

# EXHIBIT A

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IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NORTH CAROLINA  
SOUTHERN DIVISION  
NO. 7:23-CV-897

IN RE: )  
 )  
Camp Lejeune Water Litigation )  
 )  
This Document Relates To: )  
All Cases )

REMOTE VIDEOTAPED DEPOSITION  
OF DANIEL CLARKE  
APPEARING VIA ZOOM  
September 3, 2025  
9:33 a.m.

Reported by: Julie Thomson Riley, RDR, CRR,  
Massachusetts CSR No. 1444S95  
Registered Professional Reporter

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18 Also present (remotely):

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I N D E X

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| by Ms. Wallace | 10   |

E X H I B I T S

|           |   |      |
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| Exhibit 1 | Document titled "VHA Produced Materials," one page.   | 18   |
| Exhibit 2 | Document titled "Plaintiffs' Notice of Deposition of Daniel Clarke," nine pages.  | 21   |
| Exhibit 3 | Document titled "United States' Objections and Responses to Plaintiffs' Notice of Deposition and Request for Production of Documents to Daniel Clarke," nine pages. | 21   |

(continued)

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| Exhibit 4                   | Résumé of Daniel J. Clarke, MSA,<br>six pages.  | 23   |
| Exhibit 6                   | Letter from Janine Genovese, dated<br>March 18, 2025, Bates Stamp Nos.<br>CLJA_VHA_0000000002 through<br>CLJA_VHA_0000000005. | 48   |
| Exhibit 11                  | Document titled "Managerial Cost<br>Accounting (MCA) Data Definitions,"<br>Bates Stamp No. CLJA_ VHA_0000000008.              | 109  |
| Exhibit 27                  | Email string, three pages.  | 117  |
| Exhibit 25                  | Document titled "Managerial Cost<br>Accounting (MCA)," one page.  | 120  |
| Exhibit 5                   | Excel spreadsheet, Bates Stamp No.<br>CLJA_VHA_0000000001.  | 124  |
| Exhibit 8                   | Excel spreadsheet Bates Stamp No.<br>CLJA_VHA_0000000006.   | 137  |
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| Exhibit 9 | Excel spreadsheet, Bates Stamp No. |      |
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MORNING SESSION  
9:33 a.m.  
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THE VIDEOGRAPHER: Good morning. We are now on the record. My name is Chris Clee. I am the videographer for Golkow, a Veritext division.

Today's date is September 3, 2025, and the time is 9:33 a.m., Eastern Standard Time.

This video deposition is being held in the matter of Camp Lejeune Water Litigation No. 7:23-CV-897 versus United States of America.

The deponent is Daniel Clarke.

Will counsel please introduce themselves.

MS. WALLACE: Yes. Good morning. This is Whitney Wallace. I'm here for the plaintiffs.

MR. CROMWELL: Michael Cromwell here on behalf of the United States. I also have my colleagues, Giovanni Antonucci and Joey Turner with the DOJ as well as Matthew Solis, who's with the VA's OGC office.

MS. WALLACE: Yes. And I'm happy to also introduce Jenna Butler and Ben VanSlyke who are

1 listening in today also with the Plaintiff Litigation  
2 Group.

3 THE VIDEOGRAPHER: The court reporter is  
4 Julie Riley and will now swear in the witness.

5 THE STENOGRAPHER: Good morning. My name  
6 is Julie Riley, RDR, CRR, Massachusetts Certified  
7 Shorthand Reporter No. 1444S95, and I am your  
8 stenographer today.

9 Today's proceedings are being held  
10 remotely via video conferencing. The attorneys  
11 participating in this deposition acknowledge and  
12 stipulate that I will be administering the oath and  
13 reporting remotely.

14 I have identified the witness as Daniel  
15 Clarke by his license.

16 Mr. Clarke, will you please raise your  
17 right hand.

18 \* \* \*

19 DANIEL CLARKE,

20 having been identified by the production of his  
21 driver's license and duly sworn pursuant to Executive  
22 Order 144 was examined and testified as follows:

23 \* \* \*

24 MS. WALLACE: Thank you, Ms. Riley.

DIRECT EXAMINATION

BY MS. WALLACE:

Q. Good morning, Mr. Clarke. How are you, sir?

A. Good. Thank you.

Q. Good. Before we get started, we've done this in all of our depositions recently. I just want to put on the record there is a CMO No. 3 that states that before a remote deposition commences, we need to state the following and make sure this is clear for the deponent.

The parties agree that no communication with the deponent by any means including but not limited to text messaging will occur out of the view of the other parties while this deposition is proceeding on the record.

Do you understand that, Mr. Clarke?

A. I do.

Q. Great. Will you please state your name for the record.

A. Daniel Clarke.

Q. What is your date of birth?

A. 9/19/1963.

Q. Who is your current employer?

1 A. Veterans Administration.

2 Q. How long have you been employed by the  
3 Veterans Administration?

4 A. Over 30 years.

5 Q. What is your current job title?

6 A. I am the acting ACFO. That is the  
7 Associate CFO for Managerial Cost Accounting.

8 Q. Do you understand that all of your  
9 testimony today is under oath and is expected to be  
10 truthful?

11 A. Yes.

12 Q. Is there any reason you might have  
13 difficulty testifying fully or truthfully today?

14 A. No.

15 Q. Where are you currently located?

16 A. I'm in my office in Braintree,  
17 Massachusetts.

18 Q. Is there anyone else there with you in the  
19 room?

20 A. There is not.

21 Q. Do you have any data or materials that are  
22 there with you?

23 A. Nothing on my desk or on my screens.

24 Q. All right. And if I ask you a question

1 today, I would ask that you not refer to any materials  
2 unless I direct them to your attention; is that fair?

3 A. Yes.

4 Q. Do you -- are you -- tell me how familiar  
5 you are with the pending Camp Lejeune litigation.

6 MR. CROMWELL: Object to form.

7 You may answer.

8 A. Thank you.

9 So I know that the PACT Act, which is a  
10 major initiative in the VA to help veterans, within  
11 that public law, there is an offset for any type of,  
12 if you will, settlement or any type of services  
13 offered that would be used to quote, unquote, offset  
14 that -- either the services offered or the payout,  
15 if you will.

16 Q. Have you read the statute --

17 A. I have --

18 Q. -- the CLJA statute?

19 A. I have looked at it, yeah.

20 Q. And I believe it uses the word "award"; is  
21 that right?

22 A. I'm not sure.

23 Q. And you mentioned the PACT Act. Have you  
24 had any role in administering the PACT Act on behalf

1 of the VA?

2 MR. CROMWELL: Object to form.

3 A. No.

4 MR. CROMWELL: You may answer.

5 A. Thank you. No, I have not.

6 Q. Are you or any of your family members  
7 veterans?

8 A. I had an uncle who passed away who was a  
9 Vietnam veteran, yes.

10 Q. Sorry for your loss.

11 Are you personally aware of anyone that's  
12 filed a Camp Lejeune claim?

13 A. I am not.

14 Q. Are you aware today of what your role and  
15 your deposition today play in this case?

16 A. Yes.

17 Q. Can you describe that in your own words,  
18 please.

19 A. I'm here to speak to the data that was  
20 pulled as it relates to the track of patients, the  
21 25 patients that were identified and their diagnostic  
22 codes related to Camp Lejeune toxic exposure.

23 Q. And are you aware that your data has been  
24 provided to an economist expert for the government?

1 A. No.

2 Q. Have you had any conversations with  
3 economists?

4 A. No.

5 Q. And have you -- and have you reviewed any  
6 opinions that the government's economists have  
7 provided regarding these plaintiffs whose data you  
8 pulled?

9 MR. CROMWELL: Object to foundation.

10 You may answer.

11 THE STENOGRAPHER: I'm sorry, Mr. Cromwell.  
12 You said object to?

13 MR. CROMWELL: Foundation.

14 You can answer, Mr. Clarke.

15 A. Okay. No, I have not.

16 Q. Have you or your staff, your department,  
17 have you ever provided similar reports for  
18 litigation purposes prior to the request of the  
19 government in this case?

20 MR. CROMWELL: Object to form.

21 You can answer.

22 A. No, we have not, to my knowledge.

23 Q. Have you ever given a deposition before?

24 A. No.

1 Q. Have you ever been a party in any civil  
2 litigation?

3 A. No.

4 Q. Can you tell me when you learned you were  
5 going to be deposed in this matter.

6 A. I would say June of this year.

7 Q. What did you -- can you tell me who is  
8 Janine -- would you help me with her last name.  
9 Genovese?

10 A. Genovese, yeah.

11 Q. Genovese. Is she still employed by the  
12 VHA?

13 A. She resigned. Retired.

14 Q. When did she retire, sir?

15 A. So she left the VA in June.

16 Q. And after that, you learned that you were  
17 going to take her place as a deponent regarding the  
18 data that your agency pulled?

19 MR. CROMWELL: Object to form.

20 You may answer.

21 A. Okay. Yes.

22 Q. Were you able to have conversations with  
23 Ms. Genovese prior to her departure regarding the  
24 data that was pulled?

1 A. Yes.

2 Q. Can you tell us generally what you guys  
3 talked about during that meeting?

4 MR. CROMWELL: Object to form.

5 You may answer.

6 A. Janine was my supervisor. I'm in charge  
7 of the group that pulled the data. So I was  
8 reporting to her, and we had multiple meetings to  
9 discuss the approach to pull the data, and then to  
10 provide the data to DOJ.

11 Q. Do I understand that you were part of the  
12 team that pulled the data?

13 A. Yes.

14 Q. Was it at Janine's direction? Who was  
15 directing that project?

16 A. It was a request from the CFO, VHA CFO  
17 from DOJ that was brought forward to the managerial  
18 cost accounting office. Janine Genovese was the  
19 ACFO at the time.

20 Q. Can you tell me who else was on your team  
21 that was working on this project?

22 A. Certainly. Kenneth Coburn.

23 Q. What's his job title, if you don't mind?

24 A. He's a financial analyst.

1 Q. Is there anyone else, Mr. Clarke?

2 A. Tamara Bernard. She is a management  
3 analyst; and Belinda Mink, and she is also a  
4 management analyst.

5 Q. Before we take a look at documents, can  
6 I ask you what you did to prepare for today's  
7 deposition, sir?

8 A. I reviewed the documents. I spoke with  
9 Mr. Cromwell.

10 Q. Without telling me the subject of your  
11 discussions, can you tell me who was present?

12 A. I know that Matthew Solis from the VA OGC  
13 was there.

14 There were three other individuals from  
15 the Department of Justice, and I don't recall their  
16 names.

17 Q. How many times did you all meet?

18 A. Once.

19 Q. And what was the duration of that meeting?

20 A. I believe it was an hour and a half.

21 Q. And you mentioned that you reviewed the  
22 documents. I want to show you our first exhibit if  
23 you give me just one moment.

24 Do you know how to look at the chat,

1 Mr. Clarke? I'm going to be dropping exhibits into  
2 the chat since we're having a remote deposition  
3 today.

4 A. I don't use Zoom. I see the chat, yep.

5 Q. Okay. Great. Let's see if this works for  
6 us.

7 All right. Mr. Clarke, can you look in  
8 the chat and see if you see an Exhibit 1.

9 (Document was premarked Exhibit No. 1 for  
10 identification.)

11 A. I do.

12 Q. Okay. I'm going to share it on the screen  
13 for you, and you'll -- bear with me. I have to put  
14 it in the chat and then open it. I can't have it  
15 open and then put it in the chat; so, it takes me  
16 just one minute to open these.

17 Oh, I need to screen share, please, whomever  
18 set up the Zoom.

19 (Attorney Wallace shared her screen.)

20 Q. Okay. Mr. Clarke, can you see Exhibit 1  
21 on the screen, sir?

22 A. I can.

23 Q. When -- I will represent to you that these  
24 are exhibits which I have pre-numbered five, six,

1 eight, nine, and eleven, and they contain Bates  
2 ranges CLJA\_VHA\_1 through 8.

3 Have you -- are these the documents or the  
4 Excels that you were mentioning earlier? Do you  
5 recognize these Bates numbers and descriptions?

6 MR. CROMWELL: Object to form and  
7 foundation.

8 You may answer.

9 A. I don't recognize the naming conventions  
10 used in all the descriptions.

11 Q. Do you recognize the Bates numbers?

12 A. I do not.

13 Q. All right. Can you tell me, in your own  
14 words, what documents that you have reviewed in  
15 preparation for your deposition today.

16 A. Reviewed the narrative that was -- so it  
17 looks like VHA CLJA Narrative. I would assume  
18 that's the narrative that I reviewed.

19 Q. And are you referring to CLJA\_VHA\_2 to 5,  
20 which is labeled Exhibit 6?

21 A. Yes.

22 MR. CROMWELL: Object to form.

23 Q. So you reviewed the cover letter of Janine  
24 Genovese and what other documents, sir?

1           A.       Without seeing the documents, the naming  
2 conventions are not familiar to me.

3           Q.       No problem.

4                    Do you independently remember what type of  
5 documents you reviewed to prepare for today?

6           A.       Sure. There was data that was presented  
7 on the 25 plaintiffs with total cost, total direct  
8 cost, both for the primary diagnosis and any  
9 secondary diagnosis.

10                   There was also a detailed data that was  
11 provided that included all services provided to  
12 those plaintiffs if found in the VHA database from  
13 2005 to December 2025.

14           Q.       Do you remember your department producing  
15 a Managerial Cost Accounting Data Definitions?

16           A.       Yes.

17           Q.       Did you have a hand in that preparation of  
18 that document?

19           A.       Yes.

20           Q.       Did you prepare it?

21           A.       With my team, yes.

22           Q.       The documents that you just mentioned, are  
23 you aware of any other documents that have been  
24 consulted, reviewed by your team with regard to the

1 plaintiffs and the data that you have provided?

2 MR. CROMWELL: Object to form.

3 You may answer.

4 A. Please restate the question.

5 Q. Besides the documents that you just named,  
6 are you aware of any other documents that your -- you  
7 or your team reviewed or consulted in preparing the  
8 documents that you just mentioned?

9 A. No.

10 MR. CROMWELL: Object to form.

11 You may answer.

12 A. Okay. No.

13 Q. Were you consulted in your subpoena  
14 response to this deposition? Have you seen that?

15 A. I've seen the subpoena, yes.

16 Q. All right. And I will include it as our  
17 Exhibit 2 and 3.

18 (Documents were premarked Exhibit Nos. 2  
19 and 3 for identification.)

20 Q. Do you know what documents were or were  
21 not produced as a result of your subpoena?

22 MR. CROMWELL: Object to form and  
23 foundation.

24 You may answer.

1 A. I don't know everything that was provided.

2 Q. You were asked to produce any information  
3 utilized by your department, the VHA, to formulate  
4 an amount that it alleged that your department  
5 alleges it has spent or will spend on behalf of any  
6 plaintiff under a VA program.

7 Is it your testimony today that you  
8 believe you've produced all such information?

9 MR. CROMWELL: Object to form.

10 You may answer.

11 A. Yes.

12 Q. Did you review any medical records for the  
13 plaintiffs that have not been produced?

14 A. No.

15 Q. Did you review any cost accounting data  
16 that has not been produced?

17 A. For this purpose, no. I'm not sure I  
18 understand your question.

19 Q. No. That's a fair clarification. For  
20 this purpose.

21 And your answer is no to that question?

22 A. No. Yeah.

23 Q. Okay. I want to talk about -- I'm going  
24 to put Exhibit 4 into the chat, and this is your CV,

1 and I'm going to share it on the screen for you.

2 A. Okay.

3 (Document was premarked Exhibit No. 4 for  
4 identification.)

5 (Attorney Wallace shared her screen.)

6 Q. Do you recognize this document, Mr. Clarke?

7 A. Yes.

8 Q. What is this?

9 A. This is the CV I produced for DOJ.

10 Q. And when was it last updated?

11 A. I don't remember, but it was several  
12 months ago.

13 Q. Thank you.

14 I'm going to scroll to the bottom.

15 (Scrolling.)

16 Q. The bottom contains your software  
17 experience; is that correct?

18 A. Yes. I see.

19 Q. Which one of these softwares did you use  
20 to prepare the data that you referenced earlier  
21 relevant for our purposes today?

22 A. So the data was collected through the CDW,  
23 Corporate Data Warehouse. My team used SQL,  
24 Structured Query Language, to pull the data into

1 Excel.

2 Q. Which one of these -- was VistA used or  
3 DSS? I understand DSS is an older system.

4 A. Yeah, the DSS mainframe is still in  
5 existence, and that is our managerial cost accounting  
6 database. VistA is the underlying data that comes  
7 from the medical record that feeds the CDW.

8 Q. All right. And it looks like -- I've  
9 reviewed your CV -- you had some experience in the  
10 Peace Corp. in Malawi. I'm sure that was  
11 fascinating.

12 And then it looks like almost directly  
13 after that, you began to work in the VA Boston  
14 Health Care System?

15 A. Yes.

16 Q. And you mentioned earlier you've had a  
17 30-year career with the VA, which I imagine started  
18 in approximately this January 1995 date?

19 A. Yes.

20 Q. Would you be able to -- it looks like you  
21 started as a social worker for eight years; is that  
22 true?

23 A. Yes.

24 Q. And then in 2000, you began a management

1 analyst role?

2 A. Yes.

3 Q. Where you stated you were responsible for  
4 processing Department Cost Management (DCM) system.

5 Can you tell us what that was.

6 A. That is a component of the managerial cost  
7 accounting system.

8 Q. And so from that point forward, have you  
9 always been in the managerial cost accounting  
10 department of the VA?

11 A. Above that is where I was an  
12 administrative officer for geriatric and extended  
13 care from 2003 to 2006.

14 Other than that, I've been affiliated with  
15 the managerial cost accounting system, which changed  
16 its name from DSS to managerial cost accounting, I  
17 forget exactly what year it did.

18 Q. Would that be approximately the 2005 time  
19 frame?

20 A. I'm not sure.

21 Q. Okay. And so the 2006 to August 2010 time  
22 frame, it says you were a site manager for Decision  
23 Support System responsible for the quality and  
24 validity of the data in the DSS software for the

1 BHCS.

2 Will you tell us what that job duty  
3 entailed, please.

4 A. I was a supervisor of processing staff,  
5 and I was responsible for the day-to-day operations.  
6 Each individual medical center, 170, have a distinct  
7 database for managerial cost accounting or decision  
8 support system. Those words can be -- those titles  
9 can be used interchangeably. 170 different  
10 diverse -- well, 170 databases that pull information  
11 from the VistA system that I spoke about a minute  
12 ago and from the financial system; so, we've got  
13 financial records and medical records that are  
14 pulled into the DSS system.

15 Q. And those 170 databases, that's the  
16 feed -- those are the feeders for the VHA Corporate  
17 Data Warehouse?

18 A. They are the feeders for the national data  
19 extracts, NDEs, that are then fed into the CDW. So  
20 we bring 170 diverse medical centers' data, which  
21 includes all of the CBOCs and all of the ancillary  
22 facilities that are associated with -- that we call  
23 them CBOCs, Community Based Outpatient Clinics that  
24 are brought together in the NDEs as a national data

1 extract that we then, in turn, publish in the CDW.

2 Q. And I was looking at the cover letter that  
3 your organization produced. It says, "The VHA is  
4 the largest health care system in the United States  
5 providing health care at 1,380 health care facilities,  
6 including 170 VA Medical Centers and 1,193 outpatient  
7 sites of care of varying complexity to over  
8 9.1 million veterans enrolled in the VA health care  
9 program."

10 Is that where you got the -- like, that's  
11 the 170 databases or is that a coincidence?

12 A. No, that is correct. That is correct.

13 Q. Okay. So you have -- so 170 VA Medical  
14 Centers all independently produce data for these  
15 9.1 -- you know, approximately 9.1 million veterans,  
16 and that goes into the NDE system, which then goes  
17 into the CDW, Corporate Data Warehouse, data  
18 repository.

19 Is that -- am I understanding your testimony  
20 correctly?

21 A. That is correct with the caveat that there  
22 are three VISNs. These are Veteran Integrated  
23 Service Networks, regional offices, if you will.  
24 There are three VISNs that have consolidated the

1 facilities into one VISN for our processing and  
2 financial reporting.

