

**UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION**

COMMISSIONERS: **Joseph J. Simons, Chairman**
 Noah Joshua Phillips
 Rohit Chopra
 Rebecca Kelly Slaughter
 Christine S. Wilson

File No. P181200

ORDER TO FILE SPECIAL REPORT

Pursuant to a resolution of the Federal Trade Commission (“FTC” or “Commission”) dated October 11, 2019, entitled “Resolution Directing Use of Compulsory Process to Collect Information Regarding Certificates of Public Advantage” a copy of which is enclosed, [COMPANY NAME], hereinafter referred to as “the Company,” is ordered to file a Special Report with the Commission no later than January 21, 2020, containing the information and documents specified herein.

The information provided in the Special Report will assist the Commission in compiling a study of certificates of public advantage.

The information requests to which you must respond are set forth in the attached Specifications. The Special Report must restate each item of this Order with which the corresponding answer is identified. Your Special Report is required to be subscribed and sworn by an official of the Company who has prepared or supervised the preparation of the Special Report from books, records, documents, correspondence, and other data and material in the Company’s possession. If the Company cannot answer any question fully, give the information that is available and explain in what respects and why the answer is incomplete.

Confidential or privileged commercial or financial information will be reported by the Commission on an aggregate or anonymous basis, consistent with sections 6(f) and 21(d) of the FTC Act. Individual submissions to this Order that are marked “confidential” will not be disclosed without first giving the Company ten (10) days’ notice of the Commission’s intention to do so, except as provided in Sections 6(f) and 21(d) of the FTC Act, 15 U.S.C. §§ 46(f) and 57b-2. This Order does not require approval of the Office of Management and Budget under the Paperwork Reduction Act of 1995.

Penalties may be imposed under applicable provisions of federal law for failure to file Special Reports or for the filing of false reports.

By direction of the Commission.

Joseph J. Simons
Chairman

SEAL

DATE OF ORDER: October 17, 2019

The Report required by this Order, or any inquiry concerning it, should be addressed to:

Stephanie A. Wilkinson
Federal Trade Commission
Office of Policy Planning
600 Pennsylvania Avenue, N.W., Mailstop H-394
Washington, D.C. 20580
Direct Dial: (202) 326-2084
Email: swilkinson@ftc.gov

SPECIFICATIONS

1. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction I11), for each inpatient admission that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the Hospital accessed by the patient) or a patient accessing a Hospital in the Relevant Area (regardless of the patient's place of residence):
 - (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, Skilled Nursing Facility ("SNF") Episodes, Hospice Episodes, Home Health Agency ("HHA") Episodes, Durable Medical Equipment ("DME") Claims, Intravenous ("IV") Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the inpatient admission, a unique inpatient admission identifier that shall also be included in each record associated with the same admission (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the Hospital at which the patient received the inpatient care, including the identity of the Hospital's owner, the address of the Hospital (including the ZIP code), and any Hospital identification number used for reimbursement purposes, including Medicare Provider ID or National Provider Identification ("NPI") number ;
 - (c) The patient's county of residence and the patient's 5-digit ZIP code of residence;
 - (d) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
 - (e) The date of admission and date of discharge;
 - (f) The Diagnosis Related Group ("DRG" or "MSDRG") and the Major Diagnostic Category ("MDC") associated with the patient's admission;
 - (g) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the patient's admission;
 - (h) The primary ICD9 or ICD10 procedure code and any secondary ICD9 or ICD10 procedure code(s) associated with the patient's admission;
 - (i) Whether the Treatment provided was for an emergency;

- (j) The source of the patient (*e.g.*, transfer or referral from another Provider), including the identity of any transferring or referring Provider;
- (k) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (l) Whether the patient obtained the Health Plan product through an employer, a private exchange, or a public exchange;
- (m) The identity of any secondary sources of payment;
- (n) For each product listed in response to Specification 1(k), whether this product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (o) Whether the Hospital identified in response to Specification 1(b) was a participating Provider under the patient’s Health Plan and, if the patient’s Health Plan had different Tiers of participating Providers, which Tier the Hospital was in;
- (p) The billed charges of the Hospital, the allowed amount under the patient’s Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (q) Whether the physician’s services were included in the bill or were billed separately;
- (r) Any additional amounts paid or to be paid by the patient to the Hospital under the patient’s Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (s) Whether the allowed amount identified in response to Specification 1(p) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) whether the Company was the designated primary payor under this arrangement; and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;

