ORIGINAL

IN RE: GLENDA MACK

CIVIL INVESTIGATIVE DEMAND

EXAMINATION TAKEN: MAY 23, 2014

* * * * *

DENISE L. CLINE
COURT REPORTER
P.O. BOX 197616
LOUISVILLE, KENTUCKY 40259
(502) 802-6544

1 A I had multiple discussions with leaders
2 to determine what their perception of it was and to
3 show them the documents of what our training said and
4 to actually discuss with them how they should educate
5 their program directors and how those discussions
6 should occur.
7 Q What leaders did you talk to?
8 A Directly, Rona Wiedmayer, Carla Wolfe,
9 Derhonda Thomas, Beth Reigart.
10 Q And I know you're still thinking. So if
11 you remember more names, feel free to go ahead and tell
12 me.
13 A Those are the ones that
14 immediately . . .
15 Q Did you ever talk to anyone senior to
16 you at Rehab Care and express your view that there
17 shouldn't be a 1.0 Medicare A Utilization target?
18 MR. HENDRIX: Objection to foundation,
19 predicate not established.
20 MR. CALLAHAN: Fair point.
21 Q Do you think that Medicare A Utilization
22 should have a target of 1.0?
23 A I believe that 1.0 will be the outcome
24 sometimes of care. I believe what our goal should be
25 is delivering care appropriately to each patient.

1 Q So my question is just a little bit
2 different. On page 29 it says the target for Medicare
3 A Utilization is 1.0. Do you agree that that should be
4 a target or do you disagree that that should be a
5 target?
6 A I don't believe it should be a target.
7 However, I believe it is an appropriate tool to assess.
8 Q The Medicare A Utilization ratio is an
9 appropriate tool?
10 A Correct.
11 Q To assess -- you don't believe the
12 target should be 1.0?
13 A Having a tool and having 1.0 being a
14 number is an appropriate thing to educate our people on
15 to understand what it means. When you say a target
16 where you mandate something and you make a right or
17 wrong judgment on it, that's what I have difficulty
18 with.
19 Q And I'm not saying anything about -- the
20 people at Rehab Care called it a target, and I'm just
21 saying it sounds to me like you're saying you disagree
22 that 1.0 should be a target for Medicare A Utilization.
23 MR. HENDRIX: Objection to foundation.
24 A What I am saying is that if we set an
25 absolute target that is the be-all, end-all right or

1 wrong on your performance, I am concerned about that.

2 Q Why are you concerned about that?

3 A Because you're not taking anything about

4 the patient into consideration.

5 Q When you spoke to these leaders at Rehab

6 Care about your concern of the target of 1.0, what did

7 they say? What was their response?

8 A I mean, varied responses, understanding

9 of what I was trying to say but some difficulty trying

10 to understand how to do it differently. And I made

11 clear direct offerings to help them manage it

12 differently.

13 Q Did the 1.0 target remain after your

14 discussions with them?

15 A Can you clarify your scope on that?

16 Q I'm not sure I know how. Was the target

17 still 1.0 after you had your discussions with them?

18 MR. HENDRIX: Objection, lack of

19 foundation.

20 A You're saying -- I guess what I need to

21 clarify, are you asking me if the people I spoke to

22 continued to have a 1.0 target for their people? Is

23 that what you're asking me?

24 Q My question is is it still a target at

25 the company today?

1 A Is it still today?

2 Q Is it a key performance indicator? Yes.

3 MR. HENDRIX: Objection to form and lack

4 of foundation.

5 A I do not believe that today it is

6 perceived as a target that we have to be at 1.0. It is

7 a tool that we still have today --

8 Q So I'm getting --

9 A -- that is assessed.

10 Q And just to make sure I'm asking the

11 right question, I'm asking about the target, not the

12 tool.

13 MR. HENDRIX: Let her finish her answer.

14 A No, I do not believe it's perceived as a

15 target today.

16 Q Do you know if it is on documents that

17 say the target for Medicare A Utilization is 1.0?

18 A I don't know if a document like that

19 exists today, no.

20 MR. CALLAHAN: This is a Rehab Care Key

21 Performance Indicator Calculation with a date of -- the

22 metadata will show it's January 1st -- actually I

23 should put an exhibit number on that -- January the

24 1st, 2012.

25

1 (Whereupon Exhibit 11 was
2 marked for identification.)
3 MR. HENDRIX: Where's the January 1st
4 date appear?
5 MR. CALLAHAN: I said in the metadata.
6 MR. HENDRIX: But you're representing
7 that?
8 MR. CALLAHAN: I'm representing that,
9 yeah.
10 Q So this still has Medicare A capped
11 minutes over RUG reimbursement minutes, correct?
12 A Yeah, but that's not what you asked me.
13 You asked me about today, and it's May of 2014.
14 Q Right. No, I understand that.
15 A You're talking about in year 2012.
16 Q Do you know if the tool is still being
17 used?
18 A This tool specifically?
19 Q Medicare A Utilization, yes.
20 A Medicare A Utilization is a tool that we
21 have. It no longer is defined as capped minutes. It
22 is defined as threshold minutes.
23 Q And how did that change come about?
24 A At my specific request.
25 Q When did you make that request?