3 Q. And what's the word that you're using  
4 there. Three?

5 A. VISNs.

6 Q. Yes. What does that mean?

7 A. It's a regional office. So it's a VISN,  
8 integrated network system.

9 THE STENOGRAPHER: Would you mind spelling  
10 that for me, sir.

11 THE WITNESS: V-I-S-N.

12 THE STENOGRAPHER: Thank you.

13 BY MS. WALLACE:

14 Q. Is that an acronym?

15 A. It is.

16 Q. Do you know what it stands for?

17 (Zoom connection dropped.)

18 THE WITNESS: I just answered twice.

19 MS. WALLACE: Oh, I'm so sorry.

20 Thank you.

21 THE STENOGRAPHER: I'm sorry. Hold on a  
22 minute. My Zoom went off. Hold on.

23 MS. WALLACE: All right. Back to your CV,  
24 we're going to talk more about the databases --

1 THE STENOGRAPHER: I'm sorry, Ms. Wallace.  
2 I'm sorry, Ms. Wallace. My Zoom just quit, and I  
3 just came back in; so, I left off at "Do you know  
4 what it stands for?" And you were speaking about  
5 the acronym for VISN.

6 MS. WALLACE: Yes.

7 THE STENOGRAPHER: So that's where I left  
8 off. I don't know what else you may have said, but  
9 that's --

10 MS. WALLACE: No problem.

11 BY MS. WALLACE:

12 Q. Poor Mr. Clarke might have to tell us one  
13 more time. I'd be happy to repeat it, Mr. Clarke,  
14 or --

15 A. Yes, please.

16 Q. -- will you tell our court reporter one  
17 more time what VISN stands for?

18 A. Sure. VISN, V-I-S-N, Veteran Integrated  
19 Service Network.

20 Q. Thank you.

21 And I was just telling Mr. Clarke that  
22 we're going to talk more about data systems when we  
23 look at the cover letter in a moment, but I want to  
24 finish going through his résumé.

1           So we're going to look back at Exhibit 4  
2 here. So my understanding -- it looks like then  
3 from 2010 to 2018, you moved to the VISN 1, DSS  
4 coordinator, which I understand to be a region.  
5 VISN 1 is a region of the VA.

6           Would you describe what you did in that  
7 role, please.

8           A.     In that role, I oversaw New England, all  
9 the facilities within New England, including the  
10 CBOCs, and I also reported to the CFO of VISN 1 and  
11 to the network director, and I was responsible for  
12 not only the integrity of the data within the  
13 New England region but also the reporting of that to  
14 the executive leadership board.

15          Q.     Were you working in managerial accounting  
16 in that role?

17          A.     Yes.

18          Q.     And then, finally, you became a project  
19 and program coordinator for the managerial cost  
20 accounting office from March of 2018 to January of  
21 2021.

22                 Can you tell us about that role?

23          A.     In that role, I was responsible for the  
24 coordination of projects, but also the program

1 coordination in terms of engaging with the field.  
2 So the VISN -- VISNs have council chairs, so a  
3 representative from each VISN, like I was in my  
4 prior position, we would bring together to coordinate  
5 efforts to standardize processes.

6 Q. And so you helped -- were you a part of  
7 the creation of some of these systems?

8 A. No.

9 Q. Then you worked to implement?

10 A. Yes.

11 Q. Okay. All right. And tell us about your  
12 current role, if you will?

13 A. So currently, a lot of things going on.  
14 I'm currently acting as the Associate CFO for  
15 managerial cost accounting, in charge of multiple  
16 sections within the program office and reporting to  
17 the acting VHA CFO, Heather Ford.

18 I'm also directly supervising about  
19 20 staff, staff focused on clinical operations and  
20 financial operations, and I directly supervise three  
21 supervisors: one responsible for operations, as it  
22 relates to the system, DSS or managerial cost  
23 accounting; one responsible for training; and  
24 another responsible for the fiscal oversight.

1 I also am engaged with EHRM, and that is  
2 the Electronic Health Record Modernization project.  
3 I'm a co-chair of the Business Operation Council and  
4 report to the acting VHA CFO, who is the executive  
5 sponsor of that. The record is Oracle Health that  
6 we're implementing nationwide.

7 Q. Have you been involved in the Oracle EMR  
8 implementation and migration?

9 A. The Oracle what? Could you repeat that.

10 Q. The Oracle implementation and migration?

11 A. Yes.

12 Q. And does that feed the national data  
13 extracts as VistA has previously?

14 A. Yes.

15 Q. For those sites that have migrated, does  
16 VistA continue to feed the national data extract?

17 A. Yes, in some situations. There's not a  
18 prosthetic solution. So we continue to pull data  
19 for prosthetics from VistA for those sites that are  
20 EHRM or Oracle Health.

21 Q. All right. And so if I have looked at  
22 your résumé and heard your answers correctly, the  
23 majority of your VA career has been in managerial  
24 cost accounting and decision support; is that true?

1 A. Yes.

2 Q. And you are not and have never been in a  
3 claims administration role?

4 A. Correct.

5 MR. CROMWELL: Object to form.

6 You can answer.

7 A. Okay. Correct.

8 Q. And your department is not a department  
9 that is responsible for the production of billing  
10 records; is that true?

11 MR. CROMWELL: Object to form and  
12 foundation.

13 You may answer.

14 A. True.

15 Q. Which department would that be?

16 A. Office of Revenue.

17 Q. The Office of Revenue?

18 A. Correct.

19 Q. Under the VA as well?

20 A. Correct.

21 Q. Do you know who heads that department?

22 A. The Office of Revenue is under the Office  
23 of Finance and overseen by the acting VHA CFO,  
24 Heather Ford.

1 Q. Thank you.

2 The managerial cost accounting system that  
3 you oversee produces cost allocations for encounters  
4 not claims or bills; is that true?

5 MR. CROMWELL: Object to form.

6 You may answer.

7 A. True.

8 Q. Does your department -- has it ever made  
9 or has it ever made future projections of cost  
10 accounting?

11 A. No.

12 Q. The cost allocations under your department,  
13 they -- is it true that they spread VA operating  
14 expenses such as salaries, utilities, overhead  
15 across patients using formulas?

16 MR. CROMWELL: Object to form.

17 You may answer.

18 A. So there's direct cost, and there's  
19 indirect cost. In terms of indirect cost, we  
20 definitely use a formula to -- called an allocation  
21 methodology approach to spread the costs of overhead.

22 Q. And is it your testimony that your direct  
23 cost allocations do not use a formula?

24 MR. CROMWELL: Object to form.

1           You may answer.

2           A.     Direct costs are costs like labor which is  
3     about 70 percent of our cost, which is directed to a  
4     specific department, oncology, orthopedics. Those  
5     labor dollars, those individual staff and their  
6     labor dollars are mapped to a specific department  
7     based on the level of care, type of care they  
8     provide.

9           Other costs would be supplies and support  
10    staff.

11          Q.     Is that cost assessment done on an  
12    individual VA Medical Center basis like one of the  
13    170 VA Medical Centers or is it more comprehensive?

14          A.     It's a bit more comprehensive in the sense  
15    that every single employee is mapped to a specific  
16    area, whether that be a direct care department or an  
17    indirect overhead department, no matter if they work  
18    at a facility, the 170 number, or they work at a  
19    CBOC, one of those outpatient based clinics.

20          Q.     And a CBOC is that the 1,193 outpatient  
21    sites of care of varying complexity?

22          A.     Yes.

23          Q.     And is that acronym -- could you spell  
24    that for the court reporter.

1           A.       CBOC, Community Based Outpatient -- I  
2 believe it's Care or Center, Center. I believe it's  
3 Center.

4           Q.       And just so I understand you were saying  
5 that when there is a formula to determine direct  
6 costs that's not necessarily one VA facility  
7 specific. It's more complicated than that?

8                   MR. CROMWELL: Object to form.

9                   You may answer.

10          A.       We have a tool called a labor mapping  
11 database where locally the MCA, managerial cost  
12 accounting staff local work with the facility to  
13 ensure accuracy of labor mapping.

14          Q.       There is a separate labor mapping database  
15 that you consult?

16          A.       Correct.

17          Q.       And help me understand what that -- how  
18 that database is used by your department?

19          A.       I'll use the same example. Oncology,  
20 orthopedics, you'll have an oncologist or a  
21 hematologist mapped to the oncology department with  
22 a nurse with support staff with associated supplies  
23 and equipment.

24                   The same is true with an orthopedic where

1 you would have potentially a nurse practitioner that  
2 runs that orthopedic clinic with support from a  
3 nurse and maybe a health tech. Those individual  
4 hours that are dedicated to that activity for those  
5 clinicians or support staff are mapped using that  
6 labor mapping tool to that specific department where  
7 not only do we have the labor and the financial  
8 information, we also bring in the workload information  
9 to create that costed product.

10 Q. And is that oncology for one VA system or  
11 oncology in a region of VA systems or oncology in VA  
12 systems and CBOC or help me understand?

13 MR. CROMWELL: Object to form.

14 You may answer.

15 A. So with the example I gave, that would be  
16 a local either at the facility or potentially at a  
17 CBOC, but they would be individual departments based  
18 on the location.

19 Q. It would be a group of individual facilities  
20 or one individual facility?

21 A. One.

22 Q. Okay. Let's keep going. I'm not totally  
23 there yet, but we're going to keep going.

24 What about -- so I want to understand that

1 the -- I want to make it clear that the dollar  
2 figures that come out of the systems, the managerial  
3 accounting systems, those are estimates of costs  
4 that using the software that you've referenced.  
5 They are not records of money paid to anyone; is  
6 that true?

7 A. No.

8 MR. CROMWELL: Object to form.

9 A. Oh, I'm sorry. No, that's not true.

10 Q. Okay. What do you disagree with?

11 A. They're not estimates.

12 We take the actual labor dollars, direct  
13 it to a department, oncology. We take other dollars  
14 that are, if you will, supply support staff, that  
15 support that department, the oncology outpatient  
16 clinic, and then we bring in the workload from the  
17 VistA system, the underlying feeder systems to come  
18 up with the costed product.

19 So it costs us this much money at that  
20 particular facility to provide that level of care.

21 Q. How is the labor direct care allocated to  
22 a specific patient encounter?

23 A. Within each department, we bring the  
24 workload from the VistA system. That is the medical

1 record.

2 Each product is an encounter. So we know  
3 what level of care was offered during that visit,  
4 and that is how individual encounters are costed.

5 Q. Then do I understand you correctly that  
6 the cost allocations are based on a snapshot of the  
7 workload at any given point in time, and they would  
8 be subject to change?

9 MR. CROMWELL: Object to form.

10 You may answer.

11 A. Okay. So the cost assignment might be a  
12 better word than allocation. The indirects are  
13 allocated. The directs are assigned based on the  
14 level of care provided.

15 Q. Do you want me to repeat my question?

16 A. Sure.

17 Can you still hear me?

18 Q. Yes.

19 A. Oh.

20 Q. I was wondering --

21 MS. WALLACE: Madam Court Reporter, could  
22 you repeat the question that I asked.

23 THE STENOGRAPHER: Sure. Hold on.

24 (Last question was read back by the court

1 reporter.)

2 MR. CROMWELL: Object to form. It's been  
3 asked and answered.

4 You may answer.

5 A. It's better to use the word cost  
6 assignment. The allocation is based on indirect  
7 costs that are allocated down to products through  
8 the departments; whereas, the costs in a department  
9 are direct costs that are related to labor, supplies,  
10 and equipment, and support staff.

11 Q. Did you understand my question about these  
12 cost assignments would be subject to change --

13 MR. CROMWELL: Object to form.

14 Q. -- based upon the workload at any given  
15 point in time?

16 A. So -- okay. They are variable. So, yes.

17 Q. And the variability, how often is your  
18 department taking snapshots of these departments in  
19 order to perform cost assignments?

20 A. Monthly.

21 Q. Monthly.

22 And so from month to month, if I understand  
23 you, direct cost assignments can change based on  
24 workload in any given department?

1           A.     Yes.    Workload and the amount of time with  
2           the labor mapping database that is allocated or  
3           directed to that specific department.

4           Q.     Where does labor mapping database reside?  
5           Is it in the CDW?

6           A.     No.    The output of the labor mapping  
7           database is in the CDW, but the labor mapping  
8           database is a stand-alone system.

9           Q.     And you said then -- did you give me a  
10          name of the labor mapping database?

11          A.     That is the name.

12          Q.     That is the name?

13          A.     Yeah.

14          Q.     Okay.  And where does it reside?

15          A.     It is a -- it is managed by managerial  
16          cost accounting office, my office, and it is a tool  
17          that is available through a front end to each of the  
18          170 facilities.

19          Q.     What is the workload based on?

20          A.     Workload comes from the underlying system  
21          VistA and/or Oracle Health, and it's based on an  
22          encounter with a practitioner that is vested to  
23          diagnose, to treat a veteran, a patient, and  
24          document an encounter against that interaction.

1 Q. Do you have experience in coding?

2 MR. CROMWELL: Object to form.

3 You may answer.

4 A. When I started in the VA, we started to  
5 introduce VistA. We didn't have an electronic  
6 health record, but it was being introduced, and yes,  
7 I was coding my encounters that I had with veterans,  
8 and that's my experience with coding.

9 Q. Do you know if the workload data that you  
10 just described, does it involve coding such as ICD-9  
11 or 10 codes or CPT codes or HCPCS or diagnostic  
12 pointers?

13 MR. CROMWELL: Object to form.

14 You may answer.

15 A. Yes, it does.

16 Q. So the workload is determined on the basis  
17 of practitioner coding?

18 MR. CROMWELL: Object to form.

19 You may answer.

20 Q. Per patient encounter?

21 A. Yes, but there's also a coding team that  
22 is responsible for oversight of coding.

23 Q. What is that team called?

24 A. HIM, Health Information Management.

1 Q. Is that a department inside the VA?

2 A. Yes.

3 Q. Who leads that department?

4 A. I forg -- Chuck Humes is the individual.  
5 I forget the exact title of his program office.

6 Q. Do you know how many people are in Chuck's  
7 department?

8 A. No.

9 Q. The HIM?

10 A. I do not.

11 Q. And tell me what the role of that department  
12 is, please.

13 MR. CROMWELL: Object to foundation.

14 You may answer.

15 A. I wouldn't be able to speak to their  
16 responsibilities. I know they oversee coding.

17 Q. Do you know if they do coding audits?

18 A. Yes, I know that only from not anything  
19 formal, but I certainly through my many years of  
20 working here, I'm aware that they do audits.

21 Q. But to the extent that they do coding  
22 audits, that's outside of your knowledge?

23 A. Correct.

24 Q. And your department does not do coding

1 audits?

2 A. Correct.

3 Q. All right. And so let me make sure I  
4 understand correctly, so -- as far as verbiage. So  
5 for direct care costs, your department generates --  
6 using a software program, your department generates  
7 cost -- I want to use the right word -- tell me the  
8 word you wanted me to use. I'm so sorry. I wrote  
9 it down. Cost assessments?

10 A. Oh, assignment.

11 Q. Okay. Thank you.

12 -- cost assignments using the software  
13 program called labor mapping database --

14 A. A correction. Using the software  
15 called -- you can call it DSS, Decision Support  
16 System. It's now owned by Strata. I think it's had  
17 multiple names through the many years.

18 Q. And for indirect care, that is a cost  
19 allocation or estimate based on what?

20 MR. CROMWELL: Object to form.

21 You may answer.

22 A. There are methodologies used for the high  
23 level administrative overhead that it trickles down  
24 to each of those 170 facilities. It's total cost,

1 operating cost for those facilities.

2 The indirect costs for the -- are  
3 maintained at the facility level is based on  
4 full-time employee equivalent, an FTE number.

5 Q. The indirect cost estimations are by  
6 facility like by 170 VA facilities?

7 A. Correct.

8 It trickles down to those community based  
9 outpatient centers as well. So it trickles down to  
10 every single facility, whether it be the 170 or the  
11 CBOCs that sit underneath that facility.

12 Q. So are the indirect cost estimations  
13 calculated based on the entirety of the VA  
14 programming -- programs and facilities?

15 MR. CROMWELL: Object to form and  
16 foundation.

17 You may answer.

18 A. The indirects are allocated to all VA  
19 facilities to include the CBOCs.

20 Q. Can you give us examples -- and I know you  
21 do in your cover letter. We're turning to that  
22 shortly, but will you give us examples of the types  
23 of cost allocations that would be included in an  
24 indirect cost estimation?

1           A.     So from central office, the work I do in  
2     the Office of Finance would be trickled down to all  
3     facilities based on total operating cost.

4                     For the local facility, Boston Health Care  
5     System as an example, the director's office, the  
6     chief of staff's office, those indirect costs are  
7     trickled down to all the departments, the oncology,  
8     orthopedics, that I used as examples before, based  
9     on total FTE within that department.

10           Q.     Would utilities be an expense that's  
11     included in the indirect costs estimations?

12           A.     Yes.

13           Q.     Security guards?

14           A.     Yes.

15           Q.     Housekeeping?

16           A.     Yes.

17           Q.     Grounds?

18           A.     Yes.

19           Q.     And administration?

20           A.     Yes.

21           Q.     And so what I think -- tell me if I'm  
22     correct on this, so direct costs would be things  
23     like the doctor's time, the nurse's time, medications,  
24     supplies used for an encounter; and indirect is

1 everything else?

2 A. Yes.

3 Q. All right. Let's look at the cover  
4 letter.

5 Oh, I'm at one hour. I was given the one-  
6 hour warning.

7 Are you -- Mr. Clarke, would you like to  
8 take a brief break?

9 A. If others need to I can, but I'm okay to  
10 proceed.

11 MS. WALLACE: Michael, what would you like?

12 MR. CROMWELL: We could go another I'd say  
13 probably 10, 15 minutes, and then take a break.  
14 It's up to you, wherever you're at a good stopping  
15 point, but at some point.

16 MS. WALLACE: Okay. I'm transitioning to  
17 the cover letter, but let's go another five minutes  
18 or so, and then we'll take a break.

19 MR. CROMWELL: That works.

20 MS. WALLACE: Okay.

21 BY MS. WALLACE:

22 Q. All right. I am going to put in the chat  
23 what has been premarked as Exhibit 6, and I'm going  
24 to put it on the screen for you, Mr. Clarke.

1 (Document was premarked Exhibit No. 6 for  
2 identification.)

3 (Attorney Wallace shared her screen.)

4 BY MS. WALLACE:

5 Q. Mr. Clarke, do you recognize this  
6 document?

7 A. Yes.

8 Q. What is this?

9 A. This is the cover letter that was sent  
10 from our office to the Department of Justice, to  
11 Michael.

12 Q. Can you tell me --

13 MR. CROMWELL: And just -- sorry, Whitney.

14 MS. WALLACE: No problem.

15 MR. CROMWELL: Just for the record, we  
16 don't have in the chat yet -- I mean I obviously  
17 have the document, but the actual marked version.

18 MS. WALLACE: Thank you for telling me  
19 that. Let's take a look at why it didn't get  
20 through.

21 Oh, because I didn't press send. That's  
22 why.

23 MR. CROMWELL: No worries.

24 MS. WALLACE: Okay.

1 MR. CROMWELL: We got it. Thank you.

2 MS. WALLACE: No problem.

3 THE STENOGRAPHER: I also don't see  
4 Exhibit 5 in there.

5 MS. WALLACE: That's right. I have  
6 premarked exhibits, and if you can bear with me  
7 today, I might go out of order. It's very possible.

8 THE STENOGRAPHER: No worries. Just  
9 wanted to be sure I didn't miss Exhibit 5.

10 MS. WALLACE: Thank you.

11 Thank you. So the exhibit on the screen,  
12 just so the record is clear has Bates Stamp numbers  
13 CLJA\_VHA\_2 to five.

14 BY MS. WALLACE:

15 Q. And you were just telling us that -- or  
16 actually my first question about this document is do  
17 you recall when you were asked by the DOJ, like,  
18 what facilitated this letter when you were first  
19 approached by the DOJ with this request?

20 MR. CROMWELL: Object to form.

21 You may answer, if you can.

22 A. Can you repeat the question.

23 Q. When were you first contacted by the DOJ  
24 that facilitated this letter?

1 A. I don't remember.

2 Q. Do you -- were you involved in drafting  
3 this letter?

4 A. Yes.

5 Q. Can you tell me which parts that you  
6 drafted.

7 A. The letter was drafted by a group to  
8 include the three individuals that I listed before,  
9 presented to myself and Ms. Genovese for review and  
10 editing.