- (t) Any breakdown of the billed charges identified in response to Specification 1(p) by any categories of Hospital services rendered to the patient (*e.g.*, medical/surgical, obstetrics, pediatrics, ICU);
 - (u) Any breakdown of the allowed amount identified in response to Specification 1(p) by any categories of Hospital services rendered to the patient (*e.g.*, medical/surgical, obstetrics, pediatrics, ICU);
 - (v) The type of admission (*e.g.*, newborn, admitted through emergency room, admitted through physician referral);
 - (w) The name, NPI number, employer or Physician Group (including NPI number), and specialty area of practice of each admitting, treating, and referring physician; and
 - (x) The patient's status (*e.g.*, normal discharge, deceased, transferred to another Hospital) upon discharge. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare Facility (including the ZIP code), any Hospital identification number, and the reason for the transfer.
2. Submit (in electronic, machine readable format directly to the Commission representative identified in Instruction I11), for each Outpatient Episode that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the Healthcare Facility accessed by the patient) or a patient accessing a Healthcare Facility in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the Outpatient Episode, a unique Outpatient Episode identifier that shall also be included in each record associated with the same Outpatient Episode (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the Healthcare Facility – including the Treatment location's address, zip code, and Healthcare Facility identification number (*e.g.*, tax identification number) – at which the Outpatient Episode occurred, the identity of the Healthcare Facility's owner, and any codes the Company uses to categorize each Healthcare Facility, including Medicare Provider ID or NPI number;

- (c) The name, NPI number, and specialty area of practice of each primary physician and Mid-level Practitioner who evaluated or treated the patient;
- (d) The identity of the employer or Physician Group of the primary physician or Mid-level Practitioner identified in response to Specification 2(c);
- (e) The patient's county of residence and the patient's 5-digit ZIP code of residence;
- (f) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
- (g) The date of the Outpatient Episode;
- (h) The Current Procedural Terminology/Healthcare Common Procedure Coding System ("CPT/HCPCS") code(s) and modifier(s) and the Ambulatory Surgical Center ("ASC") and Ambulatory Payment Classification ("APC") code(s) associated with each Treatment, procedure, or service performed, and any other code(s), used for billing;
- (i) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the Outpatient Episode;
- (j) The primary ICD9 or ICD10 procedure code and any secondary ICD9 or ICD10 procedure code(s) associated with the Outpatient Episode;
- (k) A brief description of the service(s), Treatment(s), and/or procedure(s) performed;
- (l) Whether the Treatment, procedure, or service provided was for an emergency;
- (m) The source of the patient (*e.g.*, transfer or referral from another Provider), including the identity of any transferring or referring Provider;
- (n) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (o) The identity of any secondary sources of payment;
- (p) For each product listed in response to Specification 2(n), whether the product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (q) Whether the Healthcare Facility identified in response to Specification 2(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the Healthcare Facility was in;

- (r) The billed charges of the Healthcare Facility (broken out by any codes and modifiers used for billing), the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
 - (s) A breakdown of the Healthcare Facility's charges by classification of physician services rendered to the patient, by CPT/HCPCS code and modifier or by any other diagnosis and/or procedure codes used by the Healthcare Facility;
 - (t) Any additional amounts paid or to be paid to the Healthcare Facility by the patient under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
 - (u) Whether the allowed amount identified in response to Specification 2(r) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) the identity of the designated primary payor under this arrangement, and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
 - (v) Whether this Outpatient Episode is part of a series of Treatment episodes and where this Treatment episode falls in that series; and
 - (w) The patient's status (*e.g.*, any morbidity, mortality, or transfer to another Healthcare Facility for care) at the end of the Outpatient Episode. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare Facility (including the ZIP code), any Hospital identification number, and the reason for the transfer.
3. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction II 1), for each Practitioner Treatment Episode that was performed by a physician or Mid-level Practitioner, that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the physician or Mid-level Practitioner accessed by the patient) or a patient accessing a physician or Mid-level Practitioner in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME

Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the Practitioner Treatment Episode, a unique Practitioner Treatment Episode identifier that shall also be included in each record associated with the same Practitioner Treatment Episode (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);

- (b) The identity of the Healthcare Facility or office – including the Treatment location's address, zip code, and Healthcare Facility identification number (e.g., tax identification number) – at which the Practitioner Treatment Episode occurred, and the identity of the Healthcare Facility's owner;
- (c) The name, NPI number, the specialty area of practice of each primary physician and Mid-level Practitioner who evaluated or treated the patient, and any codes the Company uses to categorize each primary physician or Mid-level Practitioner;
- (d) The identity of the employer or Physician Group of the primary physician or Mid-level Practitioner identified in response to Specification 3(c);
- (e) The patient's county of residence and the patient's 5-digit ZIP code of residence;
- (f) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
- (g) Whether the Practitioner Treatment Episode involved Inpatient Services or Outpatient Services;
- (h) A place of service code, either used by Medicare or internal codes, for each Practitioner Treatment Episode;
- (i) If the Practitioner Treatment Episode involved inpatient care, the date of admission and date of discharge;
- (j) If the Practitioner Treatment Episode involved inpatient care, the DRG or MSDRG and the MDC associated with the patient's admission, and the primary ICD9 or ICD10 diagnosis and procedure codes and any secondary ICD9 or ICD10 diagnosis and procedure codes associated with the patient's admission;
- (k) If the Practitioner Treatment Episode involved outpatient care, the date of the visit or procedure(s);
- (l) If the Practitioner Treatment Episode involved outpatient care, the CPT/HