane Powell, LLC
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

0166

A-P-P-E-A-R-A-N-C-E-S

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For Defendant:

Eric J. Rothschild
Barry Boise (via speaker phone)

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A. Yes, we do treat those as binding.
Q. Okay. Could this work in the opposite way that all -- there is ten drugs in a class and nine of them you say class effect they are all pretty much the same, but there is one you actually want to drop, treat as non-preferred, could that happen?
A. That could happen.
Q. And that would again happen for clinical reasons?
A. Correct.
Q. So if there is a safety problem with one particular drug in the class, that might get non-preferred for that reason?
A. Correct.
Q. So now we have got a PDL. What does that mean in terms of reimbursement for the medications?
A. What that means is if a drug is non-preferred, in order for Medicaid to reimburse that drug, the physician would have to indicate that it's medically necessary on the prescription or if the prescription is phoned in the physician or the person that's calling in the prescription would have to indicate that the physician has determined that this is medically necessary. It's a non-preferred drug.
Q. Are there criteria that physicians are supposed to use to determine that a drug is medically necessary?
A. No.
Q. Once a physician certifies that the medication is medically necessary, is that the end of the process, the drug is then reimbursed?
A. Unless there is a prior authorization on the drug also.
Q. The fly in the ointment of the PDL would seem to be that doctors can just sort of ignore it and just say, "I am going to keep prescribing what I want because I will just certify it as medically necessary."
Is there any monitoring supervision, any process that stops that from happening?
A. We have a couple of different things. There is a retrospective review of who is prescribing the non-preferred drugs. And there is a pharmacist working for First Health back in Virginia that sends a letter to the physician.
"We see that you're prescribing these non-preferred drugs at a higher than average level. Why are you doing that or, you know, could you consider going to the preferred drugs?"
So we have that retrospective part. Also, physician claims and physician charts are open to audit.
Q. What do you mean by that?
A. They could be audited and anything that is placed on prescription or orders could be a subject of an audit.
Q. So you can actually go to a prescriber and say, "Give me all your medical records for a patient, the following ten patients"?
A. We could do that.
Q. Is that done?
A. Sometimes.
Q. And the physicians are required to produce in that situation?
A. That's correct.

Q. Is there any sanction with teeth in it, so to speak, anything that can happen to the physician in terms of reimbursement beyond this communication process?

A. Nothing with teeth. I would like to say that the compliance with this program is very high and in the 80 percent range.

Q. So if you -- if this process results in a medication being non-preferred for whatever reason, your experience is that it will be prescribed quite a bit less?

A. Correct.

Q. And safety reasons is one of those reasons?

A. Correct.

Q. Not all classes of drugs have been reviewed for the PDL?

A. That's correct.

Q. What is the process for deciding which drugs are going to be reviewed for the PDL?

A. Basically, the drugs that First Health gets bids on, drug classes.

Q. Is that the only trigger for a drug to be reviewed?

A. That is one trigger. As I mentioned yesterday, we had reviewed Levothyroxine also.

Q. And the reason for that again?

A. Prescribers in the community had wanted that reviewed.

Q. And the reason -- what was the issue there?

A. Well, the issue was that it was -- there is a number of generics that are manufactured for Levothyroxine and there is one brand name, and the use of the generics was basically higher than what some of the physicians wanted, so they wanted to see if we could just prefer all the different brands and then there wouldn't be substitution of medications, generic substitution in that class.

Q. They thought that was a medical issue?

A. That was a medical issue.

Q. HSS could determine to review a class of drugs for reasons other than the prospect of supplemental rebates, correct?

A. Correct.

Q. You could take a class of drugs and decide we're going to review it for clinical effectiveness and safety, correct?

A. Correct.

Q. And the result of that could be that the class of drugs is segmented into preferred drugs that you think are safer and more effective than non-preferred drugs that are less safe and less effective, right?

A. Correct.

Q. And that could be done even though it's not going to change the financial arrangement at all?

A. Correct.

Q. Is it possible for First Health to have a class of drugs where some manufacturers have agreed to supplemental rebates, but the state determines not to put that class up for review anyway?

A. That could happen.

Q. Has the state ever conducted an audit of its Medicaid program or any aspect of it?
A. There is a legislative audit that occurs every year of different parts of the Medicaid program. There are audits that are done on providers.
There is -- you know, those are the two audits that I know of that occur.

Q. Has the state ever conducted an audit of its MMIS system?
A. I can't answer that.
Q. You can't answer that?
A. I can't answer that.
Q. Who would be the best person to answer that?
A. Linda Walsh.
Q. The state has the right to request medical records for participants in its Medicaid program?
A. Correct.
Q. And that's actually part of the Medicaid application?
A. Correct.
Q. Why does the state -- why has the state created that right in itself to gather medical records?
A. To use it for authorization, to use it for determining the effect of treatment, to ensure the proper use of services.
Q. When you say for the "proper use of services," what do you mean by that?
A. Such as medications, want to see that other medications have used or will it be meeting an indication that is a listed indication.
Q. Do you know whether the state has actually gathered medical records for those purposes over the years?
A. Yes.
Q. Does the state sometimes gather medical records to determine whether the -- withdraw that.
You said that one of the reasons is to make sure that medications are being prescribed for proper uses, correct?
A. Correct.
Q. You said "indicated uses," correct?
A. Correct.
Q. You would acknowledge that some of the uses that you might -- that might be deemed proper could be off-label uses?
A. Could be off-label uses.
Q. Why is it that you need medical records to determine whether the medication is being properly prescribed?
A. In order to find out whether a person is receiving all of the prescriptions the doctor is writing, determine whether or not that person is actually not having prescriptions filled or not having those prescriptions paid for by the Medicaid program even though the prescriber is prescribing those, just a check and balance.
Q. Why can't those checks and balances be done just with the claim system?
A. They can be at least determined, or you can look at the claim system, but you have to get the actual

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record to have a more complete picture.
Q. what do you mean by that?
A. In the claim record, you would have the doctor's notes, what had happened or what he had been diagnosing for, and you would have more information about outcomes.
Q. You just said claims records before you started that. Did you mean medical records?
A. Claims records won't give you all of the backup information. The medical records would give you more information.
Q. Has it been your experience that doctors don't always report accurate diagnoses in their claims forms?
A. I would have to speculate on that.
Q. Do you have any firsthand experience with that, you know, or studying that?
A. Offhand, I don't remember any experience with that.
Q. Does the state use medical records to determine whether claims information is properly being recorded?
A. They have done that in audits.
Q. And to determine whether claims are properly being paid?

0322

A. Correct.
Q. So, for example, someone could record a diagnosis or a procedure in their claim submission, but that's not necessarily true and gathering medical records is one way to check that, right?
A. Right.
Q. Has the federal government or any unit of the federal government performed any audits of the state's Medicaid program?
A. CMS has done audits, the OIG has done audits.
Q. Are those audits done on a regular period or are they --
A. The OIG audits are done on an irregular period. If they have an issue that they want to look at, that will be done when they determine that issue.
Q. And CMS?
A. CMS, at least to my knowledge, they have done audits of different types of claims, and it's not necessarily by a frequency, a regular frequency.
Q. Have you ever heard of a PERM audit?
A. Yes.
Q. What does PERM stand for?
A. Payment error rate methodology.
Q. What is that?
A. It's a new type of audit that CMS will be

0323

conducting. They did a pilot for this audit back in 2006, I believe it was, and in that pilot, we had looked at claims and determined how -- when they go live with this project what they will be looking at and then what kind of error rate we had at that time.
Q. The PERM audit system has not gone officially into effect yet?
A. It has gone officially into effect. The contractor started off with that, but there has been contract issues and contractor issues with that.
And it's my understanding that the project is way behind.
Q. So there was a pilot run and they actually did an audit of Alaska as part of the pilot program?

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A. In the pilot program, Alaska did the auditing.
Q. Pursuant to the methodology, as you understand it?
A. Pursuant to the methodology that was laid out with the PERM program. And they had done a random sampling of claims and had obtained records for those claims.
Q. When was this done?
A. As far as the records, the only records I really have any experience with were the pharmacy records, the prescriptions. This was done either 2005 or 2006.

0324

Q. In this pilot, you said Alaska did it. Who actually did it for Alaska?
A. There was a team that had done it, and by the end of the program, had dwindled down to one person doing the work with the PERM project.
Q. Who was that?
A. I'm drawing a blank. I can't remember.
Q. Is that -- was it an employee of the state or a contractor?
A. It was an employee of the state.
Q. Not in your division?
A. Well, it was in our division and she had worked part of the time in our office. Actually, I do remember. It's Brenda Menge, M-e-n-g-e.
Q. What is this PERM methodology? What error rate is it looking for?
A. It's looking for a payment error rate, but it's based on provider claim information, so if you are looking at it, you are thinking, well, this is because the state made improper payments.
It's really looking at what the providers had submitted for payment, what kind of information they had submitted.
Q. Okay. And so using this methodology, the state determined an error rate?

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A. Right.
Q. And what was that error rate?
A. I only remember it for pharmacy, and that was a 43 percent error rate.
Q. When you say it's a 43 error rate, that means it's a claim that shouldn't have been paid or not enough? What does that mean?
A. There was one provider in there that did not have proper backup for prescriptions, at least based on their definition of prescriptions.
If we look at what the state Pharmacy Practice Act requires for prescriptions, I believe that they did meet at least the Pharmacy Practice Act.
Q. And an error rate was determined for medical claims as well?
A. That's correct.
Q. Was it broken down by hospital versus physician or a composite?
A. I don't remember.
Q. Does the state keep have a record of the results of the PERM audit?
A. I don't know.
Q. Who would know that?
A. Probably Randall Shlapia.
Q. Remind me what his position is again.

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A. Deputy director.
Q. And you were, I think, trying to explain to me what it means to have an error. I think what you are trying to communicate is it wasn't that the MMIS system, that the error resulted in the way the MMIS system operated; is that fair?
A. Right.
Q. The problem was that a claims form was submitted by the provider and when you look behind that claims form at what the records were to support it, it didn't necessarily support that claim?
A. Correct.
Q. How did the person who ran the PERM audit determine that the claim form was incorrect?
A. I don't know.
Q. Was it the case that it was necessary to get the medical records or the pharmacy records, the prescriptions in order to make that determination?
A. I don't know.
Q. I mean if it wasn't on the computer end, it had to be on the input end, right?
A. Well, what do you mean by the "computer end"?
Q. You are telling me that the error rate was not the result of mistakes happening from the processing of the claims form through the MMIS system; is that right?

0327
A. That's right.
Q. That is not the source of the error rate at all?
A. It's my understanding that's not the source of the error rate.
Q. The source of the error rate is that the information on the claims form, which is what is used to issue payment, was not accurate as compared to what actually happened, right?
MR. HAHN: Objection; calls for speculation.
A. The information on the claim form wasn't backed up by a prescription.
Q. Okay. And so I mean, you know, remove any subtlety here. We're obviously looking at a lot of Zyprexa prescriptions and a lot of diabetic medication prescriptions.
What I think I'm understanding is that if we look at any collection of prescriptions, this study is showing that 43 percent of them which were paid aren't backed up by actual prescriptions?
A. That's what that audit concluded, and that was done on one provider that did not have the backup that the PERM was looking for.
Q. And what time period was this audit done for?
A. I don't remember.
Q. And I guess I'm a little confused about the one

0328
provider. Did the -- was the audit literally only of one provider or was that one provider the source of most of the error rate for providers generally?
A. That one provider was responsible for the error rate for pharmacy.
Q. Meaning the overall audit showed a 43 percent error rate?
A. No. The overall audit did not show a 43 percent error rate. The pharmacy part showed a 43 percent error rate.

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Q. For all pharmacy providers that were audited?
A. Correct.
Q. And do you know how many pharmacy providers that was?
A. I don't remember.
Q. I'm trying to understand why you are singling out this one provider. I mean was this one provider and its problems the source of the entire 43 percent error rate?
A. That I don't remember.
Q. I mean, why are we focusing on one provider when it's an audit that shows a 43 percent error rate for all providers audited?
A. That was just my recollection and understanding that there was one provider that stood out in that error rate.

0329

Q. Has the state taken any steps to -- in terms of the time period it was being audited, do you know whether it was a month, a year or five years?
A. I don't remember.
Q. Has the state taken any steps to address the error rate that it discovered through this audit?
A. I believe that audit or that provider was recommended to the audit committee, who determines who will be audited by our contractor.
Q. Has the state done any audits that are similar in terms of what they are looking for in terms of this error rate as what you described with this PERM audit?
A. Yes.
Q. It has done -- since 1996 to 2006 period?
A. I don't remember when it started. It had -- was ongoing for a period of time. At least the last couple of years, we have had a contractor to do audits for us, and they audited similar material.
I know that as far as pharmacies that were audited by that methodology, there were very little errors. And a number of pharmacies got basically 100 percent clear of the claims that had been audited.
Q. Do you know what contractor did the state's audits?
A. Myers and Stauffer.

0330

Q. Do you know -- can you estimate when they started doing audits?
A. I'm not sure when it was. I think it's been the last couple of years. The contract is just up and they are reviewing an RFP right now for a new contractor.
Q. And when you say "very little errors," do you have an estimate for the percentage?
A. No, I don't.
Q. Was the audit you are describing just pharmacy audits?
A. They were all provider audits.
Q. Do you know whether the other providers had low error rates such as you are describing for pharmacy providers?
A. I know that DME providers had high error rate.
Q. What is DME?
A. Durable medical equipment. And there was some other areas that had a significant error rate. I don't know what it was. And I'm not -- I don't have the information as far as the other providers.
Q. Do you have documentation of the audit as it

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applies to pharmacy providers?
A. I have had documentation. I probably still have documentation of the pharmacy audits that have been conducted.

Q. And do you know who would have the documentation of the rest of the audits?
A. All of the audits are with Margaret Summers.
Q. Who is she?
A. She is the manager for the -- what is it? Quality assurance unit, program integrity unit.
Q. When we're talking about these audits, in order to conduct these audits, did Myers and Stauffer seek backup to the claims such as medical records and prescriptions?
A. Yes.
Q. This audit also doesn't sound like it's an audit of the MMIS system itself; is that fair?
A. Right. It's an audit for what's provided for backup to claims.
Q. Has there been any audits of the MMIS system?
A. You previously asked that.
Q. I'm sorry. What was the answer?
A. The answer was I believe so, and you should contact Linda Walsh for that.
Q. I apologize for repeating. Other than the PERM audit that we talked about, has the federal government previously done audits?
A. I can't answer that.
Q. Have you heard of a PAM audit?

A. No, I'm not familiar with that.
Q. Who would be the best person to ask about other federal government audits?
A. Either Linda Walsh or Margaret Summers.
(Exhibits No. 16 and No. 17 marked.)
Q. Mr. Campana, do you recognize the two documents I have marked as Exhibits No. 16 and No. 17?
A. Yes, I do.
Q. What are they?
A. They are letters to the drug utilization review committee.
Q. Who is the drug utilization review committee comprised of?
A. It's a committee of pharmacists and physicians who are providers to the Medicaid program and sign up for a three-year term as a volunteer on the committee.
Q. Each of the letters to the committee has an attachment of meeting minutes, do you see that?
A. Yes.
Q. And it lists who was present at the meeting?
A. Yes.
Q. The first Exhibit No. 16, which has a November 2nd, 2004 letter, has meeting minutes for October 22, 2004 and it has a list of individuals present and excused. Do you see that?

A. Yes.
Q. Is that list of names, if you include both present and excused, are those all the members of the DUR committee as of that time?
A. I believe that is.
Q. And of the individuals on the committee, and I

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FILED
STATE OF ALASKA
THIRD JUDICIAL DISTRICT
07 OCT -2 PM 3:14
CLERK TRIAL COURTS
BY
DEPUTY CLERK

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

v.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630 CI

DEFENDANT LILLY'S REQUEST FOR ORAL ARGUMENT

COMES NOW, defendant Eli Lilly and Company, by and through counsel, pursuant to Civil Rule 77(e), and requests oral argument on Defendant Eli Lilly and Company's Motion for an Extension of Court-Ordered Deadlines.

DATED this 2nd day of October, 2007.

Attorneys for Defendant

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LANE POWELL LLC

By _____
Brewster H. Jamieson, ASBA No. 8411122
Andrea E. Girolamo-Welp, ASBA No. 0211044

I certify that on October 2, 2007, a copy of the foregoing was served by hand-delivery on:

Eric T. Sanders, Esq., Feldman Orlansky & Sanders
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_____
009867/0038/161837.1

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A B

IN THE SUPERIOR COURT FOR THE STATE OF ALA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

v.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630 CI

DEFENDANT LILLY'S REQUEST FOR ORAL ARGUMENT RE APPEAL

COMES NOW, defendant Eli Lilly and Company, by and through counsel, pursuant to Civil Rule 77(e), and requests oral argument on Defendant's Appeal From Order of the Discovery Master.

DATED this 2nd day of October, 2007.

Attorneys for Defendant

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I certify that on October 2, 2007, a copy of the foregoing was served by hand on:

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

FILED in the Trial Courts
State of Alaska Third District
OCT 02 2007
Clerk of the Trial Courts
By _____ Deputy

STATE OF ALASKA,

Plaintiff,

v.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630 CI

DEFENDANT ELI LILLY AND COMPANY'S MOTION FOR AN EXTENSION OF COURT-ORDERED DEADLINES

Defendant Eli Lilly and Company ("Lilly") respectfully seeks a six-month extension of all Court-imposed deadlines in this action for the following reasons:

- Each set of claims data being relied up on by plaintiff, the State of Alaska (the "State"), has been produced to Lilly months after the data was made available to, and analyzed by, the State's experts;
- The State deleted key fields from the data before producing it to Lilly;
- The State repeatedly represented that it had made a full production of its database, when that is not the case;
- Some of the data produced to Lilly was not deidentified correctly, making it impossible to analyze;
- The State waited until September 18, 2007, the day that its 30(b)(6) designee was deposed, to begin the process of extracting essential claims and enrollment data – that data has not yet been produced to Lilly;
- Once database production is completed, Lilly's experts will need the same six month time period to analyze the data and develop expert reports that they would have had if the necessary data had been timely produced.

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As a direct result of the State's delay in providing usable data, it is impossible for Lilly to meet the Court's November 12 deadline for service of expert reports. An extension is necessary.

I. INTRODUCTION

This is a complex case involving Lilly's antipsychotic medication Zyprexa and the State's Medicaid system. The State alleges that Zyprexa is defective, and that fraudulent representations and improper marketing by Lilly caused physicians to prescribe Zyprexa to Medicaid recipients, resulting in medical injuries. The State seeks to recover the costs incurred to treat these patients allegedly injured by Zyprexa, and some undefined portion of the cost of the medication itself. Under the present scheduling order, the parties are to simultaneously serve expert reports on November 12; trial is set to commence on March 3, 2008, only five months from now.

The State seeks to prove its case in an unprecedented manner, relying almost entirely on statistical evidence derived from its Medicaid claims database. The State seeks to prove that Zyprexa caused injury to beneficiaries through experts who will compare the coding of database entries in the Medicaid database of recipients who used Zyprexa to those of a control group who did not. These experts will then use these comparative statistics to "show the extent to which diabetes and diabetes-related illness increase among Zyprexa users

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in Alaska's Medicaid population."[1] The State will also use the claims data to demonstrate the costs associated with treating injuries allegedly caused by Zyprexa use.

Because the State has proposed to prove its claim through statistics gleaned from its Medicaid database, it acknowledges, as it must, that Lilly's is entitled to its entire Medicaid claims database: "it wouldn't make any sense otherwise."[2] On numerous occasions, the State has misrepresented the status of the database production to the Court and to Lilly, asserting that the *complete* database had been produced over three months ago, when it had not. To date—with the deadline for expert reports a mere six weeks away—the State has still not produced to Lilly a database that can serve as the basis of any analysis of disease incidence and treatment costs. Instead, what has been produced is a useless slice of the database that omits crucial medical and pharmacy claims and key fields of data. Acknowledging the deficiencies in the database production, on September 18, 2007, the State directed its database vendor to extract replacement data. That data has not yet been produced to Lilly. The stark reality is that that Lilly is not even at the starting-line in terms of a working database, whereas the State has been analyzing data for months. Once workable data is produced, Lilly estimates that it will need at least six months to analyze the data and prepare its expert reports, which is how much time it would have had if a complete production had been made in April 2007, in response to Lilly's discovery requests.

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[1] Pl's Memo. Describing Its Claims and Proofs at 1.
[2] Tr. of August 2, 2007 Meet and Confer Conference Call ("Meet and Confer") at 5 (Ex. A).

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In addition, Lilly requests that the Court modify the scheduling order so that the timing of the parties' service of expert reports will be staggered, rather than simultaneous. Lilly's expert reports should follow reports from the State, so that Lilly's experts do not have to speculate about what injuries are being studied, what control groups are being used, and other aspects of the State's methodology. Rather than guess at what methodology the State may seek to employ, it would better serve the parties and the Court if Lilly were able to direct its expert reports to the methodology that the State uses in its expert reports. Alternatively, Lilly should be afforded the opportunity to serve rebuttal expert reports.

II. FACTUAL BACKGROUND

A. The State Did Not Timely Produce to Lilly the Data It Extracted for Its Own Experts

On February 14, 2007, Lilly served its First Sets of Interrogatories and Requests for Production of Documents on the State. Lilly sought documents and information about Zyprexa prescriptions allegedly induced by Lilly's misconduct, and medical treatment of Zyprexa-related injuries reimbursed or paid for by the State.

On March 1, the State filed its Memorandum Describing Its Claims and Proofs, in which it stated that it will prove its case "through expert testimony based on scientifically derived statistical evidence of Zyprexa's effect upon the State's Medicaid population and the damages the State has sustained as a result of Lilly's actions."[3] In that filing, the State

[3] Pl's Memo. Describing Its Claims and Proofs at 2.

disclosed that "[t]he methodology that the State will use in this case is comparable to that reported in a recently published study," Guo, et al., *Risk of Diabetes Mellitus Associated With Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder: A Nested Case-Control Study*, Pharmacotherapy (Vol. 27 No. 1 January 2007).[4] The State represented that it maintains an "immense database" of information on the benefits it provides through its Medicaid program," including "information concerning the diagnosis and treatment of all recipients."[5] The State represented that:

> by comparing the group of Medicaid recipients who took Zyprexa against similar, properly controlled groups who did not take Zyprexa, the State can measure the increased incidence of diabetes in users of the drug, and thereby prove the number of diabetes cases within the Medicaid population that are directly attributable to Zyprexa. From its records, the State also can accurately calculate the increased costs it already has incurred to provide care for Zyprexa-related diabetes, and it can project the extra costs it will incur in the future to provide care for Medicaid recipients who developed diabetes and diabetic complications as a result of consuming Zyprexa.[6]

On April 23, the State served its responses to Lilly's First Interrogatories and Requests for Production. Its responses stated that it would provide in electronic form data "from which Alaska is extracting the comparative data which will substantiate its claims."[7]

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[4] *Id.* at 10.
[5] *Id.* at 6.
[6] *Id.* at 7.
[7] *See generally* Pl's Responses to Def's First Sets of Interrogatories and Requests for Production of Documents (Ex. B).

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Indeed, months earlier, in December 2006, Dave Campana, the State's Medicaid Pharmacy Program Manager, had begun the process of extracting certain data from the State's Medicaid database at the direction of the State's counsel.[8] Mr. Campana obtained the data in February 2007 and provided it to counsel in April 2007.[9] It is Lilly's understanding that the data was forwarded to the State's experts for analysis at that time.

On June 8, the State served its First Supplemental Responses to Lilly's First Set of Requests for Production, which included 17 Access tables of Medicaid data.[10] At the July 12 oral argument on the State's Memorandum Describing Its Claims and Proofs, the State represented to Lilly and to the Court that "we have given them the Medicaid database."[11]

The State had not, in fact, made a complete production of its Medicaid database. In fact, the State did not even make a complete production of the subset of data that Mr. Campana extracted from the database in February. Rather, the State stripped out key data fields before producing it to Lilly.[12]

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[8] Campana Tr. at 104 (Ex. C); Ex. 7 to Campana Dep. (December 4, 2006 work order) (Ex. D).
[9] Campana Tr. at 73, 87 – 88 (Ex. C).
[10] *See* Pl's First Supplemental Responses to Def's First Set of Requests for Production of Documents at 2 (Ex. E).
[11] Tr. of Oral Argument, July 12, 2007 at 74. (Ex. F).
[12] *See* Campana Tr. at 85 – 86 (Ex. C); Ex. 6 to Campana Dep. (exemplary printouts from June 2007 database production) (Ex. G).

For example, the State had removed the patient identifier information (*i.e.*, "recipient" and "original recipient" data)[13] that would allow specific patients' claims history to be tracked over time, an essential component of any epidemiological study of disease incidence.[14] This data was gathered by Mr. Campana, but removed prior to production to Lilly:

> Q. And what you gave to counsel in April of 2007 had the ICN numbers, correct?
> A. Correct.
> Q. Did it have some -- did it have a recipient and original recipient column?
> A. Yes, it did.[15]

Additionally, the production did not identify what prescription medications were reimbursed, by medication name or NDC number, so Lilly had no way of identifying claims for Zyprexa use, or for any other medications. This data was stripped out after Mr. Campana provided it to counsel:

> Q. Are there any NDC codes on there?
> A. It doesn't appear that there is any NDC codes on there.
> Q. Again, the pharmacy data that you provided to counsel had the NDC codes on it, correct?
> A. That's correct.

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[13] The parties dispute whether information should be provided permitting the identification of actual patients (*i.e*, names and addresses). But there is no dispute that some masked patient coding must be provided to permit the tracking of the individual patients' medical treatment and medication history over time.

[14] *See* Guo, et al., *Risk of Diabetes Mellitus Associated With Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder: A Nested Case-Control Study*, Pharmacotherapy (Vol. 27 No. 1 January 2007) ("Guo Study") at 29 (Ex. H).

[15] Campana Tr. at 88 (Ex. C).

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Q. Do you know how they were removed for this table?
A. I have no idea.
Q. You didn't have anything to do with that?
A. That's correct, I did not.[16]

The State also did not produce eligibility data, such as gender and enrollment date, which are necessary to epidemiological studies using claims databases.[17]

B. The State Has Not Cured Deficiencies Identified by Lilly

Even before the Court's ruling on the State's Claims and Proofs, Lilly raised the database deficiencies with the State and advised that it needed "access to the State's full Medicaid database during the relevant years."[18]

On August 2, immediately after the Court's ruling on the State's Claims and Proofs, the parties conferred concerning the State's discovery responses. In that conference, the State agreed that, other than the removal of patient identifying information to protect the confidentiality of individuals, Lilly was entitled to all data regarding all Medicaid claimants and claims, and represented that it had been produced: "all of the data is on there.... In other words, we haven't selected anything. All we did was deidentify the database so it wouldn't be—you couldn't trace it back to any particular people. But otherwise, my understanding is you have all of the data."[19] To avoid any confusion that its request was limited to only Zyprexa users or only antipsychotic users, counsel for Lilly confirmed "[s]o, in other words,

[16] *Id.* at 93.
[17] *See* Guo Study at 28-29 (Ex. H); Virnig Aff. at ¶¶ D.2-4 (Ex. I).
[18] July 25, 2007, Letter from E. Rothschild to E. Sanders (Ex. J).
[19] Tr. of Meet and Confer at 3-4 (Ex. A).

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if there is someone who was treated in Medicaid for a heart attack or cancer, doesn't have any antipsychotics, they're in there."[20] The State responded: "Sure. It wouldn't make any sense, otherwise."[21]

On August 6, Lilly filed its Motion to Compel Discovery, which addressed, *inter alia*, the deficiencies with State's Medicaid claims database production.[22]

On August 10, the State produced new database files to Lilly. This "new" data was comprised of the files that Mr. Campana had extracted for use by the State in December 2006, before it was stripped of essential information for production to Lilly.[23] When Lilly inquired about the completeness of the medical claims in this production, the State described these files as "the original data files" and represented that it "knows of no others."[24]

On August 15, the State responded to Lilly's Motion to Compel Discovery, representing to the Court that it had provided Lilly with "a useful claims database on June 8, 2007."[25] And, referring to the August production, the State represented that Lilly "has received or will be receiving shortly the information it claims it needs *to make the database complete*."[26]

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[20] *Id.* at 4 – 5.
[21] *Id.* at 5.
[22] Lilly's Motion to Compel at 8 – 9.
[23] Campana Tr. at 83 – 85 (Ex. C).
[24] *See* August 27, 2007 letter from C. Marcum to E. Rothschild (Ex. K).
[25] Pl's Response to Def's Motion to Compel Discovery at 5, 7.
[26] *Id.* at 9 (emphasis added)

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But the August production did not complete the database. Like the June production, it is just another slice of the complete Medicaid database, and, also like the June production, omits key data fields.

First, the August production excludes data reflecting prescription claims for non-mental health medications.[27] Thus, there is no data showing whether any Medicaid recipient ever received diabetes medication—data which the Guo researchers used to register incidence of diabetes.[28] The absence of non-mental health prescription claims also means that there is no data showing which patients were prescribed medications that can raise blood glucose levels, such as beta blockers. These are medications that must be controlled for in any epidemiological analysis of the incidence diabetes among populations, as they are potentially confounding medications.[29]

Second, the August production did not include **all** of the medical procedure claims for non-Zyprexa users.

> Q. The intention was not to give us 100 percent of medical claims?
> A. Correct. Well, the intention was to answer what counsel wanted.
> Q. Counsel for the state?
> A. Correct.[30]

[27] That is, medicines outside of therapeutic class 07. *See* August 27, 2007 letter from C. Marcum to E. Rothschild (Ex. K); Campana Tr. at 69 – 70, 104 (Ex. C); Ex. 7 to Campana Dep. (December 4, 2006 work order) (Ex. D).
[28] Guo Study at 29 (Ex. H).
[29] *Id.* at 30.
[30] Campana Tr. at 75 (Ex. C). The work order that counsel directed Mr. Campana to issue extracted only a subset of medical claims. The subset only includes medical claims to the extent that the medical claims mirrors the medical claims of Zyprexa users. *See* Ex. 7 to Campana Dep. (December 4, 2006 work order) (Ex. D).

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Third, the medical claims for patient hospitalizations omit revenue codes, procedure codes, and a complete recording of diagnosis codes. These are the codes that explain why the patient was hospitalized and what treatment the patient received. As acknowledged by Mr. Campana at his deposition, without those fields there is no way of telling what happened to the patient at that hospital visit.[31] Mr. Campana acknowledged that the hospital claims were useless without those fields:

> Q. You would agree that if we're going to have useful information about hospital claims, we need to get those revenue codes and procedure codes?
> A. Yes.[32]

When asked why these codes were not provided, Mr. Campana, who drafted the work order to extract the hospital data, explained that he simply "missed that." [33]

Fourth, the August production omits data typically included in enrollment or eligibility files, such as recipients' race, gender, basis for Medicaid eligibility, and time on the Medicaid rolls—factors relied upon in the Guo study.[34]

C. The State's Database Production Must Be Completely Redone

In early September, Lilly supplemented the briefing for its Motion to Compel to address the deficiencies with the State's August database production. As part of this briefing, Lilly submitted an affidavit from Beth Virnig, Ph.D, an epidemiologist at the University of

[31] Campana Tr. at 109 (Ex. C).
[32] *Id.* at 110 – 11.
[33] *Id.* at 108.
[34] Guo Study at 28 – 30 (Ex. H).

Minnesota School of Public Health who, at Lilly's request, analyzed the Medicaid data that the State produced to Lilly and identified numerous deficiencies.[35] Lilly explained at the hearing that the Virnig affidavit was intended to be illustrative of the deficiencies, not exhaustive.[36] Lilly had not, and still has not, received a complete description of all data maintained by the State, such that it could identify all deficiencies in the production.

Faced with these indisputable deficiencies, at the September 11 hearing on Lilly's Motion to Compel, the State agreed to supplement its production. The State agreed to provide Lilly with the eligibility data for Medicaid recipients, which would include date of enrollment and gender. The State also agreed to provide "all of the pharmacy records for all of the medications that are in the database."[37]

At this hearing, however, the State represented to the Discovery Master that it had already produced certain data when that was not actually the case.

> I do believe that beta blockers are in [the production] because that is a potential confounder, and so I believe that it is there. I believe that information is there with respect to diabetic medications because that is the measure that we are using to determine whether somebody has diabetes or not."[38]

[35] *See* Virnig Aff. (Ex. I).
[36] Tr. of September 11, 2007 Motion to Compel Oral Argument ("Mot. to Compel") at 18 (Ex. L).
[37] *Id.* at 13.
[38] *Id.* at 14.

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In fact, prescription claims for non-mental health medication (including beta blockers and diabetes medication) had not been produced, as had already been acknowledged in correspondence by another of the State's counsel.[39]

The State also acknowledged at the September 11 conference that that it had already performed "statistical analysis" on the confounder and diabetic medication data.[40] This statement not only confirms that this data is necessary and central to this case, but also reveals that the State's experts have possessed this data for some time.[41] Lilly has never received the confounding medication data, and was not provided data reflecting diabetic medications until September 18. Dave Campana testified that he placed a work order for the diabetic medication data on June 29 and produced it to the counsel shortly afterwards.[42] The State has not explained why it did not provide this essential data to Lilly until September 18.

At the request of the State's expert, the State also gathered gender data through a work order dated July 30.[43] However, even though gender data has been referred to in virtually every communication between the parties regarding the database since the August 2 Meet and Confer, that data too was not produced to Lilly until Mr. Campana's deposition on

[39] August 27, 2007 letter from C. Marcum to E. Rothschild (Ex. K).
[40] Tr. of Mot. to Compel at 14 (Ex. L).
[41] *Id.*
[42] Campana Tr. at 104 – 05 (Ex. C).
[43] *Id.* at 25 – 27.

September 18.[44] In addition, the diabetic medication data and gender data produced to Lilly is unusable. These data sets have been represented to connect diabetes medication history and gender to the deidentified patients that are enumerated in previously produced data. However, the patient numbers in the diabetes medication and gender tables simply do not match up with any other data. It is impossible, therefore, to determine the gender of any particular Medicaid recipient who used Zyprexa, or discern his or her diabetes medication history.[45]

Finally, on September 18, in response to Lilly's Motion to Compel and issues raised in the Virnig Affidavit, Dave Campana commenced anew the process of extracting data from the Medicaid database.[46] The work order expands upon the data previously

[44] *See* Tr. of Meet and Confer at 6 (Ex. A); August 7, 2007 letter from E. Rothschild to J. Steele (Ex. M); August 10, 2007 letter from E. Rothschild to M. Garretson (Ex. N); August 22, 2007 letter from E. Rothschild to M. Garretson (Ex. O); August 30, 2007 letter from E. Rothschild to C. Marcum (Ex. P).

[45] The database table "DiabZYPR1_DaveC.mdb" purports to set forth the diabetes medication history by recipient number of each of the Zyprexa users identified in the database table "JS6H1204B_Zyprex1_DaveC.mdb." None of the 717 patient numbers contained in "DiabZYPR1_DaveC.mdb is found in "JS6H1204B_Zyprex1_DaveC.mdb." Similarly, the database table "gender zyp.mdb" purports to set forth the gender of each of the Zyprexa users identified in the database table "JS6H1204B_Zyprex1_DaveC.mdb." But only 95 of the 6,455 patients numbers listed in "gender zyp.mdb" are even found in the "JS6H1204B_Zyprex1_DaveC.mdb" table. Each of these 95 patients has a birth date reflected in the "gender zyp.mdb" table that is different than his or her birth date reflected in the "JS6H1204B_Zyprex1_DaveC.mdb" table, demonstrating that these 95 matching numbers do not refer to the same patient at all.

[46] *See* Campana Tr. at 160 (Ex. C).

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produced, but still excludes many data fields maintained by the State.[47] Lilly has asserted, both in correspondence and in motion practice, its request for all fields. The State advised that the new data would be supplied within two-weeks from the date of the of the work order, but it has not yet been produced. However, once the data is ultimately provided, it will be necessary to determine whether it suffers from the same deficiencies as previous productions. It will also be necessary to for Lilly to assess the accuracy and integrity of the database. Dave Campana revealed at his deposition that internal audits of the database indicate that high error rates exist in the claims submissions, which are the source of the Medicaid data produced in this litigation.[48] Lilly will also need to take discovery based on information learned from this production, including discovery from physicians identified in the database.

III. ARGUMENT

A. The State's Production of Its Medicaid Claims Database Is Materially Deficient

While Lilly does not accept the premise that a mere analysis of Medicaid claims can be sufficient to meet the State's burden, it is undisputed that the State's Medicaid claims database has been placed squarely at issue in this action by the State's proposed method of proof. As such, Lilly has attempted to secure the entire claims database, but, as described above, the database files that the State has produced to Lilly not only omit key fields of data,

[47] *See id.* at 171; Ex. 14 to Campana Dep. (field glossary) (Ex. Q).
[48] Campana Tr. at 323 – 25 (Ex. C); *see* Lilly's Appeal from the Order of the Discovery Master, dated October 2, 2007 at p. 6.

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but omit wide swaths of claims that are necessary for any statistical analysis of disease incidence and treatment costs.

Essential data, all of which is missing from the existing productions, include the pharmacy claims for all medications and for all Medicaid recipients, not just mental health drugs; medical claims for all Medicaid recipients; procedure and revenue codes for hospitalization claims; eligibility data, including race, basis for Medicaid eligibility, date of enrollment, time on Medicaid rolls, and source of admission.[49] The relevance of much of this data has been admitted by the State,[50] and is confirmed not only by the fact that the State's experts have performed analyses on the very data that Lilly is requesting (*i.e*, confounding medication and diabetes medication history), but also by the very study that the State touts as a model for its analysis. The database used in the Guo study included "*each* patient's date of enrollment and pharmacy, medical and institutional claims;"[51] the State's production does not. Each medical claim in the Guo database contained information that explained what medical service was performed;[52] again, the State's production does not. The Guo study used non-mental health medications to score disease incidence, and account for potentially confounding diabetagenic agents.[53] The Guo study also used enrollment data, including for

[49] *See* Virnig Aff. at ¶¶ D.2-4 (Ex. I).
[50] Tr. of Mot. to Compel at 14 (Ex. L); Campana Tr. at 110 – 11 (Ex. C).
[51] *See* Guo Study at 28 (Ex. H).
[52] *See id.* at 28, 29
[53] *See id.* at 30.

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potentially confounding patient characteristics such as gender.[54] Lilly is still waiting for most of this data.

Also, the data that has been produced is rife with error, and therefore of no utility. For example, the data that the State produced which purports to set forth Medicaid recipients' gender and diabetes medication history was not deidentified such that it could be linked with the data previously produced.

B. Additional Time Is Needed to Permit Lilly's Experts to Perform a Meaningful Analysis of a Complete Database.

Due process and fundamental fairness require that Lilly be afforded appropriate time to analyze the Medicaid database -- the central evidence in this case, and which the State has had in its possession long before it filed this lawsuit and has been analyzing for months. In *Siggelkow v. Siggelkow*, the Alaska Supreme Court ruled that the "[d]enial of a motion for continuance constitutes an abuse of discretion 'when a party has been deprived of a substantial right or seriously prejudiced.'"[55] The Court further instructed that a "trial court's legitimate concern for preventing delay should not prejudice the substantial rights of parties by forcing them to go to trial without being able to fairly present their case."[56]

Lilly's indisputable right to obtain and analyze the Medicaid data upon which the State bases its claims is being thwarted. And with the deadline for expert reports fast

[54] *See id.* at 28-29; *see also* Virnig Aff. at ¶ D.3 (Ex. I).
[55] *Siggelkow v. Siggelkow*, 643 P.2d 985, 986 -87 (Alaska 1982) (*quoting Barrett v. Gagnon*, 516 P.2d 1202, 1203 (Alaska 1973)).
[56] *Id.* at 987.

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approaching, Lilly is seriously prejudiced because, while the State's experts have been running analyses, as revealed by counsel at the September 11 conference, Lilly and its experts have been stymied due to the State's delay and failure to produce usable data to Lilly.

In April, the State received the Medicaid data that Dave Campana extracted. But rather than produce that data at that time, the State waited until June to make its initial production, and inexplicably stripped out key data fields before producing it to Lilly, rendering this data useless. The second iteration of its production to Lilly was in August, but this production also omitted key information precluding meaningful analysis. The State extracted diabetes medication history data in June, and gender data in July. Yet, again, inexplicably, the State did not produce either of these data sets to Lilly until September 18.[57]

Meanwhile, Lilly has been diligent in its pursuit of the data. It voiced concerns with the database production even before the Court's ruling on the State's Proof and Claims. And immediately after that ruling, on August 2, Lilly initiated a meet and confer conference concerning the inadequate production. Lilly filed its Motion to Compel on August 6 and noticed the Rule 30(b)(6) deposition of the State for August 20. But the State refused to produce a witness with knowledge of the database until September 18, and moreover, refused to answer many questions describing the database until the deposition.[58] It was not until

[57] As noted, this September production has no utility at all because the data cannot be matched up to the claims in the prior data productions.
[58] *See* August 16, 2007 letter from C. Marcum to E. Rothschild (Ex. R); September 4, 2007 letter from C. Marcum to E. Rothschild (Ex. S).

September 18 that the State placed a work order attempting to obtain the data that it told the Court on June 8 it had already produced. Lilly is still waiting for the production of this data.

While the State was busy not producing data for Lilly to supply to its experts, the State's own experts were reviewing and analyzing the data they had asked for. The details of what State supplied to its experts are not known to Lilly, but what is clear is that these experts were reviewing data that was not produced to Lilly, as is evidenced by the State's counsel's September 11 discussion of the State's analyses of the diabetes medication and confounding medication data.

Incredibly, against this background, the State has repeatedly represented to both Lilly and the Court that it had complied with its discovery obligations and produced the complete Medicaid database.

- At the July 12 oral argument on the State's Memorandum Describing Its Claims and Proofs, the State represented to Lilly and to the Court that "we have given them the Medicaid database."[59]
- During the August 2 meet and confer conference, the State represented that it had produced "all of the data" in its Medicaid database, except for patient identifying information.
- On August 15, the State represented to the Court that it had provided Lilly with "a useful claims database on June 8, 2007,"[60] and that the August production would "make the database complete."[61]

[59] Tr. of Oral Argument, July 12, 2007 at 74 (Ex. F).
[60] Pl's Response to Def's Motion to Compel Discovery at 5, 7.
[61] *Id.* at 9 (emphasis added).

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- On August 27, the State described the subset of medical claims in the August production as "the original data files" and that it "knows of no others."[62]

- On September 11, the State represented that data reflecting confounding medication and diabetic medication history had already been produced.[63]

But each one of these representations turned out to be untrue.

It is now less than six weeks before expert reports are scheduled to be served, and because of the State's delays in providing a complete, usable database, it is impossible to comply with the November 12 deadline. Seven months of the nine-month discovery period have elapsed and Lilly is not even at the starting-line with respect to the database because it has no usable data that it can even provide to its experts for analysis. Meanwhile, the State's experts have had access to the Medicaid database since as early as April, and have collected supplemental data as they thought necessary.[64]

Based on the State's description of the data it is now extracting, Lilly estimates that it will need approximately six months from the date when the full database production is completed to analyze the data and prepare reports. Lilly will be able to give a more refined estimate after its expert have had an opportunity to review the data for completeness and integrity. This proposed extension also corresponds with the amount of time that Lilly would have had if usable data had been produced in April, when the State's discovery responses

[62] *See* August 27, 2007 letter from C. Marcum to E. Rothschild (Ex. K).
[63] Tr. of Mot. to Compel at 14 (Ex. L).
[64] Campana Tr. at 25 – 27 (Ex. C)

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were served, and the time that Lilly understands the State's experts have had to work with the data they requested.

The deadlines in this case were established prior to the interlude of briefing regarding the scope of the State's claims, and without foreknowledge of the database production issues set forth above, and should not be reflexively adhered to, to the detriment of either party. The requested extension of time will place this case on a schedule that is more appropriate given the complex epidemiological and statistical issues that it raises. The parties and the Court have recognized that this case is not routine,[65] but have nevertheless been bound by a routine scheduling order that is more appropriate for a simple civil matter. The Janssen litigation in Louisiana, an almost identical case in which Louisiana seeks to recoup Medicaid expenditures allegedly related to Janssen's antipsychotic medicine Risperdal, was filed in September 2004. The parties in that case are still engaged in discovery. This case is the first of nine similar state lawsuits involving Zyprexa, some of them brought by the State's counsel, and should not be rushed to judgment on an incomplete record.

C. **The Court Should Recalibrate the Schedule for Service of Expert Reports So That Lilly's Experts Reports Follow the State's**

The present scheduling order calls for simultaneous service of expert reports with no opportunity for rebuttal. The State, which bears the burden of proof, proposes to prove its

[65] Supplemental Scheduling Order, dated July 30, 2007.

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tort claims using a statistical methodology that has not been tested in other litigation or disclosed to Lilly. Necessarily, Lilly's experts will be responding to the State's proposed methods of statistical proof. Thus, to avoid the situation of two ships passing in the night, the parties and the Court would be better served if service of Lilly's expert reports were to follow service of the State's reports. Otherwise, Lilly's experts are effectively operating in a vacuum, merely speculating about what the State's statistical analysis might comprise. The logic of this approach had been recognized by the Federal Rules Advisory Committee:

> [I]n most cases the party with the burden of proof on an issue should disclose its expert testimony on that issue before other parties are required to make their disclosures with respect to that issue.[66]

The Manual for Complex Litigation provides similar guidance:

> Scheduling [of expert discovery] should take into account that the parties may lack sufficient information to select expert witnesses until the issues have been further defined and certain discovery is completed; a party's decision may also await the disclosure of the opinions of experts selected by other parties.[67]

Accordingly, Lilly requests that the Court modify the schedule for the service of expert reports so that Lilly's expert reports follow the State's reports by a reasonable period of time. Certainly there is nothing preventing the State from serving its expert reports by the existing November 12 deadline, which would not only minimize delay, but also afford Lilly the opportunity to focus its own experts on the statistical methodology that the State actually

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[66] Fed. R. Civ. Pr. 26(a)(2) Advisory Committee Notes to 1993 Amendments.
[67] MANUAL FOR COMPLEX LITIGATION (FOURTH) § 11.481 (2006).

intends to employ. Alternatively, Lilly requests the opportunity to serve rebuttal expert reports.

IV. CONCLUSION

For the foregoing reasons, Lilly requests that the Court enter Order in the form submitted herewith, extending the deadlines for expert reports six months from the date of the State's production of a complete Medicaid database, and extending all other deadlines in the Routine Pre-trial Order accordingly.

DATED this 2nd day of October, 2007.

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I certify that on October 2, 2007, a copy of the foregoing was served by hand-delivery on:

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009867.0038/161827.1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

IN RE: :
:
ZYPREXA PRODUCTS : MDL-1596
LIABILITY LITIGATION :

- - -
AUGUST 2, 2007
- - -

T E L E C O N F E R E N C E

(11:00 a.m. - 11:58 a.m.)

Reported and transcribed by:

Constance E. Perks, CCR, CRR, CLR
Certified Court Reporter
CCR License No. XI01429

- - -

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MR. SUGGS: As Eric indicated in the letter or email, the main purpose of this was to talk about your July 25 letter about our discovery responses, and there we have four numbered items to go through.

The first one was the supplementation of the states claims data.

MR. ROTHSCHILD: Yeah. Do you mind if I start with that?

MR. SUGGS: Oh, sure.

MR. ROTHSCHILD: I think probably the easiest way to proceed is for you to tell us what you gave us; meaning, how did you select which claims you would produce and which fields for those claims.

MR. SUGGS: Okay. Joe is going to cover that.

MR. STEELE: We didn't. We gave you the database, so

everything should be on there. In other words, we didn't --

MR. ROTHSCHILD: Okay. You gave us -- I'm sorry.

MR. STEELE: We didn't take anybody out of the -- as far as I know, all of the data is on there.

MR. ROTHSCHILD: So clearly, every --

MR. STEELE: Yeah.

MR. ROTHSCHILD: We're interrupting each other, guys.

MR. STEELE: Sorry. Everything. In other words, we haven't selected anything. All we did was deidentify the database so it wouldn't be -- you couldn't trace it back to any particular people. But, otherwise, my understanding is you have all of the data.

MR. ROTHSCHILD: Okay. So, in other words, if there is someone who was treated in

Medicaid for a heart attack or cancer, doesn't have any antipsychotics, they're in there just as much as someone who took antipsychotics?

MR. STEELE: Sure. It wouldn't make any sense, otherwise. You can select and cut and do whatever you want with it. We're trying to make it similar to the way that this is usually studied, where, as you guys know, you have done some looks at Medicaid data, so we haven't selected for you.

MR. ROTHSCHILD: Okay.

It appears to us that we don't have all the fields that might be available. You might tell me I'm wrong, but things like --

MR. STEELE: Not entirely wrong. We have looked into it since then. But go ahead and give

me the ones that you think you don't have.

MR. ROTHSCHILD: And this is not an exclusive list, but certainly, for example, things like age and gender are not on there.

MR. STEELE: We can give you gender. We've asked for that. We expect to have it soon. I can check on age.

MR. ROTHSCHILD: Race.

MR. STEELE: I don't think we're ever going to have race data. I can give you this information.

In Alaska, the Native Health takes care of the native population, so our belief is that there is no native population in the Medicaid database. With respect to non-white races, it would be about three percent Asian and three percent black, something

like that, but no specific race data is available, I'm led to believe.

MR. ROTHSCHILD: Can you just give us a list of all available fields so we know what we're getting and not getting?

MR. STEELE: Yes.

MR. ROTHSCHILD: Okay.

MR. STEELE: So we're going to give you the age data and list of all available fields.

Now, my understanding, too, is that you do not have the pharma data, meaning prescriptions that went with the visits.

MR. ROTHSCHILD: Well, that's not clear. There is in -- what I have looked at is, in the spread sheets, the Excel spread sheets you gave us, there are 17 separate spread sheets, all quite voluminous. In spread sheets 1 through 12, we have a column for

C E R T I F I C A T E

I, CONSTANCE E. PERKS, a Certified Court Reporter of the State of New Jersey certify that the foregoing is a true and accurate transcript of the conference as taken stenographically by and before me at the time, place, and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

CONSTANCE E. PERKS, CCR, CRR, CLR, CCP
Certified Court Reporter #300XI01429
Certified Realtime/LiveNote Reporter
Certified Communications Access Provider

Dated: August 2, 2007

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 3AN-06-05630 CI
	)	
ELI LILLY AND COMPANY,	)	
	)	
Defendant.	)	
	)	

PLAINTIFF'S RESPONSES TO DEFENDANT'S FIRST SET OF INTERROGATORIES

Pursuant to Rule 33 of the Alaska Rules of Civil Procedure, Plaintiff provides the following Responses to Defendant's First Set of Interrogatories. Plaintiff specifically reserves the right to supplement and amend these responses as provided by the applicable rules of procedure.

INTERROGATORIES

INTERROGATORY NO. 1: Identify each Medicaid State Plan in effect for the State of Alaska since 1996, and for each plan:

a. state whether pharmacy benefits are offered as part of the coverage;

b. state whether pharmacy benefits are offered for Zyprexa prescriptions; and

c. describe in detail any rules and/or restrictions relating to the pharmacy benefits offered for Zyprexa.

ANSWER: The current Medicaid plan in effect for the State is on the State Health Department website and may be accessed at: http://www.hss.state.ak.us/commissioner/medicaidstateplan/default.htm. The State will produce

copies of all responsive plans in its possession as soon as possible. Upon information and belief, the following has been true from 1996 to the present:

a. Pharmacy benefits are offered.

b. Pharmacy benefits are offered for Zyprexa prescriptions.

c. Zyprexa benefits are available for "medically necessary" prescriptions. To be "medically necessary," a prescription must comply with FDA approved uses or be for a use found within standard medical or pharmaceutical compendia.

INTERROGATORY NO. 2: Identify each formulary and/or Preferred Drug List (PDL) in effect for the State of Alaska's Medicaid State Plan since 1996, and for each formulary and/or PDL:

a. state whether Zyprexa is on the formulary and/or PDL;

b. describe in detail any rules and/or restrictions on the formulary and/or PDL relating to Zyprexa; and

c. state whether any other atypical antipsychotic is on the formulary and/or PDL.

ANSWER: See response to Request for Production No. 3. The State has had a formulary since approximately 1995. The State has had a PDL since approximately 2004. The PDL does not include any atypical antipsychotic medications.

a. Zyprexa is on the formulary but it is not on the PDL.

b. There are no rules, regulations and/or restrictions on the prescription of Zyprexa except the general requirement that the prescription be "medically necessary."

c. Other atypical antipsychotic medications are on the formulary but there are no atypical antipsychotics on the PDL.

INTERROGATORY NO. 3: Did you ever modify the formulary and/or PDL for any antipsychotic drug? If so, explain why.

ANSWER: Neither the PDL nor the formulary has ever been modified for any antipsychotic drug.

INTERROGATORY NO. 4: Identify the Alaska employees or representatives who communicated with Lilly about Zyprexa since 1996.

ANSWER: David Campana, Lynda Walsh, and Tom Porter, M.D.

INTERROGATORY NO. 5: Identify each employee of Alaska that had supervisory or management responsibility for any of the pharmacy benefits offered to Medicaid recipients, or any role in selecting drugs for the formulary and/or PDL, since 1996. For all employees identified in response to this interrogatory, identify all documents they considered regarding Zyprexa.

ANSWER: Upon information and belief, the individuals most knowledgeable about the selection of drugs for the formulary are David Campana and Tom Porter, M.D. Plaintiff objects to the request to identify all documents these individuals "considered" regarding Zyprexa on the grounds that it is overbroad, vague and burdensome.

INTERROGATORY NO. 6: Identify each of Alaska's committees, including its P&T Committees, and its constituent members, that have had supervisory or management responsibility for any of the pharmacy benefits offered to Medicaid recipients, or any role in selecting drugs for the formulary and/or PDL, since 1996. For all committees and members identified in response to this interrogatory, identify all documents they considered regarding Zyprexa.

ANSWER: Upon information and belief, the State has not organized a P & T committee since 1996 that had any management or supervisory role in the selection of pharmacy benefits offered to Medicaid recipients or any role in selecting drugs for the formulary or PDL.

INTERROGATORY NO. 7: Did Alaska retain a PBM to assist in the development or administration of its Medicaid pharmacy benefit? If the answer is yes, identify the PBM(s), the

Alaska employees with any supervisory or management responsibility for the relationship between Alaska and Alaska's PBM(s) since 1996, and the individuals at Alaska's PBM(s) with whom Alaska communicated regarding Zyprexa since 1996, and any documents exchanged with the PBM(s) regarding Zyprexa since 1996.

ANSWER: The State of Alaska has engaged the services of a PBM, First Health Services, Corporation. First Health's services have been limited to administrating the pharmacy program. It has had no responsibility for selecting drugs to include on the formulary or PDL. David Campana and Lynda Walsh are the State's employees with responsibility for communicating with First Health. Plaintiff objects to the interrogatory to the extent it requests Plaintiff to identify any documents exchanged with the PBM(s) regarding Zyprexa since 1996 on the grounds that the request is overbroad, vague, and burdensome.

INTERROGATORY NO. 8: Identify any false or misleading statements alleged to have been made to Alaska by Lilly.

ANSWER: The State reserves the right to supplement this response as discovery progresses in this case. The following is a general description of the types of false or misleading statements made by Lilly regarding Zyprexa. As discovery has only begun in this case, it is neither intended to be exhaustive nor exclusive.

Lilly's false and misleading statements regarding Zyprexa span a decade beginning with the launch of the drug in 1996 and continuing through the FDA mandated label change for all atypical antipsychotics in 2003.

In 1995, a prelaunch analysis by Lilly of data from its HGAJ study of Zyprexa showed a statistically significant increased incidence of high blood glucose in Zyprexa patients as compared to patients using Haldol. This analysis has never been disclosed to prescribing

physicians. In October 1996, Lilly began its Zyprexa marketing campaign by characterizing weight gain on Zyprexa as "therapeutic" instead of an adverse event. By 1998, despite Lilly's knowledge of significant numbers of post-marketing adverse event reports related to weight gain and hyperglycemia, Lilly continued to refer to these adverse events as "infrequent" events seen in clinical studies and made no mention of them in post-marketing reports. Also, by 1998 Lilly employees were internally discussing the link between atypical antipsychotics, weight gain and diabetes, but declined to notify physicians or the public of their concerns.

In 1999, Lilly knew there was a reasonable association between Zyprexa and treatment-emergent hyperglycemia, yet it refused to provide any such information to physicians or the public because it would be damaging to Zyprexa. In early 2000, however, Lilly's Global Product Labeling Committee was reviewing information in consideration of a labeling change regarding hyperglycemia. The information indicated that analyses of Lilly's clinical trial data showed an incidence of treatment-emergent hyperglycemia in Zyprexa patients that was 3 ½ times higher than in patients treated with placebo. Rather than providing this information to physicians, however, Lilly engaged in a tortured reanalysis of the data and in May of 2000 issued a label change without prior FDA approval claiming there was no significant difference in treatment-emergent hyperglycemia rates between Zyprexa and placebo. Lilly had its sales force actively promote this tortured data nationwide. Five months later, in October 2000, FDA demanded that Lilly remove the language from the label claiming there was no difference in the rates of treatment-emergent hyperglycemia, noting that the changed label inappropriately implied that Zyprexa was safe.

In 2000, while trumpeting the supposedly superior efficacy of Zyprexa and falsely stating that it carried no significant risk of treatment-emergent hyperglycemia, Lilly additionally began a

nationwide campaign to promote Zyprexa to primary care physicians for non-indicated or off-label uses. Lilly not only falsely promoted Zyprexa as safe and effective, it promoted it for a wide array of intentionally broad and vague mental disorders. At the same time, outside Lilly consultants were warning the company to "come clean" on the hyperglycemia issue, yet Lilly failed to do so. Instead, in 2001 Lilly tripled its direct-to-physician promotion of Zyprexa using a "sell sheet" which featured its tortured clinical trial data analysis and a "comparable rates" message claiming Zyprexa patients had rates of hyperglycemia and diabetes comparable to those treated with other antipsychotics. Internally, however, Lilly acknowledged that appropriate analysis of clinical trial data showed that Zyprexa treatment resulted in statistically significant mean increases in random glucose compared with both placebo and other antipsychotics.

Regardless, in 2002 Lilly's position was that diabetes occurred at comparable rates across antipsychotics. While it knew this position was false, it believed that advancing it would help eliminate diabetes concerns from the risk-benefit equation. Further, Lilly advanced the position that weight gain on Zyprexa was manageable for most patients even though it knew that position was false. Lilly instructed its sales force to avoid the issue of hyperglycemia altogether if possible, and if confronted with it, to use the "comparable rates" story.

In July 2003, Lilly intensified its efforts to influence the public that Zyprexa did not cause diabetes and that if diabetes occurred with Zyprexa use it did so at "comparable rates" with other antipsychotics. While admitting internally that weight gain caused by Zyprexa could be a substantial contributing factor pushing some patients into diabetes, Lilly falsely represented to the public that there was no causal link, that weight gain was manageable, and that diabetes occurred at "comparable rates" across all antipsychotics. Even after the September 2003 label change mandated by the FDA, Lilly continued to trumpet its "comparable rates" message, even

though subsequent pronouncements by the ADA Consensus Conference and the Veterans Healthcare Administration clearly demonstrated that the consensus of the medical community most knowledgeable on this issue was that use of Zyprexa resulted in more weight gain and a higher risk of diabetes than most other atypical antipsychotics.

INTERROGATORY NO. 9: Identify any false or misleading statements alleged to have been made to Alaska's PBM(s) by Lilly.

ANSWER: See response to Interrogatory No. 8 above.

INTERROGATORY NO. 10: Identify every on-label Zyprexa prescription that you reimbursed or paid for as a result of Lilly's alleged wrongful conduct.

ANSWER: The State objects to this interrogatory to the extent it seeks information and/or documents, the disclosure of which would violate the privacy or confidentiality rights of non-parties including, but not limited to, those privacy rights guaranteed by the Federal and state constitutions as well as Federal and state statutes and regulations. Subject to and without waiving this objection, upon the execution of a proper confidentiality agreement, Alaska will provide in electronic form data which does not identify individuals from which Alaska is extracting the comparative data which will substantiate its claim.

INTERROGATORY NO. 11: For each Zyprexa prescription identified in response to Interrogatory No. 10:

a. identify the patient;

b. identify the age of the patient;

c. identify the patient's diagnosis for which Zyprexa was prescribed;

d. identify the period of time the patient took Zyprexa;

e. state whether the patient is still being prescribed Zyprexa;

f. state what treatment, if any, you contend the patient would have received if the Zyprexa prescription you allege was the result of Lilly's wrongful conduct was not prescribed;

g. identify the prescriber;

h. state whether the prescriber continues to prescribe Zyprexa;

i. state whether you contend that Zyprexa was not efficacious for the patient;

j. state whether you contend that Zyprexa caused a physical injury(ies) to the patient, and if so, what injury(ies) were caused; and

k. state the dollar amount Alaska is seeking to recover from Lilly for that prescription.

ANSWER: See response to Interrogatory No. 10 above. The State further objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence. As the State noted in its Memorandum Describing its Claims and Proofs, because the State seeks compensation for increased costs within a population, its burden is to establish generic causation in that population (i.e., the rate by which Alaska Medicaid recipients who took Zyprexa show an increased incidence of diabetes compared to the background rate of the disease in matched controls). The State does not need to prove specific causation in any particular individual.

Subject to and without waiving these objections, the State will provide in electronic form the data described in Interrogatory No. 10 above. Further, to the extent this interrogatory seeks information related to the State's damages, this response will be supplemented and made as part of the expert disclosures and accompanying reports related to its proof of damages in this case.

INTERROGATORY NO. 12: Identify every off-label Zyprexa prescription you reimbursed or paid for as a result of Lilly's alleged wrongful conduct.

ANSWER: See response to Interrogatory No. 10 above. Subject to and without waiving this objection, the State will provide in electronic form the data described in Interrogatory No. 10 above.

INTERROGATORY NO. 13: For each Zyprexa prescription identified in response to Interrogatory No. 12:

a. identify the patient;

b. identify the age of the patient;

c. identify the patient's diagnosis for which Zyprexa was prescribed;

d. identify the period of time the patient took Zyprexa;

e. state whether the patient is still being prescribed Zyprexa;

f. state what treatment, if any, you contend the patient would have received if the Zyprexa prescription you allege was the result of Lilly's wrongful conduct was not prescribed;

g. identify the prescriber;

h. state whether the prescriber continues to prescribe Zyprexa;

i. state whether you contend that Zyprexa was not efficacious for the patient;

j. state whether you contend that Zyprexa caused a physical injury(ies) to the patient, and if so, what injury(ies) were caused; and

k. state the dollar amount Alaska is seeking to recover from Lilly for that prescription.

ANSWER: See responses to Interrogatory Nos. 10 and 11 above. Subject to and without waiving these objections, the State will provide in electronic form the data described in Interrogatory No. 10 above. Further, to the extent this interrogatory seeks information related to the State's

damages, this response will be supplemented and made as part of the expert disclosures and accompanying reports related to its proof of damages in this case.

INTERROGATORY NO. 14: Describe in detail how Lilly's alleged wrongful conduct caused you to reimburse or pay for each of the Zyprexa prescriptions identified in response to Interrogatories 10 and 12.

ANSWER: Lilly's wrongful conduct, the general nature of which is described in response to Interrogatory No. 8 above, caused the State to pay for numerous Zyprexa prescriptions when there were safer, equally efficacious treatments available which could have been used if the physicians and the public had known the true risks and benefits of Zyprexa. Additionally, Lilly's wrongful conduct described generally in Interrogatory No. 8 caused the State to pay for numerous prescriptions of Zyprexa that were not medically necessary.

INTERROGATORY NO. 15: Identify every person whose alleged deception by Lilly caused your reimbursement or payment for a Zyprexa prescription identified in response to Interrogatories 10 and 12.

ANSWER: The State objects to this interrogatory in that it is vague, ambiguous, and unintelligible. To the extent this interrogatory seeks the identities of specific Lilly employees or representatives who made misrepresentations; the State reserves the right to respond as discovery progresses.

INTERROGATORY NO. 16: Identify each physician that has written a prescription for Zyprexa the cost of which was reimbursed or paid for by Alaska, that you allege was deceived by Lilly and that but for the deception would not have prescribed Zyprexa to some or all of his/her patients.

ANSWER: See responses to Interrogatory Nos. 10 and 11 above.

INTERROGATORY NO. 17: For each physician identified in response to Interrogatory No. 16, identify any false or misleading statements made to him or her by Lilly.

ANSWER: See responses to Interrogatory Nos. 10 and 11 above.

INTERROGATORY NO. 18: Do you contend that the price to you of Zyprexa would have been lower but for Lilly's alleged wrongful conduct? If so, identify each fact that forms the basis of that contention, identify the amount at which you contend Zyprexa should have been priced, and set forth your methodology and data for calculating the difference in price.

ANSWER: The State objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties, is not reasonably calculated to lead to the discovery of admissible evidence, and is vague and ambiguous. The State contends it paid for unnecessary Zyprexa prescriptions, regardless of price, because it was deceptively and illegally marketed.

INTERROGATORY NO. 19: Do you contend that Lilly's alleged wrongful conduct increased the number of on-label Zyprexa prescriptions you reimbursed or paid for? If so, identify each fact that supports that contention.

ANSWER: Yes, the State alleges that Lilly's wrongful conduct increased the number of on-label Zyprexa prescriptions. Had Lilly appropriately warned the State, physicians and the public about the true efficacy and side effects of Zyprexa, there would have been fewer prescriptions. The State intends to provide proof, as described in its Memorandum Describing Claims and Proofs, that a reasonable physician would have instead prescribed equally efficacious and safer alternatives to Zyprexa. While the State reserves the right to supplement this response with more specific facts as discovery progresses, see generally the facts discussed in response to

Interrogatory No. 8 above. Additionally, the number of prescriptions has declined since the FDA mandated label change.

INTERROGATORY NO. 20: Please quantify the number of additional on-label prescriptions you contend were caused by Lilly's alleged wrongful conduct and set forth your methodology and data for calculating the increased number of on-label Zyprexa prescriptions and the excess dollar amount that you reimbursed or paid as a result of Lilly's alleged wrongful conduct.

ANSWER: The State's response to this interrogatory will be part of its expert disclosures and accompanying reports related to its proof of damages in this case.

INTERROGATORY NO. 21: Do you contend that Lilly's alleged wrongful conduct increased the number of off-label Zyprexa prescriptions you reimbursed or paid for? If so, identify each fact that supports that contention.

ANSWER: Yes, the State of Alaska maintains that Lilly's wrongful conduct increased the number of off-label Zyprexa prescriptions. The State intends to provide proof, as described in its Memorandum Describing Claims and Proofs, that Lilly promoted Zyprexa for numerous non-indicated or off-label uses which resulted in prescriptions which were not medically necessary. While the State reserves the right to supplement this response with more specific facts as discovery progresses, see generally the facts discussed in response to Interrogatory No. 8, above.

INTERROGATORY NO. 22: Please quantify the number of additional off-label prescriptions you contend were caused by Lilly's alleged wrongful conduct and set forth your methodology and data for calculating the increased number of on-label Zyprexa prescriptions and the excess dollar amount that you reimbursed or paid as a result of Lilly's alleged wrongful conduct.

ANSWER: The State's response to this interrogatory will be supplemented and made as part of its expert disclosures and accompanying reports related to its proof of damages in this case.

INTERROGATORY NO. 23: Identify all payments for medical treatment of injuries you allege were caused by Zyprexa for which you seek damages in this matter.

ANSWER: The State's response to this interrogatory will be supplemented and made as part of its expert disclosures and accompanying reports related to its proof of damages in this case.

INTERROGATORY NO. 24: For each payment identified in response to Interrogatory No. 23:

a. identify the patient;

b. identify the age of the patient;

c. identify the patient's diagnosis for which Zyprexa was prescribed;

d. identify the period of time the patient took Zyprexa;

e. state whether the patient is still being prescribed Zyprexa;

f. state what treatment, if any, you contend the patient would have received if the Zyprexa prescription you allege was the result of Lilly's wrongful conduct was not prescribed;

g. identify the prescriber;

h. state whether the prescriber continues to prescribe Zyprexa;

i. identify any misrepresentations you allege caused the physician to prescribe Zyprexa;

j. identify the injury you allege was caused by Zyprexa for which you seek damages;

k. identify the physician that diagnosed the injury;

l. identify all physicians that treated the injury; and

m. state the dollar amount that Alaska is claiming against Lilly in damages.

ANSWER: See responses to Interrogatory Nos. 10 and 11 above.

INTERROGATORY NO. 25: Identify any communications since 1996 by Alaska to Medicaid recipients concerning Zyprexa.

ANSWER: The State has no documents or communications responsive to this request.

INTERROGATORY NO. 26: Identify any communications since 1996 by Alaska to physicians concerning Zyprexa.

ANSWER: The State objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties, is not reasonably calculated to lead to the discovery of admissible evidence, and is vague and ambiguous. Subject to and without waiving these objections, the State has no documents or communications responsive to this request.

INTERROGATORY NO. 27: Identify any Drug Utilization Reviews and/or Drug Class Reviews done by Alaska since 1996 concerning Zyprexa.

ANSWER: The State did a review of atypical antipsychotic medications in approximately 2005 with respect to their propensity to cause diabetes. The minutes of this review meeting are being produced with the State's responses to Lilly's Requests for Production.

INTERROGATORY NO. 28: Identify any algorithms or protocols adopted by Alaska for treatment of schizophrenia, bipolar disorder, and/or any other algorithms or protocols that include Zyprexa.

ANSWER: The State of Alaska has used a protocol for the use of atypical antipsychotic medications, although it does not specifically address Zyprexa. This protocol was developed by

a grant from Eli Lilly. It is generally known as the BPMS program and is run by a contractor, CNS.

INTERROGATORY NO. 29: Identify any studies or analyses performed by Alaska to assess the effect on overall costs to the state of prescribing atypical anti-psychotics to mental health patients.

ANSWER: The State objects to this interrogatory in that it is vague and ambiguous. Subject to and without waiving this objection, and assuming this interrogatory is limited to the Medicaid program, cost reports were prepared in response to a request from the Anchorage Daily News in approximately 2005. These reports are produced in the State's responses to Lilly's Requests for Production.

INTERROGATORY NO. 30: Identify all employees of Alaska with knowledge of the events alleged in the Complaint.

ANSWER: David Campana, Lynda Welch and Tom Porter, M.D.

INTERROGATORY NO. 31: Identify any lawsuits filed by plaintiff against any manufacturer of atypical anti-psychotics other than Lilly.

ANSWER: The State objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence. Subject to and without waiving these objections, the State has filed no other such lawsuits.

INTERROGATORY NO. 32: Identify all Alaska Medicaid recipients who have filed lawsuits or otherwise asserted claims against Lilly on their own behalf in connection with their ingestion of Zyprexa.

ANSWER: The State objects to this interrogatory to the extent it seeks information and/or documents, the disclosure of which would violate the privacy or confidentiality rights of non-parties including, but not limited to, those privacy rights guaranteed by the Federal and state constitutions as well as Federal and state statutes and regulations. The State further objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence.

INTERROGATORY NO. 33: Did you ever take any steps to reduce the amount you were paying or reimbursing for any anti-psychotic drug? If the answer is anything but an unqualified "no," describe in detail what steps you took.

ANSWER: The State is and has been working on a formulary aimed at reducing the amount paid for all pharmaceuticals, including atypical antipsychotics. The State participated in the BPMS program sponsored by Lilly. Additionally, the State has investigated the possibility of joining with other states to negotiate further rebates. Further, the State limits the prescription of pharmaceuticals as set out in the answer to interrogatory 1(c).

INTERROGATORY NO. 34: Did Alaska impose the maximum allowable charges pursuant to Alaska Stat. §47.07.042 or any predecessor statute for purchases of Zyprexa? If the answer is anything but an unqualified "yes," explain the reason why not.

ANSWER: The maximum allowable charge is $3.00 per co-payment. The State has chosen to impose a co-payment of $2.00 as being more reasonable given the finances of Alaska Medicaid recipients.

INTERROGATORY NO. 35: Has Alaska involuntarily medicated any Alaska citizens with Zyprexa? If the answer is yes, please state when such involuntary medications have occurred,

the conditions for which Zyprexa was prescribed, and identify any court filings relating to the involuntary medications.

ANSWER: See response to Interrogatory No. 10 above. The State further objects to this interrogatory in that it seeks information that is irrelevant to the claims and defenses of the parties, is not reasonably calculated to lead to the discovery of admissible evidence.

INTERROGATORY NO. 36: State when you first became aware that:

a. Lilly advertised and sold Zyprexa for non-approved or "off-label" uses as alleged in paragraph 12 of the Complaint, and what actions, if any, you took upon discovering those facts.

b. Beginning in 1998, scientific journals began to publish studies that established a causal association between using Zyprexa and developing or exacerbating diabetes mellitus and development of dangerously high blood sugar levels, also known as hyperglycemia, as alleged in paragraph 14 of the Complaint, and what actions, if any, you took upon discovering those facts.

c. In April 2002, the British Medicines Control Agency warned about the risk of diabetes for patients prescribed Zyprexa, of diabetes, hyperglycemia, diabetic ketoacidosis, diabetic coma, and one death among and required Lilly to warn consumers about the risk of diabetes and diabetic ketoacidosis, and further required Lilly to instruct patients who were using Zyprexa to monitor their blood sugar levels, as alleged in paragraph 15 of the Complaint, and what actions, if any, you took upon discovering those facts.

d. In April 2002, the Japanese Health and Welfare Ministry issued emergency safety information regarding the risk of diabetes, diabetic ketoacidosis, and diabetic coma for users of Zyprexa, as alleged in paragraph 16 of the Complaint, and what actions, if any, you took upon discovering those facts.

e. Lilly had failed to warn consumers in this country, including Alaska, about the serious risks of diabetes, hyperglycemia, diabetic ketoacidosis, and other serious conditions associated with the use of Zyprexa, as alleged in paragraph 17 of the Complaint, and what actions, if any, you took upon discovering those facts.

f. Lilly failed to warn consumers, including Alaska, its physicians, and Medicaid recipients, of the dangerous and permanent health consequences caused by the use of Zyprexa, and instructed its representatives to minimize and misrepresent the dangers of Zyprexa, as alleged in paragraph 19 of the Complaint, and what actions, if any, you took upon discovering those facts.

g. Beginning in the 1990s, Lilly's strategy has been to aggressively market and sell Zyprexa by willfully misleading potential users about serious dangers resulting from the use of Zyprexa and that Lilly advertised the use of Zyprexa for off-label uses, including geriatric dementia, pediatric symptoms, and for general depression, as alleged in paragraph 20 of the Complaint, and what actions, if any, you took upon discovering those facts.

h. Lilly engaged in an advertising program that purposefully disguised the risks associated with Zyprexa use, including serious illness and death, as alleged in paragraph 22 of the Complaint, and what actions, if any, you took upon discovering those facts.

i. Lilly in making Zyprexa available to Medicaid patients, knowingly misrepresented to the State of Alaska that Zyprexa was safe and effective, as alleged in paragraph 25 of the Complaint, and what actions, if any, you took upon discovering those facts.

ANSWER: The general answer to all subparts is that when the State of Alaska became aware of Lilly's misrepresentations, it filed a lawsuit. This general awareness took place in the summer of 2005.

However, Lilly took affirmative actions to hide the true nature of Zyprexa and its side effects from the State. For example in 2002, Lilly's representative Kevin Walters met with David Campana to discuss Lilly products. He focused upon diabetic products. With respect to atypical medications, he introduced the BPMS system but did not disclose the evidence connecting Zyprexa with diabetes. In approximately the same time period, Alaska joined a group of other States, led by Missouri, to negotiate manufacturer rebates. At no time did Lilly or its representatives disclose the connection between Zyprexa and diabetes.

Lilly consistently concealed important safety information regarding Zyprexa from plaintiff, physicians and the public. When such information surfaced in the popular or scientific press, Lilly took steps to blunt the information or spin available data to its purposes, primarily further concealing the risks of Zyprexa. Thus, Lilly falsely maintained that weight gain due to Zyprexa was manageable for most patients, that there was no association between Zyprexa and hyperglycemia, and that even if hyperglycemia occurred in patients taking Zyprexa, it occurred at rates comparable to other antipsychotics.

INTERROGATORY NO. 37: Identify all witnesses you intend to call to testify at the trial of this matter.

ANSWER: The State will designate witness at the time called for under the pre-trial order.

INTERROGATORY NO. 38: Identify all expert witnesses you intend to call to testify at the trial of this matter.

ANSWER: The State will designate expert witness, provide reports and make those experts available for deposition in accordance with the pre-trial report.

Respectfully SUBMITTED and DATED this 23rd day of April, 2007

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BY _____

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CERTIFICATE OF SERVICE

Plaintiff, State of Alaska, hereby certifies that it has caused to be served upon the below listed individuals copies of Plaintiff's Answers to Defendants First set of Interrogatories by placing copies of same in a Federal Express envelope, postage prepaid, on April 23, 2007.

Respectfully submitted,

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Dated: April 23, 2007

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 3AN-06-05630 CI
	)	
ELI LILLY AND COMPANY,	)	
	)	
Defendant.	)	
	)	

PLAINTIFF'S RESPONSES TO DEFENDANT'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS

Pursuant to Rule 34 of the Alaska Rules of Civil Procedure, Plaintiff provides the following Responses to Defendant's First Set of Requests for Production of Documents. Plaintiff specifically reserves the right to supplement and amend these responses as provided by the applicable rules of procedure.

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1: Any charts that identify the State of Alaska's Department of Health and Social Services organizational structure from 1996 to the present, including but not limited to, charts that set forth the organization of the various departments and the heads and/or employees of each such department.

RESPONSE: See ZYP-AK-00001-00002.

REQUEST FOR PRODUCTION NO. 2: Each Medicaid State Plan in effect for the State of Alaska since 1996.

RESPONSE: See the website referred to in the State's response to Interrogatory No. 1. The State will produce copies of all Medicaid Plans in its possession as soon as possible.

REQUEST FOR PRODUCTION NO. 3: Each formulary and/or Preferred Drug List (PDL) in effect for the State of Alaska's Medicaid State Plan since 1996.

RESPONSE: See ZYP-AK-00003-00166. The State will supplement this response with additional documents as soon as possible.

REQUEST FOR PRODUCTION NO. 4: Any manuals provided to Medicaid providers from 1996 to the present that relate to Zyprexa or reimbursement for prescription drugs.

RESPONSE: The pharmacy provider manual is found on the Medicaid website and can be located at http://Alaska.fhsc.com. See also ZYP-AK-00167-00892. The State will supplement this response with additional documents as soon as possible.

REQUEST FOR PRODUCTION NO. 5: Any documents demonstrating payments Alaska made for Zyprexa since 1996 for which Alaska seeks reimbursement from Lilly in this litigation, including the documents that reflect the amount that Alaska has paid, to whom it made payments, and for whose prescription it has made payments.

RESPONSE: The State objects to this request to the extent it seeks information and/or documents, the disclosure of which would violate the privacy or confidentiality rights of non-parties including, but not limited to, those privacy rights guaranteed by the Federal and state constitutions as well as Federal and state statutes and regulations. The State further objects to this request in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence.

Subject to and without waiving these objections, the State will provide in electronic form the data described in the State's response to Interrogatory No. 10. Further, to the extent this request seeks information related to the State's damages, this response will be supplemented and

made as part of the expert disclosures and accompanying reports related to its proof of damages in this case.

REQUEST FOR PRODUCTION NO. 6: All medical records from the birth of the patient to the present for any patient whose Zyprexa prescription(s) were paid for by Alaska, and which Alaska seeks reimbursement for in this litigation.

RESPONSE: See response to Request for Production No. 5 above. As the State noted in its Memorandum Describing its Claims and Proofs, because the State seeks compensation for increased costs within a population, its burden is to establish general causation in that population (i.e., the rate by which Alaska Medicaid recipients who took Zyprexa show an increased incidence of diabetes compared to the background rate of the disease in matched controls). The State does not need to prove specific causation in any particular individual.

REQUEST FOR PRODUCTION NO. 7: Any documents demonstrating payments Alaska made for treatment of injuries allegedly caused by Zyprexa for which Alaska seeks reimbursement from Lilly in this litigation, including the documents that reflect the amount that Alaska had paid, to whom it made payments, and for whose treatment it has made payments.

RESPONSE: See response to Request for Production No. 5 above.

REQUEST FOR PRODUCTION NO. 8: All medical records from birth of the patient to the present for any patient whose treatment for medical injuries was paid for by Alaska, and for which Alaska seeks reimbursement in this litigation.

RESPONSE: See responses to Requests for Production Nos. 5 and 6 above.

REQUEST FOR PRODUCTION NO. 9: Any documents reflecting communications or transactions relating to Zyprexa between Alaska and Alaska's PBM(s) including (a) agreements, (b)

pharmacy benefit design records, (c) drug utilization reviews, (d) formulary management programs, (e) records relating to mental health disease management, and (f) communications to physicians.

RESPONSE: The State will produce the minutes of a Drug Utilization Review concerning the connection between Zyprexa and diabetes. Because those minutes contain patient health information, they cannot be produced until the entry of an appropriate protective order. See responses to Request for Production Nos. 5 and 6 above. Upon information and belief, the State has no other documents responsive to this request.

REQUEST FOR PRODUCTION NO. 10: Any documents reflecting the agreements concerning Zyprexa between Alaska and Alaska's PBM(s) (including those related to rebate sharing arrangement).

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 11: Any formularies and/or Preferred Drug Lists (PDLs) relating to Zyprexa.

RESPONSE: See response to Request for Production No. 3 above.

REQUEST FOR PRODUCTION NO. 12: Any documents concerning Zyprexa considered by any Pharmacy & Therapeutics ("P&T") Committee, or similar committee or individual, or by any individual with supervisory or management responsibility for any of the pharmacy benefits offered to Medicaid recipients, or any role in selecting drugs for the formulary and/or PDL.

RESPONSE: The State objects to this request as vague, ambiguous, and unintelligible. Subject to and without waiving this objection, upon information and belief, the State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 13: Any documents concerning clinical summaries of Zyprexa performed by Alaska, or Alaska's PBM(s).

RESPONSE: See response to Request for Production No. 12 above. Subject to and without waiving this objection, see response to Request for Production No. 9 above.

REQUEST FOR PRODUCTION NO. 14: Any documents concerning Alaska's review of, or proposed changes to, any formulary or PDL relating to Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 15: Any documents concerning Alaska's decision to include or not to include Zyprexa on its formulary, or PDL, to place restrictions on Zyprexa, or any other decision concerning the formulary or PDL status of Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 16: Any documents reflecting misrepresentations by Lilly to Alaska.

RESPONSE: The State has in its possession documents produced by Lilly in the MDL collection. Discovery in this case has just begun, thus the list of documents provided is neither intended to be all-inclusive nor exhaustive, but merely illustrative of the types of documents the State intends to use to prove its claims. The State reserves its right to supplement this response as discovery progresses. See generally the documents produced by Lilly in the MDL and listed on ZYP-AK-00893-00970.

REQUEST FOR PRODUCTION NO. 17: Any documents reflecting misrepresentations by Lilly to Alaska's PBMs.

RESPONSE: See response to Request for Production No. 16 above.

REQUEST FOR PRODUCTION NO. 18: Any documents reflecting misrepresentations by Lilly to physicians that prescribed to Alaska Medicaid recipients.

RESPONSE: See response to Request for Production No. 16 above.

REQUEST FOR PRODUCTION NO. 19: Any documents reflecting misrepresentations by Lilly to Alaska's Medicaid recipients.

RESPONSE: See response to Request for Production No. 16 above.

REQUEST FOR PRODUCTION NO. 20: Any documents concerning communications or transactions between Alaska and any consultant related to pharmacy benefits for Alaska's Medicaid recipients.

RESPONSE: The State objects to this request in that it seeks information that is irrelevant to the claims and defenses of the parties, is not reasonably calculated to lead to the discovery of admissible evidence, and is overly broad. Subject to and without waiving these objections, the State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 21: Any documents concerning transactions or communications between Alaska or Alaska's PBMs and Lilly regarding Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 22: Any documents concerning communications between Alaska and physicians regarding Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 23: Any documents concerning communications by Alaska to Medicaid recipients regarding Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 24: Any documents concerning transactions or communications between Alaska and any anti-psychotic manufacturer other than Lilly regarding Zyprexa.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 25: Any documents concerning the pricing of Zyprexa.

RESPONSE: Such documents are contained in the pharmacy benefits manual. See the administrative code, Medicaid website and pharmacy benefits manual provided in response to Request for Production No. 4 above.

REQUEST FOR PRODUCTION NO. 26: Any documents concerning communications to any other states relating to Zyprexa.

RESPONSE: The State objects to this request in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence. The State further objects that this request seeks information which is beyond the scope of permissible discovery and which is protected from disclosure by the attorney-client privilege and/or the attorney work product doctrine.

REQUEST FOR PRODUCTION NO. 27: Any Drug Utilization Reviews and/or Drug Class Reviews by Alaska concerning Zyprexa.

RESPONSE: See response to Request for Production No. 9 above.

REQUEST FOR PRODUCTION NO. 28: Any treatment algorithms or protocols concerning Zyprexa, schizophrenia, or bipolar disorder recommended to physicians or required for physicians by Alaska.

RESPONSE: The only protocol in use in Alaska is the BPMS program provided by a grant from Eli Lilly.

REQUEST FOR PRODUCTION NO. 29: Any documents concerning any involuntary medications by Alaska using Zyprexa.

RESPONSE: The State objects to this request to the extent it seeks information and/or documents, the disclosure of which would violate the privacy or confidentiality rights of non-parties including, but not limited to, those privacy rights guaranteed by the Federal and state constitutions as well as Federal and state statutes and regulations. The State further objects to this request in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence.

REQUEST FOR PRODUCTION NO. 30: Any documents concerning lawsuits filed by Alaska against any manufacturer of atypical anti-psychotics other than Lilly.

RESPONSE: The State has no documents responsive to this request.

REQUEST FOR PRODUCTION NO. 31: Any studies or analyses performed by Alaska to assess the effect of prescribing atypical antipsychotics to mental health patients on overall costs to the state.

RESPONSE: See ZYP-AK-00971-00984.

REQUEST FOR PRODUCTION NO. 32: Any documents provided to or developed by your expert witnesses.

RESPONSE: The State objects to this request in that it seeks information which is beyond the scope of permissible discovery and which is protected from disclosure by the attorney-client privilege and/or the attorney work product doctrine. Subject to and without waiving this objection, this response will be supplemented and any non-privileged materials made available as part of the expert disclosures and accompanying reports in this case.

REQUEST FOR PRODUCTION NO. 33: Any documents provided to the Garretson Law Firm for the purpose of developing liability or damages models.

RESPONSE: See response to Request for Production No. 32 above.

REQUEST FOR PRODUCTION NO. 34: Any liability or damages models developed by the Garretson Law Firm for this matter.

RESPONSE: See response to Request for Production No. 32 above.

REQUEST FOR PRODUCTION NO. 35: Any claims profiles or damages profiles concerning Alaska Medicaid recipients, and any documents used to develop those profiles.

RESPONSE: See response to Request for Production No. 7 above.

REQUEST FOR PRODUCTION NO. 36: Any documents identified in, or consulted in preparing, your response to Defendant's First Set of Interrogatories.

RESPONSE: See documents provided with the State's responses to these Requests for Production.

REQUEST FOR PRODUCTION NO. 37: Any documents that you intend to rely upon to prove your claims in this matter.

RESPONSE: As discovery has just begun in this case, the State reserves the right to supplement this response as discovery progresses. Generally, the State may rely upon any documents produced by any party or non-party in discovery in this matter, and any documents produced by any party or non-party in the MDL litigation.

Respectfully SUBMITTED and DATED this 23rd day of April, 2007

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CERTIFICATE OF SERVICE

Plaintiff, State of Alaska, hereby certifies that it has caused to be served upon the below listed individuals copies of Plaintiff's Responses to Defendants Request for Production by placing copies of same in a Federal Express envelope, postage prepaid, on April 23, 2007.

Respectfully submitted,

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Dated: April 23, 2007

IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,
Plaintiff,
vs.
ELI LILLY AND COMPANY,
Defendant.

Case No. 3AN-06-05630

VIDEOTAPED 30(b)(6) DEPOSITION OF STATE OF ALASKA DESIGNEE: DAVID CAMPANA

Tuesday, September 18, 2007
10:00 a.m.
Volume I

Taken by Counsel for Defendant
at
Lane Powell, LLC
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

A. Yes.
Q. Where are those maintained?
A. In my desk.
Q. How did you know what to put in the work orders for the data that was extracted for the state's experts?
A. We met, let's see, sometime I believe it was in December was about the first time we met and talked generally about what kind of data would be needed and what -- how they were going to put a case together.

And then I clarified that again in January and just made sure that I was thinking along the same lines that they were and verified what kind of fields they would need.

And based on what has happened and what has transpired, it looked like we got the data that they were requesting, except for the gender, and we had to come back and redo that.
Q. When you say "We met in December 2006," who is the "they"?
A. Ed Sniffen, myself, and let's see. It was probably Joe Steele. I don't know for sure, but as far as I remember, we were talking to attorneys in Salt Lake City. Also, there was Eric Sanders was in on that.
Q. Was an attorney named Matt Garretson involved?
A. Could be. I don't remember and I don't know have

my notes with me.

Q. Were there any non-attorneys involved in this process?

A. I'm not sure if the data people were involved in that. I don't remember.

Q. Are you familiar with the name "Dennis Tolley"?

A. Yes.

Q. Who is he?

A. He is -- I believe he is an epidemiologist out of Brigham Young University.

Q. Have you met with him?

A. I have only talked with him and corresponded with him. I have talked to him over the phone and corresponded by e-mail.

Q. When has that occurred?

A. Up until about a week ago, so we were talking about the different files and the data fields that were on the files and making sure he had understood the data that I had extracted.

And so back and forth on that to make sure that he was understanding what he had.

Q. Did he ever give you any instructions about what data he wanted extracted?

A. He did talk about that he needed the gender and we tried, attempted to get that a couple of times and

the programmer wasn't understanding what we wanted and how we wanted it, so it took a couple extra weeks.

Q. But you have now provided that to Dr. Tolley?

A. That's correct.

Q. When you say you have gender data, is that gender data included with each claim entry or how has that been produced?

A. It was produced based on recipient ID number. It ended up the final data that we received had to have three different columns for recipient ID.

There is the regular recipient ID, which is usually a number starting with 06. There is original ID, which is if they are older in the system and they have been in Medicaid for a long time, they have a number that's a different configuration than that.

And if they have changed their name, they have maybe even a different number yet, so we pulled it based on those three different columns of recipient ID numbers and put in the gender from that.

Q. Then sort of produced a new table with gender included?

A. Right.

Q. When did Dr. Tolley request gender data from you?

A. It was actually late in July that I had talked to him about that because I was going on vacation right

about then.

Q. Other than seeking gender data, did Dr. Tolley ever give you instructions about what data he wanted extracted from the Medicaid system?

A. He didn't -- you know, the original data, and I don't know if he was on that. I don't remember if he was on that call, but that original data probably came from him or came from the people that were going to work on the case.

Q. But I mean so far as you know, your instructions about what data to pull came from counsel?

A. Correct.

Q. And similarly, the instructions for what data to pull to produce to Eli Lilly came from counsel?

A. Correct.

Q. Did you receive different instructions about what to pull for Eli Lilly than you received to pull for Dr. Tolley?

A. Well, the data that they wanted pulled for Dr. Tolley was designed based on how they wanted to do the study.

The data that Eli Lilly wants is basically everything we have in our database from 1994.

Q. Okay. You're really talking now about the most updated request?

A. Right, the present request.

Q. Let's put that aside for a moment because I know you are starting to work on that and I'm really talking about Lilly received data twice; once in June and then again in August with what I would call, you know, lawyers kind of arguing about how complete it is, but certainly more complete than what we received in June.

So those were two separate data pulls. And what I'm trying to understand is whether the instructions you had about what data to pull to produce to Lilly previously in June and August was the same or different from what you had been instructed to pull for Dr. Tolley.

A. Well, there was only one major data pull. That was submitted to First Health in January.

The data came and, basically, we had it and kept it until counsel decided that they needed it, and we sent it down.

Now, there was only one data pull, one major data pull. Now, when I got it and looked at it, I found that one of the tables was missing data, so I went back and had them rerun that.

And so the data that we sent, I'm not sure exactly which date it was, although it's all in my notes, we sent everything at once.

A. Correct.
Q. This is non-medication claims?
A. This is non-pharmacy claims.
Q. But it literally should have every claim submitted by this recipient except for medication claims?
A. As along as the claim paid.
Q. And good clarification. Were the instructions for claims submitted or for claims paid?
A. For claims paid.
Q. Has that been the protocol for any type of table you have generated for this litigation?
A. Yes.
Q. All right. So then -- so we got our Zyp med universe. Working from the Zyp med universe, how did we get the med one universe?
A. From the Zyp med, we took all the primary and secondary diagnoses from those two files, grouped them all together so that you get -- you eliminate any duplicates in there, and then we ran those two filters against all medical claims for the time period.
Q. Okay. And that is what resulted in the med one files?
A. Correct.
Q. And when you -- so, for example, if even one

Zyprexa user was treated for a heart condition, then you would run every diagnosis code for that heart condition in the database and generate entries for every -- every claimant who had that same condition?

A. Correct.

Q. If someone got treated for pancreatic cancer, that was the diagnosis, then every pancreatic cancer case would show up from 1996 to 2006 as long as the claim was paid?

A. Correct.

Q. Who was the reason that that instruction was used for the med one claim?

A. That was going to be the control file.

Q. Control for what?

A. Control for the study that they were doing for this case.

Q. How did you develop that understanding?

A. In discussions with counsel.

Q. So if it was the case that a Zyprexa user was treated for pancreatic cancer -- I'm sorry. If no Zyprexa user had pancreatic cancer during the time period, we would see no pancreatic cancer medical claims in med one?

A. Correct.

Q. And now I think you have described what claims

were selected for each of the files except for one labeled JTC07. Can you tell me what is?

A. That's a therapeutic class 07, which is all pharmacy claims. And therapeutic class 07 is all tranquilizer-type drugs, so it's your typical and atypical tranquilizers.

Q. Would it take in more than just the typical and atypical anti-psychotics?

A. There could be more in that file.

Q. What was the reason that that file was generated?

A. Basically, to look at other drugs in that class, to look at all of the atypicals.

Q. Was any effort made to generate the equivalent of a Zyp med one file for those patients who were in the JTC07 file?

A. No.

Q. Was any effort made to generate any med one files similar to what you had generated?

A. No.

Q. If I'm understanding how the Zyp med one and the med one files were generated, every Zyp med one claim should also appear in the med one file, correct?

A. Correct.

Q. Okay. If that doesn't occur, there is something wrong with the instructions, correct?

A. Correct.
Q. Was any testing done to determine whether in fact every Zyp med one file claim also appeared in the med one claims?
A. No.
Q. Are you aware that Lilly did that comparison with a subset of the entries and found that there was not a complete overlap?
A. I'm not aware of that.
Q. I want to ask you more questions about these tables, the ones that you have just described, but I do want to spend a little time on the files I showed you on the computer screen.
And those files did not have these same labels and they have different information in their fields. I'm just trying to understand -- it sounds like you have a good understanding of what you did to get these files we're now talking about.
You gave an explanation that was very helpful to me, but I'm trying to understand how did we get the files that were produced in June that I provided to you on the computer screen?
A. I really don't know. I sent them to counsel and I have no dates and when they sent -- where they sent it.

Q. Okay. The files that you have identified in this letter with these particular descriptors, these are the descriptors -- as you look at these labels, these were the labels that you were aware of from the first time you did the data pull?

A. Yes.

Q. And as you said, you only did one big data pull?

A. Right.

Q. There weren't two iterations of this?

A. There was one big data pull, and, as I went through the claims -- and I did test as far as for 1996 were all of the claims in there for 1996.

And there was one set of data in here that wasn't what it said, and I had that rerun.

Q. Was that some of these later years?

A. Yeah, I believe it was 2000 -- I think 2004, 2005, somewhere in there, the CD that I received did not actually contain what it was supposed to contain.

Q. Okay.

A. So I had the programmer rerun that.

Q. How did you discover that?

A. Basically, going through each of those CDs to make sure that it said what it said -- it had what it said.

Q. When did you do that?

A. Prior to sending it to counsel.
Q. Let's sort of --
A. As far as time period, approximately April.
Q. So let's back up a little bit. You did what you would call your major data pull in --
A. I ordered it in January and it arrived sometime in February. And I finally got to look at it probably sometime in March, and then counsel asked when they could receive it.
Q. So you're looking at it in March and you are actually opening up these disks with tables on it, right?
A. Correct.
Q. And you are looking at the fields and seeing what they have on it?
A. Correct.
Q. And then in some period after you have looked at it, counsel says, "Will you send it to us"?
A. Correct.
Q. Prior to sending it to counsel, you are saying you did do some testing to see whether the claims data was complete?
A. Correct.
Q. What exactly did you do?
A. Just look at the from and to dates on each file

to determine that they were as stated in the title.

Q. So it's not -- you are not running tests? You are really eyeballing it to see what time period is covered?

A. Correct.

Q. You wouldn't know, for example, if 5 percent or 15 percent of 1996 claims that should have been extracted using your protocol weren't there? You wouldn't know that?

A. Yeah, I didn't do tests of that data.

Q. When you reviewed the Virnig affidavit, one of the things she says is she looked at one year, 2002, and she said, "I know how many enrollees there were because that's reported by CMS. It's about 125,000, but I only see 100,000 unique claimants."

And she said, "That sounds low to me, 80 percent." Do you agree with that?

A. No, I don't.

Q. What's your experience?

A. My experience is that not everyone who is enrolled in Medicaid receives a claim.

Q. So it certainly wouldn't be 100 percent, but does 80 percent sound low?

A. No. And my experience, of course, is in pharmacy, and out of 120,000-some recipients, somewhere

around 25 to 30, or 25 to 35 receive drugs.

Q. 25 to 35 percent?

A. No. 25,000 to 35,000 receive drugs.

Q. Of course, we know here anyway that med one wouldn't have all claims anyway because of the protocol you used with only diagnoses that were also experienced by Zyprexa users?

A. Right, the diagnosis filter.

Q. The intention was not to give us 100 percent of medical claims?

A. Correct. Well, the intention was to answer what counsel wanted.

Q. Counsel for the state?

A. Correct.

Q. And counsel for the state was not asking for 100 percent of medical claims? It was asking for medical claims fitting a particular description?

A. Correct.

Q. Let me try -- and, again, I'm happy to let you look at the disks as well, but I think it may be easier, at least at the start, to try and look at printouts from the disk so you can get a feel for the differences in fields in the first production versus the second.

Let's try and work through it that way. If that becomes a problem, you will let me know.

MR. STEELE: Can we go off the record for a second?

VIDEOGRAPHER: Off record. The time is 12:18.

(There was a lunch break.)

VIDEOGRAPHER: We're back on the record. The time is 1:27.

Q. Good afternoon.

A. Good afternoon.

Q. Before we start looking at the spreadsheets of claims data, are you aware that your counsel has provided to us, or attempted to provide to us today, a couple of additional disks of claims data?

A. I'm not aware of that.

Q. Let me try and ask this in a different way. You indicated earlier that you recognize the descriptors of the data tables on Exhibit No. 4, correct?

A. Correct.

Q. Do you know, looking at that list, whether that is all of the tables that were extracted when you pulled data?

A. I believe that is all, except for the -- we did provide gender for the all the recipients identified in these tables.

Q. When did you extract gender information?

of the tables that are indicated on Exhibit No. 4, the letter from Mr. Marcum.

Why don't we start -- and if you want to take a minute -- let me know if you want to take a minute to look through them. I'm going to start by asking you some questions about the med one tables.

Looking at -- and you can flip through the first, say, three or four or five pages there, what I'm representing to you is that these are pages from the table that was labeled "Med one 1996 Dave C".

Looking at the document, does this look like a printout of the information that was on the med one tables?

A. Yes.

Q. Okay. And then if you flip back a bit further, you'll see that there are printouts from the Zyp med tables?

A. Okay.

Q. And do you recognize that as containing the information that was on the Zyp med tables that you prepared?

A. Well, at least it's similar to what would be on the Zyp med.

Q. What --

A. Similar in format as far as does this line here

equate to one that was on the Zyp med, I can't tell that.

Q. But in terms of the columns of fields, is this the same as what you remember seeing and having prepared?

A. Yes.

Q. And then if you flip back a few more, you will see that there is the one that is labeled "Zyprex one Dave C"?

A. Okay.

Q. Do you recognize that as having all the fields that was in the Zyprex table that you had prepared?

A. Yes.

Q. And just one more, if you flip back to the next, behind the next green tab, you see there is the JTC07 table?

A. Okay. Yes, I see that.

Q. Does that have all the fields that you remember for the JTC07 table that you had prepared and then produced?

A. It looks like it contains all of the fields that were in that.

(Exhibit No. 6 marked.)

Q. What I have marked as Exhibit No. 6 are similar printouts, but from the earlier production, the one that

Lilly received in June of 2007.

You see that there is a spreadsheet here that indicates it's from med one.

Does this med one version look like the document you had prepared?

A. Other than -- it looks similar, although the ID number is different than the ICN number.

Q. And is it also the case that -- so am I correct in understanding that in the Exhibit No. 5 there is something called the ICN number, which is a multi-digit number probably close to a dozen digits?

A. That ICN is on Exhibit No. 5 and not on Exhibit No. 6.

Q. And what is an ICN number?

A. Internal control number.

Q. Is that something that is found in the Medicaid database?

A. Yes. Just to -- in some cases, it will come out as CCN, which is claim control number.

Q. That ICN number does not appear on Exhibit No. 6?

A. That's correct.

Q. When you produced the tables to counsel in January of 2007, were there ICN numbers on the data you produced?

A. Yes.

MR. HAHN: Objection.

Q. Is it also the case that Exhibit No. 5 has "recipient number" and "orig recip number"?

A. Well, this printout doesn't show that. I'm sorry. Yes, it does. It does have a number under recipient and original recipient. It's not the configuration of the state numbers.

Q. Okay. And that's -- you understand that's because of the de-identification?

A. I understand that to be.

Q. Does Exhibit No. 6 have recipient or original recipient numbers?

A. No, it doesn't.

Q. When you provided the data to counsel in January of 2007, were there any kind of recipient numbers on the data you produced?

MR. HAHN: Objection. You are stating facts that aren't in evidence. He has never said that it was in January that he gave us the data.

MR. ROTHSCHILD: I appreciate the correction.

Q. When did you give the data to counsel?

A. It was approximately April.

Q. So April 2007?

A. Correct.

Q. And April 2007 is when you gave all the files with the identifiers that we see in Exhibit No. 4, correct?

A. At least the headings for the identifiers.

Q. In the --

MR. JAMIESON: You mean Exhibit No. 5?

A. In Exhibit No. 5, the headings or the column names for the identifiers.

Q. And what you gave to counsel in April of 2007 had the ICN numbers, correct?

A. Correct.

Q. Did it have some -- did it have a recipient and original recipient column?

A. Yes, it did.

Q. Do you see that on Exhibit No. 6 on that first page there is a PROC column?

A. Yes.

Q. What does that stand for?

A. Procedure code.

Q. Now, if you flip back, and I'll show you on the document I'm looking at, to the table that's labeled "med 14".

A. About how thick is it? Okay. Down at the bottom end. Got it.

Q. On the page that's labeled "med 14," do you see

any column for PROC or procedure?
A. No, I don't.
Q. Do you know why that is?
A. No, I don't.
Q. When you produced the data to counsel, that included the files we have discussed before with medication information, correct, Zyprexa and the anti-psychotics?
A. Correct.
Q. And that -- did that, what you produced to counsel have a code that would indicate which medication was in each claim?
A. For pharmacy claims, it would have an NDC code.
Q. What you gave counsel had that NDC code?
A. Correct.
Q. Are there any NDC code entries in any of the pages that are produced as Exhibit No. 6?
A. I would have to look through it all, and I doubt I have the time.
Q. Do you want to take a look and see if there is any in there?
A. If these are all med one claims, there wouldn't be any NDC codes because the NDC codes are in pharmacy claims only.
Q. If they were med one claims, they should have a

claims, correct?

A. Now, it appears med 17, even though that would not indicate in my naming convention pharmacy claims, there appear to be pharmacy claims in the provider is a PH provider number.

Q. And the units have high indicating pills, correct?

A. Indicating drugs units.

Q. There is no NDC code there, right?

A. There is no NDC code, although this is a report out of the data table and there is a possibility that not everything is copied over from that data table.

Q. Should we look at that on the production? If you close down the one you are in, or actually you just go to that original access database, if you go to the DB seven.

A. Try that again, I guess. Is that on the C drive?

Q. I'm not sure.

A. I'll just go back.

Q. Does that say "med 17" on that?

A. That says "med 17".

Q. Why don't you open that all the way up. That's got -- the med 17 contains claims with provider numbers that begin with "PH," correct?

A. That's correct.

Q. Are there any NDC codes on there?
A. It doesn't appear that there is any NDC codes on there.
Q. Again, the pharmacy data that you provided to counsel had the NDC codes on it, correct?
A. That's correct.
Q. Do you know how they were removed for this table?
A. I have no idea.
Q. You didn't have anything to do with that?
A. That's correct, I did not.
Q. If we could go back to med 14.
A. Is that in Exhibit No. 6?
Q. It is. You want to look at mine?
A. This has got to be it, by a process of elimination.
Q. I'll give you mine.
A. I'll take yours.
Q. You are looking at printouts from med 14?
A. It looks like a printout or representation of med 14.
Q. And you had noted earlier when I asked you that there were hospital claims printed out under med 14, correct?
A. Correct.
Q. But if you flip through it, it's actually not all

hospital claims, right? There is some laboratory claims. There is some MH. What does that stand more?

A. Community mental health center.

Q. There is some MDs as well, right?

A. Right. Transportation, lab.

Q. A bunch of MDs, right?

A. Right.

Q. But there is no procedure code column here, correct?

A. There is no procedure code column.

Q. And would you expect that for hospital claims you would have a procedure code?

A. Hospital outpatient, you would expect a procedure code. Inpatient, would not have a procedure code.

Q. The outpatient -- there are actually outpatient entries in here, right?

A. That's correct, such as "HS13OP" for outpatient.

Q. And MD you would expect a procedure code, correct?

A. Correct.

Q. Pretty much every claim would have one, right?

A. Correct.

Q. When you prepared the med one tables that we have discussed before, those actually did have a procedure code column, didn't it?

A. Correct.
Q. A lot more for hospitals, correct?
A. I wouldn't say it's any more.
Q. And do they reside in the same place in the database, I mean, or is there a hospital sub-system to it?
A. No. There is a claim sub-system and all the claims are in that. As I mentioned before, there is also a reference sub-system in that there are several different types of reference files.
MR. ROTHSCHILD: Go off the record for a moment.
VIDEOGRAPHER: Off record. The time is 2:32.
(There was a short break.)
VIDEOGRAPHER: Back on the record. The time is 2:41.
(Exhibit No. 7 marked.)
Q. Mr. Campana, I have marked as Exhibit No. 7 a group of documents that your counsel just provided to me. Can you tell me what those are?
A. These are system alerts or work orders from the Department of Health and Social Services to First Health Services Corporation.
Q. Are these all the work orders that you have

prepared for this litigation?

A. Yes.

Q. And they are in fact four separate work orders, correct?

A. Correct.

Q. Without going into detail of each request, but just sort of giving the general review, what are each of these work orders?

A. The first one, S06H1204, was the very first work order that I ordered for the Zyprexa claims.

Q. It's dated December 4, 2006, correct?

A. Right.

Q. Is what you requested in this work order what was necessary to generate the 20 or so tables that we see listed on Exhibit No. 4?

A. Yes.

Q. What about the next one?

A. The next one -- and I was incorrect when I testified before about therapeutic class 58 -- is the diabetic medications.

This file was -- we took the recipients from the first Zyprexa table and ran them against therapeutic class 58, and then took the recipients from the control file and ran them against therapeutic class 58.

Q. And that was dated June 29, 2007, correct?

A. Correct.
Q. And you got that data back relatively -- in ten days or so after you asked for it?
A. Yeah, I believe it came within that time period.
Q. And you produced that to counsel right after you received it?
A. Yes.
Q. Just so we can be clear on the contents of it, when you say "the control group," you were doing the same query you did for Zyprexa users against a group of other anti-psychotic users, correct?
A. Actually -- well, the control group was all of those recipients who had one of the diagnoses that was in the original run against -- well, it was basically the Zyprexa users against medical claims.

That produced a list of recipients and that was run against the therapeutic class 58. The control file was the recipients who had similar diagnoses to those who were in the Zyprexa med run.
Q. So it would really be all recipients in med one, correct?
A. Yes.
Q. Would the result of doing the query that way mean that this -- it would have all the Zyprexa users and non-Zyprexa users in the file you want to name "DIAB

control one"?
A. Yes.
Q. And then the third file, it has a typewritten date of June 29, 2007, but then a handwritten date July 30, '07?
A. Right. And what I often do is take the old file, which was 6/29, and copy it over so that I get the same fields, although it ended up with different fields that we were going to use, so that's how come the 7/30 date was written above that.
Q. Who wrote that 7/30?
A. That's my writing.
Q. And this was your effort to get gender data for all recipient IDs?
A. That's correct.
Q. And the universe of recipients who you wanted gender data for, would that come from med one?
A. That came from the Zyprexa file and med one.
Q. And then we have the work order that's dated September 18, 2007, which is today.
And does this work order represent your efforts to request data that you understand Eli Lilly is requesting in this litigation?
A. Yes.
Q. Let's go to the first work order, which is

December 4, 2006. How did you decide which fields you should extract?

A. That was based on experience from looking at different files, pulling data for different files.

Q. Was it based on instructions or guidance from anyone besides yourself?

A. Some guidance from counsel.

Q. In your experience, claims from physicians should always have a procedure code, correct?

A. Yes.

Q. That's -- is it necessary for a claim to be reimbursed that a physician put in a procedure code?

A. Yes.

Q. Is it also necessary for a physician's claim to be reimbursed if they include a diagnosis code?

A. Yes.

Q. So you would never -- you should never have a paid claim in the database that was submitted by a physician provider that is missing data on procedure or diagnosis, correct?

A. Correct.

Q. The system will kick it back?

A. It would deny the claim.

Q. In the case of hospital outpatient claims, is that also true, that you need to have a procedure code

and a diagnosis code for the claim to be reimbursed?
A. It's my understanding that, yes, it does need both the procedure code and diagnosis code.
Q. If you go to Exhibit No. 5, go back three pages.
A. Page three?
Q. Yeah. You see there is an "HSO20T" provider code that's missing a procedure?
A. Right.
Q. So how do you explain that?
A. Well, it's my understanding that hospital claims don't always have a procedure code because the hospital claims are paid based on revenue codes.
And I read something in the hospital manual that said if it's a lab code, it would have an actual procedure code, so hospital claims don't always need a procedure code.
Q. Do hospital claims always need a revenue code?
A. It's my understanding that they do.
Q. Inpatient and outpatient?
A. Yes.
Q. Why didn't you include revenue codes in the work order?
A. Just a miss -- missed that.
Q. What do revenue codes tell you?
A. They tell you basically a generic service that

happens in the hospital, and there will be a unit for the service and then there will not always be a price associated with that or a cost associated with that.

Q. Without a revenue code or a procedure code, there is really no way of telling what happened to the patient at that hospital visit, correct?

A. Yeah. You would need a revenue code or a procedure code to determine what was --

Q. And when hospitals submit revenue codes, I mean if you have somebody stay at the hospital for a month, a lot of things happen to them typically, right?

A. Right.

Q. You just don't get the stitches. If you are there for a month, you might have 15 or 50 things happen?

MR. SNIFFEN: I'm going to object to that. I don't know if he is qualified to answer what happens to patients in a hospital for an extended period of time. Answer if you know.

Q. You do know that when hospitals submit claims, particularly for extended stays, they submit many revenue codes, correct?

A. They submit many procedure codes and revenue codes for services rendered during a long stay.

Q. And they also aren't necessarily -- in terms of

the diagnosis information, they will often have more than two diagnoses; isn't that correct?