11 Q. And so one of the other three individuals  
12 you named, and I'm going to say their names again:  
13 Tamara Bernard, Kenneth Coburn and Belinda Mink, did  
14 the initial draft of this letter?

15 A. Yes.

16 MR. CROMWELL: Object to form.

17 You may answer.

18 A. Yes.

19 Q. And you and/or Janine made edits to the  
20 letter?

21 A. Yes.

22 Q. Can you tell me any edits that you made.

23 A. I don't recall.

24 Q. The -- and you said Janine was your

1 supervisor at the time that this letter was written?

2 A. Yes.

3 Q. And do you now hold her role?

4 A. Yes.

5 Q. I see.

6 And so your role right before she left was  
7 in your résumé. I don't know that it -- was it  
8 director of clinical operations and analytics or was  
9 it something different?

10 A. That is correct.

11 Q. And now your role is associate chief  
12 financial officer?

13 A. For managerial cost accounting, yes.

14 Q. Who is -- it says, "My primary duties  
15 include advising the Chief Financial Officers of the  
16 VHA."

17 Who are they?

18 A. That would be the acting VHA CFO.

19 Q. Is that a he or a she?

20 A. That's Heather Ford.

21 Q. Okay. Do you -- you testified earlier  
22 that you had never been asked to pull data such as  
23 this before; correct?

24 A. Yes.

1 Q. Would you agree that typically when  
2 billing is created, it is done by a different  
3 department that you told me earlier is called -- can  
4 you remind us?

5 A. Office of Revenue.

6 Q. Office of Revenue; is that true?

7 MR. CROMWELL: Object to form.

8 You may answer.

9 A. Billing is done through the Office of  
10 Revenue.

11 Q. Can you tell us, explain what the purpose  
12 of managerial cost accounting is to the VA?

13 MR. CROMWELL: Object to form.

14 You may answer.

15 A. It was established as a decision support  
16 tool, hence the name decision support system.

17 The purpose is to provide cost accounting  
18 information for both local, program office, and  
19 central office decision-making. It's used in the  
20 budget for each of the facilities for the yearly  
21 budget for each of the facilities.

22 Q. It's a decision support tool and a  
23 budgeting tool; is that correct?

24 A. It is a decision support tool, and the

1 cost data is used within the budgeting tool.

2 Q. In order to allocate resources to VA  
3 facilities and C Max [sic]?

4 A. CBOC.

5 Q. Sorry.

6 MR. CROMWELL: Object to form.

7 You may answer.

8 A. Okay. It directs money to the VISN which,  
9 in turn, allocates money to the facilities. That's  
10 where it stops. The CBOCs are under the facilities,  
11 and that's managed locally.

12 Q. So it is a decision support tool and a  
13 budgeting tool related to just the 170 VA medical  
14 centers?

15 MR. CROMWELL: Object to form.

16 You may answer.

17 A. Okay. Not a budgeting tool. The cost is  
18 used, the managerial cost accounting cost is used in  
19 the budgeting tool, and, yes, it goes to the VISNs  
20 and trickles down. The model also has budget  
21 allocation down to the facility level.

22 Q. And are you saying so it has budget  
23 allocation also to the CBOCs in addition to the  
24 170 medical centers?

1           A.       The budgeting is done in a different  
2 office, and I don't believe it goes to the CBOC  
3 level, but that's not within my scope of work.

4           Q.       Your scope of work is to provide them the  
5 data, and they make the budgeting decisions; is that  
6 true?

7           A.       That is true.

8           Q.       Okay. Let's take a short 5-minute break.  
9                    When we come back, we're going to talk  
10 about process.

11          A.       Okay.

12          Q.       Okay. Thank you.

13                   THE VIDEOGRAPHER: Going off the record.  
14 The time is 10:40 a.m.

15                   (Short break taken.)

16                   THE VIDEOGRAPHER: All right. Stand by.  
17                   We are now back on the record. The time  
18 is 10:55.

19 BY MS. WALLACE:

20          Q.       Thank you.

21                   Mr. Clarke, before our brief break, I was  
22 sharing Exhibit No. 6, and I'll put that back on the  
23 screen. This is the cover letter that you've  
24 identified coming from your department.

1 I wanted to talk about this sentence where  
2 my cursor is, and I'll read it. "I provide analysis,  
3 oversight models, and financial reports to the Agency  
4 leadership to ensure compliance with federal  
5 managerial cost accounting practices."

6 I think you're describing your job duties  
7 there. Will you tell us what that sentence means.

8 A. Well, there's a federal law that requires  
9 managerial cost accounting within federal agencies,  
10 so within the VA, we have three pillars. We have  
11 Veterans Benefits Administration VBA; we have  
12 National Cemetery Administration, NCA; and, of  
13 course, we have what we're talking about today,  
14 Veterans Health Administration.

15 We are responsible for providing reports  
16 to each of these agencies, each of these sections  
17 within the agency to help with decision support.

18 Q. All right. Are you aware are those the  
19 only departments that the VA -- that fall under the  
20 VA?

21 MR. CROMWELL: Object to form.

22 You may answer.

23 A. Yes. Those are the three pillars of the  
24 VA.

1 Q. And it says that your colleague that  
2 retired had 14 years of her 28-year VHA career as  
3 the -- and this is our favorite acronym -- the VISN,  
4 Veterans Integrated Service Network Chief Financial  
5 Officer.

6 Did you ever maintain that role?

7 A. No.

8 Q. What was that role, if you know?

9 A. Within the VISN, each of the VISNs has a  
10 CFO that manages the VISN budget that's allocated  
11 down to the facilities.

12 Q. So that's the -- taking the data that your  
13 managerial accounting office provides and taking  
14 that next step to actually work on the budgeting?

15 A. Taking the managerial cost accounting data  
16 that's used for the budget model, taking that budget  
17 that's allocated to the VISN and managing that at  
18 the VISN level is the chief financial officer at  
19 the VISN responsibility.

20 Q. And am I -- how many VISNs are there or  
21 regions?

22 A. I believe there's 18 at the moment.  
23 You're going to see VISN 22 because some have been  
24 consolidated over the years, but I believe there are

1 18 active VISNs.

2 Q. And so she was the CFO for 22 for 14 years?

3 A. Correct.

4 Q. For VISN 22?

5 A. Yes.

6 Q. And each one has their own independent  
7 CFO?

8 A. Yes.

9 Q. That manages the budget based on managerial  
10 cost accounting data that comes from your department?

11 MR. CROMWELL: Object to form.

12 You may answer.

13 A. So it's the cost data used in the budget  
14 model. The budget model defines the dollars sent to  
15 each VISN.

16 Q. And the CFO manages the budget that's  
17 determined?

18 A. Yes.

19 Q. All right. I want to talk about the task  
20 that you were given here.

21 Can you explain in your own words or  
22 referring to the exhibit on the screen what you were  
23 asked to do by the DOJ?

24 A. We were asked to identify costs related to

1 25 veterans or plaintiffs as it relates to diagnostic  
2 codes provided by the HOME team. The HOME team  
3 provided us with the ICD-9 and 10 codes that would  
4 be associated with the five categories: leukemia,  
5 kidney cancer, Parkinson's, non -- I can't remember  
6 the non-Hopkins [sic] lymphoma, and I get -- it was  
7 kidney and -- oh, I forget the fifth one. Bladder.

8 Q. And you used the words costs. Can you be  
9 more specific, because --

10 A. I --

11 MR. CROMWELL: Object to form.

12 Sorry. Go ahead, Whitney.

13 MS. WALLACE: No. You're fine.

14 BY MS. WALLACE:

15 Q. I was just going to clarify there are no  
16 costs to these veterans; correct?

17 MR. CROMWELL: Object to form.

18 You may answer.

19 A. I'm not -- I'm not sure. I don't know  
20 if -- what billing took place or did not take place  
21 if that's what you're asking.

22 Q. Can you describe what you mean when you  
23 use the word "cost," please.

24 A. Activity-based costing. An encounter, a

1 clinical encounter, that took place between a  
2 patient/veteran and a provider.

3 Q. So are you using -- we used the words  
4 previously a cost estimate for indirect cost, cost  
5 estimation, and then we used -- you were comfortable  
6 with the word "cost assignment" as it related to  
7 direct care costs.

8 Is that what you mean by costs?

9 A. Yes.

10 MR. CROMWELL: Object to form.

11 You may answer.

12 A. Yes.

13 Q. So were you specifically asked to perform  
14 labor mapping and analysis in order to come up with  
15 both direct care cost assignments and indirect cost  
16 estimations? Was it that specific of a request?

17 A. No. I don't believe the DOJ's aware of  
18 our labor mapping database. It's an internal tool  
19 used to do our cost accounting.

20 Q. So you were asked -- so tell me one more  
21 time. So what did they ask you to do?

22 A. They asked --

23 MR. CROMWELL: Object to form. Asked and  
24 answered.

1                   You may answer.

2           A.       Thank you.

3                   They asked us to identify the costs  
4 related to those five categories, those ICD-9 and  
5 ICD-10 codes through the time frame of 2005 to  
6 December 2025.

7           Q.       Did they give you that time frame?

8           A.       Yes.

9           Q.       And why -- do you know why that particular  
10 time frame was selected?

11          A.       I do not.

12          Q.       Do you have encounter cost estimations  
13 prior to 2005?

14          A.       We do not.

15          Q.       So the universe of cost assignments and  
16 cost estimations starts in approximately 2005?

17          A.       To my knowledge.

18          Q.       Do you know why that particular -- why it  
19 starts on that date?

20          A.       I don't believe that corporate data  
21 warehouse was active prior to that.

22          Q.       Was managerial accounting such as what you  
23 do in practice prior to 2005?

24          A.       Yes.

1 Q. But not the labor mapping database?

2 MR. CROMWELL: Object to form.

3 You may answer.

4 A. So I think you mean not the national data  
5 extracts that have the cost?

6 Q. Yes.

7 A. And, no, they were not available.

8 Q. And so as far as what you do with regard  
9 to the NDEs and trying to make cost estimations at  
10 the encounter level, that program did not exist  
11 prior to 2005?

12 MR. CROMWELL: Object to form.

13 You may answer.

14 A. The program existed. What we -- there are  
15 170 hospital systems that have their own database,  
16 and my understanding is in 2005, the national data  
17 extracts were created to bring all of those 170  
18 facility data into one, if you will, record, based  
19 on a number of different NDEs: outpatient treating  
20 specialty, pharmacy, et cetera.

21 Q. So what you produced in this case for  
22 these plaintiffs could not have been done prior to  
23 2005?

24 A. Correct.

1 Q. So you were given the plaintiffs -- you  
2 were given two pieces of information, if I understand  
3 the cover letter correctly: the identity of  
4 25 individuals that are -- that were the plaintiffs  
5 under the Camp Lejeune Justice Act. Their Social  
6 Security numbers is one of the data you were given;  
7 is that correct?

8 A. Yes.

9 Q. And it looks like you write on page -- and  
10 I'll scroll to it -- on page 2 --

11 (Scrolling.)

12 Q. -- that you were also provided not by the  
13 DOJ but by the VA Office of Patient Care Services  
14 Health Outcomes Military Exposures (HOME) Team gave  
15 you a chart of ICD-9 and 10 codes; is that correct?

16 A. Yes.

17 Q. What is the HOME team?

18 A. My understanding is that they are  
19 responsible for the oversight of exposures,  
20 specifically toxic exposures. So we have Agent  
21 Orange, which has been around since Vietnam; burn  
22 pit, which is recent with the PACT Act.

23 Q. And if you know, what is -- what's the  
24 responsibility of HOME team?

1 A. I do not know.

2 Q. Do you know why they were consulted to  
3 pull together the list of ICD-9 and 10 codes?

4 A. It's my understanding that Janine reached  
5 out to them because they were managing a big part of  
6 the PACT Act.

7 Q. Do you have any independent understanding  
8 of why these particular ICD-9 and 10 codes were  
9 selected?

10 A. I do not.

11 Q. Have you personally looked up these ICD-9  
12 and 10 codes that you were provided by HOME team?

13 A. As a team we did to validate that they  
14 aligned with as a first example bladder cancer.

15 Q. Do you know independently whether any of  
16 these ICD-9 and 10 codes include cancers for  
17 diagnoses that are in remission?

18 MR. CROMWELL: I'll object to form and  
19 foundation.

20 You may answer.

21 A. I do not know.

22 Q. Would it surprise you if several of them  
23 did include ICD-9 and 10 codes where the cancer was  
24 in remission?

1 MR. CROMWELL: Object to form.

2 You may answer.

3 A. I have -- I don't have an answer. It  
4 wouldn't surprise me, but it wouldn't -- I don't  
5 know whether they include them or not, and I am not  
6 sure.

7 Q. The bottom of the Exhibit 6 that's on the  
8 screen, the first page, with the Bates Stamp VHA\_2,  
9 it says, "These ICD codes assist in identifying  
10 specific care rendered to the 25 patients within the  
11 five conditions."

12 Can you tell me what you and/or your team  
13 meant with that sentence?

14 A. So we had the Social Security numbers, so  
15 we could identify the 25 individuals. There were  
16 three individuals who were not found at all in the  
17 database. We took the remaining patients that were  
18 found, the 22, and we used those ICD codes to  
19 identify clinical encounters and inpatient stays  
20 that were related to those ICD codes.

21 Q. Related in any way?

22 MR. CROMWELL: Object to form.

23 You may answer.

24 A. We did identify those that were quote,

1 unquote, in the primary or first position and those  
2 that followed, whether it be in the second or an  
3 additional position within the coding.

4 Q. On that point, let's go to your last page  
5 of this exhibit.

6 Did you help to prepare this page? It  
7 starts with "Per VHA Health Information Management  
8 System (HIMS) (VHA Coding)."

9 A. I did.

10 Q. All right. I want to take a moment and  
11 read it. Make sure we have the same understanding.

12 It says, "For inpatient services," so  
13 that's everything that would include hospitalization  
14 typically?

15 A. Yes.

16 Q. "Coding guidelines direct that the  
17 principal diagnosis," so that's the diagnosis that's  
18 in the principal spot; right?

19 A. Yes.

20 Q. It is, quote, "That condition established  
21 after study to be chiefly responsible for  
22 occasioning the admission of the patient to the  
23 hospital for care," end quote.

24 And then it goes on to say, "Since diagnoses

1 are only listed one time per code, for inpatient  
2 only one diagnosis is listed as primary. There are  
3 many conventions of ICDs that offer direction to  
4 combination codes to cover a scenario where one  
5 condition may affect another, but only one may be  
6 primary."

7 Did I read that correctly?

8 A. Yes.

9 Q. What is your -- why was this important to  
10 include in your letter, this VHA coding information?

11 A. It was gathered from the HIMS, Health  
12 Information Management System. Within the inpatient  
13 setting, we have one discharge diagnosis.

14 So the patient may have been admitted for  
15 multiple reasons, but the discharge ICD was based on  
16 the primary reason for the admission, so ...

17 Q. Are you saying that you think the  
18 discharge, the stop code is always the same as the  
19 primary or did I misunderstand you?

20 A. You misunderstood.

21 So there's no discussion about stop codes  
22 at this point. So for the inpatient services,  
23 there's a discharge ICD that is used and done by  
24 coding.

1 All inpatient records are managed by HIMS,  
2 encoded by HIMS.

3 Q. Did you pull the discharge codes?

4 A. The discharge ICD.

5 Q. And you pulled that in your data that you  
6 provided?

7 A. Yes, for those patients that had an  
8 inpatient stay related to those five categories of  
9 care.

10 Q. And so it's your testimony that the  
11 primary code and the discharge code should match?

12 MR. CROMWELL: Object to form.

13 You may answer.

14 A. Terminology wise I'm not sure, but it  
15 seems based on what HIMS provided, yes.

16 Q. Okay. And do you understand that the  
17 primary reason for the admission for inpatient  
18 services should -- is the condition that's chiefly  
19 responsible for the admission?

20 Did you understand my question or should I  
21 reword it?

22 A. Reword it, please.

23 Q. Okay. Thanks. Let me try it again.

24 Do you understand that the primary reason

1 that a patient goes to the hospital should be coded  
2 in the primary position?

3 MR. CROMWELL: Object to form. Foundation.  
4 You may answer.

5 A. My understanding is that a patient may  
6 present to an inpatient ward and have a diagnosis  
7 that is a working diagnosis, and that after  
8 treatment, upon discharge, the coders code the  
9 record with the primary diagnosis for the patient  
10 stay.

11 Q. I understand.

12 Let's read the paragraph that starts with  
13 "Thus": "Thus, a condition is not both a  
14 principal/first-listed and a secondary. The coder  
15 must determine by the documentation presented and  
16 the Official Guidelines for Coding and Reporting  
17 that are effective for that date of service --  
18 service, which condition to list first. If the  
19 documentation is unclear, coders must clarify with  
20 the attending provider."

21 Do you understand that paragraph?

22 A. Yes.

23 Q. What does that mean?

24 A. That means it's related --

1 MR. CROMWELL: Object to form.

2 A. Okay. Sorry.

3 MR. CROMWELL: That's okay.

4 You may answer.

5 A. Okay. That means it's related to the  
6 paragraph above, not the first paragraph, but for  
7 the outpatient services, and it means that for  
8 records that are coded by the coding department that  
9 they, in fact, are the ones that do the official  
10 coding prior to any quote, unquote, billing that  
11 might take place. If they're unclear, then they  
12 work with the attending provider to either have  
13 documentation updated and/or modify the code.

14 Q. All right. And let's read the paragraph  
15 above it: "For outpatient service."

16 So that's all of your professional  
17 services or primary care visits or oncology,  
18 anything not including the hospitalization; right?

19 MR. CROMWELL: Object to form.

20 You may answer.

21 A. All outpatient care.

22 Q. Okay. And it states "the first listed  
23 diagnosis is used in lieu of principal diagnosis."

24 So are those interchang -- but they're

1 interchangeably meanings for inpatient versus  
2 outpatient; is that your understanding? It's just  
3 first-listed versus principal?

4 A. Yes.

5 Q. And then it says, "List first the ICD code  
6 for the diagnosis, condition, problem, or other  
7 reason for the encounter/visit shown in the medical  
8 record to be chiefly responsible for the services  
9 provided," which is the same instruction essentially  
10 as for inpatient services. You should always put  
11 the first primary or first-listed diagnosis as the  
12 condition chiefly responsible for the visit; correct?

13 A. Yes.

14 Q. And then --

15 A. My understanding.

16 Q. Yes. And then there's this next sentence  
17 that says, "List additional codes that describe any  
18 coexisting conditions."

19 Would those additional codes, they would  
20 fall into a secondary diagnosis position as far as  
21 coding goes?

22 MR. CROMWELL: Object to form. Foundation.

23 You may answer.

24 A. Yes, as I understand it.

1 Q. All right. So we're in agreement that  
2 just because one of the ICD-9 and 10 codes that were  
3 provided to you in the chart, if those are in a  
4 secondary position, that does not necessarily mean  
5 it was the reason for the visit. It could have been  
6 coded as a coexisting condition at the time of the  
7 visit?

8 MR. CROMWELL: Object to form and  
9 foundation.

10 You may answer.

11 A. It's something I can't answer. A clinician  
12 would have to answer that.

13 Q. Well, you testified earlier that you  
14 pulled secondary diagnoses where these ICD-9 and 10  
15 codes fell into the secondary diagnoses positions in  
16 your data; is that true?

17 A. Yes.

18 Q. But according to your cover letter, it  
19 looks like you and/or your team is aware that there  
20 are occasions where the visit, if one of those  
21 diagnoses is in the secondary position, it could  
22 have just been coded as a coexisting condition and  
23 not related to the visit?

24 MR. CROMWELL: Same objection.

1 Q. Are we in agreement on that?

2 A. This would be something that a clinician  
3 would have to answer.

4 As an example, somebody goes to podiatry,  
5 and they have non-Hodgkin's lymphoma, and as a  
6 result, they have issues with their feet. That is  
7 not up to me to determine whether it's related or  
8 not. The clinician coded that, not me. So I'm not  
9 in a position to be able to answer those clinical  
10 questions.