1 A It would have been in the spring of last
2 year.
3 Q Spring of 2013?
4 A Yes.
5 Q After you received a subpoena from the
6 government?
7 MR. HENDRIX: Objection, form and
8 foundation, assumes a --
9 Q By that time you knew a government
10 investigation was ongoing, correct?
11 A Correct, I did know that.
12 Q Was any company-wide communication
13 distributed to inform program directors that 1.0 was
14 not a Medicare A Utilization target?
15 A We did company-wide trainings with the
16 area directors of operation and the regional vice
17 presidents that was focused on clinically appropriate
18 intervention with our patients, and as a part of that
19 we discussed the utilization numbers, what they meant,
20 what they did not mean and how they would be used going
21 forward and how they would be changed going forward.
22 And that was done by myself and by Matt Sivret
23 personally.
24 Q Did you or Matt tell program directors
25 and other therapists that 1.0 was not a target for

1 Medicare A Utilization?
2 A Did I myself directly tell a program
3 director that? I did in individual conversations.
4 Q Did you say you did?
5 A I did in individual conversations. I
6 know Matt did in individual conversations. We had
7 those conversations at the ADO level with the
8 expectation that each ADO would be having those
9 discussions as well with their program directors.
10 Q Did you tell the ADOs that they should
11 communicate to their program directors that 1.0 was not
12 a target for Medicare Utilization?
13 A The whole point of these meetings, these
14 in-person meetings, bring all the ADOs and all RVPs
15 together, was that these meetings were to be taken back
16 to their facilities, and these discussions were to be
17 repeated at each facility with not only the PDs but
18 also the therapists. And they had a specified time
19 frame in which to complete that, and they had to report
20 it back.
21 Q And when you said they had to go tell
22 the program directors that that 1.0 was not a Medicare
23 A Utilization target --
24 A They had to go back -- not just that.
25 They had to talk about the utilization and how we

1 I opened it, I saw it and moved on.

2 Q Have you ever heard of an auto planner?

3 A I've heard that term, yes.

4 Q What is it?

5 A As I understand it, if minutes are
6 missed on a day and those minutes have been planned for
7 a patient, then the minutes would go to the next day
8 for a particular discipline.

9 Q And do you know whether that auto
10 planner works in the assessment period and the
11 nonassessment period before the October rule changes?

12 A I do not know. I never used it.

13 Q If the auto planner is used, do you
14 think it should be used only during the assessment
15 planner and not during -- I mean, only during the
16 assessment period and not during the nonassessment
17 period?

18 A If the auto planner is being used,
19 should it be used -- I'm sorry, I'm getting tired. So
20 could you please ask again?

21 Q Sure. I'll ask a clearer question. The
22 auto planner automatically rolls over minutes that are
23 missed, correct?

24 A As I understand it.

25 Q And then should that process of having

1 minutes automatically roll over that are missed, should
2 that occur in the ARD period as well as outside an ARD
3 period?
4 A If I were creating it, that's the way I
5 would design it.
6 Q Would there be any clinical reason why
7 it would only be used during an ARD period?
8 A Nothing that's immediately popping into
9 my head.
10 Q If it was only used in an ARD period and
11 not outside an ARD period, would you see a problem with
12 that?
13 A Well, as I said, it's not the way I
14 would design it. Is it technically inaccurate? No,
15 but it's not the way I would design it.
16 Q One of the reasons you wouldn't design
17 it that way -- or is one of the reasons you wouldn't
18 design it that way because it would have the effect of
19 making sure you get all the plan minutes during an ARD
20 period but not making sure you hit all the plan minutes
21 outside an ARD period?
22 A I would not state it that way. I would
23 state it as I would plan it such that the plan minutes
24 were carried over throughout the course of the stay
25 just to be consistent with the plan of care throughout

1 ARD period?
2 A No, that's not a clinical discussion.
3 Q The care should be -- the way that
4 therapist treats that patient should be the same
5 whether it's inside or outside, correct?
6 MR. HENDRIX: Objection.
7 A What I believe to be true is that the
8 care for the patient should be driven off of the plan
9 that's been developed by the discipline.
10 Q Do you know at Rehab Care if there was
11 ever a policy of where program directors were supposed
12 to plan minutes out for Medicare A patients who were in
13 the assessment period before planning minutes for
14 anybody else?
15 MR. HENDRIX: Objection, lack of
16 foundation.
17 A I don't know if there was or wasn't a
18 policy.
19 Q You were weren't familiar with anything
20 like that? You've never seen anything like that?
21 A I wasn't personally familiar with that
22 as policy.
23 Q Can you think of any clinical reason why
24 patients -- before the rules changed why patients in an
25 ARD period should have their minutes planned first

1 before anybody else?

2 A From a clinical perspective I can't off

3 the top of my head give you a very specific reason.

4 Q Can you think of any reason why program

5 directors would be instructed to plan care for Medicare

6 A patients in an assessment period before planning care

7 for others who are not in an assessment period?

8 MR. HENDRIX: I'm not sure why -- again,

9 here we're now seven hours and 37 minutes after the

10 deposition began we're asking these just sort of

11 hypothetical, please speculate, non-fact based

12 questions of this witness. It just seems intended to

13 drag this thing out for no good reason.

14 Q Go ahead.

15 A Can you repeat the question, please?

16 Q Sure. Can you think of any reason why

17 it would be beneficial or useful to plan a Medicare A

18 patient's therapy minutes when they're in an ARD period

19 before going on to plan patients' therapy who are not

20 in an ARD period?

21 A Yes.

22 Q Why?

23 A Resource allocation, insuring we can

24 continue to have appropriate therapies available to

25 meet the needs ongoing.