A. They can have more than two. Our database only holds two.

Q. Okay. We'll come back to that. What about procedures, how many procedures does the database hold?

A. That I don't know.

Q. What about revenue codes, how many revenue codes does the database hold?

A. I understand that it holds more than one revenue code, and the hospital claims are laid out a little differently than other claims.

You will see several revenue codes and then you will come down to one revenue code that will have the total amount in it. And I don't know how many iterations you can have of revenue codes all on a bill.

Q. You don't know how many procedure codes?

A. Yeah, I don't know how many procedure codes.

Q. But you do feel confident that the diagnosis codes, its only two?

A. It's only two.

Q. Do hospitals submit more information than that?

A. I don't know.

Q. You would agree that if we're going to have useful information about hospital claims, we need to get

those revenue codes and procedure codes?

A. Yes.

Q. I am truly mystified about the distinction between recipient number and original recipient number. You did some explaining this morning and I didn't quite follow it, so why don't you try me again.

A. Okay.

Q. I'm sorry. Just to interrupt. I guess it makes sense for you to describe it in terms of what's actually in the database, because what we see is some random coding process, right?

A. And why don't you ask me what you want about it?

Q. What does the recipient number -- recipient number and original recipient number are both fields that are actually maintained in the MMIS, correct?

A. Correct.

Q. What does the recipient number signify?

A. The recipient number signifies the unique recipient and it is a marker for their eligibility. The current recipient numbers that are being used are numbers that start with 06.

Q. I'm not going to see that here?

A. You are not going to see that there. The original ID was used prior to some period of time, and I don't know what that period of time is, and it has a

different configuration, 00 or 02 configuration.

And those were used up to a point in time, and then they went to the 06 ID number. Not all recipients will have a 06 and a regular recipient ID and a original recipient ID. In many recipients, they will be equal.

Older recipients who came on the program much earlier would have two recipient ID numbers.

Q. Okay.

A. They would have a regular and an original recipient ID number.

Q. Can you estimate when the original recipient number went out of fashion?

A. I have no idea when that was.

Q. Was it prior to your employment?

A. Most likely.

Q. Okay. Fair to say someone who came on the rolls in 2003 wasn't operating under the original recipient?

A. Yes.

Q. Would they have no number there under original recipient then?

A. The regular ID would be populated in the original recipient ID field.

Q. It would be -- recipient and original recipient would be identical numbers?

A. Correct.

you just described. How long has that been used by pharmacy providers in Alaska?

A. The realtime system has been in use since 1995.

Q. Has that been the norm for most pharmacies since that time?

A. For most pharmacies, yes, it has been the norm. There have been some claims come in on the paper form, which is the universal claim form for pharmacy.

Q. What is the methodology for reimbursing pharmacy providers in Alaska?

A. There is a couple different methodologies. We pay the lower of billed or the EAC, plus dispensing fee, or the federal upper limit, plus a dispensing fee for Alaska providers.

If they are out-of-state providers, then we pay the rate that is in effect in their Medicaid program in that state.

Q. For Alaska providers, it's the lower of billed, the federal limit --

A. Well, the EAC, plus dispensing fee, which is estimated acquisition cost, plus dispensing fee, or the federal upper limits plus dispensing fee.

Q. The lower of those three?

A. The lower of those three. It compares all three of those, a total or an aggregate of all three of those

and pays the lowest of those.

Q. Is there a claims form that physicians are required to submit in order to be reimbursed?

A. Yes.

Q. What is that form called?

A. The CMS 1500 or the electronic 837.

Q. Do you know what fields they are required to fill out to be reimbursed?

A. No.

Q. Do you know what the methodology is for reimbursing physicians in Alaska?

A. It's the RVU, RVS methodology, and a price is determined for each procedure code. And then they are paid at the lower of billed or that procedure code, or the price on that procedure code.

MR. ROTHSCHILD: It's been a long day. Should we break it here?

MR. STEELE: My understanding from Mr. Rothschild is that the disks that were transmitted by us to him are not currently in his possession, that those are at Eli Lilly.

Have I understood correctly?

MR. ROTHSCHILD: Pepper Hamilton.

MR. STEELE: So what you have here is the downloaded from the disks information in your computer?

MR. ROTHSCHILD: Right. We took your disks, put them on our hard drive and then the disks I brought here were copies of that. Yours were password protected.

This way we didn't have to go through the whole password. Otherwise, they are identical.

MR. STEELE: We would like to see the original disks to see what, if any, problem exists with those.

So hold onto those, and at some point in time, we can figure out how to look at them.

MR. ROTHSCHILD: I'm happy to have a duplicate made and sent to you.

MR. STEELE: If you have a duplicate made and then send me the originals that might help me.

MR. ROTHSCHILD: I'm not sure there is any difference, but --

MR. STEELE: I'm not either, but that might help. I think it would just make sense to look at what was sent by us to your office.

Then I have six disks, which are everything currently in our possession, at least to my understanding, in terms of data, and this includes the gender data as well.

So I'm going to give those to you now.

CERTIFICATE

I, SONJA L. REEVES, Registered Professional Reporter and Notary Public in and for the State of Alaska, do hereby certify that the witness in the foregoing proceedings was duly sworn; that the proceedings were then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed by computer transcription; that the foregoing is a true record of the testimony and proceedings taken at that time; and that I am not a party to nor have I any interest in the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 20th day of September 2007.

SONJA L. REEVES, RPR
My Commission Expires 8/7/11

IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

ELI LILLY AND COMPANY,

Defendant.

Case No. 3AN-06-05630

VIDEOTAPED 30(b)(6) DEPOSITION OF
STATE OF ALASKA
DESIGNEE: DAVID CAMPANA

Wednesday, September 19, 2007
9:30 a.m.
Volume II

Taken by Counsel for Defendant
at
Lane Powell, LLC
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

the data element dictionary as to how to describe that field.

And if I can correct myself, or at least go back to something I said yesterday about status, status is listed in here and it gives the different designations under status and the definition for that designation. It's about -- there, I think you have it.

Then the next page is -- let's see. It lists under note, month to date files or MTD files, "Claims file and history file will contain the following status codes: One equals approved or three equals denied."

The next page is a claim, claim type modifier and the different codes for that are one to four. One being original claim. Two is the debit adjustment. Three is a credit adjustment. And four is a void.

Q. So we would expect the vast majority of claim entries would have CTM one, and you would have periodically these other entries?

A. Well, we took paid claims, so it would be CTM one or CTM two, the debit adjustment, which is another way to say a paid claim.

(Exhibit No. 14 marked.)

Q. Okay. Your counsel gave me a second document, which I'm going to mark as Exhibit No. 14. It's getting a heading "Ad Hoc Fields" on it.

And let me just ask, before I go onto Exhibit No. 14, when did you generate Exhibit No. 13?

A. That was at least provided on 4/26. It was generated within a couple of days before that.

Q. So you gave it to counsel around April 26, 2007?

A. Correct.

Q. Was that done pursuant to a request by counsel?

A. Yes.

Q. Was the request specific to --

A. We need to know what these fields are.

Q. Let me hand you Exhibit No. 14 and have you tell me what that is.

A. This is the data element dictionary description for the individual fields that are available on the ad hoc -- not on the ad hoc report, but on the ad hoc query system.

Q. Could I take your pile of exhibits for a moment? You can keep Exhibit No. 14.

Is the document we marked as Exhibit No. 14 an attempt to describe the fields listed in Exhibit No. 8?

A. Yes, it is.

Q. When was this generated?

A. This was generated early in September and then provided on 9/7.

Q. '07?

A. 9/7/07, correct.
Q. Which is indicated on the document, correct?
A. Right.
Q. Why did you generate this document?
A. Counsel had indicated that the experts had wanted to know what fields were available.
Q. When you say "expert," what expert are you referring to?
A. That I don't know. It came through the -- the request came to me through the counsel.
Q. How did you -- were you the person who generated this document?
A. Yes.
Q. How did you go about doing that?
A. I researched the data element dictionary for the field names and then provided the brief description on the different field names.
Q. Now, if we wanted a more complete description of what was there, you would actually go to the data dictionary and it would have entries like we have on the second page of Exhibit No. 13, correct?
A. That's correct.
Q. Is there any reason you didn't generate that document for this list?
A. Basically, they just indicated they wanted a

A. Correct.
Q. So, for example, someone could record a diagnosis or a procedure in their claim submission, but that's not necessarily true and gathering medical records is one way to check that, right?
A. Right.
Q. Has the federal government or any unit of the federal government performed any audits of the state's Medicaid program?
A. CMS has done audits, the OIG has done audits.
Q. Are those audits done on a regular period or are they --
A. The OIG audits are done on an irregular period. If they have an issue that they want to look at, that will be done when they determine that issue.
Q. And CMS?
A. CMS, at least to my knowledge, they have done audits of different types of claims, and it's not necessarily by a frequency, a regular frequency.
Q. Have you ever heard of a PERM audit?
A. Yes.
Q. What does PERM stand for?
A. Payment error rate methodology.
Q. What is that?
A. It's a new type of audit that CMS will be

conducting. They did a pilot for this audit back in 2006, I believe it was, and in that pilot, we had looked at claims and determined how -- when they go live with this project what they will be looking at and then what kind of error rate we had at that time.

Q. The PERM audit system has not gone officially into effect yet?

A. It has gone officially into effect. The contractor started off with that, but there has been contract issues and contractor issues with that.

And it's my understanding that the project is way behind.

Q. So there was a pilot run and they actually did an audit of Alaska as part of the pilot program?

A. In the pilot program, Alaska did the auditing.

Q. Pursuant to the methodology, as you understand it?

A. Pursuant to the methodology that was laid out with the PERM program. And they had done a random sampling of claims and had obtained records for those claims.

Q. When was this done?

A. As far as the records, the only records I really have any experience with were the pharmacy records, the prescriptions. This was done either 2005 or 2006.

Q. In this pilot, you said Alaska did it. Who actually did it for Alaska?

A. There was a team that had done it, and by the end of the program, had dwindled down to one person doing the work with the PERM project.

Q. Who was that?

A. I'm drawing a blank. I can't remember.

Q. Is that -- was it an employee of the state or a contractor?

A. It was an employee of the state.

Q. Not in your division?

A. Well, it was in our division and she had worked part of the time in our office. Actually, I do remember. It's Brenda Menge, M-e-n-g-e.

Q. What is this PERM methodology? What error rate is it looking for?

A. It's looking for a payment error rate, but it's based on provider claim information, so if you are looking at it, you are thinking, well, this is because the state made improper payments.

It's really looking at what the providers had submitted for payment, what kind of information they had submitted.

Q. Okay. And so using this methodology, the state determined an error rate?

A. Right.
Q. And what was that error rate?
A. I only remember it for pharmacy, and that was a 43 percent error rate.
Q. When you say it's a 43 error rate, that means it's a claim that shouldn't have been paid or not enough? What does that mean?
A. There was one provider in there that did not have proper backup for prescriptions, at least based on their definition of prescriptions.
If we look at what the state Pharmacy Practice Act requires for prescriptions, I believe that they did meet at least the Pharmacy Practice Act.
Q. And an error rate was determined for medical claims as well?
A. That's correct.
Q. Was it broken down by hospital versus physician or a composite?
A. I don't remember.
Q. Does the state keep have a record of the results of the PERM audit?
A. I don't know.
Q. Who would know that?
A. Probably Randall Shlapia.
Q. Remind me what his position is again.

A. Deputy director.
Q. And you were, I think, trying to explain to me what it means to have an error. I think what you are trying to communicate is it wasn't that the MMIS system, that the error resulted in the way the MMIS system operated; is that fair?
A. Right.
Q. The problem was that a claims form was submitted by the provider and when you look behind that claims form at what the records were to support it, it didn't necessarily support that claim?
A. Correct.
Q. How did the person who ran the PERM audit determine that the claim form was incorrect?
A. I don't know.
Q. Was it the case that it was necessary to get the medical records or the pharmacy records, the prescriptions in order to make that determination?
A. I don't know.
Q. I mean if it wasn't on the computer end, it had to be on the input end, right?
A. Well, what do you mean by the "computer end"?
Q. You are telling me that the error rate was not the result of mistakes happening from the processing of the claims form through the MMIS system; is that right?

A. That's right.
Q. That is not the source of the error rate at all?
A. It's my understanding that's not the source of the error rate.
Q. The source of the error rate is that the information on the claims form, which is what is used to issue payment, was not accurate as compared to what actually happened, right?
MR. HAHN: Objection; calls for speculation.
A. The information on the claim form wasn't backed up by a prescription.
Q. Okay. And so I mean, you know, remove any subtlety here. We're obviously looking at a lot of Zyprexa prescriptions and a lot of diabetic medication prescriptions.
What I think I'm understanding is that if we look at any collection of prescriptions, this study is showing that 43 percent of them which were paid aren't backed up by actual prescriptions?
A. That's what that audit concluded, and that was done on one provider that did not have the backup that the PERM was looking for.
Q. And what time period was this audit done for?
A. I don't remember.
Q. And I guess I'm a little confused about the one

provider. Did the -- was the audit literally only of one provider or was that one provider the source of most of the error rate for providers generally?

A. That one provider was responsible for the error rate for pharmacy.

Q. Meaning the overall audit showed a 43 percent error rate?

A. No. The overall audit did not show a 43 percent error rate. The pharmacy part showed a 43 percent error rate.

Q. For all pharmacy providers that were audited?

A. Correct.

Q. And do you know how many pharmacy providers that was?

A. I don't remember.

Q. I'm trying to understand why you are singling out this one provider. I mean was this one provider and its problems the source of the entire 43 percent error rate?

A. That I don't remember.

Q. I mean, why are we focusing on one provider when it's an audit that shows a 43 percent error rate for all providers audited?

A. That was just my recollection and understanding that there was one provider that stood out in that error rate.

Q. Has the state taken any steps to -- in terms of the time period it was being audited, do you know whether it was a month, a year or five years?

A. I don't remember.

Q. Has the state taken any steps to address the error rate that it discovered through this audit?

A. I believe that audit or that provider was recommended to the audit committee, who determines who will be audited by our contractor.

Q. Has the state done any audits that are similar in terms of what they are looking for in terms of this error rate as what you described with this PERM audit?

A. Yes.

Q. It has done -- since 1996 to 2006 period?

A. I don't remember when it started. It had -- was ongoing for a period of time. At least the last couple of years, we have had a contractor to do audits for us, and they audited similar material.

I know that as far as pharmacies that were audited by that methodology, there were very little errors. And a number of pharmacies got basically 100 percent clear of the claims that had been audited.

Q. Do you know what contractor did the state's audits?

A. Myers and Stauffer.

Q. Do you know -- can you estimate when they started doing audits?

A. I'm not sure when it was. I think it's been the last couple of years. The contract is just up and they are reviewing an RFP right now for a new contractor.

Q. And when you say "very little errors," do you have an estimate for the percentage?

A. No, I don't.

Q. Was the audit you are describing just pharmacy audits?

A. They were all provider audits.

Q. Do you know whether the other providers had low error rates such as you are describing for pharmacy providers?

A. I know that DME providers had high error rate.

Q. What is DME?

A. Durable medical equipment. And there was some other areas that had a significant error rate. I don't know what it was. And I'm not -- I don't have the information as far as the other providers.

Q. Do you have documentation of the audit as it applies to pharmacy providers?

A. I have had documentation. I probably still have documentation of the pharmacy audits that have been conducted.

Q. And do you know who would have the documentation of the rest of the audits?

A. All of the audits are with Margaret Summers.

Q. Who is she?

A. She is the manager for the -- what is it? Quality assurance unit, program integrity unit.

Q. When we're talking about these audits, in order to conduct these audits, did Myers and Stauffer seek backup to the claims such as medical records and prescriptions?

A. Yes.

Q. This audit also doesn't sound like it's an audit of the MMIS system itself; is that fair?

A. Right. It's an audit for what's provided for backup to claims.

Q. Has there been any audits of the MMIS system?

A. You previously asked that.

Q. I'm sorry. What was the answer?

A. The answer was I believe so, and you should contact Linda Walsh for that.

Q. I apologize for repeating. Other than the PERM audit that we talked about, has the federal government previously done audits?

A. I can't answer that.

Q. Have you heard of a PAM audit?

A. No, I'm not familiar with that.
Q. Who would be the best person to ask about other federal government audits?
A. Either Linda Walsh or Margaret Summers.
(Exhibits No. 16 and No. 17 marked.)
Q. Mr. Campana, do you recognize the two documents I have marked as Exhibits No. 16 and No. 17?
A. Yes, I do.
Q. What are they?
A. They are letters to the drug utilization review committee.
Q. Who is the drug utilization review committee comprised of?
A. It's a committee of pharmacists and physicians who are providers to the Medicaid program and sign up for a three-year term as a volunteer on the committee.
Q. Each of the letters to the committee has an attachment of meeting minutes, do you see that?
A. Yes.
Q. And it lists who was present at the meeting?
A. Yes.
Q. The first Exhibit No. 16, which has a November 2nd, 2004 letter, has meeting minutes for October 22, 2004 and it has a list of individuals present and excused. Do you see that?

CERTIFICATE

I, SONJA L. REEVES, Registered Professional Reporter and Notary Public in and for the State of Alaska, do hereby certify that the witness in the foregoing proceedings was duly sworn; that the proceedings were then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed by computer transcription; that the foregoing is a true record of the testimony and proceedings taken at that time; and that I am not a party to nor have I any interest in the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 21st day of September 2007.

SONJA L. REEVES, RPR
My Commission Expires 8/7/11

Control Number: S06-H1204
CC:

First Health Services Corporation

Department of Health and Social Services

Work Order

TO: ☒ FHSC Anchorage (Steve Phillimore)
☐ FHSC Richmond (Everett Irving)

DATE: 12/4/06

FROM:
Name: Dave Campana
Division: (DBH, DHCS, DSDS)

Keep Copy of Attached ☒

DHCS Authority Work Order Categories:

NOTE: *The following types of Work Orders require approval by DHCS Management.*

File Updates:

- ☐ Formulary
- ☐ Diagnosis
- ☐ Error Text
- ☐ Rate Files
- ☐ TPL
- ☐ Provider
- ☐ Recipient
- ☐ Claim Check
- ☐ Collo Code

Financial ☐ Maintenance ☐

Security ☐ Enhancement ☐

Designated DHCS Mgr Approval: DC

DHSC Deputy Director Approval: _____

Direct Work Order Categories:
Operations:

- Claims Resolution ☐
- Hearings ☐
- Appeals ☐
- SURS ☐
- Provider Manuals ☐ *(if a manual update is needed, list provider type(s) affected:____*
- FHSC Web Site ☐
- Provider Enrollment ☐
- Provider Inquiry ☐
- Provider Training ☐
- Prior Authorization ☐
- Quality Control ☐
- Office P & P ☐
- Ad Hoc Reports ☒
- Recipient Services ☐

Designated Division Approval:

Explanations/Attachments: Please complete adhoc reports as noted below: Please query pharmacy claims data from the history file. In the report find all paid (Status 1) (Claim Type Modifier 1 or 2, pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 in Therapeutic Class 07 name this **TC 07** and place in an Access file and burn to a CD, extract the following fields ICN, DOS, DOP, original recipient ID, recipient ID, status, claim type modifier, NDC, provider ID, prescriber ID, units, billed amount, allowed amount, payment, recipient date of birth.

Then complete another adhoc report with pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 with any of the Generic Codes (DE 5061) in the following list. Find all paid (Status 1) (Claim Type Modifier 1 or 2, pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 and extract the following fields ICN, DOS, DOP, NDC, original recipient ID, recipient ID, status, claim type modifier, provider ID, prescriber ID, units, billed amount, allowed amount, payment, recipient date of birth and place in an Access file and burn to a CD, name this file **Zyprex1**, also create a filter with the recipient ID's from this file and use to run the next ad hoc report.

Name	GenCD
Zyprexa	15081
Zyprexa	15082
Zyprexa	15083

Exhibit D
Page 1 of 6

EXHIBIT 7 9-07 CAMPANA

001055

E F G

506-H1204 pg 2/2

Zyprexa	15084
Zyprexa	15085
Zyprexa	15086
Zyprexa	17407
Zyprexa	34022
Zyprexa	34023
Zyprexa	92007
Zyprexa	92008

Third file: query against all non-pharmacy claims with the recipient ID's from the last file for dates of service 1-1-1996 thru 11-30-06. Please supply in the report, ICN, original Recip ID, recipient ID, Status, Claim Type Modifier, Proc Code, units, billed amount, allowed amount, paid amt, date of service, date of payment, recipient date of birth, billing provider number, rendering provider number, service from date, service thru date, Primary ICD 9 Diagnosis Code, Secondary Diagnosis Code. Name this file **ZypMed1**. Please place in an Access file place on a CD, deliver to me, then use the primary and secondary diagnoses from this file in the next file.

Fourth File: combine and group the primary and secondary diagnoses into one list and run against primary and secondary diagnoses of all non-pharmacy claims with dates of service 1-1-1996 thru 11-30-06 to determine: ICN, original Recip ID, recipient ID, Prov ID, Status, Claim Type Modifier, Proc Code, units, billed amount, allowed amount, paid amt, date of service, date of payment, recipient date of birth, billing provider number, rendering provider number, service from date, service thru date, Primary ICD 9 Diagnosis Code, Secondary Diagnosis Code. Name this file **Med1**. Please place in an Access file place on a CD, deliver to me

Thank you.

Work Order due date: 12/12/06
For internal use only: Ad hoc Zyprexa
(Cannot include patient identifiers)

Authorized Signature (Sender)

Database input
Version 4/30/2004

001056

Exhibit D
Page 2 of 6

E F G

Control Number: 507-H0751
CC:

First Health Services Corporation

Department of Health and Social Services

Work Order

TO: ☒ FHSC Anchorage (Steve Phillimore)
☐ FHSC Richmond (Everett Irving)

DATE: 6/29/07

FROM:
Name: **Dave Campana**
Division: (DBH, DHCS, DSDS)

Keep Copy of Attached ☒

DHCS Authority Work Order Categories:

NOTE: ***The following types of Work Orders require approval by DHCS Management.***

File Updates:

- ☐ Formulary
- ☐ Diagnosis
- ☐ Error Text
- ☐ Rate Files
- ☐ TPL
- ☐ Provider
- ☐ Recipient
- ☐ Claim Check
- ☐ Collo Code

Financial ☐ **Maintenance** ☐

Security ☐ **Enhancement** ☐

Designated DHCS Mgr Approval: DC
DHSC Deputy Director Approval: _____

Direct Work Order Categories:
Operations:

- Claims Resolution ☐
- Hearings ☐
- Appeals ☐
- SURS ☐
- Provider Manuals ☐ *(if a manual update is needed, list provider type(s) affected:* ____
- FHSC Web Site ☐
- Provider Enrollment ☐
- Provider Inquiry ☐
- Provider Training ☐
- Prior Authorization ☐
- Quality Control ☐
- Office P & P ☐
- Ad Hoc Reports ☒
- Recipient Services ☐

Designated Division Approval:

Explanations/Attachments: Please complete adhoc reports as noted below: Please query pharmacy claims data from the history file using the recipient file with the name **Zypr1** on the attached CD. In the report find all paid (Status 1) (Claim Type Modifier 1 or 2, pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 in Therapeutic Class **58.** Extract the following fields ICN, DOS, DOP, original recipient ID, recipient ID, status, claim type modifier, NDC, provider ID, prescriber ID, units, billed amount, allowed amount, payment, recipient date of birth. Place this file in an Access file and name this file **Diab Zypr 1** and burn to a CD.

Then complete another adhoc report with pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 using the recipients in the file named **Control 1.** Find all paid (Status 1) (Claim Type Modifier 1 or 2, pharmacy claims with a date of service and payment from 1-1-1996 thru 11/30/2006 in Therapeutic Class **58** and extract the following fields ICN, DOS, DOP, NDC, original recipient ID, recipient ID, status, claim type modifier, provider ID, prescriber ID, units, billed amount, allowed amount, payment, recipient date of birth and place in an Access file and burn to a CD, name this file **Diab Control 1** and deliver to me.

Thank you.

W[illegible]rder due date: 7/15/07
Fo[illegible]ernal use only: Ad hoc Zyprexa 2
(Cannot include patient identifiers)

Dave Campana
Authorized Signature (Sender)

Database Input: _____
Version 4/30/2004

001057

Exhibit D
Page 3 of 6

E F G

Control Number: SC7-HC852
CC:

First Health Services Corporation

Department of Health and Social Services
Work Order

TO: ☒ FHSC Anchorage (Steve Phillimore)
☐ FHSC Richmond (Everett Irving)

7-30-07
DATE: 6/29/07

FROM:
Name: **Dave Campana**
Division: (DBH, DHCS, DSDS)

Keep Copy of Attached ☐

DHCS Authority Work Order Categories:

NOTE: ***The following types of Work Orders require approval by DHCS Management.***

File Updates:

☐ Formulary	☐ TPL
☐ Diagnosis	☐ Provider
☐ Error Text	☐ Recipient
☐ Rate Files	☐ Claim Check
	☐ Collo Code

Financial ☐ **Maintenance** ☐

Security ☐ **Enhancement** ☐

Designated DHCS Mgr Approval: _____
DHSC Deputy Director Approval: _____

Direct Work Order Categories:
Operations:

Claims Resolution	☐
Hearings	☐
Appeals	☐
SURS	☐
Provider Manuals	☐ *(if a manual update is needed, list provider type(s) affected:____*
FHSC Web Site	☐
Provider Enrollment	☐
vider Inquiry	☐
Provider Training	☐
Prior Authorization	☐
Quality Control	☐
Office P & P	☐
Ad Hoc Reports	☒
Recipient Services	☐

Designated Division Approval:
Explanations/Attachments: Please complete two adhoc report as noted. Please use the recipient lists from S07-H0751, to determine gender for recipient ID in S07-H0751. Query for each file and place in two Access tables and burn to a CD, name the first smaller file 'Gender Zyp' and the second larger file 'Gender Control'. Please deliver to Ed Bako for mailing.

Thank you.

Work Order due date: 8/7/07
For internal use only: Ad hoc Zyprex gender
(Cannot include patient identifiers)

Database Input: _____
Version 4/30/2004

Dave Campana
Authorized Signature (Sender)

001058

Exhibit D
Page 4 of 6

E F G

Control Number: SC7H1040
CC:

First Health Services Corporation

Department of Health and Social Services

Work Order

TO: ☒ **FHSC Anchorage (Sagran Moodley)**
☐ **FHSC Richmond (Tracey McDonnell)**

DATE: 9/18/07

FROM:
Name: **Dave Campana**
Division: (DBH, DHCS, DSDS)

Keep Copy of Attached ☒

Direct Work Order Categories:
Operations:

Claims Resolution	☐
Hearings	☐
Appeals	☐
SURS	☐
Provider Manuals	☐ *(if a manual update is needed,list provider type(s) affected:____*
FHSC Web Site	☐
Provider Enrollment	☐
Provider Inquiry	☐
Provider Training	☐
Prior Authorization	☐
Quality Control	☐
Office P & P	☐
Ad Hoc Reports	☒
Recipient Services	☐

DHCS Authority Work Order Categories:

NOTE: ***The following types of Work Orders require approval by DHCS Management.***

File Updates:

☐ Formulary	☐ TPL
☐ Diagnosis	☐ Provider
☐ Error Text	☐ Recipient
☐ Rate Files	☐ Claim Check
	☐ Collo Code

Financial ☐ **Maintenance** ☐

Security ☐ **Enhancement** ☐

Designated DHCS Mgr Approval: KJe
DHSC Deputy Director Approval:_____

Designated Division Approval:

Explanations/Attachments: Please complete adhoc reports as noted below:

Please complete an adhoc report of pharmacy claims with a date of service and payment from 1-1-1994 thru 11/30/2006. Find all paid (Status 1) (Claim Type Modifier 1 or 2, pharmacy claims, extract the following fields ICN, DOS, DOP, NDC, original recipient ID, recipient ID, status, claim type modifier, provider ID, prescriber ID, units, billed amount, allowed amount, payment, recipient date of birth and place in an Access file and burn to a CD, name this file **All Rx 0907** if this file requires more than one table name each subsequent table All Rx 0907-1,-2,-3 etc. Deliver to me and provide a layout for this database.

Second file: query against all "non-pharmacy claims" for dates of service 1-1-1994 thru 11-30-06. Please supply in the report, ICN, original Recip ID, recipient ID, Status, Claim Type Modifier, Proc Code, units, Revenue Code, Revenue Code Units, billed amount, allowed amount, paid amt, date of service, date of payment, recipient date of birth, billing provider number, rendering provider number, service from date, service thru date, primary diagnosis code, secondary diagnosis code. Name this file **NonRx 0907**, name each subsequent table Non Rx 0907-1,-2,-3 etc. Please place in an Access file place on a CD, deliver to me with a layout.

Third File: Obtain records from the recipient eligibility system, obtain recipient ID's, original ID's, DOB, race, gender, TPL status, eligibility codes with from and through dates of these codes, basis of eligibility, from and to dates of eligibility, and any third party insurer name and dates of coverage under that insurer. Name this file **Elig 0907**, name each subsequent table Elig 0907-1,-2,-3 etc. If there is limited information for a recipient

Exhibit D
Page 5 of 6
001059

E F G

obtain data from the most recent time backward. Please place in an Access file place on a CD, deliver to me with a layout.

Thank you.

Work Order due date: 9/28/07
For internal use only: Ad hoc Zyprexa
(Cannot include patient identifiers)

Dave Campagna
Authorized Signature (Sender)

Database input: _____
Version 4/30/2004

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 3AN-06-05630 CI
	)	
ELI LILLY AND COMPANY,	)	
	)	
Defendant.	)	
	)	

PLAINTIFF'S FIRST SUPPLEMENTAL RESPONSES TO DEFENDANT'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS

Pursuant to Rule 34 of the Alaska Rules of Civil Procedure, Plaintiff provides the following First Supplemental Responses to Defendant's First Set of Requests for Production of Documents. Plaintiff specifically reserves the right to further supplement and amend these responses as provided by the applicable rules of procedure.

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 2: Each Medicaid State Plan in effect for the State of Alaska since 1996.

RESPONSE: See ZYP-AK-01916 through ZYP-AK-03110.

LAW OFFICES
FELDMAN ORLANSKY
& SANDERS
500 L STREET
FOURTH FLOOR
ANCHORAGE, AK
99501
TEL: 907.272.3538
FAX: 907.274.0819

REQUEST FOR PRODUCTION NO. 3: Each formulary and/or Preferred Drug List (PDL) in effect for the State of Alaska's Medicaid State Plan since 1996.

RESPONSE: See ZYP-AK-00985 – ZYP-AK-01915.

REQUEST FOR PRODUCTION NO. 6: All medical records from the birth of the patient to the present for any patient whose Zyprexa prescription(s) were paid for by Alaska, and which Alaska seeks reimbursement for in this litigation.

RESPONSE: The State objects to this request to the extent it seeks information and/or documents, the disclosure of which would violate the privacy or confidentiality rights of non-parties including, but not limited to, those privacy rights guaranteed by the Federal and state constitutions as well as Federal and state statutes and regulations. The State further objects to this request in that it seeks information that is irrelevant to the claims and defenses of the parties and is not reasonably calculated to lead to the discovery of admissible evidence.

Subject to and without waiving these objections, see Disk 3 – de-identified health information.

REQUEST FOR PRODUCTION NO. 8: All medical records from birth of the patient to the present for any patient whose treatment for medical injuries was paid for by Alaska, and for which Alaska seeks reimbursement in this litigation.

RESPONSE: See Plaintiff's Supplemental Response to Requests for Production No. 6 above.

LAW OFFICES
FELDMAN ORLANSKY
& SANDERS
500 L STREET
FOURTH FLOOR
ANCHORAGE, AK
99501
TEL: 907.272.3538
FAX: 907.274.0819

REQUEST FOR PRODUCTION NO. 9: Any documents reflecting communications or transactions relating to Zyprexa between Alaska and Alaska's PBM(s) including (a) agreements, (b) pharmacy benefit design records, (c) drug utilization reviews, (d) formulary management programs, (e) records relating to mental health disease management, and (f) communications to physicians.

RESPONSE: See ZYP-AK-03344 – ZYP-AK-03353.

REQUEST FOR PRODUCTION NO. 27: Any Drug Utilization Reviews and/or Drug Class Reviews by Alaska concerning Zyprexa.

RESPONSE: See Plaintiff's Supplemental Response to Request for Production No. 9 above.

DATED this 8 day of June, 2007.

FELDMAN, ORLANSKY & SANDERS
Counsel for Plaintiff

BY _____
Eric T. Sanders
Alaska Bar No. 7510085

GARRETSON & STEELE
Matthew L. Garretson
Joseph W. Steele
5664 South Green Street
Salt Lake City, UT 84123
(801) 266-0999
Counsel for Plaintiff

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TEL: 907.272.3538
FAX: 907.274.0819

RICHARDSON, PATRICK, WESTBROOK
& BRICKMAN, LLC
H. Blair Hahn
Christiaan A. Marcum
P.O. Box 1007
Mt. Pleasant, SC 29465
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Certificate of Service
I hereby certify that a true and correct copy of **Plaintiff's First Supplemental Responses to Defendant's First Set of Requests for Production of Documents** was served by messenger on:

Brewster H. Jamieson
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By _____
Date 6/8/04

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,
Plaintiff,
vs.
ELI LILLY AND COMPANY,
Defendant.
Case No. 3AN-06-05630 Civil

ORAL ARGUMENT

July 12, 2007 - Pages 1 through 80

A-P-P-E-A-R-A-N-C-E-S

and used in this State.

What did they rely on? It was not just statements from Lilly. There is

literature. The State has a Pharmaceutical and Therapeutics Committee that decides what to put on a formulary and how to restrict it. They receive -- there are doctors involved. They read the medical literature. They talk to other doctors. It's not something that they're receiving in a vacuum, just information from Lilly. It's not like the cigarette cases where there's nationwide advertising and uninformed consumers. There are informed consumers both at the State level and at the level of the doctors. And they're receiving information at both levels in making informed decisions based upon many, many factors, none of which can be explained by statistics. Thank you.

THE COURT: Briefly, Mr. Steel.

MR. STEEL: Briefly. Responding to the last point. What's the benefit to doctors of knowing the truth? What could be the possible benefit to doctors of believing a lie? That's what we're talking about here.

Getting to specific points.

Remoteness. If Mattingly was the State of Alaska versus Zyprexa it would have been a lot better case because as Lilly well

knows, its biggest customer is government, and its biggest customer in Alaska for Zyprexa is the government. Lilly has a whole division called Business to Government where they do things like lobby states for access to funding. This is with respect to antipsychotic medications. Work with states on funding management, develop advocacy relationships, work with the state, county and local entities for product access. This is all about the State.

It's not the least bit remote, and it is not remote under traditional proximate cause criteria because the embroiling of the doctors and the State into this scheme so that Zyprexa gets paid for is part of the plan and Lilly knew exactly what it was doing.

ICD-9 codes are individual data. In other words, we are giving them -- and Mr. Rogoff is apparently out of date -- we have given them the Medicaid database that contains the descriptions of each individual who has received Medicaid. So they have as to each individual who has received Medicaid the ICD-9 codes, which is diagnosis of disease as to specific individuals. We are talking about what

happened to specific individuals. And that should be perfectly clear and we've given that to them now.

Reliance. How you prove reliance through statistical evidence is described very adequately by Judge Weinstein on page 10 of the memorandum that you wrote -- or that you read. How you prove causation is described by Judge Weinstein in his memorandum and also in the Schwab case as well as Blue Cross.

Injunctive relief. The reason we didn't ask for injunctive relief is the AG -- apparently the AG understands 501 in a disjunctive. If the Court understands it to be in the conjunctive, if that is you have to have A in order to get B, then so be it. We will ask for injunctive relief, and you are correct, it relates to the marketing and sales. And we do not agree that what we're talking about is in the past. The recent communication from Lilly to -- from the FDA to Lilly with respect to its new product, combining Zyprexa and Prozac, suggests that the warning currently is not adequate to inform physicians of the risks related to diabetes. So there's plenty to

enjoin here.

Thank you.

THE COURT: I thank the parties

TRANSCRIBER'S CERTIFICATE

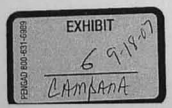
I, LESLIE J. KNISLEY, hereby certify that the foregoing pages numbered 1 through 80 are a true, accurate, and complete transcript of the requested proceedings in Case No. 3AN-06-05630 Civil, State of Alaska vs. Eli Lilly and Company, transcribed by me from a copy of the electronic sound recording to the best of my knowledge and ability.

July 20, 2007

LESLIE J. KNISLEY

Report Showing All Fields for a Subset of Records of Table Med1 from Database DB1.mdb

ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	6/24/1996	6/24/1996	9/10/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
2	6/25/1996	6/25/1996	9/10/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
3	6/26/1996	6/26/1996	9/10/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
4	7/5/1996	7/5/1996	10/8/1996	1	1		HS21IP	0	$19.58	$19.58	$19.58	486		1920
5	7/11/1996	7/11/1996	10/8/1996	1	1		HS21IP	0	$11.00	$11.00	$11.00	8798		1920
6	7/29/1996	7/29/1996	10/8/1996	1	1		HS21IP	0	$11.00	$11.00	$11.00	490		1920
7	9/25/1996	9/25/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
8	9/26/1996	9/26/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
9	9/27/1996	9/27/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
10	10/14/1996	10/14/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
11	10/15/1996	10/15/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
12	10/16/1996	10/16/1996	11/19/1996	1	1		HS21IP	0	$12.70	$12.70	$12.70	V726		1920
13	12/20/1996	12/20/1996	1/28/1997	1	1		HS21IP	0	$72.00	$72.00	$72.00	72190		1920
14	11/1/1996	11/1/1996	5/20/1997	1	1		HS13OP	0	$46.60	$46.60	$46.60	V679		1920
15	10/29/1996	10/29/1996	7/15/1997	1	1		HS13OP	0	$46.60	$46.60	$46.60	3669		1920
16	3/28/1996	3/28/1996	7/9/1996	1	1	99213	HS21OP	1	$5.74	$5.74	$5.74	53550		1920
17	12/20/1996	12/20/1996	4/15/1997	1	1	99213	HS21OP	1	$6.04	$6.04	$6.04	72190		1920
18	11/23/1996	11/26/1996	6/2/1998	1	1		HS05IP	0	$736.00	$736.00	$736.00	486	496	1910
19	11/26/1996	11/26/1996	2/11/1997	1	1	E0570	MS2102	1	$5.34	$5.34	$5.34	496		1910
20	1/15/1996	1/15/1996	2/27/1996	1	1		HS03IP	0	$77.54	$77.54	$77.54	4019		1908
21	1/15/1996	1/15/1996	3/12/1996	1	1	71020	GR0138	1	$12.67	$12.67	$12.67	V725		1908
22	4/4/1996	4/4/1996	5/14/1996	1	1		HS03IP	0	$102.31	$102.31	$102.31	7245		1906
23	4/4/1996	4/4/1996	7/2/1996	1	1	72100	GR0138	1	$2.53	$2.53	$2.53	V725		1906
24	10/29/1996	10/29/1996	9/29/1998	1	1		HS05OP	0	$46.60	$46.60	$46.60	4139	4019	1909
25	8/27/1996	8/27/1996	10/8/1996	1	1	E0244	MS6339	1	$48.00	$48.00	$48.00	7169		1929



Report Showing All Fields for a Subset of Records of Table Med1 from Database DB1.mdb

ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	4/19/1996	4/19/1996	5/14/1996	1	1	2820	CL0635	0	$800.00	$668.41	$668.41	463		1968
27	4/18/1996	4/18/1996	5/21/1996	1	1	85027	LB191B2	1	$16.20	$9.62	$9.62	V726		1968
28	4/18/1996	4/18/1996	5/21/1996	1	1	85730	LB191B2	1	$23.90	$8.92	$8.92	V726		1968
29	4/18/1996	4/18/1996	5/21/1996	1	1	85610	LB191B2	1	$17.70	$5.85	$5.85	V726		1968
30	4/18/1996	4/18/1996	5/21/1996	1	1	84703	LB191B2	1	$30.50	$11.08	$11.08	V726		1968
31	4/19/1996	4/19/1996	5/14/1996	1	1	88304	GR0825	2	$304.00	$284.00	$281.00	V726	7999	1968
32	1/31/1996	1/31/1996	5/7/1996	1	1	99202	MD1507	1	$72.00	$70.00	$67.00	463		1968
33	4/19/1996	4/19/1996	5/7/1996	1	1	42826	MD1507	1	$798.00	$585.60	$582.60	463		1968
34	11/27/1996	11/28/1996	12/17/1996	1	1	[illegible]	HS21IP	1	$1,295.52	$1,295.52	$1,245.52	4750		1962
35	4/16/1996	4/16/1996	4/30/1996	1	1	[illegible]	HS21OP	0	$362.50	$235.18	$223.42	71690		1962
36	7/15/1996	7/15/1996	7/23/1996	1	1	[illegible]	HS21OP	0	$7.45	$7.45	$7.08	6961		1962
37	9/5/1996	9/5/1996	9/17/1996	1	1	[illegible]	HS21OP	0	$229.25	$143.51	$136.33	7140		1962
38	5/1/1996	5/1/1996	10/29/1996	1	2	[illegible]	HS21OP	0	$526.00	$526.00	$499.70	7295	V4361	1962
39	9/18/1996	9/18/1996	10/29/1996	1	1	[illegible]	HS21OP	0	$156.00	$34.61	$32.88	V726		1962
40	11/7/1996	11/7/1996	11/26/1996	1	1	[illegible]	HS21OP	0	$253.45	$156.24	$148.43	6960	78550	1962
41	11/25/1996	11/25/1996	12/10/1996	1	1	[illegible]	HS21OP	0	$406.00	$406.00	$385.70	92401		1962
42	12/16/1996	12/16/1996	2/25/1997	1	1	[illegible]	HS21OP	0	$135.00	$135.00	$128.25	4659	[illegible]	1962
43	1/12/1996	1/12/1996	2/6/1996	1	1	99212	MD2369	1	$58.00	$33.60	$30.60	4900		1962
44	4/16/1996	4/16/1996	4/30/1996	1	1	99213	MD2427	1	$74.00	$53.22	$50.22	71690	[illegible]	1962
45	6/12/1996	6/12/1996	7/9/1996	1	1	99213	MD2907	1	$74.00	$53.22	$50.22	V6759	V4361	1962
46	7/15/1996	7/15/1996	7/23/1996	1	1	99213	MD2369	1	$74.00	$53.22	$50.22	6961		1962
47	7/22/1996	7/22/1996	8/6/1996	1	1	99213	MD0189	1	$58.00	$53.22	$50.22	6960	V679	1962
48	11/27/1996	11/27/1996	9/9/1997	1	2	99221	MD2907	1	$135.00	$99.00	$96.00	475		1962
49	11/29/1996	11/29/1996	9/9/1997	1	2	99213	MD2907	1	$74.00	$74.00	$71.00	V675	475	1962
50	11/25/1996	11/25/1996	9/9/1997	1	2	99284	MD1933	1	$198.00	$198.00	$195.00	92401		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	11/7/1996	11/7/1996	9/9/1997	1	2	99213	MD0189	1	$74.00	$74.00	$71.00	6960	7865	1962
52	12/16/1996	12/16/1996	9/16/1997	1	2	99213	MD2884	1	$74.00	$74.00	$71.00	4659		1962
53	11/26/1996	11/26/1996	9/16/1997	1	2	99212	MD9821	1	$58.00	$43.00	$40.00	463		1962
54	1/9/1996	1/9/1996	2/13/1996	1	1		HS11IP	0	$206.68	$206.68	$206.68	4279		1924
55	1/26/1996	1/26/1996	4/16/1996	1	1		HS11IP	0	$181.52	$181.52	$181.52	4281	42731	1924
56	3/25/1996	3/25/1996	7/15/1997	1	1		HS13OP	0	$46.60	$46.60	$46.60	V726		1924
57	1/10/1996	1/10/1996	2/13/1996	1	1	78465	GR0122	1	$47.65	$47.65	$47.65	4279		1924
58	1/26/1996	1/26/1996	3/5/1996	1	1	71020	GR0122	1	$2.53	$2.53	$2.53	4279		1924
59	1/26/1996	1/26/1996	3/5/1996	1	1	93010	HS11IP	1	$2.64	$2.64	$2.64	4281		1924
60	1/26/1996	1/26/1996	3/5/1996	1	1	99284	HS11IP	1	$19.08	$19.08	$19.08	4281		1924
61	1/26/1996	1/26/1996	6/11/1996	1	1	93307	HS11IP	1	$14.76	$14.76	$14.76	4281		1924
62	1/26/1996	1/26/1996	6/11/1996	1	1	93320	HS11IP	1	$7.20	$7.20	$7.20	4281		1924
63	5/9/1996	5/9/1996	7/2/1996	1	1	99212	MD3085	1	$5.38	$5.38	$5.38	4149		1924
64	1/18/1996	1/18/1996	2/20/1996	1	1	86701	LB322C	1	$39.88	$13.20	$13.20	V828		1963
65	1/18/1996	1/18/1996	2/20/1996	1	1	87178	LB322C	2	$68.20	$49.42	$49.42	V828		1963
66	8/27/1996	8/27/1996	9/24/1996	1	1	87178	LB322C	1	$68.20	$24.71	$24.71	V726		1963
67	1/18/1996	1/18/1996	4/8/1997	1	2	99203	GR0159	1	$125.00	$78.00	$75.00	0999	V222	1963
68	1/18/1996	1/18/1996	4/8/1997	1	2	G0001	GR0159	1	$22.00	$3.00	$3.00	0999	V222	1963
69	1/18/1996	1/18/1996	4/8/1997	1	2	87210	GR0159	1	$28.00	$6.34	$6.34	0999	V222	1963
70	1/18/1996	1/18/1996	4/8/1997	1	2	81025	GR0159	1	$22.00	$9.40	$9.40	0999	V222	1963
71	7/12/1996	7/12/1996	4/8/1997	1	2	99203	GR0159	1	$125.00	$78.00	$75.00	5990		1963
72	7/12/1996	7/12/1996	4/8/1997	1	2	87210	GR0159	1	$28.00	$6.34	$6.34	5990		1963
73	7/12/1996	7/12/1996	4/8/1997	1	2	99070	GR0159	1	$18.00	$18.00	$18.00	5990		1963
74	7/12/1996	7/12/1996	4/8/1997	1	2	99070	GR0159	1	$18.00	$18.00	$18.00	5990		1963
75	8/26/1996	8/26/1996	4/8/1997	1	2	99204	GR0159	1	$175.00	$144.09	$141.09	V222		1963

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	8/26/1996	8/26/1996	4/8/1997	1	2	87210	GR0159	1	$28.00	$6.34	$6.34	V222		1963
77	11/18/1996	11/18/1996	12/23/1996	1	1	99203	NM0349	1	$110.00	$88.00	$88.00	V762	V723	1963
78	11/1/1996	11/1/1996	7/14/1998	1	1	[illegible]	HS05OP	0	$46.60	$46.60	$46.60	4019	V1005	1918
79	11/25/1996	11/25/1996	12/30/1996	1	1	99213	GR0146	1	$7.60	$7.60	$7.60	2304		1918
80	3/5/1996	3/5/1996	4/30/1996	1	1	[illegible]	HS02IP	0	$2.50	$2.50	$2.50	2395		1918
81	7/3/1996	7/3/1996	9/3/1996	1	1	[illegible]	HS02IP	0	$23.76	$23.76	$23.76	7245		1918
82	10/11/1996	10/11/1996	11/26/1996	1	1	11710	PD1612	1	$6.19	$6.19	$6.19	44020		1918
83	10/11/1996	10/11/1996	11/26/1996	1	1	11711	PD1612	1	$3.79	$3.79	$3.79	44020		1918
84	12/2/1996	12/2/1996	1/14/1997	1	1	99214	PD1612	1	$11.63	$11.63	$11.63	68111		1918
85	2/11/1996	2/11/1996	6/11/1996	1	1	4751E	MS8060	1	$29.00	$29.00	$29.00	59654		1910
86	2/11/1996	2/11/1996	5/7/1996	1	1	E0163	MS8060	1	$101.21	$101.21	$101.21	59654		1910
87	6/4/1996	6/4/1996	7/30/1996	1	1	71020	GR0138	1	$7.70	$7.70	$7.70	V725		1910
88	6/4/1996	6/4/1996	7/30/1996	1	1	73562	GR0138	1	$6.93	$6.93	$6.93	V725		1910
89	11/26/1996	11/26/1996	12/23/1996	1	1	99214	NP6394	1	$11.63	$11.63	$11.63	4860		1910
90	11/26/1996	11/26/1996	12/23/1996	1	1	90780	NP6394	1	$9.38	$9.38	$9.38	4860		1910
91	11/26/1996	11/26/1996	12/23/1996	1	1	J0696	NP6394	8	$17.74	$17.74	$17.74	4860		1910
92	11/27/1996	11/27/1996	12/30/1996	1	1	99212	NP6394	1	$5.38	$5.38	$5.38	4860		1910
93	11/27/1996	11/27/1996	12/30/1996	1	1	90780	NP6394	1	$9.38	$9.38	$9.38	4860		1910
94	11/27/1996	11/27/1996	12/30/1996	1	1	J0696	NP6394	8	$17.74	$17.74	$17.74	4860		1910
95	11/27/1996	11/27/1996	12/30/1996	1	1	J7060	NP6394	1	$1.96	$1.96	$1.96	4860		1910
96	12/2/1996	12/2/1996	12/30/1996	1	1	99212	NP6394	1	$5.38	$5.38	$5.38	4860		1910
97	11/25/1996	11/25/1996	1/21/1997	1	1	71020	GR0138	1	$7.70	$7.70	$7.70	V725		1910
98	3/28/1996	3/28/1996	8/6/1996	1	1	8010F	MH0539	1	$125.00	$85.00	$85.00	V611		1964
99	4/5/1996	4/5/1996	8/6/1996	1	1	8473F	MH0539	2	$85.00	$75.00	$75.00	V611		1964
100	4/9/1996	4/9/1996	8/6/1996	1	1	8475F	MH0539	1	$12.50	$12.50	$12.50	V611		1964

Report Showing All Fields for a Subset of Records of Table Med10 from Database DB4.mdb

ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	11/17/2005	11/17/2005	10/17/2006	1	1	90853	MH0159	2	$45.00	$45.00	$18.42	2989		1972
2	11/10/2005	11/10/2005	10/17/2006	1	1	90853	MH0159	1	$22.50	$22.50	$7.50	2989		1972
3	12/7/2005	12/7/2005	10/17/2006	1	1	90804	MH0159	2	$100.00	$80.00	$30.00	2989		1972
4	10/7/2005	10/7/2005	10/17/2006	1	1	90804	MH0159	2	$100.00	$80.00	$30.00	2989		1972
5	11/7/2005	11/7/2005	7/18/2006	1	1	CDAKQ	MH0159	8	$60.00	$60.00	$60.00	2989		1972
6	10/14/2005	10/14/2005	8/15/2006	1	2	CDAKQ	MH0159	16	$120.00	$120.00	$120.00	2989		1972
7	11/15/2005	11/15/2005	8/15/2006	1	2	CDAKQ	MH0159	18	$135.00	$135.00	$135.00	2989		1972
8	12/20/2005	12/20/2005	8/15/2006	1	2	CDAKQ	MH0159	16	$120.00	$120.00	$120.00	2989		1972
9	8/2/2005	8/2/2005	8/15/2006	1	2	CDAKQ	MH0159	24	$180.00	$180.00	$180.00	2989		1972
10	8/10/2005	8/10/2005	8/15/2006	1	2	CDAKQ	MH0159	17	$127.50	$127.50	$127.50	2989		1972
11	8/17/2005	8/17/2005	9/12/2006	1	2	CDAKQ	MH0159	21	$127.50	$127.50	$127.50	2989		1972
12	10/17/2005	10/17/2005	9/26/2006	1	2	CDAKQ	MH0159	26	$195.00	$195.00	$195.00	2989		1972
13	9/22/2005	9/22/2005	11/1/2005	1	1		HS13OP	0	$74.20	$74.20	$74.20	53540	53081	1972
14	12/16/2005	12/16/2005	1/31/2006	1	1		HS13OP	0	$74.20	$74.20	$74.20	8930	V065	1972
15	9/23/2005	9/23/2005	11/1/2005	1	1	90862	MDG420	1	$34.69	$34.69	$34.69	2989		1972
16	10/4/2005	10/4/2005	11/1/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
17	10/4/2005	10/4/2005	11/1/2005	1	1	90853	MDG420	4	$18.99	$18.99	$18.99	2989		1972
18	9/22/2005	9/22/2005	11/1/2005	1	1	99282	CL4320	1	$7.85	$7.85	$7.85	53540		1972
19	10/6/2005	10/6/2005	11/8/2005	1	1	90853	MDG420	4	$19.93	$19.93	$19.93	2989		1972
20	9/24/2005	9/24/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
21	10/11/2005	10/11/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
22	8/19/2005	8/19/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
23	8/31/2005	8/31/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
24	8/11/2005	8/11/2005	11/8/2005	1	1	90853	MDG420	8	$26.58	$26.58	$26.58	2989		1972
25	8/2/2005	8/2/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	8/9/2005	8/9/2005	11/8/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
27	9/27/2005	9/27/2005	11/8/2005	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
28	9/29/2005	9/29/2005	11/8/2005	1	1	90853	MDG420	2	$15.00	$15.00	$15.00	2989		1972
29	10/11/2005	10/11/2005	11/15/2005	1	1	90853	MDG420	4	$18.99	$18.99	$18.99	2989		1972
30	10/18/2005	10/18/2005	11/15/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
31	9/13/2005	9/13/2005	11/15/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
32	10/7/2005	10/7/2005	11/15/2005	1	1	90806	MDG420	1	$50.00	$50.00	$50.00	2989		1972
33	9/23/2005	9/23/2005	11/15/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
34	9/25/2005	9/25/2005	11/15/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
35	7/5/2005	7/5/2005	11/22/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
36	7/12/2005	7/12/2005	11/22/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
37	7/26/2005	7/26/2005	11/22/2005	1	1	90862	MDG420	1	$37.50	$37.50	$37.50	2989		1972
38	7/19/2005	7/19/2005	11/22/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
39	7/8/2005	7/8/2005	11/22/2005	1	1	90806	MDG420	1	$50.00	$50.00	$50.00	2989		1972
40	7/7/2005	7/7/2005	11/22/2005	1	1	90853	MDG420	8	$26.58	$26.58	$26.58	2989		1972
41	7/28/2005	7/28/2005	11/22/2005	1	1	90806	MDG420	1	$50.00	$50.00	$50.00	2989		1972
42	10/13/2005	10/13/2005	11/22/2005	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
43	9/26/2005	9/26/2005	11/22/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
44	10/20/2005	10/20/2005	11/22/2005	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
45	10/28/2005	10/28/2005	11/29/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
46	11/4/2005	11/4/2005	11/29/2005	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
47	10/31/2005	10/31/2005	12/13/2005	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
48	12/14/2005	12/14/2005	1/10/2006	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
49	12/7/2005	12/7/2005	1/10/2006	1	1	90806	MDG420	1	$50.00	$50.00	$50.00	2989		1972
50	12/22/2005	12/22/2005	1/24/2006	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	12/29/2005	12/29/2005	1/31/2006	1	1	99211	MDG420	1	$3.04	$3.04	$3.04	2989		1972
52	12/16/2005	12/16/2005	1/31/2006	1	1	99282	CL4320	1	$9.24	$9.24	$9.24	8930		1972
53	11/10/2005	11/10/2005	2/7/2006	1	1	90853	MDG420	2	$15.00	$15.00	$15.00	2989		1972
54	11/17/2005	11/17/2005	2/7/2006	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
55	11/22/2005	11/22/2005	2/7/2006	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
56	11/21/2005	11/21/2005	2/7/2006	1	1	90853	MDG420	4	$26.58	$26.58	$26.58	2989		1972
57	11/28/2005	11/28/2005	2/14/2006	1	1	90853	MDG420	4	$18.99	$18.99	$18.99	2989		1972
58	12/28/2005	12/28/2005	4/18/2006	1	1	[illegible]	HS05OP	1	$485.40	$391.00	$391.00	V7231	3899	1963
59	11/14/2005	11/14/2005	7/18/2006	1	1	99213	MDG944	1	$170.40	$65.97	$65.97	92420		1963
60	8/23/2005	8/23/2005	1/31/2006	1	1	[illegible]	HS13OP	1	$152.16	$346.00	$224.27	57420	V7283	1983
61	11/6/2005	11/6/2005	11/22/2005	1	1	K0004	MS8060	1	$26.70	$26.70	$26.70	7876		1912
62	11/16/2005	11/16/2005	12/20/2005	1	1	E0910	MS3444	1	$3.56	$3.56	$3.56	71518	[illegible]	1912
63	11/16/2005	11/16/2005	12/20/2005	1	1	E0260	MS3444	1	$28.09	$28.09	$28.09	71518	[illegible]	1912
64	12/16/2005	12/16/2005	2/7/2006	1	1	E0260	MS3444	1	$28.09	$28.09	$28.09	71518	[illegible]	1912
65	12/16/2005	12/16/2005	2/7/2006	1	1	E0910	MS3444	1	$3.56	$3.56	$3.56	71518	[illegible]	1912
66	11/6/2005	11/6/2005	5/16/2006	1	1	99349	MDG944	1	$281.50	$136.72	$136.72	4019		1916
67	12/15/2005	12/15/2005	6/13/2006	1	1	99213	MDG944	1	$170.40	$65.97	$65.97	7862		1916
68	7/1/2005	7/1/2005	9/27/2005	1	1	T1019	PCG414	4	$76.00	$21.00	$21.00	3310		1916
69	7/20/2005	7/28/2005	9/20/2005	1	1	0722	HS13IP	0	$912.00	$912.00	$912.00	1890	2761	1916
70	8/30/2005	8/30/2005	10/4/2005	1	1	[illegible]	HS13OP	0	$74.20	$74.20	$74.20	1891		1916
71	8/31/2005	8/31/2005	11/22/2005	1	1	[illegible]	HS13OP	0	$74.20	$74.20	$74.20	V5849	1890	1916
72	11/1/2005	11/1/2005	1/31/2006	1	1	[illegible]	HS05OP	0	$74.20	$74.20	$74.20	7862	1539	1916
73	12/20/2005	12/20/2005	5/2/2006	1	1	[illegible]	HS05OP	0	$74.20	$74.20	$74.20	7862	V1005	1916
74	9/12/2005	9/12/2005	5/2/2006	1	1	[illegible]	HS05OP	0	$74.20	$74.20	$74.20	7862	4019	1916
75	7/20/2005	7/20/2005	8/16/2005	1	1	99243	CL4320	1	$119.39	$119.39	$119.39	V7283		1916

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	7/19/2005	7/19/2005	8/23/2005	1	1	74170	CL4320	1	$24.30	$24.30	$24.30	5939		1916
77	7/19/2005	7/19/2005	8/23/2005	1	1	72194	CL4320	1	$21.14	$21.14	$21.14	5939		1916
78	7/20/2005	7/20/2005	8/23/2005	1	1	93010	CL4320	1	$3.04	$3.04	$3.04	V7281		1916
79	7/21/2005	7/21/2005	8/23/2005	1	1	00862	CL4320	11	$112.11	$112.11	$112.11	1890		1916
80	7/21/2005	7/21/2005	9/6/2005	1	1	50230	CL4320	1	$407.58	$407.58	$407.58	1890		1916
81	7/21/2005	7/21/2005	9/6/2005	1	1	44005	CL4320	1	$158.22	$158.22	$158.22	5680		1916
82	8/30/2005	8/30/2005	10/18/2005	1	1	74160	CL4320	1	$22.15	$22.15	$22.15	27549		1916
83	8/30/2005	8/30/2005	10/18/2005	1	1	72193	CL4320	1	$20.13	$20.13	$20.13	27549		1916
84	8/30/2005	8/30/2005	10/18/2005	1	1	71020	CL4320	1	$3.80	$3.80	$3.80	V6709		1916
85	7/27/2005	7/27/2005	10/18/2005	1	1	71020	CL4320	1	$3.80	$3.80	$3.80	4293		1916
86	8/17/2005	8/17/2005	5/23/2006	1	1	99213	MDG945	1	$133.85	$65.97	$65.97	37230		1945
87	7/25/2005	7/25/2005	9/13/2005	1	1		HS26OP	1	$836.00	$391.00	$391.00	30500	7905	1970
88	7/24/2005	7/24/2005	9/13/2005	1	1		HS26OP	1	$996.00	$391.00	$391.00	30500	7905	1970
89	7/18/2005	7/18/2005	8/23/2005	1	1	10060	MDG449	1	$272.00	$118.69	$118.69	6822	3051	1970
90	9/15/2005	9/15/2005	5/2/2006	1	1	99212	MDG945	1	$104.90	$48.59	$48.59	7862		1928
91	8/9/2005	8/9/2005	6/6/2006	1	1	99213	MDG945	1	$133.85	$65.97	$65.97	7862		1928
92	7/29/2005	7/29/2005	9/13/2005	1	1	T1019	PCG414	4	$76.00	$21.00	$21.00	496		1928
93	7/28/2005	7/28/2005	9/13/2005	1	1	T1019	PCG414	3	$57.00	$15.75	$15.75	496		1928
94	7/27/2005	7/27/2005	9/13/2005	1	1	T1019	PCG414	14	$266.00	$73.50	$73.50	496		1928
95	7/26/2005	7/26/2005	9/13/2005	1	1	T1019	PCG414	6	$114.00	$31.50	$31.50	496		1928
96	7/25/2005	7/25/2005	9/13/2005	1	1	T1019	PCG414	5	$95.00	$26.25	$26.25	496		1928
97	7/22/2005	7/22/2005	9/13/2005	1	1	T1019	PCG414	5	$95.00	$26.25	$26.25	496		1928
98	7/21/2005	7/21/2005	9/13/2005	1	1	T1019	PCG414	5	$95.00	$26.25	$26.25	496		1928
99	8/10/2005	8/10/2005	9/13/2005	1	1	T1019	PCG414	5	$95.00	$26.25	$26.25	496		1928
100	8/9/2005	8/9/2005	9/13/2005	1	1	T1019	PCG414	5	$95.00	$26.25	$26.25	496		1928

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	2/13/2006	2/13/2006	3/28/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1962
2	3/16/2006	3/16/2006	4/25/2006	1	1	CDAKQ	MH0157	4	$40.00	$30.00	$30.00	29570		1962
3	2/24/2006	2/24/2006	5/2/2006	1	1	T1016	MH0157	10	$150.00	$125.00	$125.00	29570		1962
4	3/9/2006	3/9/2006	5/2/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
5	3/10/2006	3/10/2006	5/2/2006	1	1	CDAEP	MH0157	1	$15.00	$12.50	$12.50	29570		1962
6	3/22/2006	3/22/2006	5/9/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
7	3/23/2006	3/23/2006	5/9/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
8	3/24/2006	3/24/2006	5/9/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
9	4/4/2006	4/4/2006	5/9/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
10	4/5/2006	4/5/2006	5/9/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
11	4/6/2006	4/6/2006	5/16/2006	1	1	T1016	MH0157	5	$75.00	$62.50	$62.50	29570		1962
12	4/10/2006	4/10/2006	5/16/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
13	4/11/2006	4/11/2006	5/16/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1962
14	4/14/2006	4/14/2006	5/16/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
15	4/12/2006	4/12/2006	5/16/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1962
16	1/12/2006	1/31/2006	2/28/2006	1	1		LT0368	20	$7,563.00	$6,684.20	$6,684.20	V5789	V5413	1918
17	2/1/2006	2/4/2006	3/14/2006	1	1		LT0368	3	$1,134.00	$1,002.63	$1,002.63	V5789	V5413	1918
18	5/8/2006	5/8/2006	8/15/2006	1	1	99211	MDG945	1	$93.60	$27.54	$27.54	V5889		1918
19	6/28/2006	6/28/2006	8/22/2006	1	1	81000	MDG944	1	$46.90	$4.43	$4.43	79029		1918
20	6/28/2006	6/28/2006	8/22/2006	1	1	99212	MDG944	1	$133.20	$48.59	$48.59	79029		1918
21	6/28/2006	6/28/2006	8/22/2006	1	1	82962	MDG944	1	$36.00	$2.53	$2.53	79029		1918
22	5/2/2006	5/2/2006	11/28/2006	1	1	99212	MDG944	1	$133.20	$48.59	$48.59	V5889		1918
23	1/1/2006	1/11/2006	3/14/2006	1	1		LT0368	0	$1,309.00	$1,309.00	$1,309.00	V5789	V5413	1918
24	1/20/2006	1/20/2006	3/28/2006	1	1		HS13OP	0	$85.16	$85.16	$85.16	V674	8208	1918
25	2/6/2006	2/6/2006	5/2/2006	1	1		HS13OP	0	$74.20	$74.20	$74.20	V571	34290	1918

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	4/14/2006	4/21/2006	6/20/2006	1	1		HS05IP	0	$952.00	$952.00	$952.00	8082	5990	1918
27	1/3/2006	1/3/2006	3/7/2006	1	1	99214	CL4320	1	$61.48	$61.48	$61.48	43491		1918
28	1/20/2006	1/20/2006	3/21/2006	1	1	99202	CL4320	1	$48.82	$48.82	$48.82	V674		1918
29	2/3/2006	2/3/2006	4/4/2006	1	1	K0001	MS237A	1	$10.65	$10.65	$10.65	8208		1918
30	3/3/2006	3/3/2006	4/4/2006	1	1	K0001	MS237A	1	$10.65	$10.65	$10.65	8208		1918
31	4/3/2006	4/3/2006	5/16/2006	1	1	K0001	MS237A	1	$10.65	$10.65	$10.65	8208		1918
32	4/21/2006	4/21/2006	5/23/2006	1	1	A0427	AA5060	1	$100.00	$100.00	$100.00	8088		1918
33	4/21/2006	4/21/2006	5/23/2006	1	1	A0425	AA5060	5	$9.17	$9.17	$9.17	8088		1918
34	4/13/2006	4/13/2006	5/23/2006	1	1	A0427	AA5060	1	$100.00	$100.00	$100.00	8088		1918
35	4/13/2006	4/13/2006	5/23/2006	1	1	A0425	AA5060	5	$9.17	$9.17	$9.17	8088		1918
36	5/3/2006	5/3/2006	6/6/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1918
37	4/12/2006	4/12/2006	6/6/2006	1	1	A0435	AA5060	81	$174.47	$174.47	$174.47	8088		1918
38	4/13/2006	4/13/2006	6/6/2006	1	1	A0430	AA5060	1	$797.98	$797.98	$797.98	8088		1918
39	4/26/2006	4/26/2006	6/6/2006	1	1	A0430	AA5060	1	$797.98	$797.98	$797.98	78009		1918
40	4/26/2006	4/26/2006	6/6/2006	1	1	A0435	AA5060	81	$174.47	$174.47	$174.47	78009		1918
41	6/3/2006	6/3/2006	6/27/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1918
42	4/17/2006	4/17/2006	7/11/2006	1	1	99212	CL4320	1	$5.04	$5.04	$5.04	8082		1918
43	6/8/2006	6/8/2006	9/19/2006	1	1	E0260	MS4667	1	$28.09	$28.09	$28.09	8088	4359	1918
44	6/8/2006	6/8/2006	9/19/2006	1	1	E0180	MS4667	1	$6.14	$6.14	$6.14	70703	8088	1918
45	5/8/2006	5/8/2006	9/19/2006	1	1	E0260	MS4667	1	$28.09	$28.09	$28.09	8088	4359	1918
46	5/8/2006	5/8/2006	9/19/2006	1	1	E0180	MS4667	1	$6.14	$6.14	$6.14	70703	8088	1918
47	6/21/2006	6/21/2006	8/8/2006	1	1		HS08OP	0	$173.40	$173.40	$173.40	319	311	1954
48	3/29/2006	3/29/2006	9/19/2006	1	1	99213	MDG945	1	$170.40	$65.97	$65.97	78900		1920
49	3/29/2006	3/29/2006	9/19/2006	1	1	81000	MDG945	1	$46.90	$4.43	$4.43	78900		1920
50	4/3/2006	4/3/2006	5/16/2006	1	1		HS08OP	0	$74.20	$74.20	$74.20	78650		1919

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	4/19/2006	4/19/2006	6/20/2006	1	1		HS08OP	0	$74.20	$74.20	$74.20	6110	69589	1919
52	2/28/2006	2/28/2006	5/2/2006	1	1	E0260	MS0656	1	$127.29	$127.29	$127.29	81220		1919
53	2/20/2006	2/20/2006	5/30/2006	1	1	99347	MDG308	1	$143.70	$56.09	$56.09	486		1914
54	2/24/2006	2/24/2006	5/30/2006	1	1	99212	MDG308	1	$113.34	$48.59	$48.59	486		1914
55	5/17/2006	5/17/2006	8/1/2006	1	1	99213	MDG308	1	$157.87	$65.97	$65.97	485	4019	1914
56	6/17/2006	6/17/2006	9/19/2006	1	1	99213	MDG308	1	$157.87	$65.97	$65.97	78650		1914
57	6/20/2006	6/20/2006	9/19/2006	1	1	99213	MDG308	1	$157.87	$65.97	$65.97	78605		1914
58	5/18/2006	5/18/2006	9/19/2006	1	1	99347	MDG308	1	$143.70	$56.09	$56.09	485		1914
59	6/18/2006	6/18/2006	12/5/2006	1	1	99212	MDG308	1	$113.34	$48.59	$48.59	9839		1914
60	2/13/2006	2/13/2006	3/28/2006	1	1		HS03OP	0	$51.98	$51.98	$51.98	7862	78605	1914
61	2/24/2006	2/24/2006	4/11/2006	1	1		HS03OP	0	$25.70	$25.70	$25.70	7862	4293	1914
62	6/21/2006	6/30/2006	8/8/2006	1	1		HS03AW	0	$952.00	$952.00	$952.00	4280	486	1914
63	2/13/2006	2/13/2006	3/21/2006	1	1	71020	GR0138	1	$11.80	$11.80	$11.80	51889		1914
64	2/13/2006	2/13/2006	3/21/2006	1	1	99212	CL0260	1	$41.09	$41.09	$41.09	496		1914
65	2/24/2006	2/24/2006	4/18/2006	1	1	71020	GR0138	1	$2.36	$2.36	$2.36	51889		1914
66	2/24/2006	2/24/2006	4/18/2006	1	1	99213	CL0260	1	$11.17	$11.17	$11.17	51889		1914
67	6/21/2006	6/21/2006	7/25/2006	1	1	71020	GR0138	1	$2.36	$2.36	$2.36	78605		1914
68	6/22/2006	6/22/2006	7/25/2006	1	1	99254	MD01421	1	$29.56	$29.56	$29.56	42823		1914
69	6/22/2006	6/22/2006	7/25/2006	1	1	93307	GR0138	1	$10.25	$10.25	$10.25	4280		1914
70	6/22/2006	6/22/2006	7/25/2006	1	1	93320	GR0138	1	$4.26	$4.26	$4.26	4280		1914
71	6/22/2006	6/22/2006	7/25/2006	1	1	93325	GR0138	1	$0.87	$0.87	$0.87	4280		1914
72	6/25/2006	6/25/2006	8/22/2006	1	1	99231	MD30142	1	$7.09	$7.09	$7.09	4148		1914
73	6/23/2006	6/23/2006	9/26/2006	1	1	99232	CL0260	1	$11.58	$11.58	$11.58	4280		1914
74	6/27/2006	6/27/2006	10/24/2006	1	1	99232	CL0260	1	$11.58	$11.58	$11.58	4254		1914
75	6/29/2006	6/29/2006	10/24/2006	1	1	99232	CL0260	1	$11.58	$11.58	$11.58	4254		1914

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	6/28/2006	6/28/2006	10/24/2006	1	1	99232	CL0260	1	$11.58	$11.58	$11.58	4254		1914
77	6/21/2006	6/21/2006	10/24/2006	1	1	99222	CL0260	1	$23.46	$23.46	$23.46	4280		1914
78	1/19/2006	1/19/2006	2/21/2006	1	1	T1999	MS9610	420	$57.00	$21.00	$21.00	78838		1922
79	1/18/2006	1/18/2006	1/31/2006	1	1	E0260	MS9610	1	$105.34	$105.34	$105.34	8208		1922
80	2/18/2006	2/18/2006	3/7/2006	1	1	E0260	MS9610	1	$36.00	$36.00	$36.00	8208		1922
81	3/18/2006	3/18/2006	4/4/2006	1	1	E0260	MS9610	1	$21.07	$21.07	$21.07	8208		1922
82	1/3/2006	1/3/2006	2/7/2006	1	1	8659	HS03OP	0	$537.41	$300.30	$285.28	8830	30500	1962
83	2/6/2006	2/6/2006	2/21/2006	1	1	[illegible]	HS03OP	0	$118.25	$66.08	$62.78	71941		1962
84	4/6/2006	4/6/2006	4/25/2006	1	1	[illegible]	HS03OP	0	$1,225.41	$684.76	$650.52	7935	28959	1962
85	5/23/2006	5/23/2006	6/20/2006	1	1	[illegible]	HS03OP	0	$104.31	$58.29	$55.38	71941		1962
86	1/23/2006	1/23/2006	3/14/2006	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
87	2/21/2006	2/21/2006	3/28/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
88	2/7/2006	2/7/2006	3/28/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
89	2/8/2006	2/8/2006	3/28/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
90	1/24/2006	1/24/2006	3/28/2006	1	1	T1016	MH0157	1	$60.00	$12.50	$12.50	29570		1962
91	4/12/2006	4/12/2006	5/23/2006	1	1	90801	MH0157	1	$250.00	$230.00	$230.00	29570		1962
92	4/18/2006	4/18/2006	6/13/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
93	5/18/2006	5/18/2006	8/1/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
94	5/19/2006	5/19/2006	8/1/2006	1	1	T1016	MH0157	3	$45.00	$37.50	$37.50	29570		1962
95	6/2/2006	6/2/2006	8/1/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
96	5/24/2006	5/24/2006	8/1/2006	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
97	5/17/2006	5/17/2006	8/15/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
98	6/8/2006	6/8/2006	8/15/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
99	6/14/2006	6/14/2006	8/15/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
100	6/21/2006	6/21/2006	8/22/2006	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	11/7/2006	11/7/2006	12/5/2006	1	1	99253	CL4320	1	$20.57	$20.57	$20.57	78079		1905
2	7/19/2006	7/19/2006	8/29/2006	1	1		HS03OP	0	$20.92	$20.92	$20.92	60490		1905
3	7/19/2006	7/19/2006	9/12/2006	1	1	99284	GR0119	1	$20.05	$20.05	$20.05	60490		1905
4	8/22/2006	8/22/2006	9/26/2006	1	1	99213	CL0260	1	$11.17	$11.17	$11.17	78039		1905
5	7/11/2006	7/11/2006	7/18/2006	1	1	T4526	MS9255	20	$18.20	$18.20	$18.20	78839		1905
6	7/11/2006	7/11/2006	7/18/2006	1	1	A4927	MS9255	1	$8.00	$7.86	$7.86	78839		1905
7	8/8/2006	8/8/2006	8/22/2006	1	1	T1999	MS9255	96	$6.72	$6.72	$6.72	78839		1905
8	8/18/2006	8/18/2006	9/26/2006	1	1	92594	AU8800	1	$58.00	$45.00	$45.00	38910		1905
9	8/18/2006	8/18/2006	9/26/2006	1	1	99212	AU8800	1	$77.00	$48.58	$48.58	38910		1905
10	8/18/2006	8/18/2006	9/26/2006	1	1	92592	AU8800	1	$58.00	$40.00	$40.00	38910		1905
11	9/1/2006	9/1/2006	9/12/2006	1	1	T4526	MS9255	20	$18.20	$18.20	$18.20	7876		1905
12	9/1/2006	9/1/2006	9/12/2006	1	1	T1999	MS9255	96	$6.72	$6.72	$6.72	78839		1905
13	11/3/2006	11/3/2006	11/21/2006	1	1	T1999	MS9255	96	$6.72	$6.72	$6.72	78839		1905
14	10/11/2006	10/11/2006	10/31/2006	1	1	V2103	OP161NY	2	$10.86	$10.86	$10.86	V720		1905
15	10/11/2006	10/11/2006	10/31/2006	1	1	V2020	OP161NY	1	$5.97	$5.97	$5.97	V720		1905
16	7/21/2006	7/21/2006	9/5/2006	1	1		CL2274	0	$74.20	$74.20	$74.20	53081	71590	1905
17	8/14/2006	8/14/2006	9/12/2006	1	1		CL2276	0	$74.20	$74.20	$74.20	25000	37300	1905
18	10/11/2006	10/11/2006	11/14/2006	1	1		CL2274	0	$69.60	$69.60	$69.60	7384	25000	1905
19	7/31/2006	7/31/2006	8/29/2006	1	1		HS03OP	0	$9.71	$9.71	$9.71	1509	7862	1905
20	8/8/2006	8/8/2006	9/5/2006	1	1		HS03OP	0	$172.43	$172.43	$172.43	53641	1490	1905
21	8/29/2006	8/29/2006	9/26/2006	1	1		HS03OP	0	$20.92	$20.92	$20.92	92410	9160	1905
22	10/18/2006	10/18/2006	11/28/2006	1	1		HS03OP	0	$191.71	$191.71	$191.71	V554		1905
23	8/6/2006	8/6/2006	11/28/2006	1	1		HS03OP	0	$93.38	$93.38	$93.38	V554	1509	1905
24	7/31/2006	7/31/2006	8/22/2006	1	1	99213	MD14421	1	$9.49	$9.49	$9.49	1509		1905
25	7/31/2006	7/31/2006	8/29/2006	1	1	71020	GR0138	1	$2.36	$2.36	$2.36	1509		1905

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	8/4/2006	8/4/2006	9/5/2006	1	1	E0570	MS0466	1	$3.22	$3.22	$3.22	486	490	1905
27	8/6/2006	8/6/2006	10/3/2006	1	1	99284	GR0119	1	$20.05	$20.05	$20.05	99669		1905
28	8/8/2006	8/8/2006	10/10/2006	1	1	99284	GR0119	1	$20.05	$20.05	$20.05	99859		1905
29	8/29/2006	8/29/2006	10/31/2006	1	1	99283	GR0119	1	$12.85	$12.85	$12.85	92410		1905
30	9/28/2006	9/28/2006	11/7/2006	1	1	71020	GR0138	1	$2.36	$2.36	$2.36	78009		1905
31	10/10/2006	10/10/2006	10/17/2006	1	1	T4522	MS4667	192	$167.04	$145.92	$145.92	78830		1905
32	10/10/2006	10/10/2006	10/17/2006	1	1	A6250	MS4667	3	$15.48	$6.90	$6.90	78830		1905
33	10/11/2006	10/11/2006	10/17/2006	1	1	T4541	MS4667	120	$75.00	$51.60	$51.60	78830		1905
34	10/11/2006	10/11/2006	10/17/2006	1	1	A4927	MS4667	8	$144.00	$62.88	$62.88	78830		1905
35	10/11/2006	10/11/2006	10/24/2006	1	1	A9901	MS4667	1	$25.05	$25.05	$25.05	78830		1905
36	10/10/2006	10/10/2006	10/24/2006	1	1	A9901	MS4667	1	$36.20	$36.20	$36.20	78830		1905
37	11/30/2006	11/30/2006	12/12/2006	1	1	A4927	MS4667	8	$144.00	$62.88	$62.88	78830		1905
38	8/11/2006	8/11/2006	11/28/2006	1	1	82962	MDG944	1	$36.00	$2.53	$2.53	56400		1905
39	8/11/2006	8/11/2006	11/28/2006	1	1	99212	MDG944	1	$133.20	$48.59	$48.59	56400		1905
40	8/11/2006	8/11/2006	11/28/2006	1	1	81000	MDG944	1	$46.90	$4.43	$4.43	56400		1905
41	8/3/2006	8/3/2006	9/5/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1905
42	8/8/2006	8/8/2006	9/19/2006	1	1	E0260	MS4667	1	$21.07	$21.07	$21.07	8088	4359	1905
43	8/8/2006	8/8/2006	9/19/2006	1	1	E0180	MS4667	1	$4.61	$4.61	$4.61	70703	8088	1905
44	7/8/2006	7/8/2006	9/19/2006	1	1	E0260	MS4667	1	$28.09	$28.09	$28.09	8088	4359	1905
45	7/8/2006	7/8/2006	9/19/2006	1	1	E0180	MS4667	1	$6.14	$6.14	$6.14	70703	8088	1905
46	9/3/2006	9/3/2006	9/26/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1905
47	9/8/2006	9/8/2006	10/3/2006	1	1	E0260	MS4667	1	$21.07	$21.07	$21.07	8088	4359	1905
48	9/8/2006	9/8/2006	10/3/2006	1	1	E0180	MS4667	1	$4.61	$4.61	$4.61	70703	8088	1905
49	10/8/2006	10/8/2006	10/31/2006	1	1	E0260	MS4667	1	$21.07	$21.07	$21.07	8088	4359	1905
50	10/8/2006	10/8/2006	10/31/2006	1	1	E0180	MS4667	1	$4.61	$4.61	$4.61	70703	8088	1905

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	11/8/2006	11/8/2006	11/28/2006	1	1	E0260	MS4667	1	$21.07	$21.07	$21.07	8088	4359	1905
52	11/8/2006	11/8/2006	11/28/2006	1	1	E0180	MS4667	1	$4.61	$4.61	$4.61	70703	8088	1905
53	11/3/2006	11/3/2006	12/5/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1905
54	10/3/2006	10/3/2006	12/19/2006	1	1	K0001	MS237A	1	$7.99	$7.99	$7.99	8208		1905
55	8/28/2006	8/28/2006	10/3/2006	1	1	E0260	MS0656	1	$28.09	$28.09	$28.09	81220		1905
56	11/10/2006	11/10/2006	12/12/2006	1	1	A9901	MS9610	1	$19.40	$19.40	$19.40	78830	61800	1905
57	11/1/2006	11/1/2006	11/21/2006	1	1	8381	HS13OP	1	$356.00	$356.00	$356.00	9058	3051	1905
58	11/2/2006	11/2/2006	11/21/2006	1	1	[illegible]	HS13OP	1	$356.00	$356.00	$356.00	6918		1905
59	7/21/2006	7/21/2006	9/12/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1905
60	7/28/2006	7/28/2006	9/12/2006	1	1	CDAEP	MH0157	2	$30.00	$25.00	$25.00	29570		1905
61	7/14/2006	7/14/2006	9/12/2006	1	1	CDAEP	MH0157	2	$30.00	$25.00	$25.00	29570		1905
62	7/7/2006	7/7/2006	9/12/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1905
63	7/10/2006	7/10/2006	9/12/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
64	7/21/2006	7/21/2006	9/12/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
65	7/26/2006	7/26/2006	9/12/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1905
66	7/28/2006	7/28/2006	9/12/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
67	7/24/2006	7/24/2006	9/12/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
68	8/15/2006	8/15/2006	10/3/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1905
69	8/31/2006	8/31/2006	10/3/2006	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1905
70	8/1/2006	8/1/2006	10/17/2006	1	1	T1016	MH0157	3	$45.00	$37.50	$37.50	29570		1905
71	8/4/2006	8/4/2006	10/17/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
72	8/7/2006	8/7/2006	10/17/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
73	8/30/2006	8/30/2006	10/17/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
74	9/5/2006	9/5/2006	10/31/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
75	9/6/2006	9/6/2006	10/31/2006	1	1	T1016	MH0157	3	$45.00	$37.50	$37.50	29570		1905

Report Showing All Fields for a Subset of Records of Table Med12 from Database DB4.mdb

ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	9/11/2006	9/11/2006	10/31/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
77	9/13/2006	9/13/2006	10/31/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
78	9/21/2006	9/21/2006	10/31/2006	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1905
79	9/5/2006	9/5/2006	11/7/2006	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1905
80	9/21/2006	9/21/2006	11/21/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1905
81	9/29/2006	9/29/2006	11/21/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1905
82	10/5/2006	10/5/2006	11/21/2006	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1905
83	10/10/2006	10/10/2006	11/28/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1905
84	10/20/2006	10/20/2006	11/28/2006	1	1	CDAEP	MH0157	1	$15.00	$12.50	$12.50	29570		1905
85	10/18/2006	10/18/2006	11/28/2006	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1905
86	10/30/2006	10/30/2006	12/5/2006	1	1	T1016	MH0157	3	$45.00	$37.50	$37.50	29570		1905
87	10/24/2006	10/24/2006	12/5/2006	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1905
88	10/18/2006	10/18/2006	10/31/2006	1	1	99213	GR0118	1	$128.00	$65.97	$62.97	4659		1905
89	9/6/2006	9/6/2006	10/17/2006	1	1	99213	CL0260	1	$157.87	$406.00	$406.00	61610		1905
90	8/1/2006	8/1/2006	10/17/2006	1	1	99213	CL0260	1	$157.87	$406.00	$406.00	8830		1905
91	9/21/2006	9/21/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$84.00	$84.00	$84.00	30000	4556	1905
92	9/14/2006	9/14/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$71.10	$71.10	$71.10	56942		1905
93	9/12/2006	9/12/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$135.60	$135.60	$135.60	56942	4019	1905
94	10/16/2006	10/16/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$104.40	$104.40	$104.40	56942	78900	1905
95	10/14/2006	10/14/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$155.40	$155.40	$155.40	78791	56949	1905
96	10/4/2006	10/4/2006	12/5/2006	1	1	[illegible]	HS23OP	0	$71.10	$71.10	$71.10	30000	30742	1905
97	7/24/2006	7/24/2006	12/12/2006	1	1	[illegible]	HS23OP	0	$120.60	$120.60	$120.60	7820	30000	1905
98	7/7/2006	7/7/2006	12/12/2006	1	1	[illegible]	HS23OP	0	$47.70	$47.70	$47.70	7820		1905
99	8/2/2006	8/2/2006	12/12/2006	1	1	[illegible]	HS23OP	0	$55.50	$55.50	$55.50	7820	2859	1905
100	11/6/2006	11/8/2006	12/19/2006	1	1	[illegible]	HS13OP	0	$952.00	$952.00	$952.00	78079	42731	1905

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	2/19/1997	2/19/1997	3/18/1997	1	1	[illegible]	HS03OP	0	$20.10	$13.27	$12.61	7999		1899
2	5/31/1997	5/31/1997	8/19/1997	1	1	7001M	CMG190	1	$75.00	$75.00	$75.00	49600	41390	1899
3	5/31/1997	5/31/1997	8/19/1997	1	1	7002M	CMG190	1	$240.00	$240.00	$240.00	49600	41390	1899
4	5/31/1997	5/31/1997	9/23/1997	1	1	7003M	CMG190	1	$320.00	$320.00	$320.00	49600	41390	1899
5	7/1/1997	7/31/1997	9/23/1997	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41390	1899
6	8/1/1997	8/31/1997	9/23/1997	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41390	1899
7	6/1/1997	6/30/1997	9/23/1997	1	1	7201M	HC1919	22	$385.44	$379.50	$379.50	49600	41390	1899
8	7/1/1997	7/31/1997	9/23/1997	1	1	7201M	HC1919	12	$210.24	$207.00	$207.00	49600	41390	1899
9	9/1/1997	9/30/1997	10/28/1997	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
10	9/1/1997	9/30/1997	10/28/1997	1	1	7201M	HC1919	17	$293.25	$293.25	$293.25	49600	41300	1899
11	10/1/1997	10/31/1997	11/18/1997	1	1	7201M	HC1919	103	$1,776.75	$1,776.75	$1,776.75	49600	41300	1899
12	10/1/1997	10/31/1997	11/18/1997	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
13	11/1/1997	11/30/1997	12/16/1997	1	1	7201M	HC1919	104	$1,794.00	$1,794.00	$1,794.00	49600	41300	1899
14	11/1/1997	11/30/1997	12/16/1997	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
15	12/1/1997	12/31/1997	1/13/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
16	12/1/1997	12/31/1997	1/13/1998	1	1	7201M	HC1919	106	$1,828.50	$1,828.50	$1,828.50	49600	41300	1899
17	2/19/1997	2/19/1997	4/8/1997	1	1	[illegible]	HS03IP	0	$2,147.68	$2,147.68	$2,147.68	V5331		1899
18	2/19/1997	2/19/1997	4/1/1997	1	1	99253	MD1335	1	$100.54	$100.54	$100.54	99601		1899
19	2/19/1997	2/19/1997	4/1/1997	1	1	33206	MD1335	1	$139.17	$139.17	$139.17	99601		1899
20	2/19/1997	2/19/1997	4/15/1997	1	1	99203	MD1621	1	$14.34	$14.34	$14.34	4269		1899
21	11/12/1997	11/12/1997	12/30/1997	1	1	93735	MD1621	1	$12.41	$12.41	$12.41	4269		1899
22	2/23/1997	2/23/1997	8/26/1997	1	2		HS20OP	0	$362.00	$135.28	$128.52	7263	[illegible]	1930
23	8/14/1997	8/14/1997	9/16/1997	1	1	[illegible]	HS13OP	1	$241.00	$241.00	$241.00	78002	4019	1930
24	8/26/1997	8/26/1997	9/16/1997	1	1	[illegible]	HS13OP	1	$241.00	$241.00	$241.00	7803		1930
25	9/8/1997	9/8/1997	9/16/1997	1	1	[illegible]	HS13OP	1	$241.00	$241.00	$241.00	7803		1930

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	8/26/1997	8/26/1997	9/23/1997	1	1	8914	HS11OP	0	$286.60	$179.78	$170.79	79402		1930
27	3/27/1997	3/27/1997	9/23/1997	1	2		HS20OP	0	$282.00	$105.38	$100.11	9231	E8850	1930
28	10/6/1997	10/6/1997	10/14/1997	1	1		HS13OP	1	$241.00	$241.00	$241.00	V6881		1930
29	10/17/1997	10/17/1997	10/28/1997	1	1		HS13OP	1	$241.00	$241.00	$241.00	7803	9952	1930
30	10/22/1997	10/22/1997	11/4/1997	1	1	9921	HS13OP	1	$241.00	$241.00	$241.00	87350	V065	1930
31	10/15/1997	10/15/1997	11/4/1997	1	1		HS13OP	1	$241.00	$241.00	$241.00	V726		1930
32	10/27/1997	10/27/1997	11/4/1997	1	1		HS13OP	1	$241.00	$241.00	$241.00	V583		1930
33	11/19/1997	11/19/1997	12/23/1997	1	1	3899	HS13OP	1	$241.00	$241.00	$241.00	V726		1930
34	2/25/1997	2/25/1997	6/3/1997	1	1	99202	MD2688	1	$93.00	$66.79	$66.79	72633		1930
35	2/25/1997	2/25/1997	6/3/1997	1	1	10060	MD2688	1	$106.00	$88.05	$88.05	72633		1930
36	2/25/1997	2/25/1997	3/25/1997	1	1	73070	GR0174	1	$98.00	$44.04	$41.04	81241		1930
37	3/17/1997	3/17/1997	3/25/1997	1	1	99212	MD2688	1	$55.00	$37.93	$34.93	72633		1930
38	2/23/1997	2/23/1997	4/15/1997	1	1	99283	MDG624	1	$145.00	$88.28	$85.28	9593		1930
39	3/27/1997	3/27/1997	4/8/1997	1	1	73080	MDG525	1	$48.00	$18.29	$15.29	9593		1930
40	4/3/1997	4/3/1997	4/8/1997	1	1	99212	MD2688	1	$55.00	$37.93	$34.93	72633		1930
41	3/27/1997	3/27/1997	4/29/1997	1	1	99283	MDG624	1	$145.00	$88.28	$85.28	92311		1930
42	2/23/1997	2/23/1997	8/19/1997	1	2	73080	MDG525	1	$48.00	$18.29	$15.29	9593		1930
43	8/26/1997	8/26/1997	9/23/1997	1	1	95819	MDG798	1	$60.00	$60.00	$57.00	79402		1930
44	3/18/1997	3/18/1997	9/9/1997	1	1		HS05OP	0	$128.20	$128.20	$128.20	71696		1918
45	6/5/1997	6/5/1997	9/30/1997	1	1		HS05OP	0	$48.20	$48.20	$48.20	7821		1918
46	6/6/1997	6/6/1997	9/30/1997	1	1		HS05OP	0	$48.20	$48.20	$48.20	7821		1918
47	5/14/1997	5/14/1997	9/30/1997	1	1		HS05OP	0	$48.20	$48.20	$48.20	4019	69589	1918
48	11/1/1997	11/2/1997	6/2/1998	1	1		HS05IP	0	$760.00	$760.00	$760.00	78901	5601	1918
49	2/3/1997	2/3/1997	3/25/1997	1	1	99212	MD4114	1	$28.43	$28.43	$28.43	4659		1954
50	4/29/1997	4/29/1997	6/3/1997	1	1	99213	MD4114	1	$40.81	$40.81	$40.81	8472		1954

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	9/26/1997	9/26/1997	12/2/1997	1	1	99213	MDG811	1	$32.77	$32.77	$32.77	94301		1954
52	12/10/1997	12/10/1997	3/17/1998	1	1	99212	MDG811	1	$5.69	$5.69	$5.69	72690		1954
53	9/22/1997	9/22/1997	12/9/1997	1	1	77315	MD3132	1	$525.00	$291.58	$288.58	1509		1926
54	9/22/1997	9/22/1997	12/9/1997	1	1	77334	MD3132	1	$350.00	$297.41	$297.41	1509		1926
55	9/22/1997	9/22/1997	12/9/1997	1	1	77300	MD3132	1	$220.00	$132.51	$132.51	1509		1926
56	9/22/1997	9/22/1997	12/9/1997	1	1	77430	MD3132	1	$900.00	$524.15	$341.73	1509		1926
57	9/23/1997	9/23/1997	12/9/1997	1	1	77300	MD3132	1	$220.00	$132.51	$129.51	1509		1926
58	9/15/1997	9/15/1997	12/9/1997	1	1	77430	MD3132	1	$900.00	$524.15	$338.73	1509		1926
59	9/16/1997	9/16/1997	12/9/1997	1	1	77300	MD3132	1	$220.00	$132.51	$129.51	1509		1926
60	9/2/1997	9/2/1997	12/30/1997	1	1	77430	MD3132	1	$900.00	$524.15	$156.31	1509		1926
61	9/3/1997	9/3/1997	12/30/1997	1	1	77300	MD3132	1	$220.00	$132.51	$129.51	1509		1926
62	9/8/1997	9/8/1997	12/30/1997	1	1	77430	MD3132	1	$900.00	$524.15	$521.15	1509		1926
63	9/9/1997	9/9/1997	12/30/1997	1	1	77300	MD3132	1	$220.00	$132.51	$129.51	1509		1926
64	10/13/1997	10/13/1997	1/6/1998	1	1	77430	MD3132	1	$900.00	$524.15	$338.73	1509		1926
65	10/14/1997	10/14/1997	1/6/1998	1	1	77300	MD3132	1	$220.00	$132.51	$129.51	1509		1926
66	1/29/1997	1/29/1997	5/20/1997	1	1		HS08OP	0	$128.20	$128.20	$128.20	V681	71590	1926
67	3/13/1997	3/13/1997	6/17/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	V681	71590	1926
68	4/24/1997	4/24/1997	7/1/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	V681	71590	1926
69	5/22/1997	5/22/1997	8/12/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	V681	71590	1926
70	7/7/1997	7/7/1997	9/9/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	V681	71590	1926
71	8/8/1997	8/8/1997	10/7/1997	1	1		HS02OP	0	$77.25	$77.25	$77.25	7872		1926
72	8/6/1997	8/6/1997	10/14/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	7872	7823	1926
73	8/11/1997	8/11/1997	10/14/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509	71590	1926
74	8/19/1997	8/19/1997	10/28/1997	1	1		HS02OP	0	$468.90	$468.90	$468.90	2390		1926
75	8/22/1997	8/30/1997	10/28/1997	1	1		HS11OP	0	$399.84	$399.84	$399.84	2390		1926

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	8/20/1997	8/20/1997	11/4/1997	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509		1926
77	8/12/1997	8/13/1997	11/18/1997	1	1		HS02OP	0	$345.03	$345.03	$345.03	1503	71690	1926
78	8/21/1997	8/21/1997	11/18/1997	1	1		HS13OP	0	$48.20	$48.20	$48.20	1991		1926
79	8/25/1997	8/25/1997	11/18/1997	1	1		HS13OP	0	$48.20	$48.20	$48.20	1991		1926
80	8/28/1997	8/28/1997	11/18/1997	1	1		HS13OP	0	$48.20	$48.20	$48.20	1991		1926
81	10/7/1997	10/27/1997	12/16/1997	1	1		HS11OP	0	$777.34	$777.34	$777.34	2390		1926
82	9/15/1997	9/19/1997	1/6/1998	1	1		HS13IP	0	$760.00	$760.00	$760.00	V581	1509	1926
83	10/20/1997	10/21/1997	1/6/1998	1	1		HS13IP	0	$105.80	$105.80	$105.80	V581	1509	1926
84	11/3/1997	11/10/1997	1/20/1998	1	1		HS11OP	0	$310.94	$310.94	$310.94	2390		1926
85	10/23/1997	10/23/1997	1/20/1998	1	1		HS13OP	0	$48.20	$48.20	$48.20	6299		1926
86	9/8/1997	9/8/1997	3/3/1998	1	1		HS13OP	0	$48.20	$48.20	$48.20	V689		1926
87	10/22/1997	10/22/1997	3/24/1998	1	1		HS13OP	0	$48.20	$48.20	$48.20	V689		1926
88	12/8/1997	12/8/1997	5/5/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	7872	1509	1926
89	12/26/1997	12/26/1997	5/5/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509	71595	1926
90	11/14/1997	11/14/1997	5/5/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1503	7872	1926
91	6/25/1997	6/25/1997	7/29/1997	1	1	99203	MD0287	1	$14.34	$14.34	$14.34	7872		1926
92	8/8/1997	8/8/1997	9/23/1997	1	1	76770	MD3015	1	$8.09	$8.09	$8.09	5997		1926
93	8/8/1997	8/8/1997	9/23/1997	1	1	74220	MD3015	1	$5.01	$5.01	$5.01	5997		1926
94	8/19/1997	8/19/1997	10/14/1997	1	1	71250	MD3015	1	$12.52	$12.52	$12.52	1509		1926
95	8/22/1997	8/22/1997	11/4/1997	1	1	77331	MD3132	1	$9.45	$9.45	$9.45	1509		1926
96	8/22/1997	8/22/1997	11/4/1997	1	1	77470	MD3132	1	$22.61	$22.61	$22.61	1509		1926
97	8/22/1997	8/22/1997	11/4/1997	1	1	99244	MD3132	1	$23.05	$23.05	$23.05	1509		1926
98	8/22/1997	8/22/1997	11/4/1997	1	1	77263	MD3132	1	$33.87	$33.87	$33.87	1509		1926
99	8/22/1997	8/22/1997	11/4/1997	1	1	77290	MD3132	1	$16.98	$16.98	$16.98	1509		1926
100	8/22/1997	8/22/1997	11/4/1997	1	1	77315	MD3132	1	$16.98	$16.98	$16.98	1509		1926

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	8/20/1998	8/20/1998	9/7/1999	1	1	4752E	MS8060	1	$4.35	$4.35	$4.35	41400	4139	1899
2	8/28/1998	8/28/1998	9/7/1999	1	1	4752E	MS8060	1	$7.35	$7.35	$7.35	41400	4139	1899
3	11/17/1998	11/17/1998	4/27/1999	1	1	99231	MD3230	1	$95.70	$58.41	$58.41	436		1899
4	1/1/1998	1/31/1998	2/10/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
5	2/1/1998	2/28/1998	3/10/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
6	2/1/1998	2/28/1998	3/10/1998	1	1	7201M	HC1919	97	$1,673.25	$1,673.25	$1,673.25	49600	41300	1899
7	3/1/1998	3/27/1998	4/14/1998	1	1	7201M	HC1919	92	$1,587.00	$1,587.00	$1,587.00	49600	41300	1899
8	3/1/1998	3/31/1998	4/14/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
9	1/1/1998	1/31/1998	4/28/1998	1	2	7201M	HC1919	109	$1,880.25	$1,880.25	$1,880.25	49600	41300	1899
10	3/28/1998	4/24/1998	5/26/1998	1	1	7201M	HC1919	103	$1,776.75	$1,776.75	$1,776.75	49600	41300	1899
11	4/1/1998	4/30/1998	5/26/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
12	5/1/1998	5/30/1998	6/26/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
13	5/31/1998	5/31/1998	6/26/1998	1	1	7004M	CMG190	1	$120.00	$120.00	$120.00	49600	41390	1899
14	5/1/1998	5/30/1998	7/7/1998	1	1	7201M	HC1919	60	$1,035.00	$1,035.00	$1,035.00	49600	41300	1899
15	6/1/1998	6/30/1998	7/21/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
16	7/1/1998	7/31/1998	8/18/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
17	8/1/1998	8/31/1998	9/22/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
18	9/1/1998	9/30/1998	11/3/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
19	10/1/1998	10/31/1998	11/3/1998	1	1	7005M	CMG190	1	$200.00	$200.00	$200.00	49600	41300	1899
20	7/1/1998	7/31/1998	12/8/1998	1	1	7201M	HC1919	97	$1,673.25	$1,673.25	$1,673.25	49600	41300	1899
21	8/1/1998	8/31/1998	12/8/1998	1	1	7201M	HC1919	44	$759.00	$759.00	$759.00	49600	41300	1899
22	9/1/1998	9/30/1998	12/8/1998	1	1	7201M	HC1919	97	$1,673.25	$1,673.25	$1,673.25	49600	41300	1899
23	10/1/1998	10/31/1998	12/8/1998	1	1	7201M	HC1919	109	$1,880.25	$1,880.25	$1,880.25	49600	41300	1899
24	11/1/1998	11/10/1998	2/23/1999	1	1	7201M	HC1919	34	$586.50	$586.50	$586.50	49600	41300	1899
25	6/9/1998	6/9/1998	7/28/1998	1	1	71020	NP1313	1	$34.20	$34.20	$34.20	4870		1899

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	6/9/1998	6/9/1998	7/28/1998	1	1	99213	NP1313	1	$37.47	$37.47	$37.47	4870		1899
27	6/15/1998	6/15/1998	8/4/1998	1	1	99213	MD3683	1	$31.48	$31.48	$31.48	4280		1899
28	6/15/1998	6/15/1998	8/4/1998	1	1	73660	MD3683	1	$5.32	$5.32	$5.32	7295		1899
29	6/24/1998	6/24/1998	8/11/1998	1	1	99213	MD3683	1	$8.82	$8.82	$8.82	4280		1899
30	6/24/1998	6/24/1998	8/11/1998	1	1	94760	MD3683	1	$2.37	$2.37	$2.37	4280		1899
31	6/24/1998	6/24/1998	8/11/1998	1	1	69210	MD3683	1	$6.56	$6.56	$6.56	3804		1899
32	4/30/1998	4/30/1998	8/25/1998	1	1	A0390	TR0136	4	$4.40	$4.40	$4.40	V709		1899
33	4/30/1998	4/30/1998	8/25/1998	1	1	A0330	TR0136	1	$54.97	$54.97	$54.97	V709		1899
34	8/23/1998	8/23/1998	10/6/1998	1	1	93010	PH0659	1	$2.70	$2.70	$2.70	41400		1899
35	8/24/1998	8/24/1998	10/6/1998	1	1	93010	PH0659	2	$5.40	$5.40	$5.40	41400		1899
36	8/24/1998	8/24/1998	10/13/1998	1	1	99232	MD9898	1	$11.89	$11.89	$11.89	4139		1899
37	8/25/1998	8/25/1998	10/13/1998	1	1	99238	MD9898	1	$13.98	$13.98	$13.98	4139		1899
38	8/22/1998	8/22/1998	10/13/1998	1	1	99215	MD99691	1	$17.70	$17.70	$17.70	78651		1899
39	8/22/1998	8/22/1998	10/13/1998	1	1	93000	MD99691	1	$5.71	$5.71	$5.71	78651		1899
40	8/23/1998	8/23/1998	10/27/1998	1	1	71010	MD1499	1	$2.09	$2.09	$2.09	78650		1899
41	8/23/1998	8/23/1998	11/3/1998	1	1	99284	GR0119	1	$20.63	$20.63	$20.63	78650		1899
42	9/18/1998	9/18/1998	11/10/1998	1	1	69210	MD99691	1	$6.56	$6.56	$6.56	3804		1899
43	9/29/1998	9/29/1998	11/24/1998	1	1	99214	MD99691	1	$13.21	$13.21	$13.21	5693		1899
44	11/13/1998	11/13/1998	12/21/1998	1	1	99232	GR0118	1	$11.89	$11.89	$11.89	5789		1899
45	11/11/1998	11/11/1998	1/12/1999	1	1	99285	GR0119	1	$32.48	$32.48	$32.48	7809		1899
46	11/11/1998	11/11/1998	1/12/1999	1	1	99214	MD99691	1	$33.01	$33.01	$33.01	2930		1899
47	11/11/1998	11/11/1998	1/12/1999	1	1	93000	MD99691	1	$6.72	$6.72	$6.72	2930		1899
48	11/11/1998	11/11/1998	1/12/1999	1	1	J2270	MD99691	1	$0.20	$0.20	$0.20	2930		1899
49	9/18/1998	9/18/1998	1/12/1999	1	1	99214	MD99691	1	$13.21	$13.21	$13.21	7847		1899
50	11/12/1998	11/12/1998	1/12/1999	1	1	99254	GR0118	1	$30.42	$30.42	$30.42	5693		1899

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	10/26/1998	10/26/1998	1/12/1999	1	1	99214	MD99691	1	$13.21	$13.21	$13.21	78900		1899
52	10/26/1998	10/26/1998	1/12/1999	1	1	71020	MD99691	1	$8.05	$8.05	$8.05	78900		1899
53	11/12/1998	11/12/1998	1/19/1999	1	1	71020	GR0138	1	$2.54	$2.54	$2.54	436		1899
54	11/12/1998	11/12/1998	1/19/1999	1	1	70450	GR0138	1	$10.02	$10.02	$10.02	436		1899
55	11/14/1998	11/14/1998	3/30/1999	1	1	99231	MD3230	1	$8.17	$8.17	$8.17	436		1899
56	11/15/1998	11/15/1998	3/30/1999	1	1	99231	MD3230	1	$8.17	$8.17	$8.17	436		1899
57	11/16/1998	11/16/1998	3/30/1999	1	1	99232	MD3230	1	$11.89	$11.89	$11.89	436		1899
58	8/20/1998	8/20/1998	6/15/1999	1	1	E0167	MS8060	1	$1.00	$1.00	$1.00	41400		1899
59	3/18/1998	3/18/1998	3/31/1998	1	1	3899	HS13OP	1	$241.00	$241.00	$241.00	V726		1930
60	4/21/1998	4/21/1998	5/5/1998	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	78039		1930
61	4/6/1998	4/6/1998	3/9/1999	1	1		HS05OP	0	$128.20	$128.20	$128.20	4019	53081	1918
62	3/20/1998	3/20/1998	8/18/1998	1	1		HS08OP	0	$128.20	$128.20	$128.20	4659		1954
63	3/3/1998	3/3/1998	11/17/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	53550		1954
64	4/6/1998	4/6/1998	6/2/1998	1	1	E0180	MS2102	1	$29.29	$29.29	$29.29	29041		1917
65	5/6/1998	5/6/1998	6/2/1998	1	1	E0180	MS2102	1	$29.29	$29.29	$29.29	29041		1917
66	3/3/1998	3/3/1998	7/7/1998	1	1	E0260	MS2102	1	$66.49	$66.49	$66.49	71509		1917
67	3/3/1998	3/3/1998	7/7/1998	1	1	E0163	MS2102	1	$21.80	$21.80	$21.80	71509		1917
68	3/3/1998	3/3/1998	7/7/1998	1	1	E0199	MS2102	1	$14.43	$14.43	$14.43	71509		1917
69	6/6/1998	6/6/1998	7/7/1998	1	1	E0180	MS2102	1	$5.86	$5.86	$5.86	29041		1917
70	4/3/1998	4/3/1998	7/7/1998	1	1	E0260	MS2102	1	$33.35	$33.35	$33.35	71509		1917
71	5/3/1998	5/3/1998	7/7/1998	1	1	E0260	MS2102	1	$33.35	$33.35	$33.35	71509		1917
72	6/3/1998	6/3/1998	7/7/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917
73	7/3/1998	7/3/1998	7/21/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917
74	7/6/1998	7/6/1998	7/21/1998	1	1	E0180	MS2102	1	$4.39	$4.39	$4.39	29041		1917
75	8/3/1998	8/3/1998	8/25/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	8/6/1998	8/6/1998	8/25/1998	1	1	E0180	MS2102	1	$4.39	$4.39	$4.39	29041		1917
77	9/3/1998	9/3/1998	9/22/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917
78	9/6/1998	9/6/1998	9/29/1998	1	1	E0180	MS2102	1	$4.39	$4.39	$4.39	29041		1917
79	10/3/1998	10/3/1998	10/20/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917
80	11/3/1998	11/3/1998	11/24/1998	1	1	E0260	MS2102	1	$25.02	$25.02	$25.02	71509		1917
81	11/6/1998	11/6/1998	11/24/1998	1	1	E0180	MS2102	1	$4.39	$4.39	$4.39	29041		1917
82	1/6/1998	1/6/1998	3/24/1998	1	1		HS13OP	0	$48.20	$48.20	$48.20	1991		1926
83	2/2/1998	2/9/1998	4/14/1998	1	1		HS11OP	0	$795.32	$795.32	$795.32	2390		1926
84	3/30/1998	4/3/1998	5/19/1998	1	1		HS02IP	0	$764.00	$764.00	$764.00	1508	5303	1926
85	2/17/1998	2/17/1998	6/2/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509	71590	1926
86	2/25/1998	2/25/1998	6/9/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509		1926
87	3/30/1998	3/30/1998	7/7/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509	5303	1926
88	4/10/1998	4/10/1998	7/7/1998	1	1		HS08OP	0	$48.20	$48.20	$48.20	1509		1926
89	2/3/1998	2/3/1998	3/24/1998	1	1	77305	MD3132	1	$8.32	$8.32	$8.32	1509		1926
90	2/2/1998	2/2/1998	3/24/1998	1	1	77430	MD3132	1	$42.18	$42.18	$42.18	1509		1926
91	1/30/1998	1/30/1998	3/24/1998	1	1	77331	MD3132	1	$10.25	$10.25	$10.25	1509		1926
92	1/30/1998	1/30/1998	3/24/1998	1	1	77300	MD3132	1	$7.29	$7.29	$7.29	1509		1926
93	1/30/1998	1/30/1998	3/24/1998	1	1	77334	MD3132	1	$14.41	$14.41	$14.41	1509		1926
94	1/30/1998	1/30/1998	3/24/1998	1	1	77315	MD3132	1	$18.42	$18.42	$18.42	1509		1926
95	1/30/1998	1/30/1998	3/24/1998	1	1	77295	MD3132	1	$52.97	$52.97	$52.97	1509		1926
96	1/30/1998	1/30/1998	3/24/1998	1	1	77263	MD3132	1	$116.75	$116.75	$116.75	1509		1926
97	3/4/1998	3/4/1998	4/14/1998	1	1	43239	MDG572	1	$45.93	$45.93	$45.93	1509		1926
98	3/23/1998	3/23/1998	4/14/1998	1	1	99211	MDG572	1	$3.08	$3.08	$3.08	1509		1926
99	4/3/1998	4/3/1998	4/21/1998	1	1	E0600	MS9255	1	$12.00	$12.00	$12.00	1509		1926
100	4/1/1998	4/1/1998	5/5/1998	1	1	43246	MDG572	1	$73.67	$73.67	$73.67	2639		1926

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	6/9/1999	6/9/1999	9/14/1999	1	1	71020	GR0138	1	$2.53	$2.53	$2.53	78605		1914
2	4/6/1999	4/6/1999	6/6/2000	1	1		HS13OP	0	$42.00	$42.00	$42.00	25000		1922
3	1/11/1999	1/11/1999	6/6/2000	1	1		HS13OP	0	$122.00	$122.00	$122.00	V723		1922
4	4/16/1999	4/16/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
5	4/20/1999	4/20/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	5990		1922
6	4/21/1999	4/21/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
7	5/7/1999	5/7/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
8	6/7/1999	6/7/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
9	7/2/1999	7/2/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
10	11/17/1999	11/17/1999	7/4/2000	1	1		HS19OP	0	$42.00	$42.00	$42.00	25000		1922
11	1/8/1999	1/8/1999	1/26/1999	1	1		HS13OP	1	$241.00	$241.00	$241.00	V7612		1959
12	4/26/1999	4/26/1999	5/4/1999	1	1		HS13OP	1	$241.00	$241.00	$241.00	92311		1959
13	1/6/1999	1/6/1999	1/12/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	30981		1959
14	1/20/1999	1/20/1999	2/2/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	30981		1959
15	2/8/1999	2/8/1999	2/9/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	4739		1959
16	2/4/1999	2/4/1999	2/9/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	V642		1959
17	12/30/1999	12/31/1999	4/25/2000	1	1	7935	HS13IP	2	$2,662.00	$2,662.00	$2,662.00	82021	78039	1930
18	3/15/1999	3/17/1999	11/23/1999	1	2	7936	HS20IP	2	$14,526.30	$3,769.57	$3,769.57	8248	78039	1930
19	4/23/1999	4/30/1999	1/25/2000	1	1		HH0174	0	$459.87	$367.90	$367.90	7812	7993	1930
20	5/1/1999	5/14/1999	1/25/2000	1	1		HH0174	0	$459.87	$367.90	$367.90	7812	7993	1930
21	4/22/1999	4/22/1999	6/15/1999	1	1	A4460	MS7394	1	$2.50	$2.25	$2.25	82322		1930
22	12/30/1999	12/30/1999	2/22/2000	1	1	73510	MDG275	1	$119.00	$17.76	$17.76	82021		1930
23	12/30/1999	12/30/1999	2/22/2000	1	1	73560	MDG275	1	$106.00	$13.88	$13.88	82021		1930
24	12/30/1999	12/30/1999	2/22/2000	1	1	71010	MDG275	1	$92.00	$15.00	$15.00	82021		1930
25	12/30/1999	12/30/1999	2/22/2000	1	1	76000	MDG275	1	$194.00	$13.88	$13.88	82021		1930

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	12/31/1999	12/31/1999	2/22/2000	1	1	73510	MDG275	1	$119.00	$17.76	$17.76	82021		1930
27	12/30/1999	12/30/1999	2/22/2000	1	1	27244	MDG275	1	$3,657.00	$1,968.71	$1,968.71	82021		1930
28	3/15/1999	3/15/1999	4/20/1999	1	1	01392	MDG567	4	$208.00	$171.60	$168.60	8248	78039	1930
29	3/15/1999	3/15/1999	4/20/1999	1	1	0010A	MDG567	15	$780.00	$540.00	$540.00	8248	78039	1930
30	3/15/1999	3/15/1999	4/20/1999	1	1	99140	MDG567	1	$104.00	$37.64	$37.64	8248	78039	1930
31	4/22/1999	4/22/1999	5/18/1999	1	1	L2116	GR0131	1	$98.50	$98.50	$95.50	82322		1930
32	4/22/1999	4/22/1999	5/18/1999	1	1	73590	GR0131	1	$86.00	$45.28	$45.28	82322		1930
33	5/24/1999	5/24/1999	6/15/1999	1	1	73590	GR0131	1	$86.00	$47.02	$44.02	82322		1930
34	5/24/1999	5/24/1999	6/15/1999	1	1	73590	GR0131	1	$43.00	$43.00	$43.00	82322		1930
35	3/15/1999	3/15/1999	7/13/1999	1	1	27759	GR0131	1	$3,120.00	$1,703.11	$1,700.11	82322		1930
36	3/25/1999	3/25/1999	7/13/1999	1	1	29405	GR0131	1	$194.00	$100.98	$97.98	8238		1930
37	3/25/1999	3/25/1999	7/13/1999	1	1	73590	GR0131	1	$86.00	$45.28	$45.28	8238		1930
38	3/25/1999	3/25/1999	7/13/1999	1	1	4591A	GR0131	5	$26.00	$26.00	$26.00	8238		1930
39	3/25/1999	3/25/1999	7/13/1999	1	1	4574A	GR0131	4	$4.00	$2.00	$2.00	8238		1930
40	3/15/1999	3/15/1999	7/27/1999	1	1	99283	MDG624	1	$156.56	$97.44	$94.44	8248	82301	1930
41	7/8/1999	7/8/1999	8/24/1999	1	1	73590	GR0131	1	$86.00	$47.02	$44.02	82322		1930
42	7/8/1999	7/8/1999	8/24/1999	1	1	99213	GR0131	1	$74.00	$66.92	$66.92	82322		1930
43	7/8/1999	7/8/1999	8/24/1999	1	1	73590	GR0131	1	$43.00	$43.00	$43.00	82322		1930
44	9/16/1999	9/16/1999	1/11/2000	1	1	1371	HS13OP	0	$201.67	$201.67	$201.67	36616	37240	1918
45	9/13/1999	9/13/1999	7/4/2000	1	1	[illegible]	HS13OP	0	$42.00	$42.00	$42.00	37300		1918
46	7/1/1999	7/1/1999	2/8/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	07999		1954
47	10/28/1999	10/28/1999	2/29/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	5640	78909	1954
48	11/1/1999	11/1/1999	2/29/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	V6759		1954
49	10/27/1999	10/27/1999	2/29/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	5640		1954
50	10/29/1999	10/29/1999	2/29/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	5640	78909	1954

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	10/12/1999	10/12/1999	3/28/2000	1	1	[illegible]	HS08OP	0	$42.00	$42.00	$42.00	78909	7875	1954
52	10/4/1999	10/4/1999	7/4/2000	1	1	[illegible]	HS19OP	0	$122.00	$122.00	$122.00	4019		1920
53	1/6/1999	1/6/1999	7/13/1999	1	1	99211	GR0224	1	$41.00	$22.80	$0.00	64243		1973
54	1/10/1999	1/10/1999	7/13/1999	1	1	99219	GR0224	1	$234.00	$181.68	$0.00	64403		1973
55	1/20/1999	1/20/1999	7/13/1999	1	1	99212	GR0224	1	$61.00	$44.05	$0.00	V222		1973
56	1/26/1999	1/26/1999	7/13/1999	1	1	99212	GR0224	1	$61.00	$44.05	$0.00	64243		1973
57	1/26/1999	1/26/1999	7/13/1999	1	1	85024	GR0224	1	$38.00	$11.70	$0.00	64243		1973
58	1/26/1999	1/26/1999	7/13/1999	1	1	84450	GR0224	1	$11.00	$7.14	$0.00	64243		1973
59	1/26/1999	1/26/1999	7/13/1999	1	1	82565	GR0224	1	$11.00	$7.07	$0.00	64243		1973
60	1/26/1999	1/26/1999	7/13/1999	1	1	84550	GR0224	1	$11.00	$6.25	$0.00	64243		1973
61	2/1/1999	2/1/1999	7/13/1999	1	1	59410	GR0224	1	$2,100.00	$1,571.40	$0.00	650		1973
62	1/29/1999	1/29/1999	7/13/1999	1	1	99212	GR0224	1	$61.00	$44.05	$0.00	64243		1973
63	1/29/1999	1/29/1999	7/13/1999	1	1	85024	GR0224	1	$38.00	$11.70	$0.00	64243		1973
64	1/29/1999	1/29/1999	7/13/1999	1	1	84450	GR0224	1	$11.00	$7.14	$0.00	64243		1973
65	1/29/1999	1/29/1999	7/13/1999	1	1	82565	GR0224	1	$11.00	$7.07	$0.00	64243		1973
66	1/29/1999	1/29/1999	7/13/1999	1	1	84550	GR0224	1	$11.00	$6.25	$0.00	64243		1973
67	1/14/1999	1/14/1999	7/13/1999	1	1	99212	GR0224	1	$61.00	$44.05	$0.00	V222		1973
68	6/9/1999	6/9/1999	10/19/1999	1	1	99212	MDG215	1	$13.22	$13.22	$13.22	490	49121	1914
69	5/12/1999	5/12/1999	6/22/1999	1	1	99214	CL0260	1	$142.00	$241.00	$241.00	78650		1914
70	5/12/1999	5/12/1999	6/22/1999	1	1	93005	CL0260	1	$43.69	$0.00	$0.00	78650		1914
71	6/16/1999	6/16/1999	8/17/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	496		1914
72	6/9/1999	6/9/1999	8/17/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	490		1914
73	8/13/1999	8/13/1999	9/21/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	6929		1914
74	11/12/1999	11/12/1999	1/4/2000	1	1	99213	CL0260	1	$97.00	$241.00	$241.00	684		1914
75	11/12/1999	11/12/1999	1/11/2000	1	1	72050	GR0138	1	$3.58	$3.58	$3.58	7231		1914

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	5/12/1999	5/12/1999	7/13/1999	1	1	71020	GR0138	1	$10.72	$10.72	$10.72	78650		1914
77	4/19/1999	4/19/1999	4/27/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	3671		1959
78	4/21/1999	4/21/1999	4/27/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	30981		1959
79	9/22/1999	9/22/1999	9/28/1999	1	1	99211	CL4320	1	$241.00	$241.00	$241.00	V2509		1959
80	1/21/1999	1/21/1999	4/6/1999	1	1	8396	HS19OP	1	$208.00	$241.00	$241.00	7393		1961
81	1/9/1999	1/9/1999	4/6/1999	1	1		HS19OP	1	$171.10	$241.00	$241.00	59080		1961
82	1/7/1999	1/7/1999	4/6/1999	1	1		HS19OP	1	$174.70	$241.00	$241.00	V724		1961
83	2/26/1999	2/26/1999	6/15/1999	1	1		HS19OP	1	$255.00	$241.00	$241.00	311		1961
84	6/8/1999	6/8/1999	7/27/1999	1	1		HS19OP	1	$194.00	$241.00	$241.00	6268		1961
85	6/2/1999	6/2/1999	7/27/1999	1	1		HS19OP	1	$173.00	$241.00	$241.00	6262		1961
86	6/25/1999	6/25/1999	8/24/1999	1	1	9032	HS19OP	1	$156.00	$241.00	$241.00	462	3051	1961
87	7/30/1999	7/30/1999	10/5/1999	1	1		HS19OP	1	$70.00	$241.00	$241.00	84500	07999	1961
88	8/24/1999	8/24/1999	9/26/2000	1	1		HS23OP	0	$122.00	$122.00	$122.00	5990	9100	1913
89	8/11/1999	8/11/1999	9/26/2000	1	1		HS23OP	0	$42.00	$42.00	$42.00	36216	36250	1913
90	2/9/1999	2/9/1999	4/6/1999	1	1	99213	CL0260	1	$97.00	$241.00	$241.00	490		1953
91	3/4/1999	3/4/1999	4/27/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	07999		1953
92	3/31/1999	3/31/1999	5/18/1999	1	1	99213	CL0260	1	$97.00	$241.00	$241.00	V829		1953
93	4/15/1999	4/15/1999	6/1/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	4659		1953
94	4/13/1999	4/13/1999	6/1/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	490		1953
95	4/2/1999	4/2/1999	6/22/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	4659		1953
96	8/16/1999	8/16/1999	9/21/1999	1	1	99213	CL0260	1	$97.00	$241.00	$241.00	486		1953
97	8/16/1999	8/16/1999	9/21/1999	1	1	90784	CL0260	1	$63.00	$0.00	$0.00	486		1953
98	8/19/1999	8/19/1999	9/21/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	486		1953
99	9/14/1999	9/14/1999	11/9/1999	1	1	99212	CL0260	1	$77.00	$241.00	$241.00	84219		1953
100	4/12/1999	4/12/1999	3/21/2000	1	1	99283	GR0119	1	$11.41	$11.41	$11.41	7806		1953

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	1/1/2000	1/6/2000	9/12/2000	1	2	7935	HS13IP	5	$6,655.00	$4,284.00	$4,284.00	82021	78039	1930
2	1/21/2000	1/21/2000	8/29/2000	1	2	[illegible]	HS13OP	1	$241.00	$304.00	$304.00	71945	V583	1930
3	4/7/2000	4/7/2000	9/19/2000	1	2	[illegible]	HS13OP	1	$241.00	$304.00	$304.00	V549		1930
4	10/19/2000	10/19/2000	9/4/2001	1	2	[illegible]	HS13OP	1	$304.00	$279.00	$279.00	V549	V4589	1930
5	11/7/2000	11/7/2000	9/4/2001	1	2	[illegible]	HS13OP	1	$304.00	$279.00	$279.00	9160	92401	1930
6	12/19/2000	12/19/2000	9/4/2001	1	2	[illegible]	HS13OP	1	$304.00	$279.00	$279.00	80701	[illegible]	1930
7	11/7/2000	11/7/2000	8/27/2002	1	1	71020	MDG276	1	$154.10	$56.87	$56.87	9160	[illegible]	1930
8	11/7/2000	11/7/2000	8/27/2002	1	1	73562	MDG276	1	$180.55	$51.24	$51.24	9160	[illegible]	1930
9	3/21/2000	3/21/2000	10/3/2000	1	2	99211	CL4320	1	$241.00	$304.00	$304.00	81602		1930
10	5/3/2000	5/3/2000	10/17/2000	1	2	99211	CL4320	1	$241.00	$304.00	$304.00	4019		1930
11	5/4/2000	5/4/2000	10/17/2000	1	2	99211	CL4320	1	$241.00	$304.00	$304.00	V726	[illegible]	1930
12	6/30/2000	6/30/2000	10/17/2000	1	2	99211	CL4320	1	$241.00	$304.00	$304.00	78039	[illegible]	1930
13	10/13/2000	10/13/2000	11/7/2000	1	1	[illegible]	HS05OP	0	$141.60	$141.60	$141.60	490	71945	1918
14	10/20/2000	10/20/2000	11/28/2000	1	1	[illegible]	HS05OP	0	$61.60	$61.60	$61.60	4019	71690	1918
15	9/12/2000	9/12/2000	1/16/2001	1	1	[illegible]	HS05OP	0	$61.60	$61.60	$61.60	71941	4019	1918
16	11/8/2000	11/8/2000	3/20/2001	1	1	[illegible]	HS05OP	0	$61.60	$61.60	$61.60	4280	4019	1918
17	3/13/2000	3/13/2000	4/18/2000	1	1	0004S	MS9255	180	$132.00	$132.00	$132.00	6256	4280	1911
18	4/1/2000	4/1/2000	4/25/2000	1	1	0004S	MS9255	150	$110.00	$110.00	$110.00	6256	4280	1911
19	4/1/2000	4/1/2000	4/25/2000	1	1	0004S	MS9255	24	$23.25	$23.25	$23.25	6256	4280	1911
20	4/1/2000	4/1/2000	4/25/2000	1	1	4752E	MS9255	1	$11.40	$11.40	$11.40	6256	4280	1911
21	4/1/2000	4/1/2000	4/25/2000	1	1	4752E	MS9255	1	$7.25	$7.25	$7.25	6256	4280	1911
22	4/10/2000	4/10/2000	5/2/2000	1	1	3314V	AU0057	2	$1,300.00	$680.00	$680.00	3891		1911
23	4/10/2000	4/10/2000	5/2/2000	1	1	3315V	AU0057	2	$60.00	$60.00	$60.00	3891		1911
24	4/10/2000	4/10/2000	5/2/2000	1	1	4400V	AU0057	12	$12.00	$10.80	$10.80	3891		1911
25	5/1/2000	5/1/2000	5/23/2000	1	1	0004S	MS9255	180	$132.00	$132.00	$132.00	515	4280	1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	5/1/2000	5/1/2000	5/23/2000	1	1	4752E	MS9255	1	$7.05	$7.05	$7.05	515	4280	1911
27	5/1/2000	5/1/2000	5/23/2000	1	1	4752E	MS9255	1	$8.45	$8.45	$8.45	515	4280	1911
28	6/1/2000	6/1/2000	7/4/2000	1	1	0004S	MS9255	180	$132.00	$132.00	$132.00	71596	4280	1911
29	6/1/2000	6/1/2000	7/4/2000	1	1	4752E	MS9255	1	$8.85	$8.85	$8.85	71596	4280	1911
30	6/1/2000	6/1/2000	7/4/2000	1	1	4752E	MS9255	1	$7.25	$7.25	$7.25	71596	4280	1911
31	7/3/2000	7/3/2000	7/25/2000	1	1	0004S	MS9255	180	$132.00	$132.00	$132.00	515	4280	1911
32	7/3/2000	7/3/2000	7/25/2000	1	1	4752E	MS9255	1	$7.15	$7.15	$7.15	515	4280	1911
33	7/3/2000	7/3/2000	7/25/2000	1	1	4752E	MS9255	1	$8.85	$8.85	$8.85	515	4280	1911
34	8/1/2000	8/1/2000	8/22/2000	1	1	0004S	MS9255	180	$132.00	$132.00	$132.00	4280		1911
35	8/1/2000	8/1/2000	8/22/2000	1	1	4751E	MS9255	1	$15.70	$15.70	$15.70	4280		1911
36	12/18/2000	12/18/2000	1/23/2001	1	1	4766S	MS9255	100	$13.00	$13.00	$13.00	515	4280	1911
37	12/18/2000	12/18/2000	1/23/2001	1	1	5141S	MS9255	68	$12.00	$8.16	$8.16	515	4280	1911
38	12/18/2000	12/18/2000	1/23/2001	1	1	5145S	MS9255	240	$6.50	$6.50	$6.50	515	4280	1911
39	12/18/2000	12/18/2000	1/23/2001	1	1	4752E	MS9255	1	$6.95	$6.95	$6.95	515	4280	1911
40	12/29/2000	12/29/2000	1/30/2001	1	1	E0184	MS9255	1	$27.00	$27.00	$27.00	5163	7070	1911
41	12/29/2000	12/29/2000	1/30/2001	1	1	4752E	MS9255	1	$12.70	$12.70	$12.70	5163	7070	1911
42	2/2/2000	2/2/2000	3/14/2000	1	1	7799M	MS0656	1	$23.00	$23.00	$23.00	496	7159	1911
43	2/2/2000	2/2/2000	3/14/2000	1	1	7533M	MS0656	1	$26.00	$26.00	$26.00	496	7159	1911
44	12/4/2000	12/4/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
45	12/11/2000	12/11/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
46	12/13/2000	12/13/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
47	12/14/2000	12/14/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
48	12/21/2000	12/21/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
49	12/29/2000	12/29/2000	2/20/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
50	11/6/2000	11/6/2000	3/6/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	11/8/2000	11/8/2000	3/6/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
52	11/14/2000	11/14/2000	3/6/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
53	11/21/2000	11/21/2000	3/6/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
54	11/27/2000	11/27/2000	3/6/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
55	11/1/2000	11/1/2000	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
56	12/26/2000	12/26/2000	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
57	12/18/2000	12/18/2000	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
58	9/27/2000	9/27/2000	3/13/2001	1	1	99212	CL0260	1	$106.00	$304.00	$304.00	V6759		1911
59	9/27/2000	9/27/2000	3/13/2001	1	1	81002	CL0260	1	$10.00	$0.00	$0.00	V6759		1911
60	9/27/2000	9/27/2000	3/13/2001	1	1	87110	CL0260	1	$75.00	$0.00	$0.00	V6759		1911
61	9/27/2000	9/27/2000	3/13/2001	1	1	87081	CL0260	1	$27.50	$0.00	$0.00	V6759		1911
62	2/11/2000	2/11/2000	3/28/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	7245		1911
63	3/28/2000	3/28/2000	7/4/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	7862	6256	1911
64	3/31/2000	3/31/2000	7/4/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	4280	515	1911
65	4/3/2000	4/3/2000	7/11/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	78609	78079	1911
66	5/12/2000	5/12/2000	7/11/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	515		1911
67	5/8/2000	5/8/2000	8/8/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	78830		1911
68	5/30/2000	5/30/2000	8/8/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	515		1911
69	3/7/2000	3/7/2000	9/12/2000	1	1		HS08OP	0	$42.00	$42.00	$42.00	515	5640	1911
70	7/3/2000	7/3/2000	10/17/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
71	7/5/2000	7/5/2000	10/17/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
72	7/18/2000	7/18/2000	10/17/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
73	7/19/2000	7/19/2000	10/17/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515	V1581	1911
74	7/12/2000	7/12/2000	10/24/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	7862	515	1911
75	7/26/2000	7/26/2000	12/12/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	7/28/2000	7/28/2000	12/26/2000	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
77	4/8/2000	4/21/2000	1/16/2001	1	1		HS08IP	0	$1,460.80	$1,460.80	$1,460.80	5163	494	1911
78	8/11/2000	8/11/2000	1/16/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
79	8/29/2000	8/29/2000	1/16/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515	25000	1911
80	9/13/2000	9/13/2000	1/16/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
81	9/21/2000	9/21/2000	1/30/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
82	9/28/2000	9/28/2000	1/30/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	4659		1911
83	10/10/2000	10/10/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
84	10/24/2000	10/24/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
85	11/7/2000	11/7/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	5640	515	1911
86	11/28/2000	11/28/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
87	11/5/2000	11/5/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	78909	25000	1911
88	12/15/2000	12/15/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
89	12/29/2000	12/29/2000	2/27/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515	5640	1911
90	2/11/2000	2/11/2000	7/24/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	7245		1911
91	3/28/2000	3/28/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	7862	6256	1911
92	3/31/2000	3/31/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	4280	515	1911
93	4/3/2000	4/3/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	78609	78079	1911
94	5/12/2000	5/12/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
95	5/8/2000	5/8/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	78830		1911
96	5/30/2000	5/30/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515		1911
97	3/7/2000	3/7/2000	7/31/2001	1	1		HS08OP	0	$61.60	$61.60	$61.60	515	5640	1911
98	2/9/2000	2/9/2000	2/29/2000	1	1	E0431	MS9255	1	$8.42	$8.42	$8.42	515		1911
99	2/9/2000	2/9/2000	2/29/2000	1	1	E1401	MS9255	1	$46.98	$46.98	$46.98	515		1911
100	3/9/2000	3/9/2000	4/4/2000	1	1	E0431	MS9255	1	$8.42	$8.42	$8.42	515		1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	1/17/2001	1/17/2001	2/27/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
2	1/18/2001	1/18/2001	2/27/2001	1	1	3715F	MH2839	4	$50.00	$50.00	$50.00	30113	31401	1989
3	1/22/2001	1/22/2001	2/27/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
4	1/23/2001	1/23/2001	2/27/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
5	1/24/2001	1/24/2001	2/27/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
6	1/25/2001	1/25/2001	2/27/2001	1	1	3715F	MH2839	8	$100.00	$100.00	$100.00	30113	31401	1989
7	1/26/2001	1/26/2001	2/27/2001	1	1	3715F	MH2839	3	$37.50	$37.50	$37.50	30113	31401	1989
8	1/28/2001	1/28/2001	2/27/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
9	1/30/2001	1/30/2001	5/29/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
10	1/31/2001	1/31/2001	5/29/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
11	2/1/2001	2/1/2001	5/29/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
12	2/2/2001	2/2/2001	5/29/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
13	2/10/2001	2/10/2001	5/29/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
14	2/13/2001	2/13/2001	5/29/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
15	1/2/2001	1/2/2001	3/6/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
16	1/3/2001	1/3/2001	3/6/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
17	1/3/2001	1/3/2001	3/6/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
18	1/29/2001	1/29/2001	3/6/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
19	1/26/2001	1/26/2001	6/12/2001	1	1	1035F	MH2839	3	$135.00	$135.00	$135.00	30113	31401	1989
20	1/27/2001	1/27/2001	6/12/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
21	1/29/2001	1/29/2001	6/12/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
22	1/30/2001	1/30/2001	6/12/2001	1	1	1035F	MH2839	2	$90.00	$90.00	$90.00	30113	31401	1989
23	2/13/2001	2/13/2001	6/12/2001	1	1	1035F	MH2839	2	$90.00	$90.00	$90.00	30113	31401	1989
24	2/26/2001	2/26/2001	6/12/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
25	2/27/2001	2/27/2001	6/12/2001	1	1	1035F	MH2839	8	$360.00	$360.00	$360.00	30113	31401	1989

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	2/28/2001	2/28/2001	6/12/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
27	2/26/2001	2/26/2001	6/12/2001	1	1	3715F	MH2839	2	$25.00	$25.00	$25.00	30113	31401	1989
28	2/27/2001	2/27/2001	6/12/2001	1	1	3715F	MH2839	1	$12.50	$12.50	$12.50	30113	31401	1989
29	2/28/2001	2/28/2001	6/12/2001	1	1	3715F	MH2839	3	$37.50	$37.50	$37.50	30113	31401	1989
30	1/29/2001	1/29/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
31	2/1/2001	2/1/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
32	2/5/2001	2/5/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
33	2/8/2001	2/8/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
34	2/12/2001	2/12/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
35	2/15/2001	2/15/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
36	2/19/2001	2/19/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
37	2/22/2001	2/22/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
38	2/26/2001	2/26/2001	3/20/2001	1	1	90804	MH2839	2	$75.00	$75.00	$75.00	30113	31401	1989
39	3/1/2001	3/1/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
40	3/2/2001	3/2/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
41	3/3/2001	3/3/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
42	3/4/2001	3/4/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
43	3/19/2001	3/19/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
44	3/20/2001	3/20/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
45	3/21/2001	3/21/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
46	3/22/2001	3/22/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
47	3/23/2001	3/23/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
48	3/24/2001	3/24/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
49	3/25/2001	3/25/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
50	3/26/2001	3/26/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	3/27/2001	3/27/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
52	3/28/2001	3/28/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
53	3/29/2001	3/29/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
54	3/30/2001	3/30/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
55	3/31/2001	3/31/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
56	4/1/2001	4/1/2001	7/31/2001	1	1	8440F	MH2839	1	$100.00	$100.00	$100.00	30113	31401	1989
57	3/1/2001	3/1/2001	5/15/2001	1	1	1035F	MH2839	6	$270.00	$270.00	$270.00	30113	31401	1989
58	3/2/2001	3/2/2001	5/15/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
59	3/3/2001	3/3/2001	5/15/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
60	3/5/2001	3/5/2001	5/15/2001	1	1	1035F	MH2839	4	$180.00	$180.00	$180.00	30113	31401	1989
61	3/6/2001	3/6/2001	5/15/2001	1	1	1035F	MH2839	8	$360.00	$360.00	$360.00	30113	31401	1989
62	3/7/2001	3/7/2001	5/15/2001	1	1	1035F	MH2839	3	$135.00	$135.00	$135.00	30113	31401	1989
63	3/18/2001	3/24/2001	4/3/2001	1	1	7201M	HC0974	50	$1,100.00	$1,100.00	$1,100.00	5163		1911
64	3/18/2001	3/24/2001	4/3/2001	1	1	7301M	HC0974	7	$140.00	$140.00	$140.00	5163		1911
65	3/7/2001	3/7/2001	4/3/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
66	3/8/2001	3/8/2001	4/3/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
67	3/25/2001	3/31/2001	4/17/2001	1	1	7201M	HC0974	58	$1,276.00	$1,276.00	$1,276.00	5163		1911
68	3/25/2001	3/31/2001	4/17/2001	1	1	7301M	HC0974	6	$120.00	$120.00	$120.00	5163		1911
69	3/5/2001	3/5/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
70	3/28/2001	3/28/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
71	3/26/2001	3/26/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
72	4/1/2001	4/7/2001	4/24/2001	1	1	7201M	HC0974	59	$1,298.00	$1,298.00	$1,298.00	5163		1911
73	4/1/2001	4/7/2001	4/24/2001	1	1	7301M	HC0974	6	$120.00	$120.00	$120.00	5163		1911
74	4/8/2001	4/14/2001	4/24/2001	1	1	7201M	HC0974	46	$1,012.00	$1,012.00	$1,012.00	5163		1911
75	4/8/2001	4/14/2001	4/24/2001	1	1	7301M	HC0974	6	$120.00	$120.00	$120.00	5163		1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	3/12/2001	3/12/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
77	3/15/2001	3/15/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
78	3/19/2001	3/19/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
79	4/2/2001	4/2/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
80	4/9/2001	4/9/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
81	4/13/2001	4/13/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
82	1/4/2001	1/4/2001	4/24/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
83	4/22/2001	4/28/2001	5/8/2001	1	1	7201M	HC0974	49	$1,078.00	$1,078.00	$1,078.00	5163		1911
84	4/22/2001	4/28/2001	5/8/2001	1	1	7301M	HC0974	6	$120.00	$120.00	$120.00	5163		1911
85	4/15/2001	4/21/2001	5/8/2001	1	1	7201M	HC0974	48	$1,056.00	$1,056.00	$1,056.00	5163		1911
86	4/15/2001	4/21/2001	5/8/2001	1	1	7301M	HC0974	6	$120.00	$120.00	$120.00	5163		1911
87	4/17/2001	4/17/2001	5/8/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
88	4/24/2001	4/24/2001	5/15/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
89	4/29/2001	4/30/2001	5/22/2001	1	1	7201M	HC0974	10	$220.00	$220.00	$220.00	5163		1911
90	5/1/2001	5/5/2001	5/22/2001	1	1	7201M	HC0974	43	$946.00	$946.00	$946.00	5163		1911
91	4/29/2001	4/30/2001	5/22/2001	1	1	7301M	HC0974	3	$60.00	$60.00	$60.00	5163		1911
92	5/1/2001	5/5/2001	5/22/2001	1	1	7301M	HC0974	3	$60.00	$60.00	$60.00	5163		1911
93	5/1/2001	5/1/2001	5/22/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
94	5/6/2001	5/12/2001	5/22/2001	1	1	7201M	HC0974	30	$660.00	$660.00	$660.00	5163		1911
95	5/6/2001	5/12/2001	5/22/2001	1	1	7301M	HC0974	5	$100.00	$100.00	$100.00	5163		1911
96	5/8/2001	5/8/2001	5/22/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
97	5/13/2001	5/19/2001	5/29/2001	1	1	7201M	HC0974	64	$1,408.00	$1,408.00	$1,408.00	5163		1911
98	5/13/2001	5/19/2001	5/29/2001	1	1	7301M	HC0974	7	$140.00	$140.00	$140.00	5163		1911
99	5/15/2001	5/15/2001	6/5/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911
100	5/16/2001	5/16/2001	6/5/2001	1	1	7212M	NA2727	1	$80.00	$80.00	$80.00	5163		1911

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	3/9/2002	3/9/2002	6/25/2002	1	1	99285	MD3739	1	$400.00	$217.92	$217.92	3009	29590	1962
2	3/23/2002	3/23/2002	7/16/2002	1	1	99283	MD4501	1	$193.00	$89.43	$89.43	462		1962
3	5/30/2002	5/30/2002	8/25/2002	1	1	74000	GR0138	1	$28.00	$13.68	$10.68	45989		1962
4	6/16/2002	6/16/2002	8/20/2002	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	70581		1962
5	5/19/2002	5/19/2002	9/3/2002	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	5259	29181	1962
6	3/9/2002	3/9/2002	11/5/2002	1	1	99222	MD1695	1	$325.00	$163.53	$160.53	29680		1962
7	3/10/2002	3/10/2002	11/5/2002	1	1	99232	MD1695	1	$160.00	$80.92	$77.92	29680		1962
8	3/22/2002	3/22/2002	5/21/2002	1	1	99213	CL0260	1	$163.80	$374.00	$374.00	5282		1962
9	4/1/2002	4/1/2002	8/6/2002	1	1	99213	CL0260	1	$163.80	$374.00	$374.00	29590		1962
10	6/10/2002	6/10/2002	8/6/2002	1	1	87210	CL0260	1	$24.80	$374.00	$374.00	5990		1962
11	6/10/2002	6/10/2002	8/6/2002	1	1	87081	CL0260	1	$30.32	$0.00	$0.00	5990		1962
12	6/10/2002	6/10/2002	8/6/2002	1	1	87110	CL0260	1	$82.68	$0.00	$0.00	5990		1962
13	6/10/2002	6/10/2002	8/6/2002	1	1	81000	CL0260	1	$19.29	$0.00	$0.00	5990		1962
14	6/10/2002	6/10/2002	8/6/2002	1	1	99213	CL0260	1	$163.80	$0.00	$0.00	5990		1962
15	5/30/2002	5/30/2002	8/6/2002	1	1	81002	CL0260	1	$11.02	$374.00	$374.00	9248		1962
16	6/18/2002	6/18/2002	2/11/2003	1	1	99212	MDG944	1	$91.20	$47.69	$47.69	38860		1918
17	6/5/2002	6/5/2002	3/18/2003	1	1	99211	MDG944	1	$74.50	$27.08	$27.08	V681	4011	1918
18	1/1/2002	1/9/2002	2/5/2002	1	1		LT0153	8	$5,308.87	$3,196.72	$3,196.72	515		1911
19	1/9/2002	1/9/2002	3/5/2002	1	1		HS02OP	0	$301.68	$301.68	$301.68	40291	515	1911
20	1/9/2002	1/9/2002	4/9/2002	1	1	A0427	TR0322	1	$49.49	$49.49	$49.49	2512		1911
21	1/9/2002	1/9/2002	4/9/2002	1	1	A0390	TR0322	1	$1.20	$1.20	$1.20	2512		1911
22	1/9/2002	1/9/2002	4/9/2002	1	1	A0422	TR0322	1	$3.60	$3.60	$3.60	2512		1911
23	1/9/2002	1/9/2002	7/2/2002	1	1	71010	MDG0001	1	$1.98	$1.98	$1.98	5180		1911
24	1/4/2002	1/4/2002	3/26/2002	1	1		HS08OP	0	$146.80	$146.80	$146.80	71592	92311	1954
25	1/30/2002	1/30/2002	4/9/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	7291	2165	1954

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	1/21/2002	1/21/2002	4/9/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	87343		1954
27	2/12/2002	2/12/2002	4/23/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	V6759	8760	1954
28	2/6/2002	2/6/2002	4/23/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	2169		1954
29	3/7/2002	3/7/2002	5/14/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	311		1954
30	3/18/2002	3/18/2002	5/14/2002	1	1		HS08OP	0	$66.80	$66.80	$66.80	37272	311	1954
31	5/28/2002	5/28/2002	8/6/2002	1	1		HS08OP	0	$72.80	$72.80	$72.80	71941	311	1954
32	5/14/2002	5/14/2002	8/6/2002	1	1		HS08OP	0	$72.80	$72.80	$72.80	71941	7295	1954
33	6/12/2002	6/12/2002	1/28/2003	1	1		HS08OP	0	$72.80	$72.80	$72.80	36500		1954
34	1/28/2002	1/28/2002	9/17/2002	1	1		HS08OP	0	$152.80	$152.80	$152.80	92411		1919
35	3/13/2002	3/13/2002	5/21/2002	1	1	71020	GR0138	1	$12.31	$12.31	$12.31	4293		1914
36	2/11/2002	2/11/2002	3/26/2002	1	1		HS19OP	0	$146.80	$146.80	$146.80	V7612	7921	1922
37	2/26/2002	2/26/2002	4/9/2002	1	1		HS19OP	0	$66.80	$66.80	$66.80	V653	25000	1922
38	3/13/2002	3/13/2002	4/16/2002	1	1		HS19OP	0	$66.80	$66.80	$66.80	25002	4019	1922
39	3/29/2002	3/29/2002	8/6/2002	1	1		HS19OP	0	$72.80	$72.80	$72.80	25000		1922
40	3/20/2002	3/20/2002	9/3/2002	1	1		HS19OP	0	$72.80	$72.80	$72.80	V7612		1922
41	3/9/2002	3/11/2002	3/26/2002	1	1		HS03IP	2	$4,715.28	$2,707.76	$2,707.76	29534	30500	1962
42	1/2/2002	1/2/2002	1/15/2002	1	1		HS03OP	0	$277.14	$153.40	$145.73	30000	E9393	1962
43	2/10/2002	2/10/2002	2/26/2002	1	1		HS03OP	0	$49.36	$27.32	$25.95	5259	52510	1962
44	2/13/2002	2/13/2002	2/26/2002	1	1	0481	HS03OP	0	$49.36	$27.32	$25.95	5259	V4589	1962
45	3/23/2002	3/23/2002	4/9/2002	1	1		HS03OP	0	$49.36	$27.32	$25.95	462		1962
46	4/1/2002	4/1/2002	4/16/2002	1	1		HS03OP	0	$348.85	$53.28	$50.62	78079		1962
47	4/13/2002	4/13/2002	4/30/2002	1	1	9929	HS03OP	0	$783.29	$382.37	$363.25	30500		1962
48	5/19/2002	5/19/2002	6/25/2002	1	1		HS03OP	0	$49.36	$27.32	$25.95	5259	2910	1962
49	6/10/2002	6/10/2002	6/25/2002	1	1		HS03OP	0	$114.01	$23.89	$22.70	5990		1962
50	5/30/2002	5/30/2002	7/2/2002	1	1		HS03OP	0	$140.54	$63.05	$59.90	78900		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	6/16/2002	6/16/2002	7/9/2002	1	1	9929	HS03OP	0	$226.74	$125.50	$119.22	70581		1962
52	1/2/2002	1/2/2002	2/5/2002	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29590		1962
53	1/17/2002	1/17/2002	2/19/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
54	1/18/2002	1/18/2002	2/19/2002	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
55	1/23/2002	1/23/2002	3/5/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
56	2/5/2002	2/5/2002	4/2/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
57	2/5/2002	2/5/2002	4/2/2002	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29590		1962
58	2/7/2002	2/7/2002	4/2/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
59	2/12/2002	2/12/2002	4/2/2002	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
60	2/15/2002	2/15/2002	4/2/2002	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
61	4/4/2002	4/4/2002	5/14/2002	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
62	3/22/2002	3/22/2002	5/14/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
63	4/4/2002	4/4/2002	5/28/2002	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29590		1962
64	4/16/2002	4/16/2002	5/28/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
65	4/17/2002	4/17/2002	5/28/2002	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
66	4/23/2002	4/23/2002	6/4/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
67	5/1/2002	5/1/2002	6/18/2002	1	1	8210F	MH0157	1	$30.00	$12.50	$12.50	29590		1962
68	5/16/2002	5/16/2002	6/25/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
69	5/28/2002	5/28/2002	7/9/2002	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29570		1962
70	5/30/2002	5/30/2002	7/9/2002	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29570		1962
71	5/20/2002	5/20/2002	7/9/2002	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
72	6/7/2002	6/7/2002	7/30/2002	1	1	8210F	MH0157	9	$135.00	$112.50	$112.50	29590		1962
73	6/10/2002	6/10/2002	7/30/2002	1	1	8214F	MH0157	4	$40.00	$30.00	$30.00	29590		1962
74	6/10/2002	6/10/2002	7/30/2002	1	1	8210F	MH0157	12	$180.00	$150.00	$150.00	29590		1962
75	6/11/2002	6/11/2002	7/30/2002	1	1	8210F	MH0157	7	$105.00	$87.50	$87.50	29590		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	6/12/2002	6/12/2002	7/30/2002	1	1	8210F	MH0157	5	$75.00	$62.50	$62.50	29590		1962
77	6/18/2002	6/18/2002	7/30/2002	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
78	6/20/2002	6/20/2002	7/30/2002	1	1	8210F	MH0157	8	$120.00	$100.00	$100.00	29590		1962
79	6/25/2002	6/25/2002	8/6/2002	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
80	6/26/2002	6/26/2002	8/6/2002	1	1	8210F	MH0157	6	$90.00	$75.00	$75.00	29590		1962
81	6/27/2002	6/27/2002	8/6/2002	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
82	6/3/2002	6/3/2002	8/20/2002	1	2	8210F	MH0157	13	$195.00	$162.50	$162.50	29590		1962
83	6/4/2002	6/4/2002	8/20/2002	1	2	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
84	6/5/2002	6/5/2002	8/20/2002	1	2	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
85	6/6/2002	6/6/2002	8/20/2002	1	2	8210F	MH0157	8	$120.00	$100.00	$100.00	29590		1962
86	1/2/2002	1/2/2002	3/19/2002	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	3079	7810	1962
87	2/10/2002	2/10/2002	4/30/2002	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	5259	V4589	1962
88	2/13/2002	2/13/2002	5/7/2002	1	1	64402	GR0119	1	$157.00	$157.00	$157.00	5259		1962
89	2/13/2002	2/13/2002	5/7/2002	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	5259	V4589	1962
90	4/13/2002	4/13/2002	7/9/2002	1	1	99283	MD0991	1	$193.00	$89.43	$89.43	30500		1962
91	5/30/2002	5/30/2002	8/6/2002	1	1	99212	CL0260	1	$117.60	$0.00	$0.00	9248		1962
92	3/14/2002	3/14/2002	9/10/2002	1	1	[illegible]	HS21OP	0	$57.45	$57.45	$57.45	7895		1906
93	3/1/2002	3/1/2002	9/10/2002	1	1	[illegible]	HS21OP	0	$53.11	$53.11	$53.11	7845	78079	1906
94	3/5/2002	3/5/2002	9/10/2002	1	1	[illegible]	HS21OP	0	$11.49	$11.49	$11.49	4359	462	1906
95	3/11/2002	3/11/2002	9/10/2002	1	1	[illegible]	HS21OP	0	$11.49	$11.49	$11.49	2765	4019	1906
96	1/28/2002	1/28/2002	3/26/2002	1	1	[illegible]	HS23OP	0	$146.80	$146.80	$146.80	4019	7242	1913
97	1/30/2002	1/30/2002	4/16/2002	1	1	[illegible]	HS23OP	0	$66.80	$66.80	$66.80	2713		1913
98	1/23/2002	1/23/2002	4/30/2002	1	1	[illegible]	HS23OP	0	$66.80	$66.80	$66.80	V532		1913
99	2/20/2002	2/20/2002	4/30/2002	1	1	[illegible]	HS23OP	0	$66.80	$66.80	$66.80	4019		1913
100	3/11/2002	3/11/2002	5/7/2002	1	1	[illegible]	HS23OP	0	$66.80	$66.80	$66.80	6929	3849	1913

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	11/22/2003	11/22/2003	12/2/2003	1	1	7535	HS17OP	0	$655.36	$377.94	$377.94	64233		1982
2	11/21/2003	11/21/2003	12/23/2003	1	1	7534	HS17OP	0	$936.00	$557.78	$557.78	64233	65573	1982
3	12/14/2003	12/15/2003	1/20/2004	1	1	7535	HS478OP	0	$436.00	$283.24	$283.24	64403		1982
4	12/21/2003	12/22/2003	2/10/2004	1	2	7534	HS478OP	0	$2,106.00	$1,207.01	$1,207.01	64233		1982
5	7/21/2003	7/21/2003	8/5/2003	1	1	81000	LB639WA	1	$17.27	$4.43	$4.43	V288		1982
6	7/21/2003	7/21/2003	8/5/2003	1	1	85027	LB639WA	1	$16.64	$9.04	$9.04	V288		1982
7	7/21/2003	7/21/2003	8/5/2003	1	1	86592	LB639WA	1	$15.19	$5.96	$5.96	V288		1982
8	7/21/2003	7/21/2003	8/5/2003	1	1	86762	LB639WA	1	$22.47	$20.11	$20.11	V288		1982
9	7/21/2003	7/21/2003	8/5/2003	1	1	86850	LB639WA	1	$18.10	$8.05	$8.05	V288		1982
10	7/21/2003	7/21/2003	8/5/2003	1	1	86900	LB639WA	1	$13.73	$4.17	$4.17	V288		1982
11	7/21/2003	7/21/2003	8/5/2003	1	1	86901	LB639WA	1	$13.73	$6.60	$6.60	V288		1982
12	7/21/2003	7/21/2003	8/5/2003	1	1	87088	LB639WA	1	$27.50	$11.31	$11.31	V288		1982
13	7/21/2003	7/21/2003	8/5/2003	1	1	87340	LB639WA	1	$31.62	$14.43	$14.43	V288		1982
14	7/22/2003	7/22/2003	8/5/2003	1	1	88164	LB639WA	1	$45.00	$14.76	$14.76	V288		1982
15	7/22/2003	7/22/2003	8/5/2003	1	1	87490	LB639WA	1	$37.25	$28.02	$28.02	V288		1982
16	7/22/2003	7/22/2003	8/5/2003	1	1	87590	LB639WA	1	$37.25	$28.02	$28.02	V288		1982
17	9/2/2003	9/2/2003	9/9/2003	1	1	87045	LB639WA	1	$37.33	$13.18	$13.18	78791		1982
18	9/2/2003	9/2/2003	9/9/2003	1	1	87177	LB639WA	1	$36.70	$12.43	$12.43	78791		1982
19	9/2/2003	9/2/2003	9/9/2003	1	1	88313	LB639WA	1	$31.55	$25.24	$25.24	78791		1982
20	9/2/2003	9/2/2003	10/21/2003	1	1	87046	LB639WA	1	$18.67	$3.30	$3.30	78791		1982
21	11/4/2003	11/4/2003	11/11/2003	1	1	82565	LB639WA	1	$6.39	$6.39	$6.39	64233		1982
22	11/4/2003	11/4/2003	11/11/2003	1	1	82950	LB639WA	1	$18.25	$6.64	$6.64	64233		1982
23	11/4/2003	11/4/2003	11/11/2003	1	1	82977	LB639WA	1	$8.48	$8.48	$8.48	64233		1982
24	11/4/2003	11/4/2003	11/11/2003	1	1	84450	LB639WA	1	$6.36	$6.36	$6.36	64233		1982
25	11/4/2003	11/4/2003	11/11/2003	1	1	84460	LB639WA	1	$6.39	$6.39	$6.39	64233		1982

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	11/4/2003	11/4/2003	11/11/2003	1	1	84520	LB639WA	1	$6.39	$5.51	$5.51	64233		1982
27	11/4/2003	11/4/2003	11/11/2003	1	1	84550	LB639WA	1	$6.39	$6.31	$6.31	64233		1982
28	11/4/2003	11/4/2003	11/11/2003	1	1	85025	LB639WA	1	$10.60	$10.60	$10.60	64233		1982
29	11/14/2003	11/14/2003	11/25/2003	1	1	82951	LB639WA	1	$41.09	$14.17	$14.17	7902		1982
30	11/14/2003	11/14/2003	11/25/2003	1	1	82952	LB639WA	1	$16.66	$5.48	$5.48	7902		1982
31	12/1/2003	12/1/2003	12/9/2003	1	1	84520	LB639WA	1	$6.39	$5.51	$5.51	64243		1982
32	12/1/2003	12/1/2003	12/9/2003	1	1	84460	LB639WA	1	$6.39	$6.39	$6.39	64243		1982
33	12/1/2003	12/1/2003	12/9/2003	1	1	84450	LB639WA	1	$6.36	$6.36	$6.36	64243		1982
34	12/1/2003	12/1/2003	12/9/2003	1	1	82977	LB639WA	1	$8.48	$8.48	$8.48	64243		1982
35	7/11/2003	7/11/2003	10/21/2003	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
36	7/14/2003	7/14/2003	10/21/2003	1	1	8210F	MH0157	10	$150.00	$125.00	$125.00	29590		1962
37	8/13/2003	8/13/2003	10/28/2003	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
38	8/19/2003	8/19/2003	10/28/2003	1	1	8210F	MH0157	1	$15.00	$12.50	$12.50	29590		1962
39	8/21/2003	8/21/2003	10/28/2003	1	1	8210F	MH0157	6	$90.00	$75.00	$75.00	29590		1962
40	8/14/2003	8/14/2003	10/28/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
41	8/27/2003	8/27/2003	10/28/2003	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
42	9/2/2003	9/2/2003	11/4/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
43	9/5/2003	9/5/2003	11/4/2003	1	1	8210F	MH0157	6	$90.00	$75.00	$75.00	29590		1962
44	9/16/2003	9/16/2003	11/4/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
45	9/17/2003	9/17/2003	11/4/2003	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
46	9/24/2003	9/24/2003	11/4/2003	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
47	8/27/2003	8/27/2003	11/4/2003	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29590		1962
48	9/15/2003	9/15/2003	11/4/2003	1	1	8210F	MH0157	11	$165.00	$137.50	$137.50	29590		1962
49	9/25/2003	9/25/2003	11/4/2003	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
50	10/2/2003	10/2/2003	11/11/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	10/9/2003	10/9/2003	11/11/2003	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
52	10/20/2003	10/20/2003	11/18/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
53	11/12/2003	11/12/2003	12/30/2003	1	1	8210F	MH0157	3	$45.00	$37.50	$37.50	29590		1962
54	11/13/2003	11/13/2003	12/30/2003	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
55	11/19/2003	11/19/2003	12/30/2003	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
56	11/25/2003	11/25/2003	12/30/2003	1	1	8210F	MH0157	5	$75.00	$62.50	$62.50	29590		1962
57	12/3/2003	12/3/2003	2/3/2004	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
58	12/10/2003	12/10/2003	2/3/2004	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
59	12/22/2003	12/22/2003	2/17/2004	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
60	12/23/2003	12/23/2003	2/17/2004	1	1	8210F	MH0157	4	$60.00	$50.00	$50.00	29590		1962
61	12/30/2003	12/30/2003	2/17/2004	1	1	8210F	MH0157	2	$30.00	$25.00	$25.00	29590		1962
62	7/10/2003	7/10/2003	8/5/2003	1	1	70450	GR0138	1	$133.00	$64.53	$61.53	3319	37943	1962
63	7/10/2003	7/10/2003	8/5/2003	1	1	70150	GR0138	1	$61.00	$19.68	$19.68	V716	37943	1962
64	7/10/2003	7/10/2003	8/26/2003	1	1	99285	GR0119	1	$433.00	$217.34	$217.34	920	9212	1962
65	9/16/2003	9/16/2003	9/30/2003	1	1	71020	GR0138	1	$37.00	$16.38	$13.38	7862		1962
66	9/26/2003	9/26/2003	11/4/2003	1	1	99283	GR0119	1	$193.00	$89.43	$89.43	9181	37991	1962
67	9/15/2003	9/15/2003	1/20/2004	1	1	99285	GR0119	1	$433.00	$217.34	$217.34	3009	29590	1962
68	9/18/2003	9/18/2003	3/9/2004	1	1	99231	MDG215	1	$93.45	$48.65	$48.65	490		1962
69	9/17/2003	9/17/2003	3/9/2004	1	1	99231	MDG215	1	$93.45	$48.65	$48.65	490		1962
70	9/16/2003	9/16/2003	5/4/2004	1	1	90801	MD23641	1	$276.16	$104.12	$101.12	29570	30300	1962
71	10/15/2003	10/15/2003	2/10/2004	1	1	99212	CL0260	1	$103.95	$360.00	$360.00	7089		1962
72	9/24/2003	9/24/2003	10/26/2004	1	2	99212	CL0260	1	$103.95	$374.00	$374.00	1330		1962
73	10/7/2003	10/7/2003	4/19/2005	1	1	99212	CL0260	1	$103.95	$360.00	$360.00	7089		1962
74	7/23/2003	7/23/2003	10/14/2003	1	1	[illegible]	HS23OP	0	$72.80	$72.80	$72.80	4739		1913
75	8/21/2003	8/21/2003	10/14/2003	1	1	[illegible]	HS23OP	0	$72.80	$72.80	$72.80	5990		1913

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	9/30/2003	9/30/2003	11/4/2003	1	1		HS23OP	0	$72.80	$72.80	$72.80	37230		1913
77	10/7/2003	10/7/2003	11/18/2003	1	1		HS23OP	0	$72.80	$72.80	$72.80	7242		1913
78	12/4/2003	12/4/2003	1/13/2004	1	1		HS23OP	0	$66.40	$66.40	$66.40	4019		1913
79	10/24/2003	10/24/2003	1/27/2004	1	1		HS23OP	0	$72.80	$72.80	$72.80	4019	5939	1913
80	7/31/2003	7/31/2003	3/2/2004	1	1		HS13IP	0	$72.80	$72.80	$72.80	V726		1913
81	7/29/2003	7/29/2003	3/9/2004	1	1		HS13IP	0	$72.80	$72.80	$72.80	462		1913
82	8/6/2003	8/6/2003	7/27/2004	1	1		HS13OP	0	$72.80	$72.80	$72.80	73300		1913
83	7/31/2003	7/31/2003	2/17/2004	1	1	74000	CL4320	1	$2.02	$2.02	$2.02	56400		1913
84	7/31/2003	7/31/2003	2/17/2004	1	1	71020	CL4320	1	$2.42	$2.42	$2.42	7867		1913
85	8/1/2003	8/1/2003	2/24/2004	1	1	74270	CL4320	1	$7.65	$7.65	$7.65	56400		1913
86	8/1/2003	8/1/2003	2/24/2004	1	1	72170	CL4320	1	$1.94	$1.94	$1.94	71945		1913
87	7/29/2003	7/29/2003	3/16/2004	1	1	99213	CL4320	1	$7.58	$7.58	$7.58	462		1913
88	8/6/2003	8/6/2003	3/16/2004	1	1	99241	CL4320	1	$7.27	$7.27	$7.27	73300		1913
89	8/7/2003	8/7/2003	9/30/2003	1	1	99213	MDG835	1	$11.46	$11.46	$11.46	38421		1953
90	8/7/2003	8/7/2003	9/30/2003	1	1	92504	MDG835	1	$5.90	$5.90	$5.90	38421		1953
91	11/10/2003	11/10/2003	12/23/2003	1	1	71020	GR0138	1	$2.42	$2.42	$2.42	4928		1953
92	7/2/2003	7/2/2003	7/8/2003	1	1	S8403	MS9255	100	$93.00	$93.00	$93.00	71590	4019	1925
93	7/2/2003	7/2/2003	7/8/2003	1	1	5141S	MS9255	96	$12.00	$11.52	$11.52	71590	4019	1925
94	8/4/2003	8/4/2003	8/12/2003	1	1	5141S	MS9255	96	$12.00	$11.52	$11.52	71590		1925
95	7/17/2003	7/17/2003	9/9/2003	1	1	99213	MD1164	1	$11.00	$11.00	$11.00	1533		1910
96	8/14/2003	8/14/2003	10/7/2003	1	1	99215	MD1164	1	$11.00	$11.00	$11.00	4280		1910
97	10/2/2003	10/2/2003	11/18/2003	1	1	99213	MD1164	1	$11.00	$11.00	$11.00	4280		1910
98	11/17/2003	11/17/2003	1/6/2004	1	1	99214	MD1164	1	$17.00	$17.00	$17.00	1533		1910
99	12/8/2003	12/8/2003	2/3/2004	1	1	99214	MD1164	1	$17.00	$17.00	$17.00	49392		1910
100	7/31/2003	7/31/2003	11/4/2003	1	1	99211	MDG944	1	$74.50	$27.08	$27.08	V811		1918

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	4/7/2005	4/7/2005	5/10/2005	1	1	99283	GR0119	1	$222.00	$75.67	$75.67	462	7245	1962
2	4/25/2005	4/25/2005	5/10/2005	1	1	99243	MD0112	1	$220.00	$179.92	$176.92	53081		1962
3	4/25/2005	4/25/2005	5/10/2005	1	1	92511	MD0112	1	$198.00	$198.00	$198.00	4760		1962
4	6/24/2005	6/24/2005	7/12/2005	1	1	92341	OP0593	1	$30.00	$30.00	$30.00	36721	3674	1962
5	6/24/2005	6/24/2005	8/2/2005	1	1	V2203	OP161NY	1	$5.37	$5.37	$5.37	V720		1962
6	6/24/2005	6/24/2005	8/2/2005	1	1	V2200	OP161NY	1	$5.37	$5.37	$5.37	V720		1962
7	6/24/2005	6/24/2005	8/2/2005	1	1	V2020	OP161NY	1	$5.63	$5.63	$5.63	V720		1962
8	1/28/2005	1/28/2005	3/29/2005	1	1	99212	CL0260	1	$103.04	$402.00	$402.00	9158	V5409	1962
9	5/12/2005	5/12/2005	7/5/2005	1	1	99212	CL0260	1	$103.04	$402.00	$402.00	1330	29570	1962
10	5/19/2005	5/19/2005	7/5/2005	1	1	99213	CL0260	1	$143.52	$402.00	$402.00	9952	3051	1962
11	6/28/2005	6/28/2005	9/13/2005	1	1	99212	CL0260	1	$103.04	$391.00	$391.00	30000	5259	1962
12	6/27/2005	6/27/2005	9/13/2005	1	1	99212	CL0260	1	$103.04	$391.00	$391.00	30000	78052	1962
13	3/16/2005	3/16/2005	11/29/2005	1	1	99212	CL0260	1	$103.04	$402.00	$402.00	4659	6929	1962
14	4/20/2005	4/20/2005	6/21/2005	1	1		HS23OP	0	$115.30	$115.30	$115.30	7030	6869	1913
15	5/18/2005	5/18/2005	11/8/2005	1	1		HS23OP	0	$27.30	$27.30	$27.30	V6759		1913
16	6/6/2005	6/6/2005	7/19/2005	1	1	V2211	OP161NY	1	$5.37	$5.37	$5.37	V720		1953
17	6/6/2005	6/6/2005	7/19/2005	1	1	V2207	OP161NY	1	$5.37	$5.37	$5.37	V720		1953
18	6/6/2005	6/6/2005	7/19/2005	1	1	V2020	OP161NY	1	$5.63	$5.63	$5.63	V720		1953
19	1/11/2005	1/11/2005	2/22/2005	1	1		HS03OP	0	$120.68	$120.68	$120.68	7931	5990	1953
20	2/3/2005	2/3/2005	3/15/2005	1	1		HS03OP	0	$344.88	$344.88	$344.88	2113	4928	1953
21	4/6/2005	4/6/2005	5/10/2005	1	1		HS03OP	0	$21.79	$21.79	$21.79	4920		1953
22	4/19/2005	4/19/2005	5/24/2005	1	1		HS03OP	0	$39.92	$39.92	$39.92	78039		1953
23	5/1/2005	5/1/2005	6/7/2005	1	1		HS03OP	0	$61.71	$61.71	$61.71	7862	78650	1953
24	5/9/2005	5/9/2005	6/28/2005	1	1		HS03OP	0	$39.92	$39.92	$39.92	78039		1953
25	1/11/2005	1/11/2005	2/22/2005	1	1	74020	GR0138	1	$23.42	$23.42	$23.42	56400		1953