11 Q. But you pulled the data where these  
12 diagnoses are in secondary positions; correct?

13 A. Correct. Yes.

14 Q. And you understand that there would need  
15 to be further analysis done when the diagnosis code,  
16 particularly, when the diagnosis code is in a  
17 secondary position as to whether that visit is  
18 related to that ICD-9 or 10 code or not; true?

19 MR. CROMWELL: Object to form. Foundation.  
20 You may answer.

21 A. I'm not sure. So repeat the question, so  
22 I'm not ...

23 MS. WALLACE: Sure. Madam Court Reporter,  
24 would you mind repeating that question, please.

1 THE STENOGRAPHER: Sure. Hold on.

2 (Last question was read back by the court  
3 reporter.)

4 MR. CROMWELL: Same objections.

5 You may answer.

6 A. So I would assume that a professional  
7 opinion by a practitioner might meet the need of  
8 that request. I'm not sure if a deep dive on an  
9 individual patient in that particular visit would  
10 be required, but that would be up for the health  
11 professional to answer.

12 Q. Then you agree with me that further  
13 analysis would need to be done by a practitioner  
14 regarding any visit where the diagnosis codes were  
15 in a secondary position?

16 MR. CROMWELL: Object to form and  
17 foundation.

18 You may answer.

19 A. My answer is I would rely on a health  
20 provider physician to answer that question.

21 Q. Okay. And so in your role, as a managerial  
22 cost accountant, or you are not -- you pulled the  
23 data, but you are not qualified to answer whether  
24 ICD-9s in the secondary position are or are not

1 related -- the visit was or was not related to that  
2 code; is that true?

3 A. Yes.

4 Q. Okay. You viewed it as your job to pull  
5 the data and someone else to further evaluate the  
6 relation of the data to the ICD-9 and 10 codes?

7 MR. CROMWELL: Object to form.

8 You may answer.

9 A. If necessary, yes.

10 Q. I'm sorry. Could you say that answer. I  
11 couldn't quite hear it.

12 A. Sure. If it was necessary to evaluate,  
13 that would go -- that would be a different role than  
14 a -- somebody from the managerial cost accounting  
15 office.

16 Q. Understood.

17 And so is that when -- in your sentence  
18 here, is that why you and your staff used the word  
19 "assist"? "These ICD codes assist in identifying  
20 specific care rendered to the 25 patients within the  
21 five conditions."

22 A. Yes.

23 Q. Okay. And your data assists but does not  
24 relate the care; is that fair?

1 MR. CROMWELL: Object to form.

2 You may answer.

3 A. I didn't catch that. Assist but not  
4 relate?

5 Q. Yeah. Your data assists in identifying  
6 care related to the five conditions, but you're not  
7 giving an opinion that it's related -- those care  
8 are related to the five conditions?

9 A. Correct.

10 Q. Okay. We are going to dive into what I  
11 consider to be, and you do not, the very complex  
12 process that is involved in your cost allocations.

13 And you actually do describe it thankfully  
14 in your cover letter, and we've talked about this  
15 earlier a little bit.

16 So I want to see if we can go step by step  
17 to understand how your cost estimations or allocations  
18 or assignments are made.

19 Can we start with the when a patient  
20 presents to a VA clinic. Who does the coding for  
21 that patient visit? Where does it go next? Can you  
22 walk us through in chronology how that works.

23 MR. CROMWELL: Object to form and  
24 foundation.

1                   You can answer, if you know.

2           A.       Based on my experience, a patient is  
3 scheduled into an appointment. A patient arrives.  
4 They're checked in. The patient sees a provider who  
5 documents and codes the encounter, the interaction  
6 with the veteran or patient.

7                   If the patient -- then the patient is  
8 checked out of the clinic. That's my understanding.

9           Q.       And who does the coding that we just  
10 talked about? And when I say the word "coding," I  
11 mean who establishes the primary diagnosis, the  
12 secondary diagnosis, the CPT codes, the diagnostic  
13 pointers, if any? Who does that?

14           MR. CROMWELL: Object to form and  
15 foundation.

16                   You may answer.

17           A.       Based on an outpatient visit, documentation  
18 and coding is done by the provider at the time of  
19 the visit and/or when recording or documenting the  
20 visit.

21           Q.       Do you have any idea how many providers  
22 there are under the VA system?

23           A.       I do not.

24           Q.       If -- would you imagine it would be in the

1 thousands?

2 A. Yeah.

3 MR. CROMWELL: Object to form and  
4 foundation.

5 You may answer.

6 A. Yeah. You know, 170 large medical centers,  
7 I would imagine it's definitely in the thousands, if  
8 not hundred thousand plus.

9 Q. And you serve nine -- over 9 million  
10 veterans through that -- through your VHA program?

11 A. Yes.

12 Q. All right. And so what -- how is the data  
13 that's produced at the provider level, where does it  
14 go next?

15 And I assume we're in an electronic -- you  
16 tell me, but are we -- is the VA all electronic or  
17 are we -- is it paper?

18 A. It's all electronic.

19 Q. Okay.

20 A. So where does it go next? So this is not  
21 within my scope of work.

22 Q. Okay.

23 A. I'm really not 100 percent sure on the, if  
24 you will, business work flows that relate to revenue

1 in coding.

2 Q. At what point do you become aware of the  
3 provider coding data that we just discussed in your  
4 line of work?

5 A. So we process on a monthly basis. The  
6 data is available on a daily basis in the CDW, but  
7 we pull a monthly extract of that data.

8 I do know that -- that the providers are  
9 to complete the record 7 days after the encounter.  
10 They have until 7 days after the encounter to  
11 complete the record. That includes at the end of  
12 the month where the close-out of those records  
13 should be completed by the 7th day, in this case, of  
14 October.

15 Q. All right. And do you agree with me that  
16 the reliability and validity of your accounting  
17 processes to come up with encounter data, it's very  
18 dependent upon the accuracy of the provider coding  
19 those primary, secondary CPT code diagnoses?

20 MR. CROMWELL: Object to form. Foundation.  
21 You may answer.

22 A. We're a derived database, and we pull in  
23 the data that is in the CDW or from the Vista  
24 record. So we do depend on the accuracy at the

1 provider in coding them.

2 Q. Is it -- how important is it to your  
3 department that the coding be accurate?

4 MR. CROMWELL: Object to form.

5 You may answer.

6 A. In some cases, it's important especially  
7 for reporting, not so much for costing because we  
8 don't cost the diagnostic code.

9 Q. You're saying, I believe, that you  
10 don't -- you don't do a cost per -- by the  
11 diagnostic code in the managerial accounting  
12 department?

13 A. Correct.

14 MR. CROMWELL: Object to form.

15 A. Okay. We cost by visit, encounter.  
16 Oftentimes it's time based.

17 Q. But -- so but the code -- all of those  
18 codes go into a visit encounter; isn't that true?

19 A. Yes.

20 Q. And so how important is the accuracy of  
21 all of the coding for a visit encounter to your  
22 department?

23 MR. CROMWELL: Object to form.

24 A. Very important for --

1 MR. CROMWELL: Go ahead.

2 A. Okay. Very important for reporting.

3 Q. And do you -- I think you testified that  
4 you're not quite sure where the provider data may go  
5 from the provider level before it gets to the CDW.

6 Did I understand that correctly?

7 A. True. I don't have a clear understanding  
8 of the business work flows for that.

9 Q. Okay. And are you -- do you have any  
10 knowledge of how vigorous or not vigorous any  
11 auditing of those codes is within a different  
12 department?

13 MR. CROMWELL: Object to form.

14 You may answer.

15 A. I do not.

16 Q. And in this case, when you pulled the data  
17 for these plaintiffs, did you -- did you or any  
18 other agency, to your knowledge, do any type of an  
19 audit to ensure that the coding was accurate for  
20 those plaintiffs?

21 MR. CROMWELL: Object to form.

22 You may answer.

23 A. We did not.

24 Q. And can you -- I still have the cover

1 letter on the screen for you.

2 I did want to distinguish, if you know,  
3 you put in the last sentence of VHA\_00002, quote,  
4 "This data does not include Community Care costs,"  
5 end quote; and then there's a footnote that you link  
6 to that describes the CCN system.

7 Do you have any independent knowledge of  
8 how different what you have done for VA data is from  
9 the community care billing system that they have?  
10 Do you have any knowledge of the difference between  
11 the two?

12 A. I do not.

13 Q. Do you know that the community care uses a  
14 contractor TriWest or Optum that actually processes  
15 billing and makes payments to providers which is  
16 paid by the VHA? Do you know that?

17 MR. CROMWELL: Object to form.

18 You may answer.

19 A. I'm aware that that is the process.

20 Q. Okay. And so do you have a general  
21 understanding that Community Care Network actually  
22 has actual billing and is not -- and does not do  
23 cost assessments or cost appropriations for their  
24 services through that program? Do you know that?

1 A. Yes.

2 MR. CROMWELL: Object to form. Foundation.  
3 You may answer.

4 A. Yes, I do know that.

5 Q. All right. And now, did you not pull  
6 that -- why did you not pull that billing data for  
7 your report?

8 A. So there's a separate office called IBC,  
9 and they maintain that data, and they report out on  
10 it.

11 Q. And you don't have access in the managerial  
12 accounting department to the billing data for  
13 Community Care Network; is that true?

14 A. We don't utilize that data.

15 Q. Are you saying you do have access to it?

16 A. Within the VA, I have access to most of  
17 the data sources, but there's many data sources I  
18 never pull from or look at, but based on my security  
19 clearance.

20 Q. And I think you testified earlier that you  
21 actually don't deal with billing data; is that true?

22 A. That is true.

23 Q. Okay. Let's go back to the process. This  
24 is as far as I am: The provider information is

1 encoded at the encounter level. We're not sure what  
2 happens in the meantime, but at some point, the  
3 provider data gets into the CDW system, which I  
4 understand to be the VA's central data repository;  
5 is that true?

6 A. Yes.

7 Q. All right. And so I want you to explain  
8 to me the next step, what you do with the data that  
9 is in the CDW from that point.

10 MR. CROMWELL: Object to form.

11 You may answer.

12 A. So we actually don't pull our data from  
13 the CDW; we pull it right from the VistA system that  
14 feeds the CDW, and we get a monthly extract from the  
15 VistA system.

16 Q. What's VistA?

17 A. I forget what it stands for, but it is the  
18 underlying electronic health record system. The  
19 front-facing GUI product is CPRS.

20 Q. So the data that you pulled for the  
21 plaintiffs, the ICD-9 and 10 data was pulled  
22 initially out of the VistA system?

23 A. So the data we pulled for this request,  
24 was done twofold. So we went into the CDW with

1 those Social Security numbers and those ICDs and  
2 identified those clinical encounters.

3 We then matched that up against our NDEs,  
4 national data extracts, for managerial cost  
5 accounting. So for the outpatient one, we used the  
6 outpatient NDE. For the inpatient, we used what we  
7 call the treating specialty NDE.

8 The primary source data that we bring in  
9 to the database comes from the VistA system or the  
10 Oracle Health system.

11 Q. I thought you testified that you pulled  
12 directly from VistA and/or Oracle, but I think  
13 you're saying you pulled from CDW and which was fed  
14 by VistA and Oracle; is that true?

15 A. I have to repeat that.

16 MR. CROMWELL: Object to form.

17 Q. I'm trying to understand did you pull the  
18 data from the CDW that was fed by VistA and Oracle  
19 or did you pull it directly from VistA or Oracle,  
20 the encounter data?

21 A. So the question was in terms of our cost  
22 accounting system, and our monthly extracts to do  
23 the processing for cost accounting, each facility  
24 pulls their own extracts from the VistA system,

1 and/or the Oracle Health system that is ingested  
2 into the managerial cost accounting database.

3 Q. I think we're talking about two different  
4 things.

5 A. We are.

6 Q. I'm still talking about the encounter data.

7 A. Okay. So you're talking about how we  
8 provided the data for this request?

9 Q. Yes.

10 A. Gotcha.

11 So we went into the CDW, and we used the  
12 outpatient visit data files to identify, based on  
13 the SSN number and the diagnostic code, to identify  
14 those encounters. That's for the outpatient piece.

15 For the inpatient piece we used the  
16 inpatient diagnostic data files, diagnosis data  
17 files, and we got those encounters, which are from  
18 admission to discharge, that length of stay.

19 Q. Okay.

20 A. We took that encounter information and  
21 went into our NDEs for outpatient, the outpatient  
22 NDE, and we identify, based on those encounters, a  
23 cost associated with that level of care or that  
24 treatment.

1           Did the same for the inpatient by using  
2           the MCAO treating speciality NDE.

3           Q.     Understand.

4           Let's see if I got it.  You pulled the  
5           encounter data from one database, and you compared  
6           it to the cost data from the MCAO outpatient NDE and  
7           the MCAO treating specialty NDE in order to do your  
8           cost assignments to the encounter?

9           A.     You got it.

10          Q.     Okay.  Can you tell me why your patient  
11          data does not include some of the coding information  
12          that is helpful to understand the clinical encounter,  
13          such as CPT codes or diagnostic pointers or CPT  
14          descriptors?

15          MR. CROMWELL:  Object to form and  
16          foundation.

17          You may answer, if you know.

18          A.     So our database contains a minimum dataset  
19          that allows us to do the cost accounting.  We do  
20          rely on -- in current state we do rely on the CDW  
21          for our reporting purposes.  So we will use that  
22          definitive data from the CDW to match up our cost  
23          accounting for some reporting purposes, where we  
24          don't have robust, if you will, clinical codes

1 and/or demographic information relative to the  
2 patient. Some of our requests are based on patient  
3 status, whether they be service connected or whether  
4 they be, you know, Vietnam era, et cetera.

5 Q. Do you not have access to some of that  
6 detailed information I just described through the  
7 CDW?

8 A. We do.

9 Q. Can you tell me why it wasn't pulled for  
10 the encounter-level data?

11 A. It wasn't pulled into the DSS or managerial  
12 cost accounting database because we have limitations  
13 on space and processing.

14 Q. But you agree with me that it would be  
15 helpful -- if we were trying to determine what the  
16 visit was related to, it would be helpful for that  
17 purpose; is that true?

18 A. No.

19 MR. CROMWELL: Object to form and  
20 foundation.

21 A. Okay. No. I don't agree.

22 So we went into the CDW. We identified  
23 that clinical encounter based on the Social Security  
24 number and the ICD code, whether it be a nine or

1 ten. We brought that back to the NDEs and matched  
2 that up.

3 Q. Yes. And it's -- I understand that it's  
4 not relevant to your cost assignment or your cost  
5 estimations, but would you agree with me that it  
6 would be relevant to better understand the reasons  
7 for the clinical visit?

8 MR. CROMWELL: Object to form and  
9 foundation.

10 You may answer.

11 A. No. The information exists. We have  
12 access to the information, and having a minimum  
13 dataset and a processing environment is more  
14 effective and efficient.

15 Q. So you disagree with me that it would be  
16 more instructive -- including CPT codes or HCPCS  
17 codes or CPT descriptors, you disagree that that  
18 would be more helpful to someone in understanding  
19 the reasons for the clinical visit?

20 MR. CROMWELL: Object to form and  
21 foundation.

22 You may answer.

23 A. My answer is that information is available  
24 to us for reporting purposes.

1 Q. Do you disagree with me that it's not --  
2 that's it helpful information to better understand  
3 the clinical visits?

4 MR. CROMWELL: Same objection and asked  
5 and answered.

6 You may answer.

7 A. My answer is it is available, and we  
8 accessed it, and we provided it as part of the  
9 report.

10 MS. WALLACE: And I'm sorry. I don't  
11 think it is asked and answered.

12 Madam Court Reporter, will you ask my  
13 question one more time. I just want to see if I can  
14 get a direct answer, please.

15 THE STENOGRAPHER: Sure. Hold on.

16 (Last question was read back by the court  
17 reporter.)

18 MR. CROMWELL: I'm sorry. Are you asking  
19 him to answer it again?

20 MS. WALLACE: Yes, please. I didn't hear  
21 a yes-or-no answer. I heard a different answer.

22 BY MS. WALLACE:

23 Q. But are you able to answer that question  
24 and if not, you can say so?

1 MR. CROMWELL: I have the same objections.  
2 You can answer, if you can.

3 A. I guess I'm not understanding the question.  
4 The information is available.

5 Q. Would you agree with me that that  
6 information, even though you talked about efficiency  
7 and how you wanted an efficient data pull, but would  
8 you agree with me that that information is relevant,  
9 if someone were trying to have a better understanding  
10 of each clinical encounter?

11 MR. CROMWELL: Object to form. Foundation.  
12 Asked and answered.

13 You can answer, if you can.

14 A. I'm going to have to say no. That  
15 information is available, and that's what we utilized,  
16 and it's within the VA corporate data warehouse.

17 Q. I believe -- didn't you testify earlier  
18 that a health care provider would need to determine  
19 if an encounter is related to a covered diagnosis?

20 A. Yes.

21 Q. And wouldn't -- as far as pulling extracted  
22 data, wouldn't it be helpful to a provider or to us  
23 and looking at your data extracts to have more details  
24 on the each encounter to better relate them to the

1 ICD-9 or 10 code?

2 MR. CROMWELL: Object to form. Foundation.  
3 Asked and answered.

4 You can answer, if you can.

5 A. I feel like I've answered it three times.  
6 I don't have a further response, I guess.

7 Q. Okay. So you had -- so what I understand  
8 is that you had access to more information on the  
9 encounter level but did not pull it into your data  
10 because -- or period.

11 MR. CROMWELL: Object to form.

12 A. Yes, we have access to additional data  
13 that wasn't pulled into this data request.

14 Q. And that additional data would include the  
15 CPT codes and descriptions of those and diagnostic  
16 pointers?

17 A. Oh, apologies. If that's the question, we  
18 did pull all that in terms of the ICD-10 codes that  
19 were requested. We did pull all of them in from the  
20 CDW into the data that was provided to you.

21 Q. Yes. You pulled ICD-9 and 10 codes?

22 A. Yes.

23 Q. Okay. And as far as coding, that -- for  
24 the visit encounter, the reason for the visit, that's

1 the primary data field that you pulled?

2 MR. CROMWELL: Object to form.

3 You can answer.

4 A. Along with the secondary or additional ICD  
5 codes that were used in that particular encounter,  
6 yes.

7 Q. Okay. Let's go back to talking about  
8 the -- unless it's time for a break? Is it?

9 Are you doing okay, Mr. Clarke?

10 A. Yes. Yep. Fine. Thank you.

11 Q. Great. Great. Let's go back to talking  
12 about the -- your data, your two cost extracts  
13 systems. I would like for you to explain to me  
14 the -- how the NDEs are created.

15 A. Okay.

16 MR. CROMWELL: Object to form.

17 You may answer.

18 A. Okay. So on a monthly basis, each medical  
19 center processes the data that they ingest into  
20 their database. We have a --

21 Q. And just to pause right there, I think  
22 you testified earlier that the things that matter  
23 are -- tell me what they're pulling. It's like  
24 duration of the visit, the amount of staff that were

1 assigned to that department, like tell me what  
2 matters that's getting pulled from the individual  
3 facilities into the NDE?

4 MR. CROMWELL: Object to form.

5 You may answer.

6 A. So what is being pulled into the database  
7 is the financial information. So we have financial  
8 extracts, and we have clinical extracts. That is  
9 pulled into each of the 170 databases for their  
10 monthly processing.

11 Q. Is it by department? By -- how is it  
12 organized?

13 A. Within each database, they have a  
14 structure that is at a department level from the  
15 director, chief of staff, those indirects, down to  
16 medical service that includes oncology, dermatology,  
17 surgical that includes orthopedics, et cetera.

18 Q. So let's take an example. Let's say it's  
19 the oncology department and let's say where I  
20 actually have one of the largest VAs in our state,  
21 right in Salisbury, North Carolina. So let's say  
22 we're at the Salisbury, North Carolina VA, and  
23 they're -- let's just say there are a large number  
24 of cancer patients in the month of September of 2025.

1           The Rowan County VA would take all of  
2 those -- so let's say it's hot and heavy in the  
3 oncology department. There's lots of treaters that  
4 are there. There -- everybody's being called into  
5 work. There's lots of cancers going on. They would  
6 take the snapshot of that month, like a very heavy  
7 cancer treatment month, let's just say, for example,  
8 and that's the type of data that might be pulled  
9 into your NDE formulas?

10           A.       So --

11           MR. CROMWELL: Object to form.

12           You may answer.

13           A.       Okay. So not a snapshot or maybe we can  
14 use that word, but it's pulling the actual encounter  
15 data that took place for that specific month.

16           Q.       And so if it's a very busy oncology month,  
17 for example, that data is going to be or that cost  
18 assignment or cost estimate even, for indirect  
19 costs, that's going to be higher out of the Rowan  
20 County Salisbury VA for that particular month in  
21 that example. That would be a higher cost assignment  
22 if it was many people that were coming in with  
23 cancer in any given month; is that true?

24           A.       No. That's not -- you know, it's very

1 dependent. It's variable. Right?

2 So if they increase the staff, and increase  
3 the staff to the point where they had excessive staff,  
4 so they have excessive dollars, in that department,  
5 it would be potentially higher costed.

6 If they saw those patients with the existing  
7 staff and didn't bring additional staff in, it's  
8 highly likely that would be a hopefully more  
9 efficient and less costed clinic encounter.

10 Q. Okay. And the opposite is true. Let's  
11 say there were no cancers in the Rowan County VA for  
12 the month of September 2025, it might -- if once  
13 this goes through your labor mapping formula, it  
14 might be a lower cost assigned to that plaintiff for  
15 that care?

16 MR. CROMWELL: Object to form.

17 You may answer.

18 A. Okay. So it would be higher because you  
19 have the same staff, but you have less patients.

20 Q. And what if they -- does it ever happen in  
21 the VA where they just don't call somebody in or is  
22 that not?

23 A. You know, I think --

24 MR. CROMWELL: Object to form.

1           You can answer.

2           A.     I think our data allows the administration  
3 to monitor that and make decisions about resource  
4 allocation.

5           Q.     But the fluctuation of the cost assignment  
6 or cost estimate for indirect, that is in direct  
7 relation to what the data shows for that month as to  
8 what was going on in any given department?

9           A.     The indirects within the direct department  
10 are based on FTE. So the number of employees that  
11 are assigned to that department, oncology, will  
12 impact the indirect allocation.

13          Q.     But do I understand that -- so there's not  
14 just a -- this is a monthly analysis. So there's  
15 not just a flat cost as it relates to a CPT code or  
16 to an ICD code. The fluctuations, as far as I  
17 understand, have to do with mapping and resources  
18 and doctors and the number of patients coming in to  
19 any given department. Am I understanding that  
20 correctly?

21          A.     You are, yes.

22          Q.     Okay. And so if we said one of our  
23 plaintiffs, Mr. Criswell, goes in for his checkup  
24 for his bladder cancer, and it's a very, very busy

1 month -- they had to hire extra staff -- his cost  
2 assignment regardless of the quality of care or what  
3 was done at his visit, he might have a higher cost  
4 assignment just because it was a busy month in the  
5 oncology department?

6 A. It's possible. I think it's -- you know,  
7 it's very variable. So you have an oncology  
8 department that might be run by a nurse practitioner  
9 at your VA. You may have at a different VA, in  
10 Connecticut, an oncology department that's run by a  
11 hematologist. The pay for those two positions are  
12 different; right? The provider gets more money.  
13 And so, likely, based on this same amount of  
14 patients seen in both clinics, that you would have a  
15 lower cost with the nurse practitioner than you  
16 would with a medical doctor.

17 So it varies based on how the facility  
18 staffs that particular department.

19 Q. Understood.

20 And the difference in staffing is really  
21 unrelated to any individual plaintiff. They would  
22 have the same visit no matter what. It really has  
23 to do with the collective number of resources for  
24 that particular department?

1 A. And facility. Correct.

2 Q. And facility.

3 Okay. I think we are at a -- I think  
4 we're at another hour.

5 Is it a good time for a break, Mr. Clarke?  
6 And I can't remember are you on East Coast time?

7 A. Yes.

8 MS. WALLACE: Okay. Michael, I'm happy to  
9 keep going. Let's go off the record maybe for a  
10 moment.

11 MR. CROMWELL: Okay.

12 THE VIDEOGRAPHER: Going off the record.  
13 The time is 11:59 a.m.

14 (Short break taken.)

15 THE VIDEOGRAPHER: We are now back on the  
16 record. The time is 12:12 p.m.

17 MS. WALLACE: Thank you. Mr. Clarke, I  
18 think you're muted.

19 THE WITNESS: Okay. I'm all set to go.

20 MS. WALLACE: Perfect. Okay. Great.

21 BY MS. WALLACE:

22 Q. All right. Before the break, we were  
23 talking about the NDE, and we had established that  
24 you took the patient encounter data, and you, I

1 believe, and this is in your cover letter, you  
2 joined it with the NDE cost assessment data; is that  
3 true?

4 A. Yes.

5 Q. All right. I want to take a moment and  
6 talk about the NDEs and what they are, and I know  
7 we've kind of talked about it some today, but the  
8 cost numbers that you have presented in those two  
9 databases, the MCAO outpatient NDE and the MCAO  
10 treating specialty NDE, they -- they're official  
11 outputs from the MCA system; is that true?

12 A. Yes.

13 Q. And each of those NDEs has dozens of  
14 fields and formulas that define how costs are  
15 assigned; is that true?

16 A. Yes.

17 Q. And those definitions are explained in a  
18 document called the MCAO NDE Technical Guide; is  
19 that true?

20 A. Yes.

21 Q. Can you tell the Court what is that guide?

22 A. It provides information relative to the  
23 approaches used for processing the derived data from  
24 the fiscal system, and from the medical records

1 system.

2 Q. Do you have access to the MCAO NDE  
3 Technical Guide?

4 A. Right now?

5 Q. (Nods.)

6 A. I do not have it. I could get it, but I  
7 don't have it in front of me.

8 Q. But you -- that's available for you to  
9 review in your role; is that true?

10 A. Yes.

11 Q. Do you know is the MCAO NDE Technical  
12 Guide, is that available to the general public?

13 A. No. It's available to VH -- VA staff that  
14 have access to the VA system.

15 Q. Was it produced to the -- was it produced  
16 in this case to support the costs estimations that  
17 you produced?

18 A. Is this an exhibit that was provided?

19 Q. No. Did you produce the MCAO NDE Technical  
20 Guide?

21 MR. CROMWELL: Object to form.

22 I guess to who, I guess, would be --

23 Q. To -- we'll start with to the DOJ?

24 A. I'm not aware if Janine provided that

1 document, but it's an available document that is  
2 updated on a yearly basis, if needed.

3 Q. And without the technical guide, I  
4 wouldn't be able to tell -- the plaintiffs wouldn't  
5 be able to tell what types of costs are included in  
6 the direct versus indirect; is that true?

7 MR. CROMWELL: Object to form.

8 A. Yes, that's a true statement.

9 Q. And I also wouldn't be able to tell how  
10 overhead costs such as utilities, security, or  
11 administration is spread across encounters; is that  
12 true?

13 A. It's true that document provides that  
14 information.

15 Q. And if the allocation roles change from  
16 year to year, those changes are only documented in  
17 the technical guide; is that true?

18 MR. CROMWELL: Objection to form.

19 A. We have other documents --

20 MR. CROMWELL: Object to form.

21 You may answer.

22 A. Thank you.

23 We have other documents that guide the  
24 facilities and their yearly conversion activities.

1 Q. What are those other documents?

2 A. So on a yearly basis we have modifications  
3 or changes that might take place based on changes  
4 that come from either legislation and/or VHA  
5 guidance, and we would publish that to the field, so  
6 that they're aware of some of those changes that  
7 might take place.

8 Q. All right. Is any of the other guides  
9 available to the general public?

10 A. Not to my knowledge.

11 Q. So without the NDE technical guide or one  
12 of those other guides, no outside auditor could  
13 independently verify how the numbers were calculated;  
14 is that true?

15 MR. CROMWELL: Object to form.

16 A. That is true. They would need those  
17 technical guides to understand the process used to  
18 identify the cost.

19 Q. And the outputs that you've produced in  
20 this case, for the plaintiffs, the formulas that  
21 generated them are not visible to the Court, and  
22 they haven't been made visible to the plaintiffs; is  
23 that true?

24 MR. CROMWELL: Object to form.

1           You may answer.

2           A.     MCAO data is not public front-facing, so  
3     that would be true.

4           Q.     So the MCA cost estimates, from my  
5     perspective, are more like black box outputs?

6           MR. CROMWELL: Object to form.

7           Q.     Do you understand what I mean by that?

8           A.     Please explain.

9           Q.     I can't tell as I sit here today, based on  
10    the information that you -- that I have access to  
11    how they were reached?

12          MR. CROMWELL: Object to form.

13          You may answer.

14          A.     I would agree.

15          Q.     Let's talk about how the joining process  
16    was done between the two systems that we've talked  
17    about, the encounter data to the NDE data.

18                 Can you explain to me how that data was  
19    joined.

20          A.     We took the SSN numbers, identified the  
21    patients within the corporate data warehouse. We  
22    looked in the outpatient visit files. We looked in  
23    the inpatient diagnosis files, got those encounters.

24                 We looked at those encounters for the

1 existence of those ICD codes that were provided to  
2 us from the HOME team.

3 We then took that information, and we  
4 matched that up against our encounter information  
5 for that same visit, same day, same time, to come up  
6 with the cost associated with that care that was  
7 provided.

8 Q. And my question is a tiny -- I think it's  
9 a little more technical where did you apply -- like  
10 how did you actually merge or join the two differing  
11 Excels? Like, were they inner joins, outer joins,  
12 left joins, right joins?

13 A. This was all done with --

14 MR. CROMWELL: Object to form.

15 A. Okay. So the three individuals that I had  
16 identified: Kent Coburn, Tamara Bernard, and Belinda  
17 Mink have SQL skills, Structured Query Language, and  
18 that's how they did the join.

19 Q. So you did not personally do the join?

20 A. Correct.

21 Q. And the two people that did, tell me it's  
22 Kenneth Coburn and Tamara Bernard?

23 A. And Belinda Mink.

24 Q. So if I had a question about how the data

1 was joined, you are not the right person to answer  
2 that question?

3 MR. CROMWELL: Object to form.

4 A. Correct.

5 Q. Okay. I'm going to ask the same question  
6 for -- and let me put Exhibit 6 back on the screen  
7 for you in case it helps.

8 (Attorney Wallace shared her screen.)

9 Q. I have the same question for how was the  
10 data rolled up, and I understand these are technical  
11 words, you know, I believe, as far as SQL skills go.

12 So how was the data rolled up?

13 A. Rolled up for the purposes of the report,  
14 the costing report that we developed?

15 Q. Yes, sir.

16 A. Yes. So we took and rolled it up under,  
17 you know, if you will, three levels. So we had the  
18 total cost. We had primary and secondary codes. We  
19 also had the direct care cost, primary and  
20 secondary.

21 We took the inpatient data, if it existed  
22 for any of those 25 plaintiffs, and added that to  
23 the overall cost, both total and -- excuse me -- total  
24 cost and direct cost.

1 Q. Did you do that process of rolling up  
2 those -- the data or would that have also been those  
3 three individuals you just named?

4 A. It was the three individuals, the team  
5 that did that and presented it to myself and Janine.

6 Q. And if I had questions about how the data  
7 was rolled up, they would be the best -- one of the  
8 three of them would be the best person to answer  
9 that question?

10 MR. CROMWELL: Object to form.

11 You may answer.

12 A. Okay. You know, I'm very aware of how  
13 they rolled it up, and it was based on the SSN  
14 number and the diagnostic codes.

15 Q. So are you the right one to answer that  
16 question?

17 A. Sure.

18 MR. CROMWELL: Object to form.

19 Q. Okay. Now, it says "provided rolled-up  
20 cost data at three levels."

21 I understood and tell me if I'm  
22 misunderstanding that the three levels were the CDW  
23 and the two MCAE -- the two NDE databases. Are  
24 those the three that were rolled?

1           A.     I think what this is alluding to is that  
2     it was rolled up based on, you know, the Social  
3     Security numbers and the ICDs, either the primary,  
4     secondary, and then a combination of primary and  
5     secondary together.

6           Q.     Okay.  And so when you use the word  
7     "rolled up," will you tell me what that means to  
8     you?  Is that more of a query or explain to me what  
9     rolled up means?

10          A.     Rolled up means that a specific plaintiff  
11     veteran, may have had multiple encounters related to  
12     their track, and, therefore, it was rolled up into a  
13     summarized cost for all of that care through 2005 to  
14     December of 2025.

15                 That is for the first iteration of data  
16     provided, and then there was a request for all-in  
17     data that is not rolled up.

18          Q.     Was that rolling up process the product of  
19     a structured query language, an SQL query?

20          A.     Yes.

21          Q.     And did you produce the SQL queries that  
22     were done for that process?

23          A.     I did not --

24                 MR. CROMWELL:  Objection to form.

1 A. Okay. I did not; the team did.

2 Q. The team did?

3 A. Yes.

4 Q. Where can I find the SQL query?

5 A. I don't believe it was requested.

6 Q. But you have it? You could produce it?

7 MR. CROMWELL: Object to form.

8 A. Yes.

9 Q. And what would it tell me?

10 A. It's code. That would tell you the  
11 algorithm used to pull the data and to roll the  
12 data, summarize the data.

13 Q. Do you know what an enterprise resource  
14 diagram is?

15 A. No.

16 Q. Do you have a data dictionary for the NDE  
17 files?

18 A. Is that a question?

19 Q. Yes, it is.

20 A. Do we have a data dictionary? Yes.

21 Q. For the NDE files?

22 A. I would have to go and see if it's specific  
23 to the NDE files or the process.

24 Q. You're unsure?

1 A. Yes.

2 Q. Can -- I'm going to put in the chat  
3 Exhibit -- what's been previously marked as  
4 Exhibit 11.

5 (Document was premarked Exhibit No. 11 for  
6 identification.)

7 Q. And I'm going to put it on the screen for  
8 you as well. This exhibit has a Bates Stamp number  
9 of CLJA\_VHA\_8.

10 And I'm going to share it for you.

11 (Attorney Wallace shared her screen.)

12 Q. What is this? Do you recognize this?

13 A. Yes.

14 Q. What is this, please?

15 A. These are data definitions that were  
16 provided to DOJ at their request.

17 Q. We have talked about a number of these  
18 today, but I do want to walk through -- I do want to  
19 walk through the MCA Total Cost, MCA Total Direct  
20 Care Cost, MCA Stop Code, and the Treating Specialty.  
21 I don't think we've discussed those yet today.

22 Would you mind explaining to me in your  
23 own words what the MCA Total Cost that you pulled  
24 for the plaintiffs was?

1 MR. CROMWELL: Object to form.

2 You may answer.

3 A. Thank you.

4 The total cost is both the indirect and  
5 the direct care cost combined to make up the total  
6 cost.

7 Q. Were you asked by the DOJ to pull direct  
8 and indirect care costs or was that a decision that  
9 was independently made by your agency?

10 A. I am not sure of that question. That  
11 might have come from Janine.

12 Q. All right. And what is the difference  
13 between the MCA Total Cost and the MCA Total Direct  
14 Care Cost?

15 A. So the direct care cost does not include  
16 the indirects, and it is truly the cost that  
17 includes labor, supplies, equipment, and support  
18 staff in that department.

19 We used oncology as an example, and those  
20 costs, those direct care costs are, indeed, married  
21 up against the encounters, the clinical information,  
22 to come up with a costed direct care cost.

23 Q. And that's that variable monthly VA-specific  
24 facility specific number that is derived through the

1 formula in the NDE Technical Guide?

2 A. Yes.

3 MR. CROMWELL: Objection to form.

4 Q. What was your answer, sir? I'm sorry.

5 A. Yes.

6 Q. Okay. And this cost, as I understand it,  
7 has this larger trickle down, indirect cost estimation  
8 excluded from it, and I think it says, for example,  
9 VISN, that's like that regional overhead is out;  
10 central office overhead, out; indirect services are  
11 out.

12 Is that -- am I reading that correctly?

13 A. Yes.

14 Q. Okay. So if we really -- as far as a cost  
15 estimation goes, if we wanted to estimate the costs  
16 during that month, of course which we understand  
17 fluctuates based on demand and staffing, if we  
18 wanted to estimate the cost -- the estimated cost of  
19 a care visit during any given month, but we didn't  
20 want to include all these external trickle down  
21 costs, this is the total that we would look at, MCA  
22 total direct care cost?

23 MR. CROMWELL: Object to form.

24 You may answer.

1 A. Yes.

2 Q. All right. And what is and why is  
3 it -- what is it and why is it important, the MCA  
4 Stop Code, please?

5 A. So the MCA Stop Code is a clinical  
6 identifier that indicates the level of care that was  
7 provided. Each specific modality of care has a stop  
8 code, whether it's in radiology, mental health,  
9 medicine, that is the encounter-level data that we  
10 use to cost an outpatient product.

11 Q. So a stop code is important for cost  
12 estimation purposes in the accounting department  
13 because -- tell me if I understand correctly -- that  
14 is what identifies the department that is being  
15 analyzed?

16 MR. CROMWELL: Object to form.

17 A. The service that --

18 Q. Did you answer that, Mr. Clarke? I'm  
19 sorry. I couldn't hear your answer.

20 A. The service that is being provided. You  
21 might have a lab visit 108 stop code. You might  
22 have a dermatology 304 stop code.

23 Q. Doctors are important to the coding, to  
24 the formula; is that true?

1           A.     It is -- it's an internal code used by the  
2 Office of Finance managerial cost accounting to  
3 identify the clinical service provided at the  
4 encounter level.

5           Q.     For formula purposes?

6           MR. CROMWELL:   Object to form.

7           A.     It's used in --

8           MR. CROMWELL:   Go ahead.

9           A.     -- the formula for the development of, if  
10 you will, the assignment of the cost, yes.

11          Q.     And tell us the -- define and tell us the  
12 significance, from your perspective, of the TRT,  
13 please, the treating specialty?

14          A.     The treating specialty is internal to VHA.  
15 It's not something used in the community. The  
16 reason we put this in is because we use the treating  
17 specialty NDE to provide the cost data for the  
18 inpatient stays.

19                 The treating specialty NDE has all of the  
20 data related to that episode of care or length of  
21 stay from admission to discharge. They may have  
22 been in a psychiatric bed. They may have been in a  
23 general medicine bed.

24          Q.     The MCA stop code, the treating specialty

1 code, do you know whether those are found in billing  
2 practices or are these criteria unique to the VHA cost  
3 assessment accounting process?

4 MR. CROMWELL: Object to form.

5 You may answer.

6 A. They're both unique to the VA.

7 Q. Is quantifying MCA Total Cost and MCA  
8 Direct Care Cost and MCA Indirect Care Costs, is  
9 that also a unique process to the VHA as opposed to  
10 other billing systems?

11 MR. CROMWELL: Object to form.

12 A. So the MCA data is not a billing system.  
13 It's an activity-based cost accounting system, and I  
14 do believe that we align with the community -- for  
15 those that use it, align with the community  
16 standards.

17 Q. What do you mean by "align with the  
18 community standards"?

19 A. For activity-based cost accounting.

20 Q. Are you saying other -- other insurance  
21 providers when they do accounting, they might use  
22 total cost or are you -- is it your testimony that  
23 it is a unique system to the VHA?

24 MR. CROMWELL: Object to form.

1           A.       I'm saying that other hospital systems,  
2           not to my knowledge any insurance companies, but  
3           other hospital systems have activity-based cost  
4           accounting systems that they use. There are other  
5           vendors in the community that offer activity-based  
6           cost accounting software.

7           Q.       And do you know whether any of that data  
8           is associated with billing practices?

9           A.       I do not know.

10          Q.       Do you know -- do you know what -- do you  
11          understand what an offset is?

12                   MR. CROMWELL: Object to form.

13          A.       Yes, I do.

14          Q.       Can you define it for me in your  
15          understanding.

16          A.       My understanding is that it is an amount  
17          of money that would quote, unquote, offset the  
18          original distribution of an award for some kind of  
19          payout.

20          Q.       Typically would a payment need to be  
21          provided in order for an offset to apply?

22                   MR. CROMWELL: Object to form and  
23          foundation.

24                   You may answer.

1 A. I don't know.

2 Q. Do you -- does the VA bill its veterans?

3 MR. CROMWELL: Object to form.

4 You may answer.

5 A. The VA does bill through the Office of  
6 Revenue.

7 Q. What are the circumstances under which the  
8 VA bills?

9 MR. CROMWELL: Object to foundation.

10 You can answer.

11 Q. If you know?

12 A. I am not familiar with those business work  
13 flows. That would be better answered by the Office  
14 of Revenue.