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	1/11/2005	1/11/2005	2/22/2005	1	1	71020	GR0138	1	$18.99	$18.99	$18.99	51889		1953
27	1/11/2005	1/11/2005	3/22/2005	1	1	99284	GR0119	1	$32.40	$32.40	$32.40	78605		1953
28	2/3/2005	2/3/2005	3/22/2005	1	1	88305	GR0356	3	$40.04	$40.04	$40.04	2113		1953
29	4/6/2005	4/6/2005	5/24/2005	1	1	71020	GR0138	1	$3.80	$3.80	$3.80	4920		1953
30	5/1/2005	5/1/2005	6/14/2005	1	1	71020	GR0138	1	$3.80	$3.80	$3.80	7862		1953
31	5/19/2005	5/19/2005	6/14/2005	1	1	[illegible]	HS19OP	1	$154.80	$402.00	$402.00	V6759	38181	1966
32	6/8/2005	6/8/2005	6/21/2005	1	1	[illegible]	HS19OP	1	$154.80	$391.00	$391.00	38870		1966
33	5/10/2005	5/10/2005	6/28/2005	1	1		HS19OP	1	$154.80	$402.00	$402.00	38010	3829	1966
34	5/3/2005	5/3/2005	5/2/2006	1	1		HS19OP	1	$24.00	$402.00	$402.00	38010	59080	1966
35	2/1/2005	2/1/2005	5/17/2005	1	1	E1086	MS2102	1	$510.00	$510.00	$510.00	9912		1966
36	2/1/2005	2/1/2005	5/17/2005	1	1	E0990	MS2102	2	$129.68	$129.68	$129.68	9912		1966
37	1/12/2005	1/12/2005	8/30/2005	1	1	A9901	MS2102	1	$37.19	$37.19	$37.19	9912		1966
38	2/18/2005	2/18/2005	4/5/2005	1	1	99213	CL1461	1	$103.00	$402.00	$402.00	9221	E9289	1966
39	1/19/2005	1/19/2005	4/12/2005	1	1	99212	CL1461	1	$81.00	$402.00	$402.00	38400		1966
40	1/18/2005	1/18/2005	5/24/2005	1	1	99214	CL1461	1	$149.00	$402.00	$402.00	7292		1966
41	1/18/2005	1/18/2005	5/24/2005	1	1	97602	CL1461	1	$60.00	$0.00	$0.00	7292		1966
42	5/19/2005	5/19/2005	6/7/2005	1	1	99213	CL1461	1	$103.00	$402.00	$402.00	V6759	38181	1966
43	5/10/2005	5/10/2005	6/7/2005	1	1	99213	CL1461	1	$103.00	$402.00	$402.00	59080		1966
44	6/8/2005	6/8/2005	6/28/2005	1	1	99214	CL1461	1	$149.00	$391.00	$391.00	38870		1966
45	2/4/2005	2/4/2005	8/16/2005	1	1	99212	MDG945	1	$104.90	$48.59	$48.59	8831		1918
46	3/22/2005	3/22/2005	8/30/2005	1	1	99211	MDG944	1	$74.50	$27.54	$27.54	4019		1918
47	2/21/2005	2/21/2005	9/20/2005	1	1	99211	MDG944	1	$74.50	$27.54	$27.54	4019		1918
48	1/17/2005	1/17/2005	11/8/2005	1	1	99212	MDG944	1	$104.90	$48.59	$48.59	37230		1918
49	6/10/2005	6/10/2005	10/4/2005	1	1	99213	MDG944	1	$133.85	$65.97	$65.97	460		1918
50	5/9/2005	5/9/2005	3/21/2006	1	1	99212	MDG944	1	$104.90	$48.59	$48.59	78650		1918

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	4/20/2005	4/20/2005	5/17/2005	1	1		HS05OP	0	$161.40	$161.40	$161.40	486	7862	1918
52	5/4/2005	5/4/2005	7/12/2005	1	1		HS05OP	0	$73.40	$73.40	$73.40	37515	3669	1918
53	6/24/2005	6/24/2005	7/26/2005	1	1		HS13OP	0	$73.40	$73.40	$73.40	59010	797	1920
54	5/7/2005	5/7/2005	1/10/2006	1	1		HS13OP	0	$74.20	$74.20	$74.20	2859		1920
55	6/24/2005	6/24/2005	8/30/2005	1	1	99284	CL4320	1	$32.40	$32.40	$32.40	59010		1920
56	3/29/2005	3/29/2005	4/19/2005	1	1	V2203	OP161NY	2	$10.74	$10.74	$10.74	V720		1919
57	3/29/2005	3/29/2005	4/19/2005	1	1	V2020	OP161NY	1	$5.63	$5.63	$5.63	V720		1919
58	3/29/2005	3/29/2005	6/7/2005	1	1		HS08OP	0	$73.40	$73.40	$73.40	36611	36250	1919
59	5/26/2005	5/26/2005	8/2/2005	1	1		HS08OP	0	$73.40	$73.40	$73.40	5990		1919
60	2/28/2005	2/28/2005	4/19/2005	1	1	E0260	MS0656	1	$116.09	$116.09	$116.09	81220		1919
61	1/11/2005	1/11/2005	8/16/2005	1	1	99212	MDG308	1	$103.04	$48.59	$48.59	490		1914
62	2/10/2005	2/10/2005	11/22/2005	1	1	T4527	MS9610	120	$120.00	$111.60	$111.60	78830		1922
63	2/10/2005	2/10/2005	12/27/2005	1	1	T1999	MS9610	2	$19.00	$0.24	$0.24	78838		1922
64	2/28/2005	2/28/2005	5/17/2005	1	1	99212	CL4320	1	$8.10	$8.10	$8.10	8088		1922
65	4/18/2005	4/18/2005	8/23/2005	1	1	E0260	MS9610	1	$28.09	$28.09	$28.09	8208		1922
66	5/18/2005	5/18/2005	8/23/2005	1	1	E0260	MS9610	1	$28.09	$28.09	$28.09	8208		1922
67	6/18/2005	6/18/2005	8/23/2005	1	1	E0260	MS9610	1	$21.07	$21.07	$21.07	8208		1922
68	3/29/2005	3/29/2005	11/1/2005	1	1	E0260	MS9610	1	$28.09	$28.09	$28.09	8208		1922
69	1/28/2005	1/28/2005	2/22/2005	1	1		HS03OP	0	$83.48	$46.65	$44.32	7295	72981	1962
70	3/3/2005	3/3/2005	3/22/2005	1	1		HS03OP	0	$570.61	$318.86	$302.92	30500	71946	1962
71	4/7/2005	4/7/2005	4/26/2005	1	1		HS03OP	0	$380.18	$143.87	$136.68	462	7245	1962
72	4/6/2005	4/6/2005	4/26/2005	1	1		HS03OP	0	$132.12	$73.83	$70.14	7862	78605	1962
73	5/19/2005	5/19/2005	6/7/2005	1	1		HS03OP	0	$402.75	$58.96	$56.01	311		1962
74	1/11/2005	1/11/2005	2/8/2005	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1962
75	1/13/2005	1/13/2005	2/8/2005	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1962

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ID	From	Thru	Pay_Date	Status	CTM	Proc	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	1/20/2005	1/20/2005	2/22/2005	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
77	2/23/2005	2/23/2005	3/29/2005	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1962
78	3/22/2005	3/22/2005	4/12/2005	1	1	T1016	MH0157	4	$60.00	$50.00	$50.00	29570		1962
79	3/22/2005	3/22/2005	4/19/2005	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
80	4/4/2005	4/4/2005	5/10/2005	1	1	T1016	MH0157	3	$45.00	$37.50	$37.50	29570		1962
81	4/25/2005	4/25/2005	5/24/2005	1	1	T1016	MH0157	10	$150.00	$125.00	$125.00	29570		1962
82	4/28/2005	4/28/2005	5/24/2005	1	1	T1016	MH0157	5	$75.00	$62.50	$62.50	29570		1962
83	5/3/2005	5/3/2005	5/24/2005	1	1	T1016	MH0157	10	$150.00	$125.00	$125.00	29570		1962
84	5/5/2005	5/5/2005	5/24/2005	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
85	4/15/2005	4/15/2005	5/24/2005	1	1	T1016	MH0157	8	$120.00	$100.00	$100.00	29570		1962
86	4/18/2005	4/18/2005	5/24/2005	1	1	T1016	MH0157	6	$90.00	$75.00	$75.00	29570		1962
87	5/17/2005	5/17/2005	6/7/2005	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
88	5/10/2005	5/10/2005	6/7/2005	1	1	CDAEP	MH0157	2	$30.00	$25.00	$25.00	29570		1962
89	5/17/2005	5/17/2005	6/7/2005	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1962
90	5/18/2005	5/18/2005	6/7/2005	1	1	CDAEP	MH0157	3	$45.00	$37.50	$37.50	29570		1962
91	4/20/2005	4/20/2005	6/7/2005	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
92	6/15/2005	6/15/2005	7/5/2005	1	1	CDAEP	MH0157	9	$135.00	$112.50	$112.50	29570		1962
93	6/16/2005	6/16/2005	7/5/2005	1	1	CDAEP	MH0157	1	$15.00	$12.50	$12.50	29570		1962
94	6/14/2005	6/14/2005	7/5/2005	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
95	6/15/2005	6/15/2005	7/5/2005	1	1	T1016	MH0157	1	$15.00	$12.50	$12.50	29570		1962
96	6/16/2005	6/16/2005	7/5/2005	1	1	T1016	MH0157	2	$30.00	$25.00	$25.00	29570		1962
97	6/16/2005	6/16/2005	7/5/2005	1	1	CDBAP	MH0157	4	$60.00	$50.00	$50.00	29570		1962
98	5/17/2005	5/17/2005	7/19/2005	1	1	90862	MH0157	1	$75.00	$75.00	$75.00	29570		1962
99	6/21/2005	6/21/2005	7/19/2005	1	1	CDAEP	MH0157	4	$60.00	$50.00	$50.00	29570		1962
100	4/22/2005	4/22/2005	12/6/2005	1	2	T1016	MH0157	9	$135.00	$112.50	$112.50	29570		1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	12/8/1999	12/11/1999	2/1/2000	1	1	HS11IP	3	$5,885.24	$2,911.42	$2,911.42	29630	30420	1968
2	5/19/1996	5/23/1996	7/9/1996	1	2	HS11IP	4	$5,094.50	$3,243.66	$3,243.66	3090	30392	1968
3	2/17/1997	2/18/1997	8/26/1997	1	2	HS20IP	1	$6,560.40	$2,451.62	$2,451.62	6500		1968
4	9/8/1996	9/11/1996	12/2/1997	1	2	HS20IP	3	$8,825.55	$2,366.12	$2,216.12	64663	59010	1968
5	10/14/1996	10/16/1996	12/2/1997	1	2	HS20IP	2	$7,319.29	$1,962.30	$1,862.30	64663	59010	1968
6	7/22/1998	7/24/1998	10/27/1998	1	1	HS11IP	2	$3,540.03	$2,098.52	$2,098.52	64663	59010	1968
7	10/21/1998	10/24/1998	1/5/1999	1	2	HS11IP	3	$3,920.76	$2,324.22	$2,174.22	66331	65941	1968
8	6/29/1997	6/29/1997	7/22/1997	1	1	HS13OP	1	$241.00	$241.00	$241.00	7804		1968
9	7/2/1997	7/2/1997	8/5/1997	1	1	HS13OP	1	$241.00	$241.00	$241.00	462		1968
10	8/6/1997	8/6/1997	8/26/1997	1	1	HS13OP	1	$241.00	$241.00	$241.00	38160	38401	1968
11	8/28/1997	8/28/1997	9/16/1997	1	1	HS11OP	0	$342.70	$214.98	$214.98	3009	78601	1968
12	9/7/1996	9/7/1996	12/2/1997	1	2	HS20OP	0	$1,527.11	$363.23	$345.07	V2220		1968
13	11/28/1997	11/28/1997	12/2/1997	1	1	HS13OP	1	$241.00	$241.00	$241.00	462		1968
14	12/30/1997	12/30/1997	1/13/1998	1	1	HS13OP	1	$241.00	$241.00	$241.00	V643		1968
15	3/16/1998	3/16/1998	4/7/1998	1	1	HS13OP	1	$241.00	$241.00	$241.00	V726		1968
16	10/21/1998	10/21/1998	11/24/1998	1	1	HS11OP	0	$132.61	$31.22	$29.66	64413	65943	1968
17	7/25/1999	7/25/1999	8/3/1999	1	1	HS13OP	1	$241.00	$241.00	$241.00	78900	7245	1968
18	10/14/1999	10/14/1999	10/26/1999	1	1	HS20OP	0	$77.56	$26.29	$24.98	V7283		1968
19	10/15/1999	10/15/1999	12/21/1999	1	1	HS20OP	0	$844.80	$219.23	$208.27	V252		1968
20	12/1/1999	12/1/1999	12/28/1999	1	1	HS13OP	1	$241.00	$241.00	$241.00	78909		1968
21	7/7/1999	7/7/1999	7/20/1999	1	1	MH3113	1	$80.00	$37.50	$37.50	30390	30420	1968
22	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$48.50	$11.46	$11.46	V222		1968
23	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$66.50	$13.20	$13.20	V222		1968
24	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$20.74	$19.14	$19.14	V222		1968
25	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$13.83	$13.83	$13.83	V222		1968

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$16.10	$15.47	$15.47	V222		1968
27	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$7.44	$7.44	$7.44	V222		1968
28	8/23/1996	8/23/1996	2/4/1997	1	1	LB4756	1	$9.80	$7.84	$7.84	V222		1968
29	8/30/1996	8/30/1996	2/11/1997	1	1	LB4756	1	$72.41	$24.26	$24.26	V222		1968
30	8/30/1996	8/30/1996	2/11/1997	1	1	LB4756	1	$62.56	$22.37	$22.37	V222		1968
31	8/30/1996	8/30/1996	2/11/1997	1	1	LB4756	1	$47.43	$35.14	$35.14	V222		1968
32	1/10/1997	1/10/1997	3/25/1997	1	1	LB4756	1	$70.24	$24.71	$24.71	V222		1968
33	1/10/1997	1/10/1997	3/25/1997	1	1	LB4756	1	$51.75	$9.62	$9.62	V222		1968
34	4/15/1998	4/15/1998	5/5/1998	1	1	LB4756	1	$41.18	$12.28	$12.28	V222		1968
35	4/15/1998	4/15/1998	5/5/1998	1	1	LB4756	1	$56.10	$20.33	$20.33	V222		1968
36	5/19/1998	5/19/1998	6/2/1998	1	1	LB4756	1	$40.31	$20.80	$20.80	V233		1968
37	5/19/1998	5/19/1998	6/2/1998	1	1	LB4756	1	$64.78	$33.43	$33.43	V233		1968
38	5/19/1998	5/19/1998	6/2/1998	1	1	LB4756	1	$44.91	$23.18	$23.18	V233		1968
39	5/20/1998	5/20/1998	5/26/1998	1	1	LB4756	1	$51.75	$9.16	$9.16	V233		1968
40	5/20/1998	5/20/1998	5/26/1998	1	1	LB4756	1	$70.24	$27.71	$27.71	V233		1968
41	3/23/1997	3/23/1997	7/7/1998	1	1	LB4756	1	$29.50	$7.34	$7.34	V242		1968
42	10/10/1997	10/10/1997	7/7/1998	1	1	LB4756	1	$25.00	$7.34	$7.34	6221		1968
43	7/30/1998	7/30/1998	9/8/1998	1	1	LB4756	1	$26.25	$6.56	$6.56	64403		1968
44	9/11/1998	9/11/1998	9/29/1998	1	1	LB4756	1	$16.00	$10.74	$10.74	V239		1968
45	9/11/1998	9/11/1998	9/29/1998	1	1	LB4756	1	$15.89	$5.42	$5.42	V239		1968
46	9/11/1998	9/11/1998	9/29/1998	1	1	LB4756	1	$41.11	$14.02	$14.02	V239		1968
47	9/11/1998	9/11/1998	9/29/1998	1	1	LB4756	1	$22.39	$4.37	$4.37	V239		1968
48	9/22/1998	9/22/1998	10/6/1998	1	1	LB4756	1	$51.75	$9.16	$9.16	V239		1968
49	2/10/1999	2/10/1999	2/23/1999	1	1	LB4756	1	$37.75	$11.16	$11.16	5990		1968
50	2/10/1999	2/10/1999	2/23/1999	1	1	LB4756	1	$15.50	$3.10	$3.10	5990		1968

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	2/10/1999	2/10/1999	2/23/1999	1	1	LB4756	1	$21.04	$11.94	$11.94	5990		1968
52	2/10/1999	2/10/1999	2/23/1999	1	1	LB4756	1	$19.71	$11.18	$11.18	5990		1968
53	2/17/1997	2/17/1997	4/15/1997	1	1	TR0136	1	$374.00	$200.00	$200.00			1968
54	8/27/1997	8/27/1997	10/14/1997	1	1	TR0136	1	$418.00	$418.00	$418.00			1968
55	10/15/1999	10/15/1999	5/2/2000	1	1	MDG567	6	$312.00	$257.40	$254.40	V252		1968
56	10/15/1999	10/15/1999	5/2/2000	1	1	MDG567	8	$416.00	$288.00	$288.00	V252		1968
57	2/22/1996	2/22/1996	3/5/1996	1	1	MD1340	1	$490.00	$156.00	$153.00	6221		1968
58	3/26/1996	3/26/1996	4/2/1996	1	1	MD1340	1	$18.00	$9.40	$6.40	V254		1968
59	5/19/1996	5/19/1996	6/11/1996	1	1	MDG798	1	$121.00	$105.00	$105.00	3090		1968
60	5/20/1996	5/20/1996	6/11/1996	1	1	MD2084	1	$250.00	$137.78	$134.78	309		1968
61	5/21/1996	5/21/1996	6/11/1996	1	1	MD2084	1	$100.00	$42.08	$39.08	309		1968
62	5/22/1996	5/22/1996	6/11/1996	1	1	MD2084	1	$100.00	$42.08	$39.08	309		1968
63	5/23/1996	5/23/1996	6/11/1996	1	1	MD2084	1	$180.00	$100.00	$97.00	309		1968
64	7/2/1996	7/2/1996	7/16/1996	1	1	MD1340	1	$15.00	$3.21	$0.21	V724		1968
65	8/22/1996	8/22/1996	9/10/1996	1	1	MD1340	1	$60.00	$29.00	$26.00	V222		1968
66	8/22/1996	8/22/1996	9/10/1996	1	1	MD1340	1	$15.00	$3.21	$3.21	V222		1968
67	8/29/1996	8/29/1996	9/10/1996	1	1	MD1340	1	$40.00	$29.00	$26.00	V222		1968
68	9/7/1996	9/7/1996	9/17/1996	1	1	MD1340	1	$195.00	$97.11	$94.11	59080		1968
69	9/8/1996	9/8/1996	9/17/1996	1	1	MD1340	1	$110.00	$55.61	$52.61	59080		1968
70	9/9/1996	9/9/1996	9/17/1996	1	1	MD1340	1	$110.00	$55.61	$52.61	59080		1968
71	9/10/1996	9/10/1996	9/17/1996	1	1	MD1340	1	$110.00	$55.61	$52.61	59080		1968
72	9/11/1996	9/11/1996	9/17/1996	1	1	MD1340	1	$130.00	$130.00	$127.00	59080		1968
73	9/2/1996	9/2/1996	9/24/1996	1	1	MD1330	1	$295.00	$169.00	$166.00	65583		1968
74	9/2/1996	9/2/1996	9/24/1996	1	1	MD1330	1	$185.00	$104.00	$104.00	65583		1968
75	9/8/1996	9/8/1996	12/10/1996	1	1	MD2074	1	$2.25	$2.25	$2.25	V221		1968

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	9/8/1996	9/8/1996	10/1/1996	1	1	MD2074	1	$2.25	$2.25	$0.00	V221		1968
77	9/8/1996	9/8/1996	10/1/1996	1	1	MD2074	1	$2.52	$2.52	$2.52	V221		1968
78	9/8/1996	9/8/1996	10/1/1996	1	1	MD2074	1	$9.58	$9.58	$9.58	V221		1968
79	9/8/1996	9/8/1996	10/1/1996	1	1	MD2074	1	$13.44	$4.81	$4.81	V221		1968
80	9/8/1996	9/8/1996	10/1/1996	1	1	MD2074	1	$13.44	$4.81	$4.81	V221		1968
81	10/13/1996	10/13/1996	10/22/1996	1	1	MD1340	1	$195.00	$97.11	$94.11	59080		1968
82	10/14/1996	10/14/1996	10/22/1996	1	1	MD1340	1	$110.00	$55.61	$52.61	59080		1968
83	10/16/1996	10/16/1996	10/29/1996	1	1	MD1330	1	$110.00	$75.00	$72.00	64663	59010	1968
84	10/16/1996	10/16/1996	10/29/1996	1	1	MD1330	1	$295.00	$169.00	$169.00	64663	59010	1968
85	10/23/1996	10/23/1996	10/29/1996	1	1	MD1340	1	$65.00	$65.00	$62.00	V239		1968
86	10/23/1996	10/23/1996	10/29/1996	1	1	MD1340	1	$15.00	$3.21	$3.21	V239		1968
87	10/16/1996	10/16/1996	11/5/1996	1	1	MD2074	1	$33.60	$13.14	$10.14	64663	59010	1968
88	10/15/1996	10/15/1996	12/10/1996	1	1	MD2074	1	$3.00	$3.00	$0.00	64663	59010	1968
89	10/15/1996	10/15/1996	12/10/1996	1	1	MD2074	1	$25.00	$16.87	$16.87	64663	59010	1968
90	10/13/1996	10/13/1996	11/12/1996	1	1	MD2074	1	$13.44	$4.81	$1.81	64663	59010	1968
91	10/13/1996	10/13/1996	11/12/1996	1	1	MD2074	1	$30.07	$11.82	$11.82	64663	59010	1968
92	11/5/1996	11/5/1996	11/19/1996	1	1	MD1340	1	$65.00	$65.00	$65.00	V239	59080	1968
93	11/5/1996	11/5/1996	11/19/1996	1	1	MD1340	1	$15.00	$3.21	$3.21	V239	59080	1968
94	10/16/1996	10/16/1996	11/26/1996	1	1	MDG525	1	$33.00	$22.00	$19.00	64663		1968
95	1/10/1997	1/10/1997	1/28/1997	1	1	MD9926	1	$175.00	$50.00	$50.00	65653		1968
96	1/10/1997	1/10/1997	1/28/1997	1	1	MD9926	1	$185.00	$104.00	$104.00	65653		1968
97	1/9/1997	1/9/1997	1/28/1997	1	1	MD1340	1	$65.00	$65.00	$65.00	V239	6565	1968
98	1/9/1997	1/9/1997	1/28/1997	1	1	MD1340	1	$15.00	$3.21	$3.21	V239	6565	1968
99	2/17/1997	2/17/1997	2/25/1997	1	1	MD1340	1	$1,550.00	$1,550.00	$1,550.00	V270		1968
100	2/18/1997	2/18/1997	2/25/1997	1	1	MD1340	1	$130.00	$125.53	$125.53	V270		1968

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	12/17/2001	12/19/2001	1/8/2002	1	1	HS03IP	2	$4,118.95	$2,633.06	$2,633.06	29590	30390	1962
2	3/9/2002	3/11/2002	3/26/2002	1	1	HS03IP	2	$4,715.28	$2,707.76	$2,707.76	29534	30500	1962
3	7/25/2002	7/26/2002	8/6/2002	1	1	HS03IP	1	$3,726.71	$1,353.88	$1,353.88	29532	29632	1962
4	9/15/2003	9/19/2003	9/30/2003	1	1	HS03IP	4	$9,672.98	$5,591.28	$5,591.28	29570	30300	1962
5	9/10/2001	9/10/2001	10/9/2001	1	1	HS03OP	0	$549.77	$145.77	$138.48	78900		1962
6	9/13/2001	9/13/2001	10/9/2001	1	1	HS03OP	0	$356.02	$197.06	$187.21	7806	57420	1962
7	9/14/2001	9/14/2001	10/9/2001	1	1	HS03OP	0	$164.33	$25.87	$24.58	57420		1962
8	7/27/2001	7/27/2001	1/22/2002	1	1	HS03OP	0	$115.24	$24.21	$23.00	29530	V5869	1962
9	12/8/2001	12/8/2001	2/5/2002	1	1	HS03OP	0	$47.01	$26.02	$24.72	4659	29181	1962
10	1/2/2002	1/2/2002	1/15/2002	1	1	HS03OP	0	$277.14	$153.40	$145.73	30000	E9393	1962
11	2/10/2002	2/10/2002	2/26/2002	1	1	HS03OP	0	$49.36	$27.32	$25.95	5259	52510	1962
12	2/13/2002	2/13/2002	2/26/2002	1	1	HS03OP	0	$49.36	$27.32	$25.95	5259	V4589	1962
13	3/23/2002	3/23/2002	4/9/2002	1	1	HS03OP	0	$49.36	$27.32	$25.95	462		1962
14	4/1/2002	4/1/2002	4/16/2002	1	1	HS03OP	0	$348.85	$53.28	$50.62	78079		1962
15	4/13/2002	4/13/2002	4/30/2002	1	1	HS03OP	0	$783.29	$382.37	$363.25	30500		1962
16	5/19/2002	5/19/2002	6/25/2002	1	1	HS03OP	0	$49.36	$27.32	$25.95	5259	2910	1962
17	6/10/2002	6/10/2002	6/25/2002	1	1	HS03OP	0	$114.01	$23.89	$22.70	5990		1962
18	5/30/2002	5/30/2002	7/2/2002	1	1	HS03OP	0	$140.54	$63.05	$59.90	78900		1962
19	6/16/2002	6/16/2002	7/9/2002	1	1	HS03OP	0	$226.74	$125.50	$119.22	70581		1962
20	10/2/2002	10/2/2002	10/22/2002	1	1	HS03OP	0	$580.74	$143.26	$136.10	6929		1962
21	1/7/2003	1/7/2003	1/28/2003	1	1	HS03OP	0	$291.99	$161.62	$153.54	30500	29590	1962
22	4/5/2003	4/5/2003	4/22/2003	1	1	HS03OP	0	$540.11	$246.85	$234.51	30300	29560	1962
23	4/22/2003	4/22/2003	5/13/2003	1	1	HS03OP	0	$613.06	$339.33	$322.36	78900	6250	1962
24	5/21/2003	5/21/2003	6/10/2003	1	1	HS03OP	0	$339.33	$187.82	$178.43	30000	7810	1962
25	7/10/2003	7/10/2003	7/29/2003	1	1	HS03OP	0	$999.62	$531.01	$504.46	9212	920	1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	9/26/2003	9/26/2003	10/14/2003	1	1	HS03OP	0	$111.01	$61.44	$58.37	7821	9181	1962
27	10/7/2003	10/7/2003	10/21/2003	1	1	HS03OP	0	$303.71	$34.71	$32.97	7088		1962
28	6/17/2001	6/17/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
29	6/17/2001	6/17/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
30	6/18/2001	6/18/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
31	6/19/2001	6/19/2001	7/31/2001	1	1	MH0157	5	$75.00	$62.50	$62.50	29590		1962
32	6/20/2001	6/20/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
33	6/20/2001	6/20/2001	7/31/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
34	6/20/2001	6/20/2001	7/31/2001	1	1	MH0157	4	$40.00	$30.00	$30.00	29590		1962
35	6/21/2001	6/21/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
36	6/21/2001	6/21/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
37	6/22/2001	6/22/2001	7/31/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
38	6/23/2001	6/23/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
39	6/23/2001	6/23/2001	7/31/2001	1	1	MH0157	3	$45.00	$37.50	$37.50	29590		1962
40	6/24/2001	6/24/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
41	6/24/2001	6/24/2001	7/31/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
42	6/25/2001	6/25/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
43	6/29/2001	6/29/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
44	6/30/2001	6/30/2001	7/31/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
45	6/30/2001	6/30/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
46	6/25/2001	6/25/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
47	6/26/2001	6/26/2001	7/31/2001	1	1	MH0157	5	$75.00	$62.50	$62.50	29590		1962
48	6/27/2001	6/27/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
49	6/27/2001	6/27/2001	7/31/2001	1	1	MH0157	3	$45.00	$37.50	$37.50	29590		1962
50	6/28/2001	6/28/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	6/28/2001	6/28/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
52	5/3/2001	5/3/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
53	5/4/2001	5/4/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
54	5/5/2001	5/5/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
55	5/6/2001	5/6/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
56	5/9/2001	5/9/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
57	5/11/2001	5/11/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
58	5/18/2001	5/18/2001	7/31/2001	1	1	MH0157	1	$7.50	$7.50	$7.50	29590		1962
59	5/23/2001	5/23/2001	7/31/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
60	5/24/2001	5/24/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
61	5/2/2001	5/2/2001	7/31/2001	1	1	MH0157	12	$300.00	$255.00	$255.00	29590		1962
62	5/3/2001	5/3/2001	7/31/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
63	5/4/2001	5/4/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
64	5/10/2001	5/10/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
65	5/16/2001	5/16/2001	7/31/2001	1	1	MH0157	4	$40.00	$30.00	$30.00	29590		1962
66	5/17/2001	5/17/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
67	5/22/2001	5/22/2001	7/31/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
68	5/23/2001	5/23/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
69	6/7/2001	6/7/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
70	6/9/2001	6/9/2001	7/31/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
71	6/9/2001	6/9/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
72	6/10/2001	6/10/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
73	6/11/2001	6/11/2001	7/31/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
74	6/12/2001	6/12/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
75	6/12/2001	6/12/2001	7/31/2001	1	1	MH0157	3	$45.00	$37.50	$37.50	29590		1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	6/13/2001	6/13/2001	7/31/2001	1	1	MH0157	5	$75.00	$62.50	$62.50	29590		1962
77	6/13/2001	6/13/2001	7/31/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
78	6/13/2001	6/13/2001	7/31/2001	1	1	MH0157	4	$40.00	$30.00	$30.00	29590		1962
79	6/14/2001	6/14/2001	7/31/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
80	6/14/2001	6/14/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
81	6/15/2001	6/15/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
82	6/16/2001	6/16/2001	7/31/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
83	5/5/2001	5/5/2001	9/11/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
84	5/13/2001	5/13/2001	9/11/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
85	5/18/2001	5/18/2001	9/11/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
86	5/20/2001	5/20/2001	9/11/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
87	5/21/2001	5/21/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
88	6/7/2001	6/7/2001	9/11/2001	1	1	MH0157	1	$15.00	$12.50	$12.50	29590		1962
89	6/8/2001	6/8/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
90	6/10/2001	6/10/2001	9/11/2001	1	1	MH0157	4	$60.00	$50.00	$50.00	29590		1962
91	6/11/2001	6/11/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
92	6/13/2001	6/13/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
93	6/19/2001	6/19/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
94	6/26/2001	6/26/2001	9/11/2001	1	1	MH0157	4	$120.00	$80.00	$80.00	29590		1962
95	7/1/2001	7/1/2001	9/18/2001	1	1	MH0157	2	$30.00	$25.00	$25.00	29590		1962
96	7/10/2001	7/10/2001	9/18/2001	1	1	MH0157	1	$20.00	$20.00	$20.00	29590		1962
97	7/13/2001	7/13/2001	9/18/2001	1	1	MH0157	3	$45.00	$37.50	$37.50	29590		1962
98	7/24/2001	7/24/2001	9/18/2001	1	1	MH0157	10	$150.00	$125.00	$125.00	29590		1962
99	7/26/2001	7/26/2001	9/18/2001	1	1	MH0157	1	$250.00	$230.00	$230.00	29590		1962
100	8/2/2001	8/2/2001	11/6/2001	1	1	MH0157	1	$75.00	$75.00	$75.00	29590		1962

Report Showing All Fields for a Subset of Records of Table Med16 from Database DB6.mdb

ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
1	11/8/2005	11/8/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
2	11/9/2005	11/9/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
3	11/10/2005	11/10/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
4	11/11/2005	11/11/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
5	11/12/2005	11/12/2005	11/22/2005	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
6	11/13/2005	11/13/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
7	11/14/2005	11/14/2005	11/22/2005	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
8	11/15/2005	11/15/2005	11/22/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
9	11/16/2005	11/16/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
10	11/17/2005	11/17/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
11	11/18/2005	11/18/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
12	11/19/2005	11/19/2005	12/13/2005	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
13	11/20/2005	11/20/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
14	11/21/2005	11/21/2005	12/13/2005	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
15	11/22/2005	11/22/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
16	11/23/2005	11/23/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
17	11/24/2005	11/24/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
18	11/25/2005	11/25/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
19	11/26/2005	11/26/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
20	11/27/2005	11/27/2005	12/13/2005	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
21	11/28/2005	11/28/2005	12/13/2005	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
22	11/29/2005	11/29/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
23	11/30/2005	11/30/2005	12/13/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
24	12/1/2005	12/1/2005	12/27/2005	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
25	12/2/2005	12/2/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922

Report Showing All Fields for a Subset of Records of Table Med16 from Database DB6.mdb

ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
26	12/3/2005	12/3/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
27	12/4/2005	12/4/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
28	12/5/2005	12/5/2005	12/27/2005	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
29	12/6/2005	12/6/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
30	12/7/2005	12/7/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
31	12/8/2005	12/8/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
32	12/9/2005	12/9/2005	12/27/2005	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
33	12/10/2005	12/10/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
34	12/11/2005	12/11/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
35	12/12/2005	12/12/2005	12/27/2005	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
36	12/13/2005	12/13/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
37	12/14/2005	12/14/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
38	12/15/2005	12/15/2005	12/27/2005	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
39	12/16/2005	12/16/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
40	12/17/2005	12/17/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
41	12/18/2005	12/18/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
42	12/19/2005	12/19/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
43	12/20/2005	12/20/2005	1/10/2006	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
44	12/21/2005	12/21/2005	1/10/2006	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
45	12/22/2005	12/22/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
46	12/23/2005	12/23/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
47	12/24/2005	12/24/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
48	12/25/2005	12/25/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
49	12/26/2005	12/26/2005	1/10/2006	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
50	12/27/2005	12/27/2005	1/10/2006	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922

Report Showing All Fields for a Subset of Records of Table Med16 from Database DB6.mdb

ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
51	12/28/2005	12/28/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
52	12/29/2005	12/29/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
53	12/30/2005	12/30/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
54	12/31/2005	12/31/2005	1/10/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
55	1/1/2006	1/1/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
56	1/2/2006	1/2/2006	1/24/2006	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
57	1/3/2006	1/3/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
58	1/4/2006	1/4/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
59	1/5/2006	1/5/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
60	1/6/2006	1/6/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
61	1/7/2006	1/7/2006	1/24/2006	1	1	PCG6003	16	$84.00	$84.00	$84.00			1922
62	1/8/2006	1/8/2006	1/24/2006	1	1	PCG6003	17	$89.25	$89.25	$89.25			1922
63	1/9/2006	1/9/2006	1/24/2006	1	1	PCG6003	22	$115.50	$115.50	$115.50			1922
64	2/16/2004	2/16/2004	5/4/2004	1	1	HS01OP	0	$107.43	$83.83	$83.83			1922
65	1/18/2005	1/18/2005	3/8/2005	1	1	HS01OP	0	$180.95	$180.95	$180.95			1922
66	7/24/2005	7/24/2005	8/23/2005	1	1	HS01OP	0	$64.55	$64.55	$64.55	7802	3310	1922
67	8/10/2005	8/10/2005	9/6/2005	1	1	HS01OP	0	$8.54	$8.54	$8.54	7862		1922
68	10/4/2005	10/4/2005	11/1/2005	1	1	HS01OP	0	$21.79	$21.79	$21.79	7862		1922
69	11/14/2005	11/14/2005	12/13/2005	1	1	HS01OP	0	$4.80	$4.80	$4.80	4580	2900	1922
70	7/13/2006	7/13/2006	8/8/2006	1	1	HS01IP	0	$2.63	$2.63	$2.63	2859	4389	1922
71	11/18/2005	11/18/2005	12/12/2006	1	2	RH177FQ	0	$28.00	$28.00	$28.00	2948	7802	1922
72	1/5/2004	1/5/2004	2/24/2004	1	1	MD1454	1	$69.00	$69.00	$69.00	92309		1922
73	3/5/2004	3/5/2004	4/27/2004	1	1	MD1454	1	$17.20	$17.20	$17.20	71941		1922
74	2/16/2004	2/16/2004	5/4/2004	1	1	MD24521	1	$31.92	$31.92	$31.92	3310		1922
75	3/10/2004	3/10/2004	7/20/2004	1	1	MDG1552	1	$167.98	$167.98	$167.98	71941		1922

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	Diag	Sec_Diag	BirthYear
76	5/25/2004	5/25/2004	10/5/2004	1	1	MD1454	1	$20.80	$20.80	$20.80	7030		1922
77	1/18/2005	1/18/2005	2/22/2005	1	1	MD6706	1	$3.80	$3.80	$3.80	2900		1922
78	2/20/2005	2/20/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
79	2/19/2005	2/19/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
80	2/18/2005	2/18/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
81	2/17/2005	2/17/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
82	2/16/2005	2/16/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
83	2/15/2005	2/15/2005	1/31/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
84	2/4/2005	2/4/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
85	2/3/2005	2/3/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
86	2/2/2005	2/2/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
87	2/1/2005	2/1/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
88	2/6/2005	2/6/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
89	2/5/2005	2/5/2005	2/7/2006	1	2	HC3654	1	$319.22	$319.22	$319.22			1972
90	2/5/2006	2/5/2006	2/7/2006	1	1	HC3654	1	$442.20	$328.38	$328.38			1972
91	2/4/2006	2/4/2006	2/7/2006	1	1	HC3654	1	$442.20	$328.38	$328.38			1972
92	2/3/2006	2/3/2006	2/7/2006	1	1	HC3654	1	$442.20	$328.38	$328.38			1972
93	2/2/2006	2/2/2006	2/7/2006	1	1	HC3654	1	$442.20	$328.38	$328.38			1972
94	2/1/2006	2/1/2006	2/7/2006	1	1	HC3654	1	$442.20	$328.38	$328.38			1972
95	1/17/2006	1/17/2006	2/7/2006	1	1	CMG594	1	$200.00	$200.00	$200.00			1972
96	3/7/2005	3/7/2005	2/14/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
97	3/11/2005	3/11/2005	2/14/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
98	3/10/2005	3/10/2005	2/14/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
99	3/9/2005	3/9/2005	2/14/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972
100	3/8/2005	3/8/2005	2/14/2006	1	2	HC3654	1	$328.37	$328.37	$328.37			1972

Report Showing All Fields for a Subset of Records of Table Med13 from Database DB5.mdb

ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
1	8/31/2005	8/31/2005	9/6/2005	1	1	PH4315	2	$7.80	$7.63	$7.63	1918
2	1/26/2001	1/26/2001	1/30/2001	1	1	PH7403	60	$60.30	$10.85	$10.85	1911
3	3/29/2001	3/29/2001	4/3/2001	1	1	PH7403	60	$41.96	$10.85	$10.85	1911
4	8/3/2001	8/3/2001	9/18/2001	1	1	PH0013	28	$13.03	$9.45	$9.45	1911
5	8/11/2001	8/11/2001	9/18/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
6	8/21/2001	8/21/2001	9/18/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
7	8/30/2001	8/30/2001	9/18/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
8	6/13/2001	6/13/2001	10/9/2001	1	1	PH7403	60	$41.96	$10.85	$10.85	1911
9	9/8/2001	9/8/2001	10/30/2001	1	1	PH0013	28	$13.03	$9.45	$9.45	1911
10	9/18/2001	9/18/2001	10/30/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
11	9/27/2001	9/27/2001	10/30/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
12	10/6/2001	10/6/2001	11/13/2001	1	1	PH0013	28	$13.03	$9.45	$9.45	1911
13	10/17/2001	10/17/2001	11/13/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
14	10/26/2001	10/26/2001	11/13/2001	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
15	12/1/2001	12/1/2001	1/15/2002	1	1	PH0013	28	$13.03	$9.45	$9.45	1911
16	12/12/2001	12/12/2001	1/15/2002	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
17	12/21/2001	12/21/2001	1/15/2002	1	1	PH0013	28	$13.03	$1.57	$1.57	1911
18	11/23/2001	11/23/2001	2/5/2002	1	1	PH0013	28	$20.85	$1.57	$1.57	1911
19	11/14/2001	11/14/2001	2/5/2002	1	1	PH0013	28	$20.85	$1.57	$1.57	1911
20	11/3/2001	11/3/2001	2/5/2002	1	1	PH0013	28	$20.85	$9.45	$9.45	1911
21	1/5/2002	1/5/2002	2/12/2002	1	1	PH0013	28	$12.80	$9.45	$9.45	1911
22	1/2/2002	1/2/2002	3/5/2002	1	1	PH0013	14	$15.05	$13.97	$13.97	1911
23	7/23/2001	7/23/2001	4/30/2002	1	1	PH7403	90	$59.19	$12.53	$12.53	1911
24	6/9/2000	6/9/2000	6/13/2000	1	1	PH0100	30	$456.35	$377.59	$377.59	1962
25	2/26/2001	2/26/2001	2/27/2001	1	1	PH4320	30	$133.56	$133.56	$133.56	1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
26	2/26/2001	2/26/2001	2/27/2001	1	1	PH4320	30	$156.36	$156.36	$156.36	1962
27	3/30/2001	3/30/2001	4/3/2001	1	1	PH4315	30	$133.55	$133.55	$133.55	1962
28	3/30/2001	3/30/2001	4/3/2001	1	1	PH4315	30	$156.36	$156.36	$156.36	1962
29	4/27/2001	4/27/2001	5/1/2001	1	1	PH4320	30	$133.55	$133.55	$133.55	1962
30	4/27/2001	4/27/2001	5/1/2001	1	1	PH4320	30	$156.36	$156.36	$156.36	1962
31	8/23/2001	8/23/2001	8/28/2001	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
32	10/10/2001	10/10/2001	10/16/2001	1	1	PH0100	60	$290.35	$240.70	$238.70	1962
33	11/7/2001	11/7/2001	11/13/2001	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
34	12/19/2001	12/19/2001	1/8/2002	1	1	PH0659	28	$159.85	$114.77	$112.77	1962
35	1/2/2002	1/2/2002	1/8/2002	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
36	12/8/2001	12/8/2001	1/8/2002	1	1	PH0659	15	$17.10	$8.35	$6.35	1962
37	2/8/2002	2/8/2002	2/12/2002	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
38	4/6/2002	4/6/2002	4/9/2002	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
39	5/9/2002	5/9/2002	5/14/2002	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
40	6/16/2002	6/16/2002	6/18/2002	1	1	PH0712	60	$270.27	$235.01	$233.01	1962
41	5/19/2002	5/19/2002	7/9/2002	1	1	PH0659	8	$14.70	$9.30	$7.30	1962
42	7/26/2002	7/26/2002	7/30/2002	1	1	PH0712	60	$282.75	$247.75	$245.75	1962
43	8/30/2002	8/30/2002	9/3/2002	1	1	PH3798	60	$282.75	$247.80	$245.80	1962
44	10/1/2002	10/1/2002	10/1/2002	1	1	PH3798	60	$282.75	$247.80	$245.80	1962
45	11/4/2002	11/4/2002	11/12/2002	1	1	PH3798	60	$282.75	$247.80	$245.80	1962
46	12/2/2002	12/2/2002	12/3/2002	1	1	PH3798	60	$282.75	$247.80	$245.80	1962
47	1/9/2003	1/9/2003	1/14/2003	1	1	PH3798	60	$294.45	$258.30	$256.30	1962
48	2/7/2003	2/7/2003	2/11/2003	1	1	PH3798	60	$294.45	$258.30	$256.30	1962
49	3/12/2003	3/12/2003	3/18/2003	1	1	PH3798	60	$294.45	$258.30	$256.30	1962
50	4/7/2003	4/7/2003	4/8/2003	1	1	PH3798	60	$294.45	$258.30	$256.30	1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
51	5/21/2003	5/21/2003	5/27/2003	1	1	PH3798	60	$294.45	$258.30	$256.30	1962
52	5/21/2003	5/21/2003	5/27/2003	1	1	PH3798	12	$15.19	$10.36	$8.36	1962
53	7/30/2003	7/30/2003	8/5/2003	1	1	PH3798	60	$318.63	$280.99	$278.99	1962
54	9/26/2003	9/26/2003	9/30/2003	1	1	PH0156	60	$301.69	$284.98	$284.98	1962
55	10/31/2003	10/31/2003	11/4/2003	1	1	PH0156	60	$301.69	$284.98	$284.98	1962
56	12/9/2003	12/9/2003	12/9/2003	1	1	PH0156	60	$301.69	$284.98	$284.98	1962
57	2/4/2004	2/4/2004	2/10/2004	1	1	PH4315	10	$53.74	$53.74	$53.74	1962
58	3/9/2004	3/9/2004	3/9/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
59	4/15/2004	4/15/2004	4/20/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
60	5/28/2004	5/28/2004	6/1/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
61	7/20/2004	7/20/2004	7/20/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
62	8/16/2004	8/16/2004	8/17/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
63	10/12/2004	10/12/2004	10/12/2004	1	1	PH0156	60	$329.14	$311.05	$311.05	1962
64	3/22/2005	3/22/2005	3/22/2005	1	1	PH0659	15	$46.13	$46.13	$44.13	1962
65	5/18/2005	5/18/2005	5/24/2005	1	1	PH0036	15	$47.88	$47.88	$45.88	1962
66	6/23/2005	6/23/2005	6/28/2005	1	1	PH0156	30	$169.77	$166.86	$166.86	1962
67	6/27/2005	6/27/2005	6/28/2005	1	1	PH0156	5	$14.95	$7.84	$7.84	1962
68	6/28/2005	6/28/2005	7/5/2005	1	1	PH0156	15	$24.84	$8.54	$8.54	1962
69	1/24/2006	1/24/2006	1/24/2006	1	1	PH0156	30	$219.69	$177.21	$177.21	1962
70	2/23/2006	2/23/2006	2/28/2006	1	1	PH0156	30	$219.69	$177.21	$177.21	1962
71	4/5/2006	4/5/2006	4/11/2006	1	1	PH0156	30	$219.69	$177.21	$177.21	1962
72	5/24/2006	5/24/2006	5/30/2006	1	1	PH0156	30	$233.32	$177.21	$177.21	1962
73	6/21/2006	6/21/2006	6/27/2006	1	1	PH3410	15	$47.49	$45.69	$43.69	1962
74	7/19/2006	7/19/2006	7/25/2006	1	1	PH0156	30	$209.71	$177.21	$177.21	1962
75	8/17/2006	8/17/2006	8/22/2006	1	1	PH0156	30	$233.32	$177.21	$177.21	1962

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
76	9/28/2006	9/28/2006	10/3/2006	1	1	PH0156	30	$233.32	$177.21	$177.21	1962
77	10/30/2006	10/30/2006	10/31/2006	1	1	PH3410	6	$24.99	$22.03	$20.03	1962
78	11/27/2006	11/27/2006	11/28/2006	1	1	PH0156	30	$233.32	$177.21	$177.21	1962
79	7/21/1999	7/21/1999	8/24/1999	1	1	PH0004	17	$52.86	$46.77	$46.77	1906
80	9/6/1999	9/6/1999	11/16/1999	1	1	PH0026	5	$23.49	$23.49	$23.49	1906
81	9/6/1999	9/6/1999	11/16/1999	1	1	PH0026	28	$78.84	$78.84	$78.84	1906
82	10/5/1999	10/5/1999	11/30/1999	1	1	PH0026	60	$155.86	$155.86	$155.86	1906
83	10/31/1999	10/31/1999	12/7/1999	1	1	PH0026	56	$146.23	$146.23	$146.23	1906
84	11/29/1999	11/29/1999	12/21/1999	1	1	PH0026	52	$136.60	$136.60	$136.60	1906
85	4/23/1999	4/23/1999	4/27/1999	1	1	PH1252	30	$93.20	$77.33	$75.33	1925
86	5/11/1999	5/11/1999	5/11/1999	1	1	PH1252	15	$19.80	$17.93	$15.93	1925
87	5/24/1999	5/24/1999	5/25/1999	1	1	PH1252	30	$93.20	$77.33	$75.33	1925
88	6/24/1999	6/24/1999	7/1/1999	1	1	PH1252	30	$93.20	$77.33	$75.33	1925
89	7/23/1999	7/23/1999	7/27/1999	1	1	PH1252	15	$19.80	$17.93	$15.93	1925
90	7/23/1999	7/23/1999	7/27/1999	1	1	PH1252	30	$93.20	$80.10	$78.10	1925
91	7/3/2000	7/3/2000	7/4/2000	1	1	PH9000	30	$92.00	$80.10	$80.10	1908
92	7/10/2000	7/10/2000	7/11/2000	1	1	PH9000	30	$92.00	$72.20	$72.20	1908
93	8/23/2000	8/23/2000	8/29/2000	1	1	PH9000	30	$92.00	$80.10	$80.10	1908
94	9/6/2000	9/6/2000	9/12/2000	1	1	PH9000	30	$92.00	$80.10	$80.10	1908
95	10/11/2000	10/11/2000	10/17/2000	1	1	PH9000	30	$92.00	$83.64	$83.64	1908
96	11/14/2000	11/14/2000	11/14/2000	1	1	PH9000	30	$92.00	$83.64	$83.64	1908
97	12/5/2000	12/5/2000	12/5/2000	1	1	PH9000	30	$92.00	$83.64	$83.64	1908
98	3/7/2001	3/7/2001	3/13/2001	1	1	PH9000	28	$86.00	$82.15	$82.15	1908
99	3/28/2001	3/28/2001	4/10/2001	1	1	PH9000	28	$86.00	$82.15	$82.15	1908
100	4/25/2001	4/25/2001	5/1/2001	1	1	PH9000	28	$86.00	$82.15	$82.15	1908

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
1	6/9/2000	6/9/2000	6/13/2000	1	1	PH0100	30	$456.35	$377.59	$377.59	1962
2	7/11/2002	7/11/2002	7/16/2002	1	1	PH4320	120	$705.87	$705.87	$705.87	1968
3	8/14/2002	8/14/2002	8/20/2002	1	1	PH4320	90	$531.28	$531.28	$531.28	1968
4	5/20/2002	5/20/2002	9/24/2002	1	1	PH4320	60	$356.68	$356.68	$356.68	1968
5	6/7/2001	6/7/2001	6/12/2001	1	1	PH2927	19	$126.89	$114.12	$112.12	1972
6	6/16/2001	6/16/2001	6/19/2001	1	1	PH2927	14	$93.49	$86.06	$84.06	1972
7	6/23/2001	6/23/2001	7/3/2001	1	1	PH2927	14	$93.49	$86.06	$84.06	1972
8	7/1/2001	7/1/2001	7/3/2001	1	1	PH2927	14	$93.49	$86.06	$84.06	1972
9	7/8/2001	7/8/2001	7/10/2001	1	1	PH2927	14	$93.49	$86.06	$84.06	1972
10	7/15/2001	7/15/2001	7/17/2001	1	1	PH2927	14	$93.49	$86.06	$84.06	1972
11	7/22/2001	7/22/2001	7/24/2001	1	1	PH0038	14	$93.49	$87.74	$85.74	1972
12	7/29/2001	7/29/2001	7/31/2001	1	1	PH0038	14	$93.49	$87.74	$85.74	1972
13	8/5/2001	8/5/2001	8/7/2001	1	1	PH0038	14	$93.49	$87.74	$85.74	1972
14	2/22/2002	2/22/2002	5/21/2002	1	1	PH0256	60	$1,184.77	$807.64	$805.64	1972
15	1/11/2002	1/11/2002	5/21/2002	1	1	PH0256	30	$575.62	$409.55	$407.55	1972
16	5/31/2002	5/31/2002	6/4/2002	1	1	PH0256	60	$1,184.77	$807.64	$805.64	1972
17	7/25/2002	7/25/2002	7/30/2002	1	1	PH0256	60	$1,184.77	$807.64	$805.64	1972
18	8/23/2002	8/23/2002	8/27/2002	1	1	PH0256	60	$1,184.77	$807.64	$805.64	1972
19	9/17/2002	9/17/2002	9/17/2002	1	1	PH0256	16	$428.63	$294.54	$292.54	1972
20	9/17/2002	9/17/2002	9/17/2002	1	1	PH0256	24	$185.73	$129.72	$127.72	1972
21	10/7/2002	10/7/2002	10/8/2002	1	1	PH0256	24	$185.73	$129.72	$127.72	1972
22	10/7/2002	10/7/2002	10/8/2002	1	1	PH0256	16	$220.05	$153.00	$151.00	1972
23	7/31/1998	7/31/1998	8/4/1998	1	1	PH0100	30	$206.35	$162.63	$160.63	1972
24	8/28/1998	8/28/1998	9/1/1998	1	1	PH0100	30	$206.35	$162.63	$160.63	1972
25	7/20/1998	7/20/1998	1/12/1999	1	1	PH0156	15	$81.83	$81.83	$81.83	1972

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
26	1/8/1999	1/8/1999	1/12/1999	1	1	PH0100	30	$211.40	$162.63	$160.63	1972
27	2/8/1999	2/8/1999	2/9/1999	1	1	PH0100	30	$211.40	$166.62	$164.62	1972
28	12/11/1998	12/11/1998	4/6/1999	1	1	PH0156	30	$155.66	$155.66	$155.66	1972
29	4/29/2004	4/29/2004	5/4/2004	1	1	PH0156	30	$183.24	$172.45	$172.45	1912
30	7/9/1999	7/9/1999	11/9/1999	1	1	PH0156	5	$32.41	$32.41	$32.41	1901
31	8/23/2002	8/23/2002	2/4/2003	1	1	PH4141	10	$61.86	$56.76	$56.76	1936
32	9/4/2002	9/4/2002	2/25/2003	1	1	PH4141	10	$61.86	$56.76	$56.76	1936
33	10/21/2002	10/21/2002	4/1/2003	1	1	PH4141	30	$165.60	$155.31	$155.31	1936
34	11/20/2002	11/20/2002	4/8/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
35	4/4/2003	4/4/2003	4/15/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
36	1/13/2003	1/13/2003	4/29/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
37	2/5/2003	2/5/2003	5/13/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
38	3/5/2003	3/5/2003	6/10/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
39	6/4/2003	6/4/2003	7/15/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
40	5/5/2003	5/5/2003	7/22/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
41	7/3/2003	7/3/2003	8/19/2003	1	1	PH4141	30	$165.60	$160.49	$160.49	1936
42	8/1/2003	8/1/2003	9/9/2003	1	1	PH4141	30	$171.04	$160.49	$160.49	1936
43	8/30/2003	8/30/2003	9/30/2003	1	1	PH4141	30	$171.04	$160.49	$160.49	1936
44	9/27/2003	9/27/2003	10/14/2003	1	1	PH4141	30	$171.04	$160.49	$160.49	1936
45	10/21/2003	10/21/2003	11/11/2003	1	1	PH4141	30	$171.04	$160.49	$160.49	1936
46	11/19/2003	11/19/2003	12/2/2003	1	1	PH4141	30	$171.04	$171.04	$171.04	1936
47	12/15/2003	12/15/2003	12/23/2003	1	1	PH4141	30	$176.69	$172.45	$172.45	1936
48	1/21/2004	1/21/2004	2/3/2004	1	1	PH4141	30	$176.69	$172.45	$172.45	1936
49	2/19/2004	2/19/2004	3/2/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
50	3/23/2004	3/23/2004	3/30/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936

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ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
51	4/21/2004	4/21/2004	4/27/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
52	5/19/2004	5/19/2004	5/25/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
53	6/21/2004	6/21/2004	6/29/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
54	7/19/2004	7/19/2004	7/20/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
55	8/11/2004	8/11/2004	8/17/2004	1	1	PH4141	30	$183.64	$172.45	$172.45	1936
56	9/6/2004	9/6/2004	9/7/2004	1	1	PH4315	14	$84.47	$84.47	$84.47	1936
57	9/27/2004	9/27/2004	10/5/2004	1	1	PH4141	30	$183.64	$180.59	$180.59	1936
58	11/18/2004	11/18/2004	11/23/2004	1	1	PH4141	30	$200.43	$180.59	$180.59	1936
59	12/17/2004	12/17/2004	12/21/2004	1	1	PH4141	30	$200.43	$180.59	$180.59	1936
60	1/22/2005	1/22/2005	1/25/2005	1	1	PH4141	30	$200.43	$180.59	$180.59	1936
61	3/1/2005	3/1/2005	3/1/2005	1	1	PH4141	30	$200.43	$180.59	$180.59	1936
62	1/7/2000	1/7/2000	1/18/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
63	1/7/2000	1/7/2000	1/18/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
64	1/18/2000	1/18/2000	1/18/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
65	1/18/2000	1/18/2000	1/18/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
66	2/2/2000	2/2/2000	2/8/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
67	2/2/2000	2/2/2000	2/8/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
68	2/15/2000	2/15/2000	2/15/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
69	2/15/2000	2/15/2000	2/15/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
70	3/28/2000	3/28/2000	4/11/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
71	4/13/2000	4/13/2000	4/18/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
72	4/13/2000	4/13/2000	4/18/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
73	3/28/2000	3/28/2000	4/25/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
74	4/24/2000	4/24/2000	4/25/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
75	4/24/2000	4/24/2000	4/25/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950

Report Showing All Fields for a Subset of Records of Table Med17 from Database DB7.mdb

ID	From	Thru	Pay_Date	Status	CTM	Prov	Units	Billed	Allowed	Payment	BirthYear
76	5/1/2000	5/1/2000	5/2/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
77	5/1/2000	5/1/2000	5/2/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
78	3/13/2000	3/13/2000	5/9/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
79	3/13/2000	3/13/2000	5/9/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
80	3/2/2000	3/2/2000	5/9/2000	1	1	PH0251	14	$76.80	$71.93	$69.93	1950
81	3/2/2000	3/2/2000	5/9/2000	1	1	PH0251	14	$88.55	$83.52	$81.52	1950
82	5/9/2000	5/9/2000	5/16/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
83	5/9/2000	5/9/2000	5/16/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
84	5/15/2000	5/15/2000	5/16/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
85	5/15/2000	5/15/2000	5/16/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
86	5/19/2000	5/19/2000	5/23/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
87	5/19/2000	5/19/2000	5/23/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
88	5/25/2000	5/25/2000	6/6/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
89	6/1/2000	6/1/2000	6/13/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
90	6/1/2000	6/1/2000	6/13/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
91	5/25/2000	5/25/2000	6/13/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
92	6/6/2000	6/6/2000	6/13/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
93	6/6/2000	6/6/2000	6/13/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
94	6/12/2000	6/12/2000	6/20/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
95	6/12/2000	6/12/2000	6/20/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
96	6/19/2000	6/19/2000	6/20/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
97	6/19/2000	6/19/2000	6/20/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
98	6/26/2000	6/26/2000	7/11/2000	1	1	PH0251	7	$50.10	$45.71	$43.71	1950
99	6/26/2000	6/26/2000	7/11/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950
100	7/3/2000	7/3/2000	7/25/2000	1	1	PH0251	7	$44.25	$39.91	$37.91	1950

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PHARMACOTHERAPY

Risk of Diabetes Mellitus Associated with Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder: A Nested Case-Control Study

Jeff J. Guo, Ph.D., Paul E. Keck, Jr., M.D., Patricia K. Corey-Lisle, Ph.D., Hong Li, Ph.D., Dongming Jiang, Ph.D., Raymond Jang, Ph.D., and Gilbert J. L Italien, Sc.D.

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Risk of Diabetes Mellitus Associated with Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder: A Nested Case-Control Study

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Study Objective. To quantify the risk of diabetes mellitus associated with atypical antipsychotics compared with conventional antipsychotics in managed care Medicaid patients with bipolar disorder.

Design. Retrospective nested case-control study.

Data Source. Integrated seven-state Medicaid managed care claims database from January 1, 1998–December 31, 2002.

Patients. Two hundred eighty-three patients with diabetes (cases) and 1134 controls matched by age, sex, and the index date on which bipolar disorder was diagnosed.

Measurements and Main Results. Cases were defined as those having an *International Classification of Diseases, Ninth Revision* diagnosis of diabetes or those receiving treatment with antidiabetic drugs. Both case and control patients had at least a 3-month exposure to either conventional or atypical antipsychotic agents or three filled prescriptions related to treatment for bipolar disorder. Of the 283 cases, 139 (49%) received atypical antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, and clozapine) and 133 (47%) were prescribed conventional antipsychotics. To compare the risk for new-onset diabetes associated with atypical versus conventional antipsychotics, we conducted a Cox proportional hazard regression, in which we controlled for age; sex; duration of bipolar disorder follow-up; use of lithium, anticonvulsants, antidepressants, and other drugs; and psychiatric and medical comorbidities. Compared with patients receiving conventional antipsychotics, the risk of diabetes was greatest among patients taking risperidone (hazard ratio [HR] 3.8, 95% confidence interval [CI] 2.7–5.3), olanzapine (3.7, 95% CI 2.5–5.3), and quetiapine (2.5, 95% CI 1.4–4.3). The risk for developing diabetes was also associated with weight gain (HR 2.5, 95% CI 1.9–3.4), hypertension (HR 1.6, 95% CI 1.2–2.2), and substance abuse (HR 1.5, 95% CI 1.0–2.2).

Conclusion. Olanzapine, risperidone, and quetiapine are all associated with development or exacerbation of diabetes mellitus in patients with bipolar disorder. When prescribing therapy for this patient population, metabolic complications such as diabetes, weight gain, and hypertension need to be considered.

Key Words: diabetes, bipolar disorder, atypical antipsychotics, managed care, Medicaid.

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Traditionally, mood stabilizers such as lithium, divalproex, and carbamazepine have been the primary agents used to treat bipolar disorder. Although conventional antipsychotics also have

been prescribed to treat acute mania, long-term maintenance use of these agents is limited due to their intolerable adverse events, including akathisia, extrapyramidal symptoms, and tardive dyskinesia. Atypical antipsychotics (aripiprazole, clozapine, olanzapine, quetiapine, risperidone, and ziprasidone) are generally regarded as having lower risk for causing extrapyramidal symptoms than conventional antipsychotics; they have been used with increasing frequency in the treatment of bipolar disorder since the mid-1990s.[1–4] This trend may reflect the antimanic or mood-stabilizing properties of atypical antipsychotics and their favorable tolerability profiles compared with conventional agents.[5–7] Recent clinical trials suggest that antipsychotic augmentation might be efficacious for treatment of bipolar depression.[7–9] Unfortunately, atypical antipsychotics are associated with metabolic complications that place patients at risk for weight gain, altered glucose metabolism, dyslipidemia, myocarditis, and cardiomyopathy.[10–13]

The increased risk for diabetes associated with atypical antipsychotics may reflect direct effects of these drugs on β-cell function and insulin action.[10, 11] Several published studies, including a number of retrospective cohort studies, have shown associations between the development of diabetes or glucose intolerance and the atypical antipsychotics clozapine, olanzapine, and risperidone in patients with schizophrenia.[14–23] A research group reported hazard ratios (HRs) for diabetes risk of 1.1–1.2 in Veterans Affairs patients who received atypical antipsychotics.[24] Two groups in the United Kingdom found that atypical antipsychotics were associated with HRs for diabetes of 4.7–5.8.[24, 25] An analysis based on the World Health Organization's adverse drug reaction database found that these agents had an HR for diabetes as high as 10.22.[26] Several cases of diabetic ketoacidosis and diabetes associated with atypical antipsychotics have been reported among adult[27] and pediatric[28, 29] patients with bipolar disorder. Although atypical antipsychotics are widely used to treat mania, their association with diabetes onset has not been adequately quantified in patients with bipolar disorder.[30]

Not only is the Medicaid program the dominant payer for mental health services in the United States,[31] but the number of Medicaid enrollees in managed care organizations has increased since the mid-1990s.[32] Studies using Iowa and California Medicaid claims databases have found that patients with schizophrenia exposed to clozapine or olanzapine were at increased risk for type 2 diabetes.[33, 34] Yet, very little information exists about the risk of diabetes associated with antipsychotic drug use among patients with bipolar disorder in the managed care Medicaid population.

We hypothesized that atypical antipsychotics would present a different risk for diabetes than conventional antipsychotics. Our objectives were to investigate the association between atypical antipsychotics and diabetes mellitus in patients with bipolar disorder in the managed care Medicaid population and compare it with the association between conventional antipsychotics and diabetes in the same patient population. In assessing the risk for diabetes, we controlled for key covariates such as age, sex, and psychiatric and medical comorbidities, as well as concomitant drugs that affect patients' risk for hyperglycemia.

Methods

Data Source

Our data source was a multistate managed care claims database (PharMetrics, Watertown, MA). The database covered over 45 million individuals enrolled in managed care organizations with 70 health plans, including seven state Medicaid managed care programs, in four U.S. regions: Midwest (34.1%), East (15.6%), South (23.9%), and West (26.4%).[35] The database included each patient's date of enrollment and pharmacy, medical, and institutional claims. Each medical claim was recorded with accompanying diagnostic codes from the *International Classification of Diseases, Ninth Revision* (ICD-9) that justified

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the medical service. This geographically diversified claims database provides a large quantity of health information pertaining to the Medicaid population. The use of Medicaid or managed care claims databases for pharmacoepidemiologic studies has been well documented.[14, 23, 24, 33, 34]

Study Design

We used a retrospective nested case-control (population-based case-control) design. Claims data from January 1, 1998–December 31, 2002 (5 calendar years) were reviewed. To protect patient confidentiality, we deleted patient names, insurance plan identification numbers, and other patient identifiers from the claims database. Randomized patient numbers and patients' birth years were used for identification and calculation of age. The research project was approved by the University of Cincinnati Medical Center's institutional review board.

Study Cohort Identification

As shown in Figure 1, from 1998–2002 a total of 48,965 managed care Medicaid patients had at least one diagnosis of an affective disorder (ICD-9 code 296.xx) or cyclothymia (ICD-9 code 301.13). We excluded 4841 patients with schizophrenia (295.xx), 30,624 patients with depression only (296.2x and/or 296.3x), and 29 patients aged 65 years or greater during the study period. These exclusions enabled us to assess patients with bipolar disorder while avoiding confounding due to patients who had schizophrenia and/or depression or who were eligible for both Medicare and Medicaid. The final cohort consisted of 13,471 patients with bipolar disorder indicated by any of the following ICD-9 codes: 296.0, 296.1, and 296.4–296.8. Because less than 0.1% of the study group had cyclothymia, patients with that disorder were not categorized separately.

In keeping with other published retrospective cohort studies,[13–25] we selected a cohort of patients who had a minimum of 3 months of exposure to atypical or conventional antipsychotics or at least three filled prescriptions related to treatment of bipolar disorder during the study period. Incident cases of diabetes were identified by either the earliest diagnosis of ICD-9 code 250.xx or treatment for diabetes after the first identified use of antipsychotics. The date for the first diabetes diagnosis or first use of antidiabetic drugs was defined as the diabetes index date. To ensure that we were identifying incident cases of diabetes, we checked medical and prescription claim records for any diagnosis or treatment of diabetes before the diabetes index date. Patients were rejected as cases if they had a prescription for oral antidiabetic agents before the diabetes index date. The oral antidiabetic agents identified were sulfonylurea drugs (acetohexamide, glipizide, glyburide), a biguanide (metformin), thiazolidinediones (pioglitazone, rosiglitazone), α-glucosidase inhibitors (acarbose, miglitol), and the new drugs repaglinide and nateglinide.

The index date of bipolar diagnosis was the first date of diagnosis indicated by designated ICD-9 codes for bipolar disorder during the study period. For each case we matched five controls according to age at bipolar diagnosis index date (standard deviation of 5 yrs), sex, and the month and year of diagnosis of bipolar disorder. Controls meeting the matching criteria were selected at random using SAS, version 8.0 (SAS Institute Inc., Cary, NC), software. Controls were selected from a population of patients who had been diagnosed with bipolar disorder but were not diagnosed with or treated for diabetes at any time during the study period. Because the

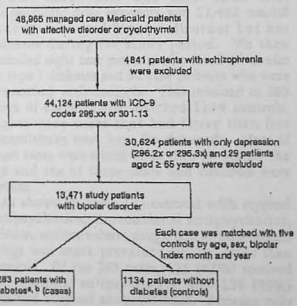

Figure 1. Patient flow diagram of incident cases of diabetes mellitus and controls from patients with bipolar disorder in the United States managed care Medicaid population, 1998–2002. [a]Incident cases of diabetes were identified by either earliest diagnosis of *International Classification of Diseases, Ninth Revision* (ICD-9) code 250.xx or treatment for diabetes. [b]Eighty-nine case patients with fewer than five matched controls were included in the analysis.

month and year of bipolar diagnosis were part of the matching criteria, the calendar time distributions of the bipolar index date were the same for both cases and controls.

Drug Use and Covariates

We classified antipsychotics as either conventional or atypical. The atypical antipsychotics were olanzapine, risperidone, quetiapine, ziprasidone, and clozapine. Aripiprazole was not included in this analysis as it was not available during the study period. The conventional antipsychotics were haloperidol, chlorpromazine, fluphenazine, loxapine, molindone, perphenazine, thioridazine, trifluoperazine, thiothixene, and pimozide. Other antipsychotics, such as thioxanthenes (flupenthixol, zuclopenthixol), pipotiazine, and methotrimeprazine were not included in this study because they were not available in the United States.

Published reports indicate that some drugs elevate blood glucose levels in some patients. Thus, our analysis incorporated data on administration of any of the following drugs during the study period: α-blockers (e.g., doxazosin, prazosin, terazosin), β-blockers (e.g., atenolol, betaxolol, bisoprolol), thiazide diuretics (e.g., chlorothiazide, chlorthalidone, polythiazide), corticosteroids (e.g., methylprednisolone, hydrocortisone), phenytoin, oral contraceptives containing norgesterol, and valproic acid.[30,36,37]

For both cases and controls, all prescription drug claims for treatment of bipolar disorder and diabetes were abstracted and reviewed. The follow-up period began with each patient's first bipolar diagnosis date and ended with the index date of diabetes, the end of the study period, or the end of the patient's enrollment in the managed care Medicaid program, whichever came first. We used dichotomous variables to indicate whether a patient had received concomitant drugs known to be associated with diabetes or hyperglycemia. All drug claims were identified by national drug codes.

In addition to drugs known to affect the risk of diabetes, we adjusted the analysis for psychiatric comorbidities (alcohol abuse, substance abuse disorder, personality disorder, anxiety disorder, and impulse-control disorder) and medical comorbidities (hypertension, weight gain, arthritis, cerebral vascular disease, chronic obstructive pulmonary disease, dyslipidemia, and coronary heart disease. The ICD-9 codes were used to identify comorbid conditions from either hospital or clinical encounters.

Statistical Analysis

All analyses were performed with SAS, version 8.0. Descriptive statistics were used to explore patient demographics and drug use categories. The age of each patient was simply the age at bipolar diagnosis. We conducted the Cox proportional hazard regression to assess the risk for diabetes associated with antipsychotic drugs due to the consideration of time-to-event with censoring and covariates. We determined hazard ratios for each risk factor with 95% confidence intervals. Patients taking conventional antipsychotics were the referent group in our comparison of diabetes risk among patients.

Results

Table 1 summarizes the characteristics of the study population. During the 5-year study period (1998–2002), of the 13,471 managed care Medicaid patients with bipolar disorder, 1730 (13%) had at least one prescription for atypical antipsychotics, 1918 (14%) had prescriptions for conventional antipsychotics, 1048 (8%) for lithium, 3013 (22%) for anticonvulsants, and 4011 (30%) for antidepressants.

The first cohorts we selected consisted of 323 case patients who developed diabetes after the bipolar index date and after their first antipsychotic drug exposure and 12,432 control patients who had bipolar disorder but not diabetes during the study period. We then excluded eight case patients who received insulin for type 1 diabetes and 32 case patients who were unmatched with controls. This resulted in 283 cases of diabetes and matched 1134 controls. Eighty-nine cases that had fewer than five controls/case were kept for the study. Most of those cases were adults older than 50 years. The age and sex of these cases and controls were similar.

As shown in Table 1, treatment with atypical antipsychotics, conventional antipsychotics, lithium, anticonvulsant drugs, and antidepressant drugs was more prevalent among cases than controls. Of the 283 cases, 133 (47%) received conventional antipsychotics, and 139 (49%) received atypical antipsychotics. Because only five patients (< 2%) received more than one atypical antipsychotic during the study period, we did not categorize this patient group.

Compared with patients receiving conventional antipsychotics, the risk for diabetes was greatest among patients taking risperidone (HR 3.8, 95% CI 2.7–5.3), olanzapine (HR 3.7, 95% CI

Table 1. Characteristics of the Study Patients

Characteristic	No. (%) of Patients	
	Cases (n=283)	Controls (n=1134)
Age (yrs)		
≤ 12	5 (1.77)	25 (2.20)
13–17	10 (3.53)	50 (4.41)
18–34	70 (24.73)	329 (29.01)
35–49	129 (45.58)	562 (49.56)
50–64	69 (24.38)	168 (14.81)
Sex		
Female	227 (80.21)	916 (80.78)
Male	56 (19.79)	218 (19.22)
Psychotherapeutic drugs[a]		
Lithium	153 (54.06)	119 (10.49)
Anticonvulsants[b]	164 (57.95)	289 (25.48)
Atypical antipsychotics	139 (49.12)	164 (14.46)
Olanzapine	51 (18.02)	79 (6.97)
Quetiapine	18 (6.36)	20 (1.76)
Risperidone	65 (22.97)	61 (5.38)
Ziprasidone	2 (0.71)	3 (0.26)
Clozapine	3 (1.06)	2 (0.18)
Antidepressants	174 (61.48)	374 (32.98)
Conventional antipsychotics	133 (47.00)	213 (18.78)
Other concomitant drugs[a]		
β-Blockers	63 (22.26)	86 (7.58)
α-Blockers	4 (1.41)	7 (0.62)
Corticosteroids	78 (27.56)	171 (15.08)
Thiazide diuretics	30 (10.60)	38 (3.35)
Oral contraceptives	9 (3.18)	17 (1.50)
Valproic acid	1 (0.35)	8 (0.71)
Phenytoin	5 (1.76)	18 (1.59)
Psychiatric comorbidities[c]		
Alcohol abuse	22 (7.77)	147 (12.96)
Substance abuse	41 (14.48)	146 (12.87)
Anxiety disorder	150 (53.00)	445 (39.24)
Impulse-control disorder	5 (1.76)	22 (1.94)
Personality disorder	21 (7.42)	65 (5.73)
Medical comorbidities[c]		
Hypertension	130 (45.94)	194 (17.11)
Weight gain	79 (27.92)	90 (7.94)
Arthritis	16 (5.65)	30 (2.65)
Chronic obstructive pulmonary disease	41 (14.49)	71 (6.26)
Cerebral vascular disease	15 (5.30)	27 (2.38)
Coronary heart disease	11 (3.88)	5 (0.44)
Dyslipidemia	8 (2.83)	5 (0.44)

[a]Some patients received more than one drug.
[b]Anticonvulsants were divalproex and carbamazepine.
[c]Some patients were diagnosed with more than one comorbid condition.

2.5–5.3), quetiapine (HR 2.5, 95% CI 1.4–4.3), and the anticonvulsants divalproex and carbamazepine (HR 1.6, 95% CI 1.2–2.1; Table 2). These data were obtained in a process that controlled for the covariates of age, sex, and duration of follow-up; use of lithium, anticonvulsants, and antidepressants; concomitant drugs (not related to bipolar disorder); and psychiatric and medical comorbidities. In addition, patients whose bipolar disorder was coupled with substance abuse, hypertension, and/or weight gain had a significantly higher risk for diabetes than their counterparts.

Discussion

This multistate, population-based, nested case-control study examined the risk of diabetes

associated with use of antipsychotics in Medicaid patients with bipolar disorder. After controlling for personal risk factors and concomitant drug use, we found that patients receiving atypical antipsychotics for bipolar disorder are at increased risk for diabetes. Our findings add to the body of observational evidence indicating that certain atypical antipsychotics may be associated with an increased risk for diabetes among patients with bipolar disorder.[27–29] It is unclear, however, whether the diabetes in the study population is due to the use of atypical antipsychotics versus the underlying condition of bipolar disorder versus characteristics of the Medicaid population, such as low socioeconomic status, poor overall physical health, unhealthy lifestyles, and poor access to health care services.

Atypical antipsychotics are generally regarded as having less potential for causing extrapyramidal symptoms and a higher serotonin:dopamine receptor affinity compared with conventional antipsychotics.[11, 12] Recent literature indicates that clozapine, olanzapine, and risperidone are more likely to be associated with diabetes (indicated by diabetic ketoacidosis and an atherogenic lipid profile) than other atypical agents.[14, 28, 29, 36, 39] One possible mechanism for hyperglycemia is impairment of insulin resistance, which may occur because of weight gain or a change in body fat distribution or by a direct effect on insulin-sensitive target tissues.[2, 10, 11]

Our findings are comparable to data from published pharmacoepidemiologic studies of patients with schizophrenia.[14, 23–25] For example, reported HRs for diabetes in patients with schizophrenia were 1.2–5.8 for olanzapine and 1.1–2.2 for risperidone.[14, 23–25, 33] These values can be compared with the HRs we obtained for the same drugs in patients with bipolar disorder: HR 3.7 (95% CI 2.5–5.3) for olanzapine and 3.8 (95% CI 2.7–5.3) for risperidone (Table 2). After controlling for comorbidities, personal risk factors, and concomitant drugs, we also found that quetiapine increases the risk for diabetes in patients with bipolar disorder (HR 2.5, 95% CI 1.4–4.4). Although quetiapine has been linked to diabetes in case reports,[40–43] earlier studies have failed to confirm this association.[33] This may be due to their small sample sizes or lack of control for confounding variables.[44] The HRs associated with clozapine (HR 2.9, 95% CI 0.9–9.6) and ziprasidone (HR 4.3, 95% CI 1.0–18.9) in our study were large, but they were not statistically significant. This might be due to the small number of patients in our study who received either clozapine or ziprasidone. Long-term data from large, randomized, controlled trials are needed to more explicitly examine the association between diabetes and various atypical antipsychotic drugs.

As shown in Table 2, in addition to antipsychotic use, diabetes risk is also associated with weight gain and hypertension. As the literature indicates, olanzapine, clozapine, and risperidone are associated with weight gain,[13, 45, 46] hyperlipidemia, and hypertriglyceridemia, all of which are independent risk factors for heart disease.[14, 47, 48] Our findings of elevated HRs for weight gain and hypertension make it likely that the incident cases of diabetes we identified were associated with metabolic syndrome. Our data also show that patients with substance abuse have a heightened risk for diabetes. It is possible that these patients might have less healthy lifestyles, poorer drug compliance, or poorer access to health care services than patients without substance abuse.[49, 50] Poor drug compliance might lead to drug overdose, which could increase the risk for diabetes in this population.[33]

Our study had several limitations. Children, women, and low-income populations are overrepresented in the Medicaid population. Thus, our findings might not be indicative of the general population. We inferred drug use from automated pharmacy claims data. Although baseline drug use differed between cases and controls, we tried to adjust for these differences with the Cox proportional hazard model. Because of the retrospective nature of a claims database review, we could not assess individual patients with regard to severity of bipolar disorder, socioeconomic class, lipid profiles, fasting glucose concentrations, or changes in body mass index related to weight gain.

Moreover, data on patients' ethnicity were missing when PharMetrics (data vendor) collected medical claims information from participating managed care organizations. Another concern is that clinicians may have prescribed one drug versus another based on patients' specific symptoms. We attempted to reduce this potential confounding bias by adjusting for known concomitant drugs and comorbidities. We also included dyslipidemia and coronary heart disease as comorbidities, as these provide a rough proxy for patients at high risk for diabetes. It is possible that we underestimated the prevalence of diabetes due to our study's limited time window, changes in

Table 2. Hazard Ratios for Diabetes Risk

Variable	Hazard Ratio[a]	95% CI
Psychotherapeutic drugs		
Conventional antipsychotic	1.000	1.000
Olanzapine	3.664	2.542–5.281
Quetiapine	2.476	1.427–4.296
Risperidone	3.771	2.699–5.269
Ziprasidone	4.297	0.976–18.923
Clozapine	2.872	0.862–9.575
Lithium	1.016	0.729–1.416
Anticonvulsant[b]	1.571	1.153–2.140
Antidepressant	1.138	0.842–1.538
Other concomitant drugs		
β-Blocker	1.329	0.960–1.839
α-Blocker	0.669	0.235–1.907
Corticosteroid	1.048	0.775–1.417
Thiazide diuretic	1.254	0.807–1.947
Oral contraceptive	1.766	0.829–3.761
Valproic acid	0.359	0.049–2.640
Phenytoin	0.428	0.167–1.098
Psychiatric comorbidities		
Alcohol abuse	0.623	0.390–0.996
Substance abuse	1.491	1.033–2.152
Anxiety disorder	1.257	0.963–1.640
Impulse-control disorder	0.499	0.183–1.360
Personality disorder	1.096	0.673–1.783
Medical comorbidities		
Hypertension	1.636	1.208–2.216
Weight gain	2.516	1.876–3.375
Arthritis	0.920	0.535–1.582
Chronic obstructive pulmonary disease	1.289	0.865–1.921
Cerebral vascular disease	1.223	0.702–2.129
Coronary heart disease	1.134	0.588–2.188
Dyslipidemia	1.844	0.813–4.182

CI = confidence interval.
[a]Model for age, sex, bipolar follow-up months, use of drugs, psychiatric and medical comorbidities.
[b]Anticonvulsants were divalproex and carbamazepine.

managed care enrollment, and the fact that some mental services may not have been billed to patients' managed care organizations. Finally, we identified comorbid conditions by diagnostic codes without considering the contribution of drugs to weight gain, hypertension, cerebral vascular disease, and other disorders.

Despite the above limitations, our study adds to the limited literature about diabetes risk in patients with bipolar disorder in managed care Medicaid programs. It provides useful information on disease management strategies in terms of selection of mood stabilizers and consideration of relevant comorbidities for patients with bipolar disorder, especially the managed care Medicaid population. Atypical antipsychotics provide great benefit to a wide variety of individuals with psychiatric disorders; nevertheless, they have a constellation of adverse effects related to increased risk for weight gain, diabetes, and dyslipidemia.[10,11]

Conclusion

The atypical antipsychotics olanzapine, risperidone, and quetiapine are consistently associated with increased risk for diabetes in patients with bipolar disorder after adjustment for relevant risk factors. Metabolic complications are a clinically important issue for patients receiving antipsychotic therapy. The choice of olanzapine, risperidone, or quetiapine for a specific patient with bipolar disorder should involve consideration of each agent's risks and benefits, with attention to comorbid conditions relevant to the patient's risk for diabetes. Thus,

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

STATE OF ALASKA,	)
	)
Plaintiff,	)
	)
	)
vs.	)
	)
ELI LILLY AND COMPANY,	)
	)
Defendant.	)
	) Case No. 3AN-06-5630CIV

AFFIDAVIT OF BETH A. VIRNIG, PH.D

I, Beth A. Virnig, being duly sworn, state as follows:

A. Background

1. I am an epidemiologist, Associate Professor at the University of Minnesota School of Public Health, Division of Health Policy and Management, and a faculty member and course instructor for the Research Data Assistance Center (ResDAC), which is funded by CMS to assist researchers using Medicaid and Medicare databases.

2. In my capacities as professor, researcher and ResDAC faculty member, I regularly work with and instruct students and other researchers about Medicaid and Medicare databases. I am familiar with the contents of those databases, including what information is submitted by applicants for coverage, and by health care providers seeking reimbursement for claims.

3. I have been retained by the law firm Pepper Hamilton LLP to serve as an expert for Eli Lilly and Company in a case captioned *State of Alaska v. Eli Lilly and Company*, Case No. 3AN-06-5630 CI (Superior Court for the State of Alaska).

B. Assignment

1. I have been informed by counsel for Eli Lilly that the State of Alaska has explained that it intends to use its Medicaid claims database to prove that Zyprexa use caused Alaska Medicaid recipients to develop medical conditions, including diabetes mellitus, at a higher rate than a control group that did not use Zyprexa.

2. I have been advised that the State has represented that the methodology the State will use to prove causation is comparable to that reported in an article by Guo, et al.,

titled *Risk of Diabetes Mellitus Associated with Atypical Antipsychotic Use Among Medicaid Patients with Bipolar Disorder: A Nested Case-Control Study*, PHARMACOTHERAPY (Vol. 27 No. 1 January 2007). Exh. A. I have reviewed that article.

3. I have been asked by counsel for Eli Lilly to evaluate, based on my knowledge and experience working with Medicaid claims databases, whether the data produced by the State to Lilly constitutes all data maintained by the Alaska Medicaid program for the period January 1996-November 2006, including all data that may be relevant to the issues of disease incidence, causation, and health care costs raised by the State's claims.

4. I have also been asked to address whether medical records are needed to address the issues of disease incidence, causation, and health care costs raised by the State's claims.

C. Description of Materials Provided

1. I have reviewed 21 access tables provided to me by Pepper Hamilton LLP.

2. I have been advised that the 21 access tables constitute the entirety of Medicaid data produced by the State to Eli Lilly.

3. I have also reviewed letters from Christiaan Marcum, an attorney for the State of Alaska, to Eric Rothschild, Pepper Hamilton LLP, making representations about the contents of the 21 access tables.

4. The access tables provided to me can be divided into four groups, based on format and Mr. Marcum's descriptions.

a. "Med1" Tables

JS06H1204H_Med1_1996_DaveC.mdb: Med1_1996
JS06H1204H_Med1_1997_DaveC.mdb: Med1_1997
JS06H1204H_Med1_1998_DaveC.mdb: Med1_1998
JS06H1204H_Med1_1999_DaveC.mdb: Med1_1999
JS06H1204H_Med1_2000_DaveC.mdb: Med1_2000
JS06H1204H_Med1_2001_DaveC.mdb: Med1_2001
JS06H1204H_Med1_2002Q1Q2_DaveC.mdb: Med1_2002Q1Q2
JS06H1204H_Med1_2002Q3Q4_DaveC.mdb: Med1_2002Q3Q4
JS06H1204H_Med1_2003Q1Q2_DaveC.mdb: Med1_2003Q1Q2
JS06H1204H_Med1_2003Q3Q4_DaveC.mdb: Med1_2003Q3Q4
JS06H1204H_Med1_2004Q1Q2Q3Q4_DaveC.mdb: Med1_2004Q1Q2
JS06H1204H_Med1_2004Q1Q2Q3Q4_DaveC.mdb: Med1_2004Q3Q4
JS06H1204H_Med1_2005Q1Q2_DaveC.mdb: Med1_2005Q1Q2
JS06H1204H_Med1_2005Q3Q4_DaveC.mdb: Med1_2005Q3Q4
JS06H1204H_Med1_2006Q1Q2_DaveC.mdb: Med1_2006Q1Q2
JS06H1204H_Med1_2006Q3-Nov_DaveC.mdb: Med1_2006Q3-Nov

b. "ZypMed" Tables – files represented to "reflect medical procedures associated with the use of Zyprexa." (August 27, 2007 Letter from Marcum to Rothschild, Exh. B)

JS06H1204_ZypMed1_1996-1999_DaveC.mdb: ZypMed1_1996-1999
JS06H1204_ZypMed1_2000-2003_DaveC.mdb: ZypMed1_2000-2003
JS06H1204_ZypMed1_2004-2006_DaveC.mdb: tblS6H1204CExpanded

c. "Zyprex1" Tables – files represented to be "all Zyprexa prescriptions through November 2006." (August 27, 2007 Letter from Marcum to Rothschild, Exh. B)

JS6H1204B_Zyprex1_Dave C.mdb: Zyprexa 1

d. "JTC07" Tables – files represented to be "all antipsychotic prescriptions trough November 2006" (August 27, 2007 Letter from Marcum to Rothschild, Exh. B)

JTC07.mdb: TC07

D. Observations Regarding Completeness of Data

1. Based on my review of the files produced by the State, it is evident that the State has not produced all the Medicaid data for the relevant period.

Enrollment Data

2. The files produced by the State to Lilly do not contain enrollment or eligibility files. Medicaid programs, including Alaska's Medicaid program, maintain records regarding their benefits recipients, which includes information that may not be separately recorded in claims records, and which is necessary to research of disease incidence, utilization and costs. Information that may be included in the enrollment files includes race, gender, basis for Medicaid eligibility, exact time on the Medicaid rolls (including departures and reentry during the studied period), and other insurance (including Medicare or private insurance).

3. The data in the enrollment or eligibility files include information relevant to the incidence and causation issues being raised by the State. For example, patient characteristics such as race and gender should be controlled for in the comparison between Zyprexa users and the control group. The Guo article relied upon by the State reports that the study used date of enrollment and gender, information that must be extracted from the enrollment or eligibility files. Exh. A at 28.

4. In addition, it is common for individuals to move on and off the Medicaid rolls over time. Enrollment data will reveal whether individuals stopped participating

in the Medicaid program for lengthy periods of time, during which time treatment and medical events relevant to the study may have occurred.

Medical Claims

5. If the sixteen "Med 1" tables are intended to be a complete production of all medical and hospitalization claims, they do not appear to be complete. According to the Medicaid Analytic Extract published by the Center for Medicare and Medicaid Services (CMS), enrollment in the Alaska Medicaid program in 2002 was 124,446. (Exh. C). However, the Med 1 tables for 2002 (JS06H1204H_Med1_2002Q1Q2_DaveC.mdb: Med1_2002Q1Q2 and JS06H1204H_Med1_2002Q3Q4_DaveC.mdb: Med1_2002Q3Q4) include claims by only 100,999 unique users, approximately 80% the number of total enrollees. This is a lower percentage then would be expected if all claims were included in the data.

Hospital Claims

6. The "Med 1" tables also do not report all data associated with hospital claims. Almost all of the claims entries with provider prefixes beginning with "HS" – which I believe to be hospital claims – have no entry under the "Proc" code. The State has represented that "[h]ospitals generally do not submit claims with "Proc" or procedure codes, but rather submit them with revenue codes." (August 27, 2007 Letter from Marcum to Rothschild, Exh. B).

7. The State has failed to provide revenue codes in the data produced to Lilly. These codes are useful for determining what services were provided to the patient.

8. The representation that hospitals do not submit claims with "procedure codes" is curious. During the relevant period, Alaska, like most states, used the UB 92 claims form for hospital claims. Exh. D. That form contains a "Principal Procedure" field, and fields for five "Other Procedures." *Id.*, fields 80-81. The Alaska Medicaid Assistance Program Inpatient/Outpatient Hospital Services Provider Billing Manual states that these are Required Fields, if applicable (meaning a procedure was performed). Exh. E, I-36. However, almost all hospital claims in the data produced lack procedure codes.

9. It is also likely that the State did not include in its hospital claims all diagnoses reported by the hospitals in their claims reimbursement forms. The UB 92 reimbursement form contains a field for "Principal Diagnosis" and 8 fields for "Other Diagnoses" Exh.D. These are required fields where applicable. Exh.E, I-32, I-35. However, the "Med 1" tables have entries only for primary and secondary diagnoses, which may result in reported data being excluded from the production.

Prescription claims

10. The production contains two tables represented to be prescription claims: "Zyprex1" (represented to be claims for Zyprexa prescriptions only) and "JTC701" (represented to be claims for all antipsychotic prescriptions). The "JTC701" table actually appears to include some mental health medications in addition to antipsychotic medications, although it is not clear

what criteria was used to select the medications. Neither table appears to contain non-mental health medications.

11. The claims data for all medications are necessary to address the claims being made by the State in this matter. For example, records of diabetic medications are relevant to the issue of whether Medicaid recipients developed diabetes, and the costs of treating them. The Guo article relied upon by the State used claims for anti-diabetic medications to register incidence of diabetes. Exh. A at 29.

12. In addition, some medications are believed to elevate blood glucose levels in some patients, and, therefore, could be a confounder to any study of the incidence of diabetes in Zyprexa users compared to some other group. The Guo article reports that their study incorporated data on non-psychiatric medications (e.g. beta blockers) to rule out this potential confounder. Exh. A at 30.

13. Medication is also one of the medical costs incurred by the Alaska Medicaid program, and is relevant to the costs associated with Zyprexa use.

Pre-1996 Data

14. The State has not produced any data prior to 1996, the year that Zyprexa was launched. Data prior to 1996 are helpful, among other reasons, to investigate whether Zyprexa users for whom injuries are being claimed were diagnosed with the alleged medical condition (i.e. diabetes) prior to using Zyprexa.

15. Data prior to 1996 will also reveal patients' experiences on mental health medications prior to taking Zyprexa.

E. Observations Regarding Need for Medical Records

1. Medical records are necessary for investigating the State's claim that Zyprexa use has caused increased disease incidence in its Medicaid population, and to study the costs associated with Zyprexa use.

2. Two major risk factors for diabetes are being overweight and family history. Any study attempting to show that an agent caused diabetes must account for these possible confounders. Neither of these factors is recorded in claims data.

3. Medical records are also necessary to investigate events that may have taken place during periods when the patient was not enrolled in Medicaid, including particularly diabetes diagnoses. The scenario of a diabetes diagnosis prior to Medicaid enrollment is particularly likely for Zyprexa users because mental health issues are often the point of entry to Medicaid.

4. Medical records are also necessary to assess the medical outcomes of patients diagnosed with diabetes. Some percentage of diagnosed diabetics are non-symptomatic, and do not require treatment, which may be relevant to the State's claims.

5. Medical records are also necessary to investigate the accuracy of the diagnosis entries in the claims data. Diagnoses entered in support of claims reimbursement can be inaccurate because of data entry errors, coverage issues, and concerns about stigma.

6. Medical records may also reveal reasons for medical decisions, including reasons for prescribing mental health medications.

Beth A. Virnig, Ph.D

SWORN TO AND SUBSCRIBED
BEFORE ME, NOTARY, this
_____ day of September, 2007

Notary Public

Pepper Hamilton LLP
Attorneys at Law

3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103-2799
215.981.4000
Fax 215.981.4750

Eric Rothschild
direct dial: 215-981-4813
rothschilde@pepperlaw.com

July 25, 2007

VIA FIRST CLASS MAIL AND EMAIL
Eric T. Sanders, Esquire
Feldman, Orlansky & Sanders
500 L Street
Suite 400
Anchorage, AK 99501-5911

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Eric:

I am responding to your email of July 18, 2007 to Brewster Jamieson, regarding our suggestion that the parties engage in a meet and confer about both parties' discovery responses. It has been our experience in the Zyprexa litigation that such discussions – which have not occurred in this case – have helped narrow disputes between the parties, including for requests similar or identical to some of those pressed by the State in its motion. For example, Lilly has reached agreements with plaintiffs in other cases on the scope of call note production and identification of sales representatives. We expect that we can have productive discussions about those issues in this case, as well as other issues raised in your motion. You may be correct that a conference call will not resolve *all* our disagreements, but it will be worthwhile to resolve or narrow as many as we can. The Alaska Rules of Civil Procedure require the parties to make this effort, and we owe it the Court to do so.

Lilly would also like to meet and confer regarding deficiencies in the State's responses to Lilly's discovery, before it files its own motion to compel. Those issues include, but are not limited to:

1. Supplementation of the State's Claims Data

The State must provide Lilly with a list of all of the data fields maintained by the State so that Lilly can select which ones are necessary for its own analysis. The claims data produced on June 8 lacks numerous fields of information necessary to render it comprehensible and usable by Lilly. There is no unique patient identifier that would allow Lilly to track the products and services provided to a Medicaid recipient over time. There is no information about what medication or service was reimbursed. Lilly cannot tell whether the claims entries

produced include only Zyprexa prescriptions or all mental health medications used over time by Zyprexa users, including other antipsychotics. There is no information about other medications, including for treatment of diabetes. All of this information will be necessary for Lilly's investigation of the State's case. There are likely many other fields maintained by the State that will be relevant to the action that are not included in its production. Lilly will also need a key to the provider numbers listed in the databases so that it can make an informed decision about which prescribers it will depose. Lilly will also need claims data for Zyprexa users before 1996 as it may reveal, among other things, treatment for diabetes prior to 1996.

In addition, the State's claims data production cannot be limited to entries for Zyprexa users only. The State has represented that it intends to prove its case through an epidemiological study comparing Zyprexa users' medical experiences to some, as yet unidentified, control group. Lilly will need to engage in the same type of analysis to defend the case. As a practical matter, the only way that Lilly can do this is to have access to the State's full Medicaid database during the relevant years, as the State is presumably providing to its own experts. As Mr. Rogoff asserted at the July 12 hearing, Lilly cannot wait until the State produces its expert reports to have access to this data.

2. Medical Records

In addition to claims data, Lilly requires production of medical records of patients whose Zyprexa prescriptions and medical treatment are the basis for the State's claims. Much of the information that will bear on the State's allegations that Zyprexa caused Medicaid recipients' injuries cannot be found in the claims data: *i.e.*, date of first diabetes diagnosis; risk factors for diabetes (weight, family history, exposure to diabetogenic agents); success or failure on other mental health drugs; and the reason for changes in mental health treatment.

3. Information About Alleged Misrepresentations and Improper Promotion

Lilly has requested information about the specific misrepresentations and improper promotion allegedly made to the State and Alaska prescribers. The State has responded with generalized descriptions about the content of Lilly misrepresentations, but has not identified who made the misrepresentations, who they were made to, or when they were made, nor has it produced any documents demonstrating misrepresentations to any Alaska state official or prescriber. Lilly is entitled to production of all of this information, so, among other reasons, it can notice the depositions of the individuals that were allegedly misled, or an unqualified declaration that the State does not have such information.

Lilly has also asked the State to identify which prescriptions were written because of Lilly's alleged misrepresentations or improper promotion. Lilly is entitled to a response identifying which prescriptions are at issue in this case, or an unqualified declaration that the State cannot distinguish Zyprexa prescriptions that were caused by Lilly's alleged misconduct from those that were not.

4. Information About the State's Administration of Medicaid

The State has provided almost no information responsive to Lilly's discovery requests regarding the State's own conduct. The State has identified only three individuals who had contacts with Lilly, or with knowledge about the facts giving rise to the Complaint, one of whom appears to be a private physician. We have some doubts that these are the only individuals associated with the State who participated in decisions about Zyprexa over the more than ten years that the State has put at issue in its Complaint.

The State has also failed to provide information about its treatment of Zyprexa on the formulary, including what information it considered. The State has also asserted that it does not have a P&T Committee, but such a body is identified on its website. The State must clarify what persons were responsible for evaluating Zyprexa during the entire time period alleged in the Complaint.

We propose that the parties set a conference call for the week of July 30 to meet and confer about discovery issues. Please advise promptly your willingness to participate in this call, and when you will be available. Following that meeting, we propose to present the parties' motions to compel on the remaining discovery issues to the Special Master, and request a conference to present arguments on both parties' motions.

Very truly yours,

Eric Rothschild

cc: David Suggs, Esquire
Brewster H. Jamieson, Esquire

EXHIBIT J
PAGE 3 OF 3

001155

RICHARDSON, PATRICK, WESTBROOK & BRICKMAN, LLC

Christiaan Marcum
843.727.6522 Direct Dial No.
843.216.6509 Direct Fax No.
cmarcum@rpwb.com

August 27, 2007

August 27, 2007

VIA FIRST CLASS MAIL AND EMAIL
Eric Rothschild, Esquire
Pepper Hamilton LLP
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103-2799

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Eric:

I am in receipt of your letter dated August 22nd regarding the database files recently produced to you. Please allow the following to serve as responses to you questions regarding the same. The responses are numbered as your questions were.

1. The data files listed are the original data files. We know of no others.

2. The data files are current through November 2006. No data has been generated for 2007.

3. The most likely reason for the lack of "Proc" codes for approximately 10% of the data is that these are hospital claims. Hospitals generally do not submit claims with "Proc" or procedure codes, but rather submit them with revenue codes. Other potential reasons for the lack of a "Proc" code would be that some data had old unused codes, some codes were not submitted by physicians, or some listings may have included denied claims.

4. The files you have listed in paragraph 4 do not all reflect prescription medication claims. The first three you have listed actually reflect medical claims associated with Zyprexa use. The fourth file is the prescription claim file for all anti-psychotic drugs. The fifth file is the prescription claim file for Zyprexa.

5. As noted above, the first three files listed in paragraph 4 are medical claim files. The fourth file contains all prescription claims for anti-psychotic drugs and the fifth file contains all such claims for Zyprexa. As noted above in paragraph 2, the data is current through November 2006.

6. The "Diag" and "Sec_Diag" fields are missing in **JTC07.mdb** and **JS6H1204B** because they are prescription files and no diagnosis code is required. The other referenced files were filtered to reflect anti-psychotic and Zyprexa use.

7. The files referenced in your paragraph 7 do not have NDC codes because they reflect medical procedures associated with the use of Zyprexa. Instead of NDC codes, they contain HCPC procedure codes (a national standard).

8. As noted above in paragraph 5, the file **JTC07** contains all antipsychotic prescriptions through November 2006 and the file **JS6H1204B** contains all Zyprexa prescriptions through the same time period. The other three files referenced in your paragraph 8 contain medical claims data associated with Zyprexa use through the same time period.

9. The "Recip" (recipient) and "Orig_Recip" (original recipient) fields in these files reflect a change in designation. The original recipient number and the recipient number were necessary to identify individual users.

As to your reference to unanswered questions from your August 10th letter, I believe you have now received my responses to those questions. I apologize that you did not receive that correspondence by both email and U.S.P.S. as intended, but your email address was keyed in incorrectly. I will, however, supplement those responses as follows, with numbered paragraphs corresponding to yours.

3. You have been provided all database files received by our experts, and you received them at approximately the same times. This includes the original de-identified data produced to you in June, and the two sets of data produced to you in August.

6. The Alaska Medicaid population is essentially homogeneous, with approximately 95% of recipients being Caucasian. Data on gender has been requested, and will be provided to you when it is received.

7. Data exists from 1989 to the present. However, according to the data managers, the data existing prior to 1996 is corrupted, invalid and otherwise useless.

I trust these responses further addresses your questions regarding the data produced to you by the State.

With kindest regards, I remain,

Sincerely yours,

Christiaan Marcum

cc: Matthew L. Garretson, Esq.
Joseph W. Steele, Esq.
Eric T. Sanders, Esq.
David Suggs, Esq.

EXHIBIT K
PAGE 2 OF 2

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,)
)
Plaintiff,)
)
vs.)
)
ELI LILLY AND COMPANY,)
)
Defendant.)
)

Case No. 3AN-06-05630 CI

MOTION ARGUMENTS BEFORE THE DISCOVERY MASTER

Pages 1 - 168
Tuesday, September 11, 2007
11:00 A.M.

at
LANE POWELL
301 West Northern Lights Boulevard, Suite 301
Anchorage, Alaska

124,000, we have no objection to giving you information on treaters that may exist in addition to the ones that you've got.

What I think happened is that the number you got are the people who in fact treated, but I'm going to check on that and make sure that you have all of that.

Number 6. I don't know what to tell you on this in the absence of Dave Campana other than we don't have what we don't have. It may be the case that the people who are filling these things out didn't do their jobs right, but I do not believe that we have what it is that you are asking for in No. 6.

With respect to No. 6, we will ask yet again if more cannot be obtained somehow or somewhere. It also may be the case that First Health may have something that we don't have or have it more conveniently. If it were to exist there, of course you can have it, and I think Mr. Marcum is going to address somewhat later those things on the subpoena to First Health that we would not be objecting to.

So on No. 6, I don't know what to tell you other than, you know, we'll get what we can get, but we don't have what we don't have.

Number 7, the revenue codes. If there are

revenue codes that we have that we have not given to you and they can be feasibly extracted from the database, we will give you those revenue codes.

Number 8. We don't think we have it. We will -- I don't know how to say this other than to say, you know, we'll make double-dog sure that we don't have it. And that's a series of these questions. As I say, I'm a lawyer, and I'm not looking at it myself, but we will see what we can find out. We have inquired. We don't think we have it, and if we don't, we don't; and if we do, you're welcome to it.

Number 9 is the same thing, if we find more diagnosis codes, you'll be the first to know.

Number 10, we will give you all of the pharmacy records for all of the medicines that are in the database. So we're not going to make a distinction about which ones do or do not have something to do with things that we are interested in. You can have all of that, assuming it is available, and I have reason to believe, based on my conversation with Mr. Garretson, that it should be. I just can't guarantee it because Mr. Campana is not around.

The same answer for No. 11. You're asking

for the same thing really as No. 10, and again you can have it if it is available and if it exists.

I would suggest to you that maybe the good doctor hasn't looked at all of the things that we have given you. Maybe she's having trouble accessing it in a database, but I know, based on our statistical analysis, that some of the things that she's talking about in 10, 11, 12 and 13, all of which relate to medications, I believe that almost all of that is in there.

For example, I do believe that beta blockers are in there because that is a potential confounder, and so I believe that it is there. I believe that information is there with respect to diabetic medications because that is the measure that we are using to determine whether somebody has diabetes or not.

So maybe she's having trouble figuring out where these things are, but it is apparent to me from reading this that she doesn't know everything that is in there. But if there is more with respect to 10, 11, 12 and 13, we'll give it to you.

With respect to pre-96 data, we understand it to be corrupted for whatever reasons it is corrupted. If it can be assembled in a form that can

be transmitted to you, and I don't know how difficult that is, but barring some unreasonable amount of expense or effort that would burden the State system, you can look at the fouled-up and corrupted 1996 data and make your own judgments. And again, I haven't been able to talk to Dave Campana about how difficult it is to bundle this up and send it to you. If it does turn out to be extraordinarily difficult, I'm sure we can work something out, pay for people's time if they have it, or we'll figure something out. But if you want to look at corrupted data, you are welcome to it.

That covers the database, and I think that that pretty much covers everything that needs to be said about it unless you guys have any other questions about -- like could we have this or could we have that.

DISCOVERY MASTER: How about if you all respond to the discrete database issue.

MR. BOISE: Sure.

DISCOVERY MASTER: If you're ready to do that.

MR. BOISE: Absolutely.

DISCOVERY MASTER: Okay.

MR. BOISE: Thank you. Much of what Mr.

Steele has articulated, we certainly have had discussions about it, indeed on-the-record discussions about where similar types of, if not agreements, willingness to look for documents and look for data have been offered. And the response has largely been: If we have it, we'll try to provide it to you, and the like. Yet we still sit here without the data, and that's what prompted, in large part, our desire to go right to the source.

We don't doubt a word that Mr. Steele has said that this is complex. We don't doubt that there is more digging that needs to be done and there is experts that need to be involved in doing that digging. And that is why what we have asked for is to go to the data source itself maintained by the agent of the State, First Health, and have our experts go in and extract the data that needs to be extracted from the database.

The first example that Mr. Steele addressed was under enrollment data, and what I understood him to say was we will get all enrollment data, but in addition to that, you're going to look for additional information on race and gender. We certainly want that as well, but that was an example of data that we're seeking in a database. What we don't know is

what we don't know.

We just received at the end of last week a listing of all the fields in the database, and there is hundreds and hundreds and hundreds of fields that are attached, I think as the last exhibit to that large pleading -- it's not there. I'll get a reference for you. Exhibit F, which we received late last week, which gives hundreds of fields of additional data items which we're just learning about.

So what happened here was we got a selective cut of data instead of the whole database. We're told it's burdensome to package it like a basketball and sort of hand it to us, and we appreciate that, but we haven't understood or heard what that burden is in any way, shape or form. We've offered to have our own experts go in and extract what we need from this database, and that's what we're really asking for here.

I mean, you have, you know, the position of the State having to go back to the one person who has the information concerning this data which was unable to answer now for a period of months, and I think it's time for us to be able to see what is in that database in its totality and be able to extract

perhaps other confounding factors or other data that's in there that are listed in all of those fields.

We appreciate that the State is not in possession of all this and all this knowledge, and that's why we're asking for other experts to go in and extract what we need.

The examples by Dr. Virnig were examples of what we could obviously see and we would obviously expect to see, while we're still kept a bit in the dark as to what the whole basketball or whole database ultimately looks like.

We have not seen the medication beyond mental health medication such as beta blockers that's referenced by Mr. Steele, and we have correspondence from your colleague, Mr. Marcum, suggesting that what we have are mental health medications. So if you're -- you know, maybe you can show us, have the database here, and you can show us where the nonmental health medications are. We're happy to have that, have that data, but we just don't see it.

So we appreciate the offer for all medication but would like at this point to have the ability to go in and really extract it ourselves.

Same with the pre-96 information. I mean,

the case here, as plaintiff is going to pursue it, really goes to whether Zyprexa caused diabetes, is one certain issue here. And important to us is whether the person had diabetes long before Zyprexa was ever on the market or ever prescribed, and without pre-96 data, that becomes very challenging. If it's corrupt, it's one more reason why we need medical records, which I'll get to separately and let the State address it first. But to have Mr. Steele at this time go back to the State and figure out what would be at issue in producing pre-96 data and then get back to us at some undefined period I think is a little bit late in that process.

What we'd like to do, again, is have our expert look at the data. We have a fight, a dispute over whether we get de-identified data or not, and we'd respect what the Court's ruling is on that issue as we get to that issue, but if we have to look at it from a de-identified perspective, you know, so be it. We have reasons why we should see the whole database in its nonde-identified form.

So I mean, these are, in a nutshell, really -- I think Mr. Steele has made the argument as to why we need to see the whole database and have our own experts come in and make some judgments as to

the things that's interesting about Dr. Virnig's declaration is that she of course doesn't opine that she needs the names of the Medicaid recipients. You can look at it from stem to stern, and the good doctor does not suggest anywhere in there that she needs the name of the Medicaid recipient.

So they can have the enrollment data but not the names of the Medicaid recipient.

Second point. With respect to the experts extracting it, I don't really know how that would be done, but it's certainly not customary. I've been doing product liability cases for 30 years, and I have yet to have General Motors let me into their computer, and I don't think that's ever going to happen. What you do is you ask them for things, and they give it to you. And they have asked us for things, and we'll give it to them insofar as what I've said we can provide to them, with the caveats that I have offered.

I have never seen a product liability case where the defense data weasels walked into GM headquarters and started diddling on their computers, and I don't think I'm ever going to see that.

The idea that they want all is -- I think doesn't make any sense. What they've got is a

they can collect and de-identify the records. That's how it should be done.

MR. BOISE: We made that proposal.

DISCOVERY MASTER: Is the beef who's going to pay for it if you go that way?

MR. STEELE: Sure. They should pay for it.

MR. BOISE: For the process of collecting? We're perfectly well to go out and hire a medical collection service and go out for the burden of collecting those records. Whether -- you know, who pays for the de-identifying process, if the State is going to pay for the process of document collection and those issues and there is going to be fee sharing along the way, I think it should be subject to discussion as to how the burden of production ultimately is done, or further order from the Court.

DISCOVERY MASTER: You want to take 10, 15, and then we'll move on to other issues?

(Recess held.)

DISCOVERY MASTER: On the record. And we have -- on the phone, who do we have?

MR. LEHNER: This is George Lehner.

MR. ROTHSCHILD: And this is Eric Rothschild.

DISCOVERY MASTER: Okay. Go ahead, Mr. Steele.