15 Q. Are you familiar with the Medical Care  
16 Costs Recovery Act?

17 A. No, not in detail.

18 Q. Do you know -- and I think you testified --  
19 and tell me if I'm wrong -- that the -- you -- in  
20 your department, you're not aware of the circumstances  
21 that a bill would be given to a veteran; is that  
22 true?

23 A. That is true.

24 Q. Do you know if veterans, under the Camp

1 Lejeune Justice Act, have been provided with their  
2 billing if they ask for it?

3 MR. CROMWELL: Object to form.

4 A. I don't know that.

5 Q. You don't know whether they were or were  
6 not provided with billing?

7 A. That is not within our scope of work. I  
8 would assume that they would be eligible for that;  
9 that they would just request it through Freedom of  
10 Information Act, but I don't know the process.

11 Q. I want to show you an exhibit that has  
12 been previously marked as Exhibit 27.

13 (Document was premarked Exhibit No. 27 for  
14 identification.)

15 Q. And I'm going to put it on the screen for  
16 you.

17 (Attorney Wallace shared her screen.)

18 Q. Do you know an individual Kimberly M. Rich,  
19 a paralegal specialist with the Department of  
20 Veteran Affairs Office of General Counsel?

21 A. No.

22 Q. All right. This document that's on the  
23 screen is a request from my law office, Wallace &  
24 Graham, to Kimberly Rich, requesting billing records

1 for Camp Lejeune cases.

2 Can you see that there on the screen?

3 A. Yes.

4 Q. And I'm going to scroll up to her  
5 response, and this is Kimberly Rich. The date of  
6 this email, as you see, is October 6, 2022, and  
7 she's writing it to Jamie Anderson who has an email  
8 address of Wallacegraham.com.

9 Is says, "Hi, Jamie, when VA creates and  
10 submits bills, it is to assert a claim for  
11 reimbursement for medical care provided at the  
12 negligence of a (nongovernmental) third party.  
13 Being that VA is a Federal agency, VA does not  
14 create a claim for reimbursement when the U.S.  
15 government is the liable party. One Federal agency  
16 does not bill another."

17 Do you see that?

18 A. I do.

19 Q. And it looks like she then quoted from the  
20 Federal Tort Claim Act, stating, "The Federal Tort  
21 Claim Act (FTCA) (28 U.S.C 2671) allows the U.S.  
22 Government to be sued for the negligent acts of  
23 Federal employees. In these cases, the U.S.  
24 Government is the defendant, and we do not generally

1 bill other Federal agencies. Per the Medical Care  
2 Cost Recovery Act, the U.S. is entitled to recover  
3 for care given to a person under circumstances  
4 creating a tort liability upon some third person,"  
5 and then she bolded this text in parentheses it  
6 says, "(other than or in addition to the United  
7 States.)"

8 Do you see that there?

9 A. I do.

10 Q. And so does it appear to you from this  
11 email that a CLJA claimant was denied access to VA  
12 medical billing?

13 MR. CROMWELL: Object to form and  
14 foundation.

15 A. I have no idea what the request is or I'm  
16 not familiar with this at all.

17 Q. All right. Okay. And I think you testified  
18 earlier that -- are you aware as to whether the  
19 individuals that you provided searches for, whether  
20 they have ever been provided with medical billing or  
21 whether they even have ever requested compensation  
22 for a medical billing associated with the VHA?

23 A. I am not aware.

24 MR. CROMWELL: Object to form.

1                   You may answer.

2           A.       Oh, I'm sorry.

3                   I am not aware.

4           Q.       And the data that you have pulled has  
5 nothing to do with billing; it's cost estimates from  
6 your department?

7                   MR. CROMWELL: Object to form. Misstates  
8 prior testimony. You may answer.

9           A.       Yes, it is cost assigned to those clinical  
10 encounters.

11           Q.       I am going to share with you an exhibit.  
12 I'm going to number it 25. It's not previously  
13 marked.

14                   (Document was marked Exhibit No. 25 for  
15 identification.)

16           Q.       And I'm going to share it on the screen  
17 for you.

18                   (Attorney Wallace shared her screen.)

19           Q.       Do you recognize the source of this  
20 document at the bottom -- oh, gosh. Sorry. My  
21 popup -- at the bottom of the document. It  
22 says -- it has a URL: [www.herc.research.va.gov](http://www.herc.research.va.gov)?

23                   MR. CROMWELL: Object to form and  
24 foundation.

1 Q. Do you recognize that website?

2 A. I recognize the HERC, which is a research  
3 entity, yes.

4 Q. What is HERC?

5 A. So they are -- I forget what the term  
6 stands for, but it's a research -- research entity  
7 of the VA, and I am aware that they do use our  
8 managerial cost accounting data for some of their  
9 studies.

10 Q. Is HERC a department within the VA?

11 A. Under the -- under research it is.

12 Q. Okay. So that's part of your agency, part  
13 of the VHA?

14 A. To my knowledge --

15 MR. CROMWELL: Object to form and  
16 foundation.

17 You may answer.

18 A. Thank you.

19 To my knowledge, yes.

20 Q. All right. And it looks like the way that  
21 they classify the managerial cost system I'm going  
22 to read what's in highlighted text, the first  
23 sentence: "The Managerial Cost Accounting System,  
24 (MCA, formerly Decision Support System or DSS) is an

1 activity-based cost allocation system that generates  
2 estimates of the cost of individual VA hospital  
3 stays and health care encounters."

4 Do you disagree with their term  
5 "estimates"?

6 MR. CROMWELL: Object to form.

7 A. I'm not sure the context that they're  
8 using it. I assume they're using it based on  
9 summarized data and average costs as opposed to  
10 individual level costing.

11 Q. Do you disagree with their use of the word  
12 "estimates"?

13 MR. CROMWELL: Object to form. Foundation.  
14 Asked and answered.

15 A. Based on not knowing the context, I don't  
16 disagree with it.

17 Q. It looks like they -- later in the  
18 document they discuss patient encounters.

19 Do you see -- do you see the paragraph  
20 that says, "Costs of intermediate products are then  
21 determined. Examples of intermediate products are  
22 chest X-rays, units of blood, 15-minute clinic  
23 visits, or days of stay in the intensive care unit."

24 Do you agree with that?

1 MR. CROMWELL: Object to form and  
2 foundation.

3 A. Yes.

4 Q. "They are called intermediate products to  
5 distinguish them from the final product -- a patient  
6 encounter, which is a bundle of intermediate  
7 products."

8 Do you agree with that?

9 MR. CROMWELL: Same objections.

10 A. Yes.

11 Q. Do you agree with their sentence that "The  
12 MCA is the most frequently used source of data for  
13 VA economic research"?

14 A. I don't have knowledge of that.

15 Q. The second to last paragraph states "MCA  
16 relies on preexisting VA databases for information  
17 on what care was provided and which patients  
18 utilized it. These data are combined with unit cost  
19 estimates to estimate the cost of hospital stays and  
20 outpatient visits."

21 Do you agree with that paragraph?

22 MR. CROMWELL: Object to form and  
23 foundation.

24 You may answer.

1           A.       We are a derived database where we extract  
2           the clinical and financial information into our  
3           database for processing, so, yes, I agree with that.

4           Q.       Okay. Great. Thank you.

5                    All right. We are going to look at some  
6           data.

7                    I am going to put on the screen and in the  
8           chat Exhibit -- what's been previously marked as  
9           Exhibit 5.

10                   (Document was premarked Exhibit No. 5 for  
11           identification.)

12           Q.       Oh, no. Close it.

13                    Okay. I've put in the chat an Excel  
14           document that bears the Bates Stamp number  
15           CLJA\_VHA\_1.

16                    And I'm going to put it up on the screen  
17           for us.

18                    (Attorney Wallace shared her screen.)

19           Q.       Do you recognize this exhibit?

20           A.       Yes.

21           Q.       What is this?

22           A.       This is the costed data summarized that we  
23           provided to the DOJ.

24           Q.       And do you know the date of this

1 production?

2 A. I don't recall the exact date we provided  
3 that.

4 Q. Do you know your cover letter read March?  
5 Do you know if it was produced before or how far  
6 before that cover letter that this was generated?

7 A. I believe the first iteration was before  
8 that, but I'm not certain on the date.

9 Q. Who pulled this data?

10 MR. CROMWELL: Object to form.

11 You can answer.

12 A. The team.

13 Q. The team -- do you know the individual  
14 that performed the SQL or the query in order to pull  
15 this data?

16 A. Kenneth Coburn, Belinda Mink, and Tamara  
17 Bernard.

18 Q. So they all were working together to pull  
19 this data?

20 A. Yes. Pull the data, validate the data,  
21 and produce the reports.

22 Q. Do you know what they did to validate the  
23 data?

24 A. They took the SSN numbers and married them

1 up against the CDW, so that we had a dataset that  
2 included all visits for those particular SSN  
3 numbers, and then used the diagnostic codes to, in  
4 turn, pull out the data related to those five  
5 tracks. Took that data --

6 Q. And --

7 A. Okay.

8 Q. Please. I'm sorry.

9 A. Took that data against the DSS or the  
10 managerial cost accounting database to match, and we  
11 did have exact matches, and that was the validation  
12 process.

13 Q. Do you know what they did to verify that  
14 the ICD-9 and 10 codes were correct?

15 MR. CROMWELL: Object to form.

16 A. We did not do that.

17 Q. Do you know why they categorized the data  
18 in the way that is depicted on the screen, and I'm  
19 going to read for the record what I mean by that.  
20 Column P, if you read with me, says "MCA Total Cost  
21 Primary Diagnostic Codes Only."

22 Column Q says, "MCA Total Direct Care Cost  
23 Primary Diagnostic Codes Only."

24 Column S says "MCA Total Cost Secondary

1 Diagnostic Codes Only."

2 Column T says "MCA Total Direct Care Cost  
3 Secondary Diagnostic Codes Only."

4 Column V says "MCA Total Cost Primary and  
5 Secondary Diagnostic Codes."

6 And column W says "MCA Total Direct Care  
7 Cost Primary and Secondary Diagnostic Codes."

8 Did I read that correctly?

9 A. Yes.

10 Q. Do you know why they pulled the data into  
11 these six columns and divided it in this manner?

12 A. I'm not sure if it was a request from DOJ  
13 or if the team -- Janine had decided that it would  
14 be best to provide additional data. So columns P,  
15 Q, S, and T are combined to make up columns V and W.

16 So I think our intention was to provide  
17 more data for decision-making.

18 Q. When you presented this data, did you or  
19 your department have any independent opinion as to  
20 which one of these fields was the appropriate one  
21 for an offset?

22 MR. CROMWELL: Object to form and  
23 foundation.

24 You may answer.

1           A.     No opinion.

2           Q.     And when you produced this information  
3 initially to the DOJ, did you produce the source  
4 data that supported these totals that are on the  
5 screen?

6           MR. CROMWELL:   Object to form.

7           A.     I am not aware that we provided the source  
8 data for this rollup until requested to do so, which  
9 was after the fact, after we produced this, we were  
10 requested for the source data, which we provided.

11          Q.     And when -- do you know whether when your  
12 team produced this summary, do you know whether the  
13 secondary diagnostic codes only, does that include  
14 any -- anywhere where that ICD-9 fell across any  
15 secondary diagnosis codes or in the second field?

16                   Are you following me?

17          A.     I am.

18                   So that field -- you know, that column  
19 represents any time that the diagnostic code fell  
20 into either the secondary column or beyond.

21          Q.     Thank you.

22                   And for the primary diagnostic code, would  
23 that ICD-9 or 10 code would have fell into only the  
24 primary diagnostic code line is your understanding?

1           A.       Correct.  And as the summary had indicated,  
2           you know, the primary diagnostic code is the first  
3           code in the outpatient environment.

4           Q.       All right.  And we -- just to be clear for  
5           the record, we are under the tab of Exhibit 5 with  
6           the Bates stamp VHA\_1 that says, Sum cost FY, which  
7           I imagine means Fiscal Year, 2005 through FP3 FY2025;  
8           is that true?

9           A.       Yes.

10          Q.       What's "FP3" stand for?

11          A.       December of 2024.  We work on a fiscal  
12          year basis.  Our fiscal year starts in October.  So  
13          next month will be fiscal period one of 2026.

14          Q.       And so tell me exactly the dates that this  
15          data ranges from, please, based on how this is  
16          labeled?

17          A.       Fiscal Year 2005 it starts October 1st of  
18          2020 -- 2004 --

19          Q.       Through --

20          A.       -- fiscal period -- understood?

21          Q.       Yes, sir.

22          A.       Okay.

23          Q.       And will you tell me the end date as well?

24          A.       Sure.  The end date is calendar date

1 December 2024.

2 Q. December 1, 2024 or December 31, 2024?

3 A. December 31st.

4 Q. Okay. I'm exactly at 1:00 if you guys  
5 want me to break for lunch.

6 Do you want to go off the record to  
7 discuss?

8 MR. CROMWELL: Sure.

9 MS. WALLACE: Are we off the record?  
10 Sorry. I usually wait for an announcement.

11 THE VIDEOGRAPHER: Oh, sorry. Going off  
12 the record. The time is 1:00 p.m.

13 (Lunch recess.)

14 -----

15 AFTERNOON SESSION

16 1:34 p.m.

17 -----

18 THE VIDEOGRAPHER: We are now back on the  
19 record. The time is 1:34 p.m.

20 BY MS. WALLACE:

21 Q. Mr. Clarke, I hope you enjoyed your lunch.  
22 We're going to get right back into data.

23 A. Okay.

24 Q. We -- before the break, we were looking at

1 Exhibit No. 5, which was the Bates Stamp number  
2 CLJA\_VHA\_1, and you were -- I think you had just  
3 told me that you are not sure if you produced the  
4 underlying data initially to accompany that  
5 document?

6 MR. CROMWELL: Object to form.

7 You may answer.

8 A. You'll have to show me the document again.  
9 Apologies.

10 Q. Sure. No problem at all.

11 (Attorney Wallace shared her screen.)

12 Q. I'm showing you Exhibit 5.

13 Do you know if you produced raw data at  
14 the same time that you produced this summary  
15 document to the DOJ?

16 A. The raw data -- the raw data -- so let me  
17 make sure I'm answering this correctly.

18 So in terms of how did we produce this  
19 data, we definitely used the raw data.

20 In terms of what DOJ asked of us in terms  
21 of produce the raw data or the detailed data, we  
22 produced that and gave that to DOJ after the fact.

23 Q. Okay. And do you know approximately how  
24 long after the fact you were asked to pull the raw

1 data?

2 A. I don't remember the timeline.

3 Q. And if the raw data, which I'm about to  
4 show you, I believe, was produced to the Plaintiff  
5 Leadership Group on June 23, 2025, does that jog  
6 your memory at all as to when you might have pulled  
7 the raw data or you just aren't sure?

8 A. I'm not sure. I would suspect it's before  
9 that date, and, therefore, DOJ sent it over the  
10 fence after that date.

11 Q. Okay. As far as Exhibit No. 5 goes, it is  
12 my understanding that this is the document that was  
13 produced to DOJ economists in order to quantify VHA  
14 costs for these plaintiffs?

15 MR. CROMWELL: Object to form and  
16 foundation.

17 You may answer.

18 A. I'm not aware of that process.

19 Q. And if -- if it is true that this is the  
20 reliance material that was provided by the DOJ  
21 economists in their expert reports, this -- this  
22 data in Exhibit 5 in and of itself does not include  
23 any encounter level data.

24 Do you agree with me?

1 MR. CROMWELL: Object to form.

2 A. Yes.

3 Q. We're not able to see how many episodes of  
4 care, where the primary or secondary diagnoses  
5 occurred. We're not -- we're just -- we're not able  
6 to have any type of an encounter-level understanding  
7 of this summary table, Exhibit 5; is that true?

8 MR. CROMWELL: Object to form.

9 A. This is summary data only. That's true.

10 Q. Okay. Were you given -- were you and your  
11 team given the date of diagnoses for the plaintiff  
12 prior to pulling this summary data?

13 A. Yes.

14 Q. You were given each plaintiff's date of  
15 diagnoses?

16 A. Oh, I don't know the timeline for us being  
17 provided the -- I wouldn't say diagnosis. We were  
18 provided the five groups. That was at the beginning  
19 of the request: SSN number and the five groups that  
20 included bladder cancer, kidney cancer, et cetera.

21 Q. Did you pull those ICD-9 codes and  
22 10 codes -- did you -- for example, I see that you do  
23 have it marked in column N which plaintiff is  
24 suffering from which disease.

1 Do you see that there in column M -- N?

2 A. Yes.

3 Q. Did you only pull the ICD-9 and 10 codes  
4 associated with those diagnoses or did your team do  
5 a data joinder for anywhere where any of the ICD-9  
6 and 10s appeared for each of the plaintiffs?

7 MR. CROMWELL: Object to form.

8 You can answer.

9 A. So we pulled the data based on that alleged  
10 track for each individual.

11 Q. The one that's in N?

12 A. Correct.

13 Q. In the spaces where it says "No SSN Data,"  
14 tell us what that means, please.

15 A. That means that that SSN number did not  
16 exist in the corporate data warehouse, nor did it  
17 exist in the managerial cost accounting database.

18 Q. And so based on the summary document,  
19 that's Ronald Lee Carter, and that's Stephen Matthew  
20 Connard, and that is Terry Dyer; is that true?

21 A. If you highlight them and go slower, I can  
22 affirm that's true.

23 MR. CROMWELL: Yeah, to the extent you  
24 need to look at the spreadsheet, feel free to do so.

1 Q. Yes. And I'll tell you what I'm going to  
2 do just for a second. If it's okay with you, if you  
3 watch me, I'm going to hide some of these, so we can  
4 see the screen --

5 A. Okay.

6 Q. -- a little more clearly together.

7 A. Okay.

8 Q. Is that better, sir?

9 A. Yes.

10 So Carter, Ronald.

11 Q. Yes.

12 A. No SSN data.

13 Conrad, Joseph, Conrad Stephen.

14 Q. It's Connard?

15 A. Yes. No SSN number.

16 And then Dyer, Terry, no SSN data.

17 Q. Thank you.

18 And what does the indicator that's for  
19 multiple plaintiffs that says "No Specific ICD  
20 Data," what does that mean?

21 A. That means we did find the individual  
22 within the database, but we did not find any ICD codes  
23 related in this case that you've highlighted to  
24 non-Hodgkin's lymphoma.

1 Q. Understood.

2 And so if we wanted to read those  
3 together -- would you like for me to read them and  
4 you follow along or would you like to read them?

5 A. Please read. Thank you.

6 Q. Okay. Diane Rothchild --

7 A. Correct.

8 Q. -- Jose Vidana, Karen Amsler, Robert Fiolek,  
9 Allan Howard, Jacqueline Tukes, Mark Cagiano, and  
10 Jimmy Laramore; is that accurate?

11 A. Yes.

12 Q. And for the others you've categorized the  
13 summaries as indicated in Exhibit 5, you and your  
14 team; correct?

15 A. Yes.

16 Q. All right. Now, at some point you were  
17 asked to produce raw data that was used by which to  
18 pull the summary data in Exhibit 5; is that true?

19 A. Yes.

20 Q. How did that request come to you and/or  
21 your department?

22 A. My understanding it came from DOJ and that  
23 the plaintiff asked for additional information.

24 Q. Was Ms. Genovese still with your department

1 at the time that that request came in?

2 A. Yes.

3 Q. Who pulled the raw data, and I'm going to  
4 show you the exhibit, so we -- I can make sure we're  
5 really clear about it.

6 Okay. I'm going to share with you  
7 Exhibit 8, what's been previously marked as  
8 Exhibit 8.

9 (Document was premarked Exhibit No. 8 for  
10 identification.)

11 Q. And I'm going to put it on the screen.

12 (Attorney Wallace shared her screen.)

13 Q. Do you recognize this spreadsheet?

14 A. Yes.

15 Q. What is this?

16 A. This is, if you click on the outpatient  
17 tab, this is the -- and then slide to the right,  
18 this is the raw data for all of the patients that  
19 had been seen in the VA for any purpose.