MR. STEELE: One thing that our side wanted to point out as sort of a general frame around all of this discussion is that one of the things that Judge Rindner has very clearly ruled on is that we have a March trial date. And a concern that we have, I think, with respect to all of the things that we're discussing here today is that we proceed consistent with the wishes of Judge Rindner and that we fashion our approach to completing the discovery in a way when it -- so that it can be accomplished within those time frames. I think that that's -- I know that that's very important to us, that we remain on schedule, and we are willing to, at least within our power, to expedite that which we can do to move things forward. So I just wanted to put that frame around our discussion.

DISCOVERY MASTER: Would you like to respond or add to the frame there, Mr. Boise?

MR. BOISE: Just to add to it, you're familiar with the history here of the Judge's desire and then declination to cut to the chase on what the proofs would look like. And really in earnest discovery began when the Judge ruled on August 1 as

to what the claims were going to look like or not look like or opted, as is his ultimate prerogative, not to rule. And Lilly is looking for an opportunity to defend itself, and if it takes more time to do that, that might be a consequence of the fact it takes more time in a hugely complex case.

We are willing to make the efforts to do what we can to speed the process along. We're sitting here still without workable data, and that's just the reality of where we sit.

DISCOVERY MASTER: All right. Thank you. Let's move on to the other issues, and although so far it seems to me that arguing issues discrete issue by discrete issue has worked pretty well, so let's continue with that unless you all want to frame this some other way. And we'll go ahead with the State's motions first, and then if there are other issues after the State has covered them, Mr. Boise can do that.

But what are you going to do -- Mr. Suggs has taken the lead seat here. What are you going to address, Mr. Suggs?

MR. SUGGS: Our First Motion to Compel.

MR. BOISE: Your Honor, just one point. I think it might be helpful. In essence we reverse

CERTIFICATE

I, DIANE M. BONDESON, Registered Professional Reporter and Notary Public in and for the State of Alaska, do hereby certify that the foregoing proceedings were taken before me at the time and place herein set forth;

That the proceedings were reported stenographically by me and later transcribed by computer transcription;

That the foregoing is a true record of the proceedings taken at that time; and

That I am not a party to nor have I any interest in the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand this FOURTEENTH day of SEPTEMBER, 2007.

Diane M. Bondeson, RPR
My Commission Expires 9/6/10

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August 7, 2007

VIA FIRST CLASS MAIL AND EMAIL
Joseph W. Steele, Esquire
GARRETSON & STEELE
5664 South Green Street
Salt Lake City, UT 84123

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Joe:

I am writing regarding the status of documents and claims data that you promised to produce to Lilly during the parties' conference on August 2, 2007, and our phone call later that day. You agreed that Lilly is entitled to all of the State's Medicaid claims data from 1996 to the present, other than fields that specifically identify individual patients (i.e. name, social security number), but admitted that much of the relevant data was omitted from the State's production. In particular, you acknowledged that the claims data spreadsheets produced by the State were lacking so many of the important fields, including the field identifying prescription drugs reimbursed, that they are useless to the parties and their experts. In light of the State's acknowledgement that Lilly is entitled to this claims data, that it is non-objectionable, and is highly relevant to the case, there is no justification for the State's deficient response to discovery requests served on February 14, 2007. This is highly prejudicial to Lilly's ability to submit expert reports by the November 12, 2007 deadline. The defects in the claims data production must be cured immediately.

As we have discussed, Lilly requires the identities of individual patients in order to subpoena medical records and take depositions, and has filed a motion to compel production of this information. Putting this dispute aside, you have agreed that the claims data should have been produced with some unique patient identifier or code, so that the medical treatment of particular Medicaid recipients over time can be determined, but the data produced lacks such identifier.

In addition to the absence of identifying information, the data the State produced to Lilly is missing many fields maintained by the State, which are essential to analyzing issues in dispute in this matter. The State should have produced the data with all fields that it maintains,

other than those few that it specifically objects to producing. When we spoke on the afternoon of August 2, 2007, you advised that you had a memo describing all of the fields maintained by the State, and would provide that information to Lilly. We are still waiting.

Even without a complete list of fields maintained by the State, we confirmed that many important fields were not included in the production. Most glaring, in this case about the effects of the prescription drug Zyprexa, is the absence of a field indicating what prescription drugs were reimbursed. In addition, five of the seventeen spreadsheets produced by the State lack any procedure ("Proc") code, and, in the other twelve spreadsheets, there are many gaps in the "Proc" field. You have promised to explore the absence of this data, which you agree is necessary for Lilly's investigation and analysis of the case. The end result is that the data produced should indicate the code for every medication, service, procedure, medical supply, hospitalization, medical visit or other claim reimbursed by Medicaid for the time period 1991-2007.

The data produced also has many gaps in the diagnosis code field. You have promised to explore why that is the case. We expect that the gaps will be remedied, or an explanation why they exist will be provided.

In addition to these crucial areas, it is apparent that the State failed to provide other fields that it maintains, including gender, race, claim type, category of service, and, surely many others that will become apparent once the State shares the information on the fields it maintains.

We have also requested that the State produce claims data back to 1991, so that Lilly can investigate pre-existing diabetes diagnoses, prior mental health treatment, and diabetes risk factors. You have represented that the State does not have claims data prior to 1996, which is rather surprising. In fact, the attached press release, reporting that the State will be replacing its outdated Medical claims system, states that the State has been using *the same* Medicaid Management Information System (MMIS) *since 1987*. Accordingly, we expect that the State will produce the claims data for the entire period requested, or explain why the data is not available on the MMIS, and whether it is stored in some other database or other medium, including paper documents. We will also be in contact to discuss the database format for the data production.

You have also advised that you are willing to provide the glossaries for all codes used in the database. We request that you produce those to us immediately.

In addition to curing database deficiencies, you have promised to get back to us on the following items:

1. Whether the State has a formulary. If so, it will be produced for the entire relevant time period.

2. Position and title of Dr. Thomas Porter, the physician identified as having relevant knowledge about the events alleged in the complaint, and a role in Alaska's reimbursement policy for antipsychotics.

3. Verification of interrogatories, including any supplementation.

Given the tight schedule the parties are operating under, we anticipate a prompt response to this letter.

Finally, you agreed that Lilly is entitled to all materials being provided to the State's experts, including claims data. Based on this representation, we understand that you have not provided your experts more complete data than has been provided to Lilly. Should this turn out not to be the case, we will seek appropriate relief from the Court.

Very truly yours,

Eric Rothschild

ER/cp
Enclosure
cc: Eric T. Sanders, Esquire
David Suggs, Esquire
H. Blair Hahn, Esquire
Brewster H. Jamieson, Esquire (all w/enclosure)

#8776865 v5

State of Alaska
DEPARTMENT OF HEALTH & SOCIAL SERVICES

Sarah Palin, Governor

Karleen Jackson
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NEWS RELEASE

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FOR IMMEDIATE RELEASE: July 26, 2007

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Susan Morgan, (907) 269-4996, Cell (907) 632-6107

State selects new company to replace Medicaid claims system

New technology will revamp outdated system of paying claims to providers

(Juneau, Alaska) – The Alaska Department of Health and Social Services announced today that a Notice of Intent has been issued to award a contract to Affiliated Computer Services, Inc. to replace the state's outdated Medicaid claims system.

"The state selected Affiliated Computer Services as its next Medicaid Management Information System contractor after a competitive process in which Affiliated Computer Services submitted the lowest cost proposal and scored the highest on the technical component," said Tony Lombardo, deputy commissioner. This Texas-based company provides business process and information technology solutions to commercial and government clients. The system that Affiliated Computer Services will develop for Alaska also is being used in New Hampshire and North Dakota.

Affiliated Computer Services will replace a computer system here that's had to process an escalating number of Medicaid claims on technology that's become obsolete. The system – commonly called the Medicaid Management Information System or MMIS – began operating in 1987. Since then, the number of Alaskans enrolled in Medicaid has more than tripled, increasing from almost 41,600 in 1987 to about 132,000 in 2006. Much of the claims processing technology, however, remains the same as it was 20 years ago.

The cost to develop a new Medicaid Management Information System for Alaska is expected to be $32.8 million. The federal Centers for Medicare and Medicaid Services generally pays 90 percent of the development costs. The state must cover the remaining 10 percent.

The new MMIS will simplify electronic billing and payment for doctors. Every year, the system pays more than $1 billion to providers who bill medical assistance programs such as Medicaid, the government assistance program for families with low incomes and people with disabilities.

First Health Services Corporation, based in Virginia, has been running Alaska's MMIS since 1987. In 2003, First Health signed a contract with the state to update the Medicaid claims system. However, that contract was terminated by mutual agreement and in fall 2006 the competitive bidding process was initiated to replace the state's system. Affiliated Computer Services won this bid. First Health will continue to run Alaska's current MMIS while Affiliated Computer Services is developing the new system. Affiliated Computer Services will operate the new system in Alaska following its completion, which is projected for summer 2009.

-###-

EXHIBIT M
PAGE 4 OF 4

001175

N O P Q R S

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August 10, 2007

VIA FIRST CLASS MAIL AND EMAIL
Matthew Garretson, Esquire
GARRETSON & STEELE
5664 South Green Street
Salt Lake City, UT 84123

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Matt:

I write to confirm the substance of yesterday's telephone conversation regarding issues relating to Alaska's database production.

1) The database files that you originally produced to us omitted patient identifier codes (*i.e.*, the *recip* and *orig recip* fields) and you agreed to provide us with new database files that contain these fields. I confirm that we received a disk containing database files today.

I note that the new files do not have the same file names as the previously produced files, thus please advise how each of the new files correlates to the old files. Also, please advise to what the ICN field refers.

2) You acknowledged that the database files containing patient identifier codes were provided to your expert, Dr. Tolley, and you agreed to advise us of the date that Dr. Tolley received those files.

3) You possess, but have not yet furnished us with, any pharmacy data. You agreed to produce the pharmacy data to us once you have removed the patient identifying information and have replaced it with a patient identifier code. You advised that Dr. Tolley has not yet been provided with this pharmacy data.

4) You agreed to advise us of the procedure by which you have de-identified the individual patients in the database.

5) You agreed to provide us with all of the provider / billing manuals for pharmacy and for medical procedures for all periods.

6) You agreed to furnish us with a Verification of Alaska's Interrogatory Answers.

7) Several outstanding issues can only be addressed by Dave Campana when he returns from vacation the week of August 20, 2007. Upon his return, Mr. Campana shall address the following issues:

- What other database fields, such as gender and race, are available;
- The existence of claims data prior to 1996;
- The missing data in the *diagnosis* column for many claims;
- The missing data in the *proc* column for many claims;
- The missing *proc* fields in five of the seventeen spreadsheets;
- Whether, aside from the preferred drug list, any other listing of medications available to Medicaid recipients, including a written formulary, exists; and
- Whether, once the pharmacy data have been produced, the State will have produced claims data for every medication, service, procedure, medical supply, hospitalization, medical visit or other claim reimbursed by Medicaid for the time period 1996 through 2007 (which should be extended to 1991 to 2007 if that data exist).

Please advise if anything in this letter is inconsistent with your understanding of yesterday's discussions.

Very truly yours,

Eric Rothschild (AM)

ER/am
cc: Joseph W. Steele, Esquire
Eric T. Sanders, Esquire
David Suggs, Esquire
H. Blair Hahn, Esquire
Brewster H. Jamieson, Esquire

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August 22, 2007

VIA FIRST CLASS MAIL AND EMAIL
Matthew Garretson, Esquire
GARRETSON & STEELE
5664 South Green Street
Salt Lake City, UT 84123

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Matt:

We have had an opportunity to review the database files that you produced on August 10, 2007. We have the following concerns and questions about the completeness of the production, and ask that you address these issues as soon as possible.

1. Please confirm that the following 16 files reflect all medical claims, other than prescription medication claims (i.e., doctors visits, hospitalizations, procedures).

JS06H1204H_Med1_1996_DaveC.mdb: Med1_1996
JS06H1204H_Med1_1997_DaveC.mdb: Med1_1997
JS06H1204H_Med1_1998_DaveC.mdb: Med1_1998
JS06H1204H_Med1_1999_DaveC.mdb: Med1_1999
JS06H1204H_Med1_2000_DaveC.mdb: Med1_2000
JS06H1204H_Med1_2001_DaveC.mdb: Med1_2001
JS06H1204H_Med1_2002Q1Q2_DaveC.mdb: Med1_2002Q1Q2
JS06H1204H_Med1_2002Q3Q4_DaveC.mdb: Med1_2002Q3Q4
JS06H1204H_Med1_2003Q1Q2_DaveC.mdb: Med1_2003Q1Q2
JS06H1204H_Med1_2003Q3Q4_DaveC.mdb: Med1_2003Q3Q4
JS06H1204H_Med1_2004Q1Q2Q3Q4_DaveC.mdb: Med1_2004Q1Q2
JS06H1204H_Med1_2004Q1Q2Q3Q4_DaveC.mdb: Med1_2004Q3Q4
JS06H1204H_Med1_2005Q1Q2_DaveC.mdb: Med1_2005Q1Q2
JS06H1204H_Med1_2005Q3Q4_DaveC.mdb: Med1_2005Q3Q4
JS06H1204H_Med1_2006Q1Q2_DaveC.mdb: Med1_2006Q1Q2
JS06H1204H_Med1_2006Q3-Nov_DaveC.mdb: Med1_2006Q3-Nov

2. Please confirm that the above 16 files represent all services, procedures, medical supplies, hospitalizations, medical visits or other claims (with the exception of prescription medication claims) reimbursed by Medicaid for the time period January 1996 through 2007. Alternatively, please supplement.

3. Please explain why the above 16 files omits "Proc" field data for approximately 10% of the line items, or supplement accordingly.

4. Please confirm that the following 5 files reflect prescription medication claims.

JS06H1204_ZypMed1_1996-1999_DaveC.mdb: ZypMed1_1996-1999
JS06H1204_ZypMed1_2000-2003_DaveC.mdb: ZypMed1_2000-2003
JS06H1204_ZypMed1_2004-2006_DaveC.mdb: tblS6H1204CExpanded
JTC07.mdb: TC07
JS6H1204B_Zyprex1_Dave C.mdb: Zyprexa 1

5. Please confirm that the above 5 files represent all prescription claims reimbursed by Medicaid for the time period January 1996 through 2007. Alternatively, please supplement.

6. Please explain why (1) the Diag and Sec_Diag fields in **JTC07.mdb: TC07** and **JS6H1204B_Zyprex1_Dave C.mdb: Zyprexa 1** are completely missing and (2) why a significant number of line items in the **JS06H1204_ZypMed1_1996-1999_DaveC.mdb: ZypMed1_1996-1999**, **JS06H1204_ZypMed1_2000-2003_DaveC.mdb**: **ZypMed1_2000-2003**, and **JS06H1204_ZypMed1_2004-2006_DaveC.mdb: tblS6H1204CExpanded** files are missing data in the Diag and Sec_Diag fields. Alternatively, please supplement.

7. The NDC columns in the **JS06H1204_ZypMed1_1996-1999_DaveC.mdb: ZypMed1_1996-1999**, **JS06H1204_ZypMed1_2000-2003_DaveC.mdb**: **ZypMed1_2000-2003**, and **JS06H1204_ZypMed1_2004-2006_DaveC.mdb: tblS6H1204CExpanded** files do not appear to contain National Drug Code numbers, but rather some unidentifiable alpha-numeric combination. Please explain or supplement.

8. Do the claims set forth in **JS06H1204_ZypMed1_1996-1999_DaveC.mdb: ZypMed1_1996-1999**, **JS06H1204_ZypMed1_2000-2003_DaveC.mdb**: **ZypMed1_2000-2003**, and **JS06H1204_ZypMed1_2004-2006_DaveC.mdb: tblS6H1204CExpanded** reflect all Medicaid-paid prescriptions claims from 1996 through 2006? If so, what do the remaining two prescription files reflect? Please explain the criteria for selecting which medications and which time periods are reflected in each of the 5 prescription claim files.

9. Please explain the difference between the Recip and Orig_Recip fields in all twenty-one files.

I also direct your attention to the following outstanding items set forth in my letter to you of August 10, 2007.

1. Advise how the files produced on August 10, 2007 correlate to the files previously produced on June 8, 2007.

2. Explain what the ICN field refers to.

3. We need to know what your experts received and when. During our conversation on August 9, you promised that you would tell us when your experts received the database files with individual recipient information. Please immediately provide us with copies of all database files that you have furnished to your experts and advise of the date when those files were provided to them.

4. Confirm that you have provided us with all of the provider / billing manuals for pharmacy and for medical procedures for all periods, or please supplement.

5. Provide us with a Verification of Alaska's Interrogatory Answers.

6. Identify all database fields available for medical procedure and prescription claims, including, but not limited to, gender and race.

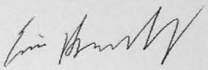
7. Advise whether claims data prior to 1996 exists. If it does not, please explain why it does not exist.

8. Advise whether, aside from the preferred drug list, any other listing of medications available to Medicaid recipients, including a written formulary, exists for any time period from 1991 – present.

We need answers to these questions immediately, so that we can ensure that our experts are working with a complete set of Medicaid claims data. The fact that the State's experts were provided with a more complete data set than the State provided to Lilly has already prejudiced Lilly's defense of the case. It is also essential that the State produce the 30(b)(6) witness(es) on the database and other issues, so that Lilly can discover the reason for the database deficiencies described above. I was advised yesterday by Christiaan Marcum that the earliest that State can produce its witness(es) is the week of September 17. Given the problems with the data produced to date, this delay of a deposition noticed for August 30, is unacceptable,

and further prejudices Lilly's ability to analyze the Medicaid claims data.

Very truly yours,



Eric Rothschild

ER/am
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August 30, 2007

VIA EMAIL AND FIRST CLASS MAIL
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Richardson Patrick Westbrook & Brickman, LLC
1037 Chuck Dawley Boulevard
Building A
Mt. Pleasant, SC 29464

Re: State of Alaska v. Eli Lilly and Company
Case No: 3AN-06-5630CIV

Dear Christiaan:

I am responding to your letters dated August 16, 2007 and August 27, 2007, regarding issues with the State's production of its Medicaid database. As you have acknowledged, the letter dated August 16, 2007 was not received by Pepper Hamilton until August 24, 2007 because of an email transmittal error by your office.

After representing to the Court that the State had produced its entire Medicaid database to Lilly, and acknowledging that Lilly is entitled to all such data, your letters confirm that the State's production continues to be incomplete, and that the State is delaying the production of a complete claims database to Lilly for as long as possible.

First, your August 27 letter represents that the only prescription drug reimbursement claims data produced are for antipsychotic medications, including Zyprexa. *See* Paragraphs 4, 5 and 8 of your August 27, 2007 letter. From our review of the file, JTC07.mdb, it appears that there are some mental health medications other than anti-psychotics. (*i.e.*, Xanax, Valium). Please explain the criteria used to select claims for this file. In addition, please explain why the State removed claims from the database for other medications, including non-mental health medications, before producing the database to Lilly, and supplement your production with all prescription claims data.

Second, after promising during our on-the-record meet and confer on August 2, 2007 (*see* attachment), and in subsequent representations by Mr. Steele and Mr. Garretson, that the State would disclose *all* data fields maintained by the State in its Medicaid claims database, you appear to be reneging on that promise in your August 16 letter. In your

August 27 letter you advise that you will produce gender data, but do not mention other fields. This is inconsistent with our discovery requests, and your promises. We have been, and continue to be, asking for *all* fields maintained by the State in its Medicaid database. We understand that some of the data fields maintained by the State may be found in enrollment or eligibility files. To the extent that is correct, those files are part of the Medicaid claims database that Lilly has requested, and we demand their production. Such production should include the reimbursement number used for each unique Medicaid recipient in the claims data, until such time as the Court rules on Lilly's entitlement to other patient identification information. Additionally, please provide us with exemplars of the forms (both current and historical) that are or were used to apply for Medicaid in Alaska, and for submitting claims for payment, including but not limited to claims for medication, services, procedures, medical supply, hospitalization, and medical visits.

Third, you have represented in Paragraph 3 of your August 27, 2007 letter that the claims submitted by hospitals do not have procedure codes, but rather revenue codes. However, you have not provided us with a field for those revenue codes, which must be produced. In addition, please advise what other fields for hospital claims are being withheld, including, but not limited to any fields describing the services provided, and produce them immediately.

Fourth, you have previously advised that the State did not maintain any data prior to 1996. Your August 27 letter reveals that, in fact, data from 1989-1996 does exist; however, you now represent that the data prior to 1996 is "corrupted, invalid and otherwise useless." Lilly would like to test that proposition itself. Please immediately produce all Medicaid data for the 1989-96 time period. This production should include all data fields maintained in the database, including fields maintained in enrollment or eligibility data.

Fifth, you have advised that the following files "reflect medical procedures associated with the use of Zyprexa":

JS06H1204_ZypMed1_1996-1999_DaveC.mdb:ZypMed1_1996-1999;

JS06H1204_ZypMed1_2000-2003_DaveC.mdb:ZypMed1_2000-2003;

JS06H1204_ZypMed1_2004-2006_DaveC.mdb:tb1S6H1204CExpanded.

August 27, 2007 Letter ¶7. Please advise what you mean by the phrase: "medical procedures associated with the use of Zyprexa," including what criteria were used to select claims to be included in these files. Please also advise whether these claims overlap claims included in other files produced by the State. Your letter also does not provide an adequate explanation for why

many of these files are missing "Procedure" or "HCPCS" codes (in the column mislabeled "NDC"), and diagnosis codes. The explanation offered by the State, that these files "were filtered to reflect anti-psychotic and Zyprexa use," August 27 letter ¶6, makes no sense, and does not explain the gaps in data.

Finally, in order to identify who the providers were for each claims entry, we need complete provider identification lists. The documents that the State has produced appear to be from 1995 (ZYP-AK-01616 – 1675) and 1999 (ZYP-AK-00739 – 834), and apply to prescribers only. We need provider identification numbers for all time periods and for all providers that submitted claims, including doctors, hospitals, laboratories, and pharmacists.

Several documents in the production (*e.g.*, ZYP-AK-00370, ZYP-AK-01023) reference an electronic Provider Identification List that the Division of Health Care Services makes available to providers on diskette. Please provide us with the most recent electronic Provider Identification List, as well as all previous iterations of this electronic file. Please provide these files in ASCII format.

As we have advised, we will be bringing these issues to the attention of the Discovery Master through supplemental briefing. In the interim, however, we expect the State will work to cure the deficiencies in its production.

Very truly yours,

Eric Rothschild

ER/awk
cc: Eric T. Sanders, Esquire
David Suggs, Esquire
H. Blair Hahn, Esquire
Brewster H. Jamieson, Esquire

EXHIBIT P
PAGE 3 OF 5

JOSEPH STEELE
(Firm and address unknown)

MR. SUGGS: As Eric indicated in the letter or email, the main purpose of this was to talk about your July 25 letter about our discovery responses, and there we have four numbered items to go through.

The first one was the supplementation of the states claims data.

MR. ROTHSCHILD: Yeah. Do you mind if I start with that?

MR. SUGGS: Oh, sure.

MR. ROTHSCHILD: I think probably the easiest way to proceed is for you to tell us what you gave us; meaning, how did you select which claims you would produce and which fields for those claims.

MR. SUGGS: Okay. Joe is going to cover that.

MR. STEELE: We didn't. We gave you the database, so everything should be on there. In other words, we didn't --

MR. ROTHSCHILD: Okay. You gave us -- I'm sorry.

MR. STEELE: We didn't take anybody out of the -- as far as I know, all of the data is on there.

MR. ROTHSCHILD: So clearly, every --

MR. STEELE: Yeah.

MR. ROTHSCHILD: We're interrupting each other, guys.

MR. STEELE: Sorry. Everything. In other words, we haven't selected anything. All we did was deidentify the database so it wouldn't be -- you couldn't trace it back to any particular people. But, otherwise, my understanding is you have all of the data.

MR. ROTHSCHILD: Okay. So, in other words, if there is someone who was treated in Medicaid for a heart attack or cancer, doesn't have any antipsychotics, they're in there

EXHIBIT P
PAGE 4 OF 5

just as much as someone who took antipsychotics?

MR. STEELE: Sure. It wouldn't make any sense, otherwise. You can select and cut and do whatever you want with it. We're trying to make it similar to the way that this is usually studied, where, as you guys know, you have done some looks at Medicaid data, so we haven't selected for you.

MR. ROTHSCHILD: Okay.

It appears to us that we don't have all the fields that might be available. You might tell me I'm wrong, but things like --

MR. STEELE: Not entirely wrong. We have looked into it since then. But go ahead and give

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me the ones that you think you don't have.

MR. ROTHSCHILD: And this is not an exclusive list, but certainly, for example, things like age and gender are not on there.

MR. STEELE: We can give you gender. We've asked for that. We expect to have it soon. I can check on age.

MR. ROTHSCHILD: Race.

MR. STEELE: I don't think we're ever going to have race data. I can give you this information.

In Alaska, the Native Health takes care of the native population, so our belief is that there is no native population in the Medicaid database. With respect to non-white races, it would be about three percent Asian and three percent black, something

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like that, but no specific race data is available, I'm led to believe.

MR. ROTHSCHILD: Can you just give us a list of all available fields so we know what we're getting and not getting?

MR. STEELE: Yes.

MR. ROTHSCHILD: Okay.

MR. STEELE: So we're going to give you the age data and list of all available fields.

Now, my understanding, too, is that you do not have the pharma data, meaning prescriptions that went with the visits.

EXHIBIT P
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Ad Hoc Fields, Description from DED

Provided to Counsel 9-07-07

Field	Description	Claim Type	
H-ICN	History Internal Claim Control		
H-JULIAN	History Julian Date		
H-INVOICE-TYPE	History Invoice Type		
H-CLAIM-CDE	History Claim Code		
H-CLAIM-TYP	History Claim Type		
H-CLAIM-TYP-MOD	History Claim Type Modifier		
H-PROV-NO	History Provider Number		
H-PROV-NO2	History Provider Number 2		
H-PROV-NO6	History Provider Number 6		
H-PROV-NO6-7	History Provider Number 6-7		
H-SVC-PROV-NO	History Servicing Provider Number		
H-SVC-PROV-NO3	History Servicing Provider Number 3		
H-SVC-PROV-NO1	History Servicing Provider Number 1		
H-SVC-PROV-NO6	History Servicing Provider Number 6		
H-RECIP-NO	History Recipient Number		
H-NDC-PROCEDURE	History National Drug Code (NDC)-Procedure Code	Pharmacy Claim	
H-NDC-1-8	History NDC positions 1-8	Pharmacy Claim	
H-NDC-LABELER-CODE	History NDC Labeler Code	Pharmacy Claim	
H-NDC	History NDC	Pharmacy Claim	
H-PROCEDURE	History Procedure		
H-PROC-CODE	History Procedure Code		
H-PROC-3	History Procedure Code 3		
H-PROC	History Procedure		
H-PROC-6	History Procedure Code 6		
H-PROC-MOD	History Procedure Modifier		
H-PROC-MODIFIER	History Procedure Modifier		
H-HCPC-MODIFIER	History Health Care Procedure Code (HCPC) Modifier		

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Deposition

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H-TREAT-PLACE	History Treatment Place		
H-ADMIT-HOUR	History Admit - hour		
H-MOTHA-BABY-IND	History Mother-Baby Indicator		
H-TOS	History Type of Service		
H-UNITS-VISITS-QUANT	History Units, Visits, Quantity		
H-UNITS-NODECIMAL	History Units no decimal		
H-FROM-DATE	History From Date		
H-THRU-DATE	History Through Date		
H-BILLING-DATE	History Billing Date		
H-DATE-ENTERED	History Date Entered		
H-STATUS-DATE	History Status Date		
H-PAYMENT-DATE	History Payment Date		
H-BILLED-CHARGES	History Billed Charges		
H-TOT-DOC-CHARGE	History Total Document Charge		
H-LINE-TPL-AMT	History Line Third Party Liability Amount		
H-TOT-TPL-AMT	History Total Third Party Liability Amount		
H-CO-PAY-AMT	History co-pay amount		
H-ALLOWED-AMT	History Allowed Amount		
H-PAYMENT	History Payment		
H-PA-NUMBER	History Prior-authorization number		
H-ACCID-IND	History Accident Indicator		
H-STICKER-IND	History Sticker Indicator		
H-ATTACHMENT-IND1	History Attachment Indicator 1		
H-ATTACHMENT-IND2	History Attachment Indicator 2		
H-ATTACHMENT-IND3	History Attachment Indicator 3		
H-ATTACHMENT-IND4	History Attachment Indicator 4		
H-ATTACHMENT-IND5	History Attachment Indicator 5		
H-EMPLOY-IND	History Employment Indicator		

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H-EPSDT-IND	History Early Periodic Screening Diagnosis and Treatment (EPSDT)		
H-FAM-PLAN-IND	History Family Planning Indicator		
H-LOCKIN-IND	History Recipient Lockin Indicator		
H-PRIOR-AUTH-IND	History Prior-authorization Indicator		
H-PROV-REV-IND	History Provider On Review Indicator		
H-RECIP-REV-IND	History Recipient on Review Indicator		
H-TPL-IND	History Third Party Liability Indicator		
H-ATTACH-ICN	History ICN of the claim that contains the attachment		
H-MED-REC-NO	History Claim Patient Account Number		
H-DIAG	History Claim Diagnosis		
H-SEC-DIAG	History Claim Secondary Diagnosis		
H-ADJ-REASON	HistoryClaim Adjustment Reason		
H-COLLOCATION	History Collocation - Code for accounting expenditure		
H-CC-COMPONENT	History Collocation Component		
H-COLLOCATE-CODE	History Collocate Code		
H-FORMER-ICN	History Fomer ICN		
H-FORMER-PAYMENT-DATE	History Former Payment Date		
H-FORMER-REMIT-ID	History Former Remit ID		
H-FORMER-CHECK-NUM	History Former Check Number		
H-OPER-CDE	History Operator Code (Claim Clerk Code)		
H-RECIP-CNTL	History Recipient Control		
H-ELIG-PROGRAM-CODE	History Eligibility Program Code		
H-ELIG-CODE	History Eligibility Code		
H-ELIG-SUBTYPE	History Eligibility Subtype		
H-ELIG-CASH-GRANT	History Recipient Eligibility for cash grant		
H-PROV-TYPE	History Provider Type		
H-PROV-SPEC	History Provider Specialty		
H-MAX-TIME	Can't find may relate to length of stay		

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Ad Hoc Fields, Description from DED

Provided to Counsel 9-07-07

H-DRG-CODE	History Diagnosis Related Group (DRG) Code		
H-MDC-CODE	Can't find		
H-REMIT-ID	History Remittance ID		
H-CHECK-NUM	History Check Number		
H-COS	History category of service		
H-STATUS	History Claim Status		
H-LINE-NOS	History Claim Line Numbers		
H-SIG-IND	History Claim Signature Indicator		
H-UB82-BILL-TYPE	History Claim UB 82 Bill Type		
H-BT-FACILITY	History Claim Bill Type Facility		
H-BT-BILL-CLASS	History Claim Hospital Bill Classification	Hospital Claim	
H-BT-FREQUENCY	History Claim Hospital Billing Frequency	Hospital Claim	
*			
H-ERRORS	History Claim Current Errors		
H-EACH-ERROR H-E	History Claim Current Errors		
H-EACH-ERROR-FLAG H-E	History Claim Error Flag		
*			
H-EACH-ERROR1	History Current Errors Counter - Occurs ten times		
H-EACH-ERROR-FLAG1	History Current Errors Flag 1		
H-EACH-ERROR2	History Current Errors Counter 2		
H-EACH-ERROR-FLAG2	History Current Errors Flag 2		
H-EACH-ERROR3	History Current Errors Counter 3		
H-EACH-ERROR-FLAG3	History Current Errors Flag 3		
H-EACH-ERROR4	History Current Errors Counter 4		
H-EACH-ERROR-FLAG4	History Current Errors Flag 4		
H-EACH-ERROR5	History Current Errors Counter 5		
H-EACH-ERROR-FLAG5	History Current Errors Flag 5		

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H-EACH-ERROR6	History Current Errors Counter 6		
H-EACH-ERROR-FLAG6	History Current Errors Flag 6		
H-EACH-ERROR7	History Current Errors Counter 7		
H-EACH-ERROR-FLAG7	History Current Errors Flag 7		
H-EACH-ERROR8	History Current Errors Counter 8		
H-EACH-ERROR-FLAG8	History Current Errors Flag 8		
H-EACH-ERROR9	History Current Errors Counter 9		
H-EACH-ERROR-FLAG9	History Current Errors Flag 9		
H-EACH-ERROR10	History Current Errors Counter 10		
H-EACH-ERROR-FLAG10	History Current Errors Flag 10		
.			
H-HIST-ERR	History Claim History Errors		
H-EACH-HIST-ERR	History Claim Each History Error		
H-EACH-HIST-ERR-FLAG	History Claim Each History Error Flag		
.			
H-EACH-HIST-ERR1	History Claim History Error 1		
H-EACH-HIST-ERR-FLAG1	History Claim History Error Flag 1		
H-EACH-HIST-ERR2	History Claim History Errors 2		
H-EACH-HIST-ERR-FLAG2	History Claim History Error Flag 2		
H-EACH-HIST-ERR3	History Claim History Error 3		
H-EACH-HIST-ERR-FLAG3	History Claim History Error Flag 3		
H-EACH-HIST-ERR4	History Claim History Error 4		
H-EACH-HIST-ERR-FLAG4	History Claim History Error Flag 4		
H-EACH-HIST-ERR5	History Claim History Error 5		
H-EACH-HIST-ERR-FLAG5	History Claim History Error Flag 5		
H-EACH-HIST-ERR6	History Claim History Error 6		
H-EACH-HIST-ERR-FLAG6	History Claim History Error Flag 6		
H-EACH-HIST-ERR7	History Claim History Error 7		

H-EACH-HIST-ERR-FLAG7	History Claim History Error Flag 7		
H-EACH-HIST-ERR8	History Claim History Error 8		
H-EACH-HIST-ERR-FLAG8	History Claim History Error Flag 8		
H-EACH-HIST-ERR9	History Claim History Error 9		
H-EACH-HIST-ERR-FLAG9	History Claim History Error Flag 9		
H-EACH-HIST-ERR10	History Claim History Error 10		
H-EACH-HIST-ERR-FLAG10	History Claim History Error Flag 10		
H-EACH-OVER-EOB1	History Claim Override/EOB (Explanation of Benefits) Indicator1		
H-EACH-OVER-EOB-FLAG1	History Claim Override/EOB Indicator Flag1		
H-EACH-OVER-EOB2	History Claim Override/EOB (Explanation of Benefits) Indicator2		
H-EACH-OVER-EOB-FLAG2	History Claims Override/EOB Flag2		
H-EACH-OVER-EOB3	History Claim Override/EOB (Explanation of Benefits) Indicator3		
H-EACH-OVER-EOB-FLAG3	History Claims Override/EOB Flag3		
H-EACH-OVER-EOB4	History Claim Override/EOB (Explanation of Benefits) Indicator4		
H-EACH-OVER-EOB-FLAG4	History Claims Override/EOB Flag4		
H-EACH-OVER-EOB5	History Claim Override/EOB (Explanation of Benefits) Indicator5		
H-EACH-OVER-EOB-FLAG5	History Claims Override/EOB Flag5		
H-EACH-OVER-EOB6	History Claim Override/EOB (Explanation of Benefits) Indicator6		
H-EACH-OVER-EOB-FLAG6	History Claims Override/EOB Flag6		
H-EACH-OVER-EOB7	History Claim Override/EOB (Explanation of Benefits) Indicator7		
H-EACH-OVER-EOB-FLAG7	History Claims Override/EOB Flag7		
H-EACH-OVER-EOB8	History Claim Override/EOB (Explanation of Benefits) Indicator8		
H-EACH-OVER-EOB-FLAG8	History Claims Override/EOB Flag8		
H-EACH-OVER-EOB9	History Claim Override/EOB (Explanation of Benefits) Indicator9		
H-EACH-OVER-EOB-FLAG9	History Claims Override/EOB Flag9		
H-EACH-OVER-EOB10	History Claim Override/EOB (Explanation of Benefits) Indicator10		
H-EACH-OVER-EOB-FLAG10	History Claims Override/EOB Flag10		
H-CUTBACK-DAYS-UNITS	History Claims Cutback Days Units		

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H-CUTBACK-AMT	History Claims Cutback Amount		
H-RESUBMITTAL-NUM1	History Resubmittal Number 1		
H-RESUBMITTAL-NUM2	History Resubmittal Number 2		
H-RESUBMITTAL-NUM3	History Resubmittal Number 3		
H-TPL-STATUS	History Third Party Liability Status		
H-PRICING-LEVEL	History Pricing Level		
H-PRICING-PCT	History Pricing Percent		
H-LOCKIN-PROVIDER	History Lockin Provider		
H-OLDEST-DOC-DATE	History Claim Oldest Document Date		
H-LATEST-DOC-DATE	History Claim Latest Document Date		
H-EMG-LTC-IND	History Emergency Long Term Care Indicator		
H-SPEC-PROG-IND	History Claim Claim Special Program Indicator		
H-NPI	History National Provider Identifier - Not completely implemented		
H-SURG-IND	History Claim Surgery Indicator		
H-FFP-TYPE	History Claim Federal Financial Participation Type		
*			
H-TT-DEDUCTIBLE	History Claim Title XVIII Cash Deductible Amount		
H-TT-COINSURANCE	History Claim Title XVIII Coinsurance		
H-TT-MEDICARE-BILLED	History Claim Title XVIII Charge Billed Medicare		
H-TT-MEDICAID-BILLED	History Claim Title XVIII Charge Billed Medicaid		
H-TT-MEDICARE-PAID-AMT	History Claim Title XVIII Medicare Paid Amount		
H-TT-MCARE-PAY-DATE	History Claim Title XVIII Medicare Paid Date		
H-TT-BLOOD-DED	History Claim Title XVIII Blood Deductible Amount		
H-TT-ASSIGNMENT-IND	History Claim Title XVIII Assignment Indicator		
H-TT-INST-TYPE	History Claim Title XVIII Institutional Type		
H-TT-ATTEND-PHYS	History Claim Title XVIII Attending Physician		
H-TT-ADMIT-PHYS	History Claim Title XVIII Admitting Physician		
H-TT-PAT-STATUS	History Claim Title XVIII Patient Status		

H-TT-DSCHG-DATE	History Claim Title XVIII Discharge Date		
H-TT-TIME-OF-DEATH	History Claim Title XVIII Time of Death		
H-TT-ADMIT-DATE	History Claim Title XVIII Admit Date		
H-TT-ADMIT-SOURCE	History Claim Title XVIII Admit Source		
H-TT-ADMIT-HOUR	History Claim Title XVIII Admit Hour		
H-TT-NATURE-ADMISN	History Claim Hospital Title XVIII Nature of Admission		
H-TT-COV-DAYS	History Claim Title XVIII Coinsurance Days		
H-TT-NON-COV-DAYS	History Claim Title XVIII Non Covered Days		
*			
H-TT-OCCURRENCE-DATA	History Claim Title XVIII Occurrence Data		
H-TT-OCC-CODE	History Claim Title XVIII Occurrence Code		
H-TT-OCC-DATE	History Claim Title XVIII Occurrence Date		
*			
H-TT-OCC-SPAN-CODE	History Claim Title XVIII Hospital Occurrence Span Code	Hospital Claims	
H-TT-OCC-SPAN-FROM	History Claim Title XVIII Hospital Occurrence Span From	Hospital Claims	
H-TT-OCC-SPAN-THRU	History Claim Title XVIII Hospital Occurrence Span Thru	Hospital Claims	
H-TT-COND-CODE1	History Claim Title XVIII Condition Code 1	Hospital Claims	
H-TT-COND-CODE2	History Claim Title XVIII Condition Code 2	Hospital Claims	
H-TT-COND-CODE3	History Claim Title XVIII Condition Code 3	Hospital Claims	
H-TT-COND-CODE4	History Claim Title XVIII Condition Code 4	Hospital Claims	
H-TT-COND-CODE5	History Claim Title XVIII Condition Code 5	Hospital Claims	
*			
H-TT-VALUE-CODES	History Claim Title XVIII Hospital/LTC Value Codes	Hospital Claims	
H-TT-VAL-CODE	History Claim Title XVIII Hospital/LTC Value Code	Hospital Claims	
H-TT-VAL-AMT	History Claim Title XVIII Hospital/LTC Value Amount	Hospital Claims	
*			
H-TT-BLOOD-FURNISHED	History Claim Title XVIII Hospital/Pints of Blood Furnished	Hospital Claims	
H-TT-BLOOD-REPLACED	History Claim Title XVIII Hospital/Pints of Blood Replaced	Hospital Claims	

H-TT-BLOOD-NOT-REPL	History Claim Title XVIII Hospital/Pints of Blood Not Replaced	Hospital Claims	
*			
H-TT-REVENUE-CODE-DATA	History Claim Title XVIII Hospital Revenue Code Data	Hospital Claims	
H-TT-PROC-CODE	History Claim Title XVIII Hospital Procedure Code	Hospital Claims	
H-TT-REV-CODE	History Claim Title XVIII Hospital Revenue Code	Hospital Claims	
H-TT-FILLER	History Claim Title XVIII Hospital Filler	Hospital Claims	
H-TT-PROC-MODIFIER	History Claim Title XVIII Hospital Procedure Modifier	Hospital Claims	
H-TT-REV-UNITS	History Claim Title XVIII Hospital Revenue Units	Hospital Claims	
H-TT-REV-AMT	History Claim Title XVIII Hospital Revenue Amount	Hospital Claims	
H-TT-REV-NON-COVD-AMT	History Claim Title XVIII Hospital Revenue Non Covered Amount	Hospital Claims	
H-TT-PROC-ALWD-AMT	History Claim Title XVIII Hospital Procedure Allowed Amount	Hospital Claims	
*			
H-TT-SURG-PROC1	History Claim Title XVIII Hospital Surgery Procedure 1	Hospital Claims	
H-TT-SURG-DATE1	History Claim Title XVIII Hospital Surgery Date 1	Hospital Claims	
H-TT-SURG-PROC2	History Claim Title XVIII Hospital Surgery Procedure 2	Hospital Claims	
H-TT-SURG-DATE2	History Claim Title XVIII Hospital Surgery Date 2	Hospital Claims	
H-TT-LTC-PATIENT-LIABI	History Claim Title XVIII Long Term Care Patient Liability	Hospital Claims	
H-TT-SPEC-PROG-IND	History Claim Title XVIII Hospital Special Program Indicator	Hospital Claims	
*			
H-HO-ATTEN-PHYS	History Claim Hospital Attending Physician	Hospital Claims	
H-HO-ADMIT-PHYS	History Claim Hospital Admitting Physician	Hospital Claims	
H-HO-PAT-STAT	History Claim Hospital Claim Hospital/LTC/Home Health/X-	Hospital Claims	
H-HO-DSCHG-DATE	History Claim Hospital Claim Discharge Date	Hospital Claims	
H-HO-TIME-OF-DEATH	History Claim Hospital Time of Death	Hospital Claims	
H-HO-ADMIT-DATE	History Claim Hospital Admission Date	Hospital Claims	
H-HO-ADMIT-SOURCE	History Claim Hospital Admission Source	Hospital Claims	
H-HO-ADMIT-NATURE	History Claim Hospital Admission Nature	Hospital Claims	
H-HO-COV-DAYS-9	History Claim Hospital/LTC Covered Days	Hospital Claims	

H-HO-NON-COV-DAYS	History Claim Hospital Non Medicaid Covered Days	Hospital Claims	
*			
H-HO-OCCURRENCE-DATA	Claim Hospital Occurrence Data	Hospital Claims	
H-HO-OCC-CODE	History Claim Hospital Occurrence Code	Hospital Claims	
H-HO-OCC-DATE	History Claim Hospital Occurrence Date	Hospital Claims	
*			
H-HO-OCC-SPAN-CODE	History Claim Hospital Occurrence Span Code	Hospital Claims	
H-HO-OCC-SPAN-FROM	History Claim Hospital Occurrence Span From Date	Hospital Claims	
H-HO-OCC-SPAN-THRU	History Claim Hospital Occurrence Span From Through	Hospital Claims	
H-HO-COND-CODE1	History Claim Hospital Claim Hospital/LTC Condition Code - For	Hospital Claims	
H-HO-COND-CODE2	History Claim Hospital Claim Hospital/LTC Condition Code - For	Hospital Claims	
H-HO-COND-CODE3	History Claim Hospital Claim Hospital/LTC Condition Code - For	Hospital Claims	
H-HO-COND-CODE4	History Claim Hospital Claim Hospital/LTC Condition Code - For	Hospital Claims	
H-HO-COND-CODE5	History Claim Hospital Claim Hospital/LTC Condition Code - For	Hospital Claims	
*			
H-HO-VALUE-CODES	History Claim Hospital Claim Hospital/LTC Value Code, for TPL	Hospital Claims	
H-HO-VAL-CODE H-H	History Claim Hospital/LTC Value Code	Hospital Claims	
H-HO-VAL-AMT H-H	History Claim Hospital/LTC Value Amount	Hospital Claims	
*			
H-HO-BLOOD-FURN	History Claim Hospital/Pints of Blood Furnished	Hospital Claims	
H-HO-BLOOD-REPL	History Claim Hospital/Pints of Blood Replaced	Hospital Claims	
H-HO-BLOOD-NOT-REPL	History Claim Hospital/Pints of Blood Not Replaced	Hospital Claims	
*			
H-HO-REV-DATA	History Claim Hospital Revenue Data	Hospital Claims	
H-HO-PROC-CODE	History Claim Hospital Procedure Code	Hospital Claims	
H-HO-REV-CODE	History Claim Hospital/LTC Revenue Code	Hospital Claims	

H-HO-REV-CODE2	History Claim Hospital/LTC Revenue Code 2	Hospital Claims	
H-HO-FILLER	History Claim Hospital/LTC Filler	Hospital Claims	
H-HO-REV-UNITS-9	History Claim Hospital/LTC Revenue Code 9	Hospital Claims	
		Hospital Claims	
H-HO-REV-AMT	History Claim Claim Hospital/LTC Revenue Code Amount	Hospital Claims	
H-HO-REV-NON-COVD-AMT	History Claim Hospital/LTC Revenue Code Amount - non covered amount	Hospital Claims	
H-HO-PROC-ALWD-AMT	History Claim Hospital/LTC Procedure Code Allowed amount	Hospital Claims	
H-HO-FILLER2	History claim Hospital/LTC filler 2	Hospital Claims	
*			
H-HO-SURG-PROC1	History Claim Hospital Surgery Procedure	Hospital Claims	
H-HO-SURG-DATE1	History Hospital Surgery Procedure date 1	Hospital Claims	
H-HO-SURG-PROC2	History Hospital Surgery Procedure two	Hospital Claims	
H-HO-SURG-DATE2	History Hospital Surgery Procedure date 2	Hospital Claims	
H-HO-LTC-PATIENT-LIABI	History Claim LTC Patient Liability	Hospital Claims	
H-HO-LTC-LOC	History Hospital Long Term Care Location	Hospital Claims	
H-HO-PER-DIEM	History Hospital Per Diem	Hospital Claims	
H-HO-LTC-HOME-LEAVE-DA	History Hospital Claim LTC Therapeutic Leave Days	Hospital Claims	
H-HO-LTC-PAE-DATE	History Hospital Claim LTC Pay Date	Hospital Claims	
*			
H-TT-PR-DEDUCTIBLE	History Claim Title XVIII Cash Deductible Amount		
H-TT-PR-COINSURANCE	History Claim Title XVIII Coinsurance Charge		
H-TT-PR-MEDICARE-BILLE	History Claim Title XVIII Amount Billed to Medicare		
H-TT-PR-MEDICAID-BILLE	History Claim Title XVIII Charge Billed to Medicaid		
H-TT-PR-MEDICARE-PAID-	History Claim Title XVIII Medicare Paid Amount		
H-TT-PR-MCARE-PAY-DATE	History Claim Medicare Payment Date		

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H-PH-DRUG-PRICE	History Pharmacy Drug Price	Pharmacy Claims Only	
H-PH-DAYS-SUPPLY	History Pharmacy Days Supply	Pharmacy Claims Only	
H-PH-COMPOUND-CODE	History Pharmacy Compound Code	Pharmacy Claims Only	
*			
H-EPSDT-SVC-CODE	History EPSDT Service Code	EPSDT Claims	

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August 16, 2007

VIA FIRST CLASS MAIL AND EMAIL
Eric Rothschild, Esq.
Pepper Hamilton
3000 Two Logan Square
Eighteenth and Arch Street
Philadelphia, PA 19103-2799

Re: State of Alaska v. Eli Lilly and Company
Case No: 3AN-06-5630CIV

Dear Eric:

I am in receipt of your letter to Matt Garretson dated August 10, 2007. I write to respond to this letter and to request that any further communication regarding discovery issues in this case be directed to me. As to the issues outlined in your letter, please see the responses below.

1. You have confirmed that you received a disc containing the new data base files referenced in your letter, but have asked how each of the new files correlates to the old files and what the ICN field refers to. The ICN field (Internal Control Number) contains a non-identifying value for each transaction (a primary key). The new files correlate as shown below:

1.mdb JS06H1204_Med1_1996_DaveC.mdb
2.mdb JS06H1204_Med1_1997_DaveC.mdb
3.mdb JS06H1204_Med1_1998_DaveC.mdb
4.mdb JS06H1204_Med1_1999_DaveC.mdb
5.mdb JS06H1204_Med1_2000_Davec.mdb
6.mdb JS06H1204_Med1_2001_DaveC.mdb
7.mdb JS06H1204_Med1_2002Q1Q2_DaveC.mdb
8.mdb JS06H1204_Med1_2003Q3Q4_DaveC.mdb
* JS06H1204_Med1_2002Q3Q4_DaveC.mdb
* JS06H1204_Med1_2003Q1Q2_DaveC.mdb
* JS06H1204H_Med1_2004Q1Q2Q3Q4_DaveC.mdb
9.mdb JS06H1204_Med1_2005Q1Q2_DaveC.mdb
10.mdb JS06H1204_Med1_2005Q3Q4_DaveC.mdb
11.mdb JS06H1204_Med1_2006Q1Q2_DaveC.mdb
12.mdb JS06H1204_Med1_2006Q3-Nov_DaveC.mdb
13..mdb JTCO7.mdb
14.mdb JS06H1204_Zypmed1_1996-1999_DaveC-mdb
15.mdb JS06H1204_Zypmed1_2000-2003_DaveC.mbd
16.mbd JS06H1204_ZypMed1_20004-2006_DaveC.mdb

17.mdb JS06H1204B_Zyprex1_DaveC.mdb

We initially provided the de-identified data to you in our supplemental discovery responses in June. It was not until our phone conference on August 2nd that you indicated you wanted to be able to identify discreet individuals. You now have that information.

2.-3. You have requested that we answer a number of questions concerning our expert Dr.Tolley's knowledge of this data base. We suggest these questions are better posed to Dr. Tolley.

4. I understand you have now been provided with an explanation of the procedure by which the individual patient data was de-identified.

5. Documents responsive to your discovery requests for provider/billing manuals for pharmacy and medical procedures have previously been provided to you in the State's responses to your requests for production and supplemental responses to the same. See specifically bates ranges ZYP-AK-0167 through 0892 and ZYP-AK-0985 through 1910.

6. We will provide you with a verification of the State's interrogatory answers.

7. As to the issues you have listed that will be resolved by Dave Campana upon his return, I note that you have now issued a 30(b)(6) deposition notice to the State on a number of issues which appear to overlap these. These issues can be covered during the 30(b)(6) deposition by the deponent or deponents presented by the State.

With regard to your 30(b)(6) deposition notice, we were a bit surprised to receive it, as it is in violation of the court's scheduling order. That order clearly requires, I believe at your insistence, that the parties make every effort to communicate regarding deposition notices and to cooperate on the scheduling of depositions. As far as I know, there was no request from Lilly for dates, nor any discussion regarding the scheduling of this deposition. The date for which the deposition is currently noticed, August 30, 2007, is not suitable to the State and it will not have deponents ready for presentation at that time. Please call me at your earliest convenience so that we may discuss rescheduling of this deposition and scheduling all subsequent depos.

With kindest regards I remain

Sincerely Yours,

Christiaan Marcum, Esquire

CHM/jw

EXHIBIT R
PAGE 2 OF 3

cc via email:

Matthew L. Garretson, Esq.	mgarretson@garretsonfirm.com
Joseph W. Steele, Esq.	jwsteele5@att.net
Eric T. Sanders, Esq.	sanders@frozenlaw.com
David Suggs, Esq.	dsuggs@attglobal.net

EXHIBIT R
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RICHARDSON PATRICK WESTBROOK & BRICKMAN, LLC

Christiaan Marcum
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September 4, 2007

VIA FIRST CLASS MAIL AND EMAIL
Eric Rothschild, Esquire
Pepper Hamilton LLP
3000 Two Logan Square
Eighteenth and Arch Streets
Philadelphia, PA 19103-2799

Re: State of Alaska v. Eli Lilly and Company
Case No.: 3AN-06-5630CIV

Dear Eric:

I am in receipt of your letter dated August 30th. We will no longer engage in a letter writing campaign with you since you insist on repeated and unfounded accusations and misrepresentations. The better course will be formal discovery and motion practice. However, I must clarify a few things below.

First, we agreed to have the August 2nd conference call with you to discuss, among other things, your concerns regarding the data the State produced to you in June. During that call, the State agreed to consider your informal requests for further data and information relevant to that data. Since that time, the State has provided you with supplemental data responsive to your informal requests, and continues to endeavor to do so despite your repeated and insulting letters to the contrary. This in spite of the fact that much of what you are now asking for was not covered in your formal discovery requests, which generally seek information from 1996 to the present, with the exception of medical records which you seek from the birth of any Medicaid recipient to the present.

Second, the State has not represented to the Court or to you that you have the State's *entire* claims database. Both our pleadings and correspondence are clear that we are continuing to provide you further data as requested. The State has represented to you and the Court that it has provided you with the Medicaid claims database that its experts are working with. If this is unclear to the Court, we shall clarify any misunderstanding the Court may have on this. To the extent you have misunderstood previous conversations with any representative of the State to mean that the State would provide you *all* Medicaid data potentially at its disposal, that misunderstanding is of your own making. To the contrary, the State has clearly and consistently maintained that it might have some objection to producing the data you requested. *See* Transcript of August 2, 2007 conference. Notwithstanding this, the State has in fact provided you with everything that has been pulled from the database to date, short of any information identifying individuals. As indicated in previous correspondence, further data responsive to your pending requests will be provided as it is obtained, but with the understanding that the State will review such data and reserves any and all objections to the production of the same. In particular, a list of all available data fields should be available for production to you this week. Beyond that, the State will do no more than it confirmed it would do

on the August 2nd teleconference or its previous correspondence, or as it is required to pursuant to its obligations under the Alaska Rules of Civil Procedure or orders of the Court.

It is clear that your letters are less about data than they are about fabricating a record of alleged delays by the State in discovery, and thus they will no longer get responses unless necessary to correct some factual inaccuracy for the Court. The State will no longer give you the courtesy of responding to your informal requests for information if they are going to be met with such belligerence and distortion. If you feel the State has not responded to a formal discovery request, then file a motion. If you seek information beyond your pending discovery requests, then serve additional ones. Except as indicated above with regard to the data the State has previously agreed to provide, there will be no more responses to your letter requests for information far beyond the scope of your initial discovery requests, which were aimed at data related to Zyprexa prescriptions and Medicaid recipients covered by the State's claims, but have now mushroomed into a demand for the *entire* Medicaid claims database. Your motive is clearly not a search for relevant data, but a never-ending ploy to create further delay of your own making in an effort to postpone the current trial date.

Finally, let me point out the irony of the shrill tone of your letters and clarify the record on another point. Though the record clearly demonstrates the State's continued cooperation in providing you discovery responses to both formal and informal requests, you continue with this "parade of horribles" regarding the State's alleged shirking of its discovery obligations. However, you have yet to provide *a single* document responsive to the State's discovery requests. Not one. I note that David Suggs emailed you on August 28 regarding certain documents you agreed to produce. Please advise when you intend to comply with your discovery obligations.

With kindest regards, I remain,

Sincerely yours,

Christiaan Marcum

cc: Matthew L. Garretson, Esq.
Joseph W. Steele, Esq.
Eric T. Sanders, Esq.
David Suggs, Esq.

EXHIBIT 5
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