20 Q. And so can you walk me through how your  
21 staff would have taken this raw data and produced  
22 the summary reports in Exhibit 5.

23 A. They would have done that based on the ICD  
24 codes.

1           So if you scroll up, you're going to see --  
2           and then maybe to the left a little bit.

3           Q.     I want to clear all the filters just make  
4           sure -- there we go.

5           A.     Excellent.

6           Q.     If you notice, the outpatient tab has  
7           approximately -- my goodness, we're in the 6,000s.

8           A.     Yep.

9           Q.     It has approximately 6,700 line items?

10          A.     6,700 plus.

11          Q.     Okay. All right. And you asked me to  
12          scroll to the top?

13          A.     Essentially this provides you with details  
14          as it relates to the patient and their SSN number,  
15          the station that they were provided the care in, the  
16          VISN, which is the regional office that oversees the  
17          station; and in some cases the division is different  
18          because it would have been a CBOC or potentially  
19          could have been a CBOC.

20                 The years, fiscal years that the service  
21          was offered or the encounter was generated, and the  
22          fiscal period within that fiscal year.

23                 You get the exact date of the visit.

24          That's the calendar date. The fiscal year is just

1 that, October to September 31st.

2 Encounter number is the number used to  
3 identify the service offered. It's a generated number  
4 with the last three digits representing the quote,  
5 unquote, stop code.

6 So column I can be aligned with column M  
7 and the last three digits of that encounter number  
8 indicates it was a general internal medicine  
9 appointment.

10 Q. We also have the columns J and K are  
11 labeled "Outpatient Total Cost," "Outpatient Total  
12 Direct Cost."

13 Were those numbers derived using the  
14 process that you described earlier in your  
15 testimony?

16 A. Yes.

17 Q. These do not represent billing of any  
18 kind; is that true?

19 A. They do not represent billing.

20 Q. And if you -- am I understanding you  
21 correctly that if you take column J which says  
22 "Outpatient Total Cost" and you subtract column K,  
23 that gives you the amount of the indirect cost for  
24 that line item?

1 A. Correct.

2 Q. So we're able to -- even though there's  
3 not a column that says outpatient total indirect  
4 cost, we're able to quite pretty easily deduce what  
5 that was based upon the two columns that we're  
6 looking at, J and K, with simple subtraction?

7 A. Correct.

8 Q. And sitting here today, do you, without  
9 having access to the formula that we talked about  
10 previously, that manual, we're not able to know  
11 exactly what went into the direct cost allocation?

12 MR. CROMWELL: Object to form.

13 A. Correct. This gives you the summary cost  
14 of that encounter.

15 Q. The summary estimated cost, like a  
16 reproduced retroactive cost?

17 A. It provides --

18 MR. CROMWELL: Object to form.

19 A. It provides the cost for that encounter.  
20 So the managerial cost -- managerial cost accounting  
21 system, the activity-based cost accounting system,  
22 it provides the cost to deliver that care.

23 Q. Yes, and can we agree it's a cost estimation  
24 based on the software and formulas that we talked

1 about earlier?

2 MR. CROMWELL: Object to form. Misstates  
3 prior testimony.

4 Q. You can answer, Mr. Clarke.

5 A. So it doesn't estimate. Right? It  
6 provides the costs based on the direct care costs  
7 that are part of that department, in this case,  
8 general medicine. That department has labor cost,  
9 potentially supply costs, maybe some equipment costs,  
10 and support costs that would go into costing that  
11 particular encounter or product.

12 Q. Okay. And this is not a cost that's  
13 billed to anyone; correct?

14 A. Correct.

15 Q. And it's not a recovered cost?

16 MR. CROMWELL: Object to form.

17 A. It is not a recovered cost.

18 Q. And it's based on fluctuations at any  
19 given point in time that the care was received at  
20 the VA center where the care was received?

21 MR. CROMWELL: Object to form.

22 A. Yes.

23 Q. Do you have -- in your department, I notice  
24 that there's no recovered co-pays or other health

1 insurance recoveries, or any type of line item like  
2 that in your database extract.

3 Do you have access to that information?

4 A. Not to my knowledge. We certainly don't  
5 work in that environment in our office. That's the  
6 Office of Revenue.

7 Q. So if the client had paid or been charged  
8 a co-pay for any of the services in this exhibit,  
9 you're not able to tell me whether -- you're not  
10 able to quantify that from your perspective?

11 A. Correct.

12 Q. And the same goes for if they had  
13 recovered any amount from other health insurance?

14 A. Correct.

15 Q. I notice -- we talked a lot earlier about  
16 CPT codes. I don't see -- and HCPCS codes for  
17 professional services. I do not see any of those in  
18 this work, your full data extract here.

19 Is that true?

20 A. Yes.

21 Q. And I think you testified earlier that you  
22 do have access to that information, but it wasn't  
23 pulled; is that true?

24 A. It wasn't requested, yes.

1 Q. Do you see any CPT descriptive column?

2 A. It's not included in this dataset.

3 You have the ICD-9s and 10s.

4 Q. Okay. And that's the universe of really  
5 of what we have access to other than the stop code  
6 and the stop code descriptions, which are used for  
7 formulaic purposes?

8 MR. CROMWELL: Object to form.

9 A. Correct.

10 Q. I was wondering why there is such a large  
11 quantity of null results that go all the way across  
12 for the primary and secondary sources, and I think  
13 I'm able -- if I'm smart enough, I think I can  
14 actually query for that, and when I did it the last  
15 time, it showed me that it was -- let me get it  
16 right.

17 A. Query for null, N-U-L-L.

18 Q. Exactly. Query for null.

19 A. You could type it in the search above.

20 Q. Oh, okay. Right here (indicating)?

21 A. No, I'm sorry. On the filter itself,  
22 yeah.

23 Q. Yeah, let's clear our filter first, and  
24 then I type it in here, up in search?

1           A.     No.  Drop down --  
2           Q.     I type it here (indicating)?  
3           A.     Yeah, drop down on your filter.  
4           Q.     Like that?  
5                    Oh, I did something wrong.  Hold on.  
6                    Did I do it wrong?  
7           A.     Yeah, just drop down -- go to your filter.  
8           Q.     Oh, go to the drop-down.  
9                    Okay.  Okay.  I've got to get the filter  
10          button back up.  Let's see this one.  
11                    Okay.  Oh, type it here (indicating)?  
12          A.     Yes.  
13          Q.     Thank you.  
14                    Oh, and then I can do it for this one too.  
15                    Okay.  Did I do that correctly?  
16          A.     Yes.  
17          Q.     And is that pulling -- tell me if I'm  
18          wrong -- 5,008 of 6,746 records of --  
19          A.     Yes.  
20          Q.     -- null all the way across?  
21                    MR. CROMWELL:  Object to form.  
22          Q.     Why would that be the case?  
23          A.     Scroll to the left, and you're going to see  
24          that some of these do not have diagnostic codes

1 based on the provider. So physical therapy, they  
2 don't diagnose. They're given an order or a  
3 referral to provide care.

4 The lab, we generally with lab and  
5 pharmacy don't have diagnostic codes associated with  
6 those either dispensed drugs, in some cases it is,  
7 but in most cases it's not, and for the lab draws,  
8 we typically do not get an ICD code for the lab  
9 work.

10 Q. What about this primary care medicine?

11 A. So if you scroll to keep that whole row  
12 highlighted --

13 Q. Mm-hmm.

14 A. -- we can look to see if, in fact, there's  
15 anything -- so there is one, and it's an ICD-9. So  
16 prior to introducing ICD-10s, the VA and nationally  
17 they used ICD-9 codes until an update was ...

18 Q. Mm-hmm.

19 I see. So then is it fair to say that the  
20 vast majority of this data pull if 5,008 of 6,746  
21 records are null, the majority of those appear to be  
22 laboratory prescription records that would not be  
23 associated with an ICD-9 or 10 code.

24 MR. CROMWELL: Object to form and

1 foundation.

2 You can answer.

3 A. In my opinion, yes, but a pharmacist or a  
4 lab phlebotomist would be in a better position to  
5 answer that; but, yes, that's my understanding.

6 Q. This one is null, and it's an X-ray and  
7 fluoroscopy. Should that have an ICD-9 or 10?

8 MR. CROMWELL: Object to form and  
9 foundation.

10 A. My -- I am not 100 percent sure in terms  
11 of if an ICD-9, a diagnostic code is required to  
12 conduct an X-ray. I'm not sure.

13 Q. What's a PM & RS physician?

14 A. Yeah, that's physical medicine and  
15 rehabilitation services.

16 Q. Okay. What about this line item that's  
17 highlighted that says, "Prosthetic and sensory aids  
18 services."

19 A. That is essentially a prosthetic device  
20 that was offered to the veteran or person.

21 Q. And it does not -- it's not typically  
22 associated with an ICD-9 or 10?

23 MR. CROMWELL: Object to form and  
24 foundation.

1                   You can answer.

2           A.       I am not sure if it's required in that  
3 case.

4           Q.       All right. So if we take -- let's clear  
5 all the filters.

6                   Sorry. I'm trying to clear it, but my  
7 Zoom is getting in the way.

8                   We should theoretically be able to  
9 reproduce the summaries from Exhibit 5 using  
10 Exhibit 8; is that true?

11          A.       That is true.

12          Q.       Okay. So if I went over here and let's  
13 do Mr. Fancher. So I'm sorting by Fancher  
14 outpatient only. Okay. And then I'm going to go  
15 over to this column and filter by just the ICD-9  
16 related to his kidney cancer which is C64.1.

17                   Do you want to confirm that with your  
18 chart in your cover letter?

19                   MR. CROMWELL: Object to form.

20          A.       I do not have anything in front of me.

21          Q.       Okay. Can I represent to you that -- well,  
22 actually I'll read them to you. How about that?  
23 It's -- for kidney cancer, ICD-10 is C64.1, 64.2,  
24 64.9, C65.1, C65.2, C65.9, and then the ICD-9 codes

1 are 189.0 through 189.4 and 189.8 to 189.9.

2 So if I select just that in the primary  
3 space, then I make sure that -- and then I look into  
4 each one of these to make sure one of those  
5 diagnoses is not in these spots. Are you watching  
6 me?

7 A. I am.

8 Q. Okay. So I'm going through -- let the  
9 record reflect I'm going through all the  
10 secondary -- I'm going through the primary, and I'm  
11 going through all the secondary, which is columns O  
12 through X to confirm that --

13 A. So what you did --

14 Q. Hmm?

15 A. Excuse me, but what you did is you filtered  
16 on the primary.

17 Q. Mm-hmm.

18 A. You would have to release the filter on  
19 the primary and go through every single secondary  
20 and look for that same code.

21 Q. Okay. Is there a way to do that all at  
22 the same time?

23 A. No, not to my knowledge.

24 Q. Okay. So I might miss one doing it this

1 way?

2 A. Yeah.

3 Q. Okay. Let's clear.

4 So on this one -- oh, I'd have to summarize  
5 it for each one. I'd have to summarize the total  
6 for each one?

7 A. You would.

8 Q. So maybe it would be easier to keep the  
9 data just like this and highlight it.

10 Let me ask you this way: Have you  
11 confirmed -- have you looked at this data to confirm  
12 that if you do the process that I'm doing right now,  
13 trying to make sure that all the primary and secondary  
14 for the plaintiffs equal the summary that's in  
15 Exhibit 5, have you or your team made sure that that  
16 was accurate?

17 A. Yes.

18 MR. CROMWELL: Object to form and  
19 foundation.

20 THE WITNESS: Sorry, Michael.

21 MR. CROMWELL: That's okay.

22 You may answer.

23 A. Yes, we have.

24 Q. Okay. Is the data that you have pulled in

1 Exhibit 8, is it static in time or does it change  
2 over time based on when it is pulled?

3 A. The data?

4 Q. And when I say the data I mean -- I'm  
5 specifically talking about column J and K, like  
6 could these amounts change based on the date that  
7 the dataset is pulled?

8 A. The data would be stagnant for 2005 through  
9 2024. We're still processing Fiscal Year '25.  
10 There is data in here that's for three fiscal  
11 periods and Fiscal Year '25.

12 That is subject to change based on the  
13 allocation methodology and monthly processing.

14 Q. But all data from -- it's your testimony  
15 that all data from 2005 to 2024 should be the same.

16 So if one of these numbers didn't add up  
17 for that period, that would not make sense to you?

18 A. Correct.

19 MR. CROMWELL: Whitney, just for the  
20 record, I'm trying to understand where the filters --  
21 did you guys create the filters on the spreadsheet?

22 MS. WALLACE: No. Well -- no --

23 MR. CROMWELL: Because I'm not familiar  
24 with them providing the filters or us producing them

1 in that manner.

2 MS. WALLACE: What do you mean?

3 MR. CROMWELL: The drop-downs, the arrows  
4 that you have for each of these.

5 MS. WALLACE: Oh, that's just an Excel  
6 feature.

7 MR. CROMWELL: Okay. Well, I --

8 MS. WALLACE: I didn't put it in any other  
9 form. It came exactly in this form. You can just  
10 add a drop-down.

11 MR. CROMWELL: You can add it, but I just  
12 want the record to reflect that wasn't how it was  
13 produced, and you've labeled it as 006 Bates number,  
14 and the actual Bates number doesn't have these  
15 filters. I understand it's a function of Excel.

16 MS. WALLACE: Exactly.

17 MR. CROMWELL: I understand that you're  
18 walking through as an example, but I just want the  
19 record to be clear, it wasn't something that they  
20 put on or we produced, so that's all.

21 MS. WALLACE: Yes. Yes. It's a  
22 function -- I'm using it as a function of Excel, but  
23 all the data is identical as to how it was produced.

24 MR. CROMWELL: Okay.

1 BY MS. WALLACE:

2 Q. Okay. So do you have -- has you and your  
3 team -- is there any other data source that you have  
4 where you've already done the analysis of -- that I  
5 was going to do earlier which is like going to the  
6 primary diagnoses code and just pulling the relevant  
7 fields, if that makes sense.

8 Do you have a different data that's doing  
9 that or did your team do it manually?

10 MR. CROMWELL: Object to form.

11 You can answer.

12 A. They used SQL language to produce the  
13 summary data.

14 Q. From this dataset or -- from this dataset?

15 A. Yeah.

16 Q. Okay.

17 A. So essentially a dataset is developed and  
18 within the SQL environment, the bottom part allows  
19 them to summarize data based on the query, based on  
20 what they want, and that's how they came up with the  
21 summarized data.

22 Q. And I don't have the SQL query that  
23 produced -- that took this Exhibit 8 and produced  
24 the summary in Exhibit 10?

1 MR. CROMWELL: Object to form.

2 Q. Is that true?

3 MR. CROMWELL: Sorry, Whitney. That's my  
4 fault.

5 MS. WALLACE: No, you're fine.

6 MR. CROMWELL: Object to form and  
7 foundation.

8 You may answer.

9 A. To my knowledge, you do not.

10 Q. Okay. I have now moved to a tab on  
11 Exhibit 8 that's titled "Inpatient."

12 Can you describe what this sheet is  
13 showing us compared to the outpatient sheet.

14 A. Sure. So, again, you've got the SSN  
15 number and patient name. Then you have the location  
16 where the inpatient event took place; the encounter  
17 number that is associated with that particular  
18 inpatient stay or those inpatient stays; the  
19 discharge date, if one exists; and then the  
20 inpatient total cost for that length of stay.

21 Q. Can the --

22 A. Next --

23 Q. Oh, I'm so sorry.

24 Where's the -- I see the discharge date.

1 Where's the admission date?

2 A. I don't believe that was provided.

3 Q. So I'm not able to tell the full range of  
4 time that they were hospitalized from this chart?

5 A. Correct.

6 Q. Okay. And is the same true for the  
7 inpatient sheet? We don't have indirect quantified,  
8 but we could do the math by subtracting column F,  
9 which is "Inpatient Total Cost" and subtracting  
10 column G, "Inpatient Total Fixed Direct Cost" to get  
11 the inpatient indirect cost?

12 A. Can you scroll over a little bit more,  
13 please.

14 Q. Yes.

15 A. So you have Inpatient Total Cost,  
16 Inpatient Total Fixed Direct Cost, and then you have  
17 the total, Inpatient Total, which should -- is there  
18 a column that's hidden?

19 Q. Let's make absolutely sure there's not.  
20 One second.

21 A. Yeah. There you go.

22 Q. Okay.

23 A. I think it was just a spacing issue.

24 Q. Okay.

1           A.       So the total cost you would take column G  
2 and H, combine those, and then subtract from the  
3 total to get your indirect cost.

4           So column G, Inpatient Total Fixed Direct  
5 Cost. What does that mean? That means that it's a  
6 fixed cost. It could be labor, a secretary on a  
7 ward. It could be a piece of equipment. It's a  
8 fixed cost.

9           Whereas, the Variable Direct Cost is  
10 typically labor and supplies, and that will vary  
11 depending on one, the treatment of the patient; and  
12 two, the length of stay.

13          Q.       Okay. Tell me again.

14          A.       Sure.

15          Q.       Tell me one more time. Give me a couple  
16 more examples because I just want to make sure I  
17 understand.

18                 Inpatient total fix direct cost is what?

19          A.       Fixed direct is essentially direct cost.  
20 That could be equipment, so no matter how many  
21 patients you see, that equipment is direct; right?  
22 It has to -- even if that patient doesn't use it,  
23 it's still equipment on the floor. That bed is  
24 still a piece of equipment on the floor available

1 for use.

2 There's also a secretary or a health  
3 assistant that would check in patients that would  
4 meet their needs. That is a fixed cost, whereas,  
5 the nursing staff would be variable direct, and  
6 their time spent with the patient at a higher acuity  
7 would require more time, and, therefore, a higher  
8 cost.

9 Q. Okay. And now are these costs then  
10 specific again to the VA facility where the care is  
11 occurring? Like how many secretaries there are or  
12 how much equipment is there?

13 A. Yes.

14 Q. So the cost to a veteran can depend for  
15 fixed direct on which VA facility he goes to, like,  
16 for example, if he goes to my Rowan County VA  
17 Salisbury facility, which is an expansive, very  
18 large, beautiful facility, with a lot of equipment  
19 and secretaries, it could be a higher cost than if  
20 he had went to a smaller VA facility in a different  
21 town?

22 MR. CROMWELL: Object to form and  
23 foundation.

24 You can answer.

1           A.     Thank you.

2                     Potentially.  That larger facility may be  
3 more efficient.  They may have a full host of  
4 patients in every single bed; whereas, that smaller  
5 facility might have two patients in the bed but have  
6 a full staffing.

7           Q.     Yes.  So, again, it's dependent upon  
8 not necessarily the quality of care.  It's more  
9 dependent on the facility that he goes to for those  
10 cost estimations?

11          A.     Yes.

12          Q.     Okay.  And I'm understanding you that the  
13 variable direct cost, is that more akin to what we  
14 were talking about earlier where when I did the  
15 very, very busy month in oncology example, and they  
16 had to bring in extra staff, like that's where that  
17 would come in?

18          A.     The majority of the variable direct cost  
19 on an inpatient would be the nurses that staff the  
20 units, but there's also supply costs that are  
21 associated with treating those inpatients.

22          Q.     Supplies for that department during that  
23 month?

24          A.     Yes, in this case, the department equals a

1 ward location.

2 Q. And so if it was a busy month in that  
3 ward, regardless of how much care the plaintiff got,  
4 it would be -- it could be a higher cost estimate  
5 here?

6 A. Or vice versa.

7 Q. Or vice versa?

8 A. If they were in an ICU bed, it's going to  
9 be expensive.

10 Q. Understood.

11 So these costs estimations, again, vary  
12 according to the formulas that we've discussed  
13 previously, which vary by hospital and vary by  
14 month?

15 MR. CROMWELL: Object to form.

16 You can answer.

17 A. Yes.

18 Q. And maybe you and I both correct ourselves.  
19 It looks like column I shows "Treating Specialty  
20 Start Date"?

21 A. Yeah.

22 Q. Is that the admission date or is that a  
23 different date?

24 A. It's a different date.

1 Q. Okay.

2 A. So the treating specialty date because we  
3 based this on the discharge diagnosis, it is related  
4 to -- so if you had a patient that was in a nursing  
5 home care unit, and then got transferred to the ICU  
6 for their Parkinson's disease, that treating  
7 specialty date would represent that transfer to an  
8 acute care unit for Parkinson's. We did not include  
9 the 500 days that they were in a nursing home care  
10 bed, just as it related to the Parkinson's treatment  
11 for that patient, and that's an example that is only  
12 an example, not related to a specific patient, but  
13 as an example.

14 Q. On the fixed direct cost, does your  
15 formula include any type of equipment depreciation?

16 A. It does.

17 Q. And that's contained within that manual  
18 that we discussed earlier that was not produced?

19 MR. CROMWELL: Object to form.

20 A. The allocation methodology and the  
21 depreciated costs would be available in our  
22 technical guides.

23 Q. Okay. So you're saying to the best of  
24 your knowledge, the Treating Specialty Start Date,

1 which is in column I and the Discharge Date in  
2 column E are intended to be limited to the ICD-9 and  
3 10 codes that are either in the primary or secondary  
4 positions?

5 A. Yes.

6 To the right, you do see the Bed Days of  
7 Care.

8 Q. Do we see CPT codes?

9 A. No.

10 Q. Can you say -- I'm sorry. I couldn't hear  
11 you.

12 A. No, you do not. No.

13 Q. Do we see CPT descriptors?

14 A. No.

15 Q. Could your staff or you have pulled those  
16 items into this summary, if you'd been asked to do  
17 so?

18 MR. CROMWELL: Object to form.

19 A. For the inpatient setting, I'm not  
20 entirely sure. All inpatient records are coded by  
21 the coding team. I believe that they code specific  
22 clinical events, but not a daily charge, if you  
23 will, or a daily CPT code. So that is nothing we  
24 cost by, and I'm not familiar with that process.

1 Q. Okay. Do you have any confidence looking  
2 at the raw data when you see the ICD-9 or 10 codes  
3 in the secondary positions, without further  
4 analysis, do you have any confidence that those  
5 visits are related to those codes?

6 MR. CROMWELL: Object to form and  
7 foundation.

8 You may answer.

9 A. Same answer as before in that that would  
10 be a clinician that would have to answer that.

11 Q. And a clinician would have to most likely  
12 look at the medical records or have knowledge of the  
13 patient?

14 MR. CROMWELL: Object to form and  
15 foundation.

16 Q. If you know.

17 A. That would be my opinion, yes.

18 Q. Okay. I wanted to -- all right. Now, and  
19 you testified earlier you are familiar with coding,  
20 but I imagine you don't have the codes memorized; is  
21 that true?

22 MR. CROMWELL: Object to form.

23 A. So familiar with the coding as it relates  
24 to the request.

1 Q. Yes. Like out in -- let me be more  
2 specific. You've used ICD-9 and 10 codes in the  
3 past?

4 A. Yes.

5 Q. But not -- not enough to have them  
6 memorized because there are a large number of ICD-9  
7 and 10 codes --

8 A. Correct.

9 Q. -- is that true?

10 A. That is true.

11 Q. Okay. I wanted to pull up for your review  
12 Mr. Fancher one more time, and I'm going to sort his  
13 outpatient visits by his kidney cancer diagnosis.

14 Do you see that?

15 A. Yes.

16 Q. I have two visits that I've identified  
17 where the ICD-9 -- I'm sorry. This is definitely an  
18 ICD-10 code. C64.1 is in the primary source position.

19 Do you have -- what would be your -- so  
20 I'm going to look at the dates of that visit.

21 And it's -- there's two dates. One is  
22 10/2/2017 and the other is 7/26/2024.

23 Do you see those dates, date of visit:  
24 10/2/2017 and 7/26/2024?

1 A. Yes.

2 Q. So looking at this data where the C64.1 is  
3 in the primary spot, and it does have a stop code  
4 description of urology clinic and primary care  
5 medicine, primary care corresponding to the  
6 7/26/2024 visit, are you able to tell me with any  
7 certainty that the primary diagnosis -- that he was  
8 seen for his kidney cancer diagnosis on the  
9 7/26/2024 or the 10/2/2017 date?

10 MR. CROMWELL: I'm going to object to  
11 form. Foundation.

12 You may answer.

13 A. Based on the coding rules that we had  
14 documented in the summary, it indicates that that  
15 primary diagnosis is what the patient was seen for.

16 Q. And my understanding from your testimony  
17 earlier is that if by the end of the visit -- you  
18 used the discharge primary codes in order to pull  
19 this data; right? So if by the end of the visit,  
20 they confirmed that it was not a kidney cancer  
21 related, then that code should not have been used?

22 A. So that was for --

23 MR. CROMWELL: Object to form. Foundation.  
24 Misstates prior testimony.

1                   You may answer.

2           A.       Okay.  Thank you.

3                   That's for inpatient only where the  
4 discharge diagnosis is used, not for outpatient.

5           Q.       Okay.  Based on your understanding of the  
6 coding rules, this diagnosis in column N, if by the  
7 end of the visit, he did not have a kidney cancer,  
8 they weren't treating him for kidney cancer, it  
9 should not reflect that in the primary diagnosis  
10 spot; is that true?

11                   MR. CROMWELL:  Object to form.

12           A.       I'm not a coding expert.  That would be my  
13 opinion, yes.

14           Q.       And so your opinion would be that if the  
15 coding was done properly, it should have been kidney  
16 cancer was the primary reason for that visit?

17           A.       Yes.

18                   MR. CROMWELL:  Object to form.  Foundation.  
19 You may answer.

20           A.       Yes.

21           Q.       Now I want to show you an exhibit that I'm  
22 going to put in the chat.

23                   I'm adding it to the chat, an exhibit with  
24 a Bates Stamp No. 00275\_Fancher\_7238, and I'm going

1 to open it on the screen for you.

2 (Document referenced but not marked.)

3 (Attorney Wallace shared her screen.)

4 Q. Okay. Do you see this date, July 26, 2024?

5 A. Yes.

6 Q. And is that one of the dates that we were  
7 just looking at for Mr. Fancher?

8 A. I don't remember.

9 Q. Okay. 7/26/2024, is that the same date  
10 that was on this document --

11 A. I think you meant to --

12 Q. -- on the top there?

13 MR. CROMWELL: Object to form.

14 Foundation.

15 A. I think you meant to share, but you didn't,  
16 but I believe you if that's what was on there.

17 Q. Okay. Okay. I'll represent to you that  
18 that was one of the two dates. It was the same  
19 date.

20 A. Okay.

21 Q. Okay. And it looks like this was entered,  
22 it looks like there was a date/time ordered July 26,  
23 new order entered by Katherine Storms.

24 I want to -- and it looks like he's -- in

1 this visit, I'll represent to you that he's seeking --  
2 he's having to use the Community Care Network in  
3 order to get an abdomen and pelvis with contrast  
4 scan performed that was ordered on that date of the  
5 visit that you just had: 7/26/2024.

6 And I'm going to scroll down to "Pertinent  
7 Patient History."

8 (Scrolling.)

9 Q. Do you see that there?

10 A. Yes.

11 Q. It says, "Left flank pain radiating  
12 abdomen, history of kidney cancer."

13 Do you see that?

14 A. Yes.

15 Q. And above it, it says, "Required ICD-10  
16 diagnosis code: Other: C64.1 left flank pain,  
17 history of kidney cancer."

18 Do you have enough knowledge of coding to  
19 know that typically a history of kidney cancer has a  
20 Z in front of an ICD-9 or 10 code?

21 MR. CROMWELL: Object to form. Foundation.

22 A. I do not have enough knowledge of that.

23 Q. Okay. Do you know what C64.1 is intended  
24 to represent as it relates to kidney cancer?

1 MR. CROMWELL: Same objection.

2 A. I do not.

3 Q. Does it appear to you from this visit that  
4 he's treating primarily related to his kidney cancer  
5 if it's left flank pain radiating abdomen as the  
6 pertinent patient history?

7 MR. CROMWELL: Object to form. Foundation.

8 A. What you're showing me is a consult for  
9 community care. So that provider, I assume, the  
10 visit on that date was maybe the primary care  
11 provider who was doing a consult to the community  
12 for this scan.

13 Q. If I were to tell you that Mr. Fancher had  
14 kidney cancer in 1997, and had a nephrectomy, and  
15 he's not been treated for recurrence or active  
16 kidney cancer since that time, would you agree with  
17 me that this visit is not coded correctly if C64.1  
18 is an active kidney cancer diagnostic code?

19 MR. CROMWELL: Object to foundation and  
20 form.

21 You can answer.

22 A. I have no knowledge of that at all. It's  
23 way out of my scope unfortunately, yeah.

24 Q. Would you agree with me that -- I think

1 you testified earlier that the primary diagnoses  
2 were not evaluated by you and your team prior to  
3 being pulled in the datasets?

4 MR. CROMWELL: Object to form.

5 A. We did not evaluate them in terms of was  
6 the coding accurate and correct. We did not. That's  
7 not our role. We pulled the data based on what's in  
8 the CDW, the authoritative data source for the VHA.

9 Q. Would you agree with me that there is  
10 possibility for errors in both the primary diagnoses  
11 and secondary diagnoses as it comes from numerous  
12 providers across the country?

13 MR. CROMWELL: Object to form. Foundation.  
14 You can answer.

15 A. In my opinion, I think human error creeps  
16 into our daily lives.

17 Q. I agree with you.

18 Thank you.

19 A. Yeah.

20 Q. I am going to pull in the chat what's been  
21 previously marked as Exhibit 9, and it is Bates  
22 stamped numbered CLJA\_VHA\_7.XLSX, and I'm also going  
23 to pull it onto the screen for you to review.

24 A. Okay.

1 (Document was premarked Exhibit No. 9 for  
2 identification.)

3 (Attorney Wallace shared her screen.)

4 Q. Do you recognize this?

5 A. Yes.

6 Q. What is this?

7 A. This appears to be the same dataset that  
8 you -- we reviewed earlier.

9 Q. With one exception, I believe, and let's  
10 see if you agree with me. It has an extra tab.

11 A. With the detail data to the right?

12 Q. Yes. It has an extra tab that I believe  
13 quantifies all care regardless of the ICD-9 or 10  
14 codes previously.

15 A. Sure. So the bottom left, hit that arrow.

16 Q. This one (indicating)?

17 A. Way on the left.

18 Q. Oh, here (indicating)?

19 A. Yes.

20 Are you able to hit that a couple times  
21 and get over?

22 Q. Ooh. I think I'm all the way over in  
23 column A.

24 A. All right. Let's look at the third tab as

1 presented.

2 Q. Oh, the third tab. No problem. Let's  
3 close this out. The third tab here (indicating)?

4 A. Now the next tab.

5 Q. Okay.

6 A. I think this is what you're talking about  
7 in terms of all the data.

8 Q. Well, actually I think --

9 A. Oh, no. No.

10 Q. Right. I think it's the first tab that  
11 has the total summary, I believe. It says, Cost  
12 Fiscal Year '05 through Fiscal Year '25 --

13 A. Okay.

14 Q. -- FP3 December - All Care.

15 A. Let's click on that.

16 Okay.

17 Q. Did you prepare this document?

18 A. My team did, yes.

19 Q. Have you reviewed it before today?

20 A. I have.

21 Q. Did you review this tab before today, the  
22 one with all care?

23 A. I have.

24 Q. Your team summarized the all care data,

1 but I understand -- do I understand correctly you  
2 don't have any opinion as to -- let's see. You  
3 don't have any opinion as to these costs being  
4 relevant to the ICD-9 or 10 codes that were provided  
5 to you?

6 MR. CROMWELL: Object to form.

7 A. Yeah, I don't remember that being my  
8 answer. So it's all in. It's an all-in view, and  
9 most of the cost here does not reflect the ICD-10s  
10 and 9s that we were provided.

11 Q. Understood. That's the question I was  
12 trying to ask you.

13 A. Okay.

14 Q. But this column, the sum, should that be  
15 an exact replica of the Exhibit 5 we looked at  
16 earlier?

17 A. I believe so.

18 Q. Okay. And I think you testified earlier  
19 it was not your job to form an opinion as to which,  
20 if any, of these cost assessments are relevant to  
21 the plaintiffs' track 1 conditions?

22 MR. CROMWELL: Object to form.

23 A. Correct.

24 MS. WALLACE: Okay. I have been going

1 another hour. Do you guys want to take a five or  
2 10-minute break?

3 THE WITNESS: Yes.

4 MR. CROMWELL: That works.

5 MS. WALLACE: All right. I'll see you  
6 shortly.

7 THE VIDEOGRAPHER: All right. We're going  
8 off the record. The time is 2:32 p.m.

9 (Short break taken.)

10 THE VIDEOGRAPHER: We are now back on the  
11 record. The time is 2:46 p.m.

12 BY MS. WALLACE:

13 Q. Mr. Clarke, we're getting close to the end,  
14 and I want to just appreciate your patience with me  
15 today especially as we've talked about a lot of coding  
16 and data systems. So thanks for bearing with me.

17 A. Okay.

18 Q. I wanted to ask you, were you asked to  
19 estimate future medical costs for any of the  
20 plaintiffs whose socials you were given?

21 A. No.

22 Q. Can managerial accounting be used to develop  
23 future medical costs?

24 A. No. It has not been used in that capacity

1 before.

2 Q. For your purposes, the cost estimations  
3 can only be done retroactively; is that true?

4 MR. CROMWELL: Object to form.

5 You can answer.

6 A. Yes, that is true.

7 Q. And I know we talked briefly about  
8 Community Care Network earlier. Do you know  
9 whether -- does Community Care Network use general  
10 accounting principles to come up with cost estimates  
11 that the VA pays?

12 MR. CROMWELL: Object to form and  
13 foundation.

14 You can answer.

15 A. Okay. They do not. So we are the  
16 managerial cost accounting system of record for the  
17 VA.

18 Q. In what circumstances, if you know, would  
19 Medicare rates be used related to VHA?

20 MR. CROMWELL: Object to form and  
21 foundation.

22 A. Yeah, my -- very limited knowledge of that.  
23 Office of Revenue may use those rates, but I'm not  
24 100 percent sure.

1 Q. But if you were asked in your department --  
2 you've been asked to estimate future -- past medical  
3 costs for these plaintiffs; true?

4 A. Apologies. Could you repeat that.

5 Q. You've -- you were asked to estimate past  
6 medical costs for these plaintiffs; is that true?

7 MR. CROMWELL: Object to form. Misstates  
8 prior testimony.

9 You can answer.

10 A. Sure. Yeah, so we were asked to provide  
11 the managerial cost accounting cost for prior  
12 treatment to February -- or December of 2025 for  
13 those 25 patients.

14 Q. And if the DOJ were going to ask an entity  
15 of the VA to estimate future medical costs, do you  
16 know which department they would rely on for that?

17 MR. CROMWELL: Object to form.

18 A. I'm not 100 percent sure.

19 Q. You've never seen that done in your  
20 department?

21 A. Correct. Never done in my department.

22 Q. And the only time -- is it true that the  
23 only time you're aware of Medicare rates being  
24 relied upon would be more in a Community Care

1 Network setting?

2 MR. CROMWELL: Object to form. Foundation.  
3 You may answer.

4 A. Okay. Totally out of my scope. I'm not  
5 sure. I'm not sure how that billing works.

6 Q. And with regard to the Exhibit 5, the  
7 summary data that we looked at earlier, I wanted to  
8 confirm it's your testimony that you do not have an  
9 opinion on which one of those buckets of costs are  
10 appropriate for offset purposes?

11 MR. CROMWELL: Object to form. Foundation.

12 A. Correct.

13 MR. CROMWELL: You can answer.

14 A. Okay. Yeah, I don't have an opinion. Yep.

15 Q. Okay. And that wasn't the purpose of why  
16 you pulled that data to give an opinion in that  
17 regard?

18 A. Correct. It was not the intent but to  
19 offer full scope of the costs.

20 Q. All right. Mr. Clarke, I don't think I  
21 have any further questions for you, and I greatly  
22 appreciate your time today.

23 A. Okay. Nice speaking with you.

24 MS. WALLACE: Nice speaking with you.

1 MR. CROMWELL: Mr. Clarke, I don't have  
2 any questions either.

3 Thank you very much. I appreciate your  
4 time and efforts with this. So I think that's it.

5 THE WITNESS: Okay.

6 THE VIDEOGRAPHER: That's the end of  
7 today's deposition. The time is 2:50 p.m. We're  
8 going off the record.

9 THE STENOGRAPHER: And, Counsel, could I  
10 just have you state your transcript orders.

11 What would you like, Ms. Wallace?

12 THE WITNESS: Okay for me to leave?

13 THE STENOGRAPHER: Yes, thank you,  
14 Mr. Clarke.

15 MR. CROMWELL: You're good to leave.

16 THE STENOGRAPHER: So, Ms. Wallace, what  
17 do you need for a transcript?

18 MS. WALLACE: Michael, what have we been  
19 ordering?

20 MR. CROMWELL: We have a standing order.  
21 I don't think we've been doing a rush or roughs or  
22 anything like that. You guys might have a  
23 different, because Jenna alluded to that last week.

24 MS. BUTLER: We have a standing order as

1 well, and it does not include roughs.

2 THE STENOGRAPHER: Okay. I don't have  
3 anything about a standing order, so who should I  
4 have them contact if they need that.

5 MS. BUTLER: I mean Golkow definitely  
6 has -- were you coordinated through Golkow through  
7 Veritext?

8 THE STENOGRAPHER: I was, but I have not  
9 seen any standing orders.

10 If you have something, that's fine, but if  
11 not who should they contact, you, Ms. Butler?

12 MS. BUTLER: They can contact me, but.

13 THE STENOGRAPHER: Okay.

14 MS. BUTLER: Yeah, that's fine if they  
15 have any questions. Yep.

16 THE STENOGRAPHER: Okay. Thank you.

17 And then, Mr. Cromwell, did you say you  
18 had a standing order as well?

19 MR. CROMWELL: We do. Golkow should have  
20 it, but, again, they can reach out to me if need be.

21 THE STENOGRAPHER: Very good. I will tell  
22 them you have the standing orders then.

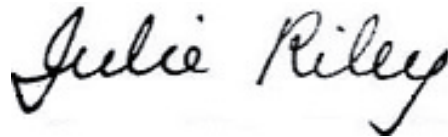
23

24 (Deposition concluded at 2:57 p.m.)

CERTIFICATE OF REPORTER

1  
2 I, Julie Thomson Riley, RDR, CRR, do certify that  
3 the deposition of Daniel Clarke, in the matter Camp  
4 Lejeune Water Litigation, on September 3, 2025, was  
5 stenographically recorded by me; that the witness  
6 provided satisfactory evidence of identification, as  
7 prescribed by Executive Order 455 (03-13), issued by  
8 the Governor of the Commonwealth of Massachusetts,  
9 before being sworn by me, a Notary Public in and for  
10 the Commonwealth of Massachusetts; that the transcript  
11 produced by me is a true and accurate record of the  
12 proceedings to the best of my ability; that I am  
13 neither counsel for, related to, nor employed by any  
14 of the parties to the above action; and further that  
15 I am not a relative or employee of any attorney or  
16 counsel employed by the parties thereto, nor  
17 financially or otherwise interested in the outcome of  
18 the action.

19  
20 September 8, 2025



21 Julie Thomson Riley, RDR, CRR  
22  
23  
24

1 WITNESS: Daniel Clarke  
2 DATE: September 3, 2025  
3 CASE: In Re: Camp Lejeune Water Litigation  
4

5 DISTRIBUTION TO COUNSEL The original signature  
6 page/errata sheet was sent to Michael W. Cromwell, to  
7 obtain signature from the deponent. When signed,  
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9

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16 SIGN AND DATE THE ERRATA SHEET before a notary public  
17 and return it, along with the transcript, to your  
18 counsel.  
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24

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NORTH CAROLINA  
SOUTHERN DIVISION

IN RE: )  
Camp Lejeune Water Litigation )  
This Document Relates To: )  
All Cases )

I, Daniel Clarke, do hereby certify, under the pains and penalties of perjury, that the foregoing testimony is true and accurate, to the best of my knowledge and belief, with the addition of the following changes/corrections:

| Page | Line | Change/Correction |
|------|------|-------------------|
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WITNESS MY HAND, this            day of            , 2025.

\_\_\_\_\_  
Daniel Clarke

cc: Whitney Wallace, Esquire, et al.

|                                   |   |   |   |
|-----------------------------------|---|---|---|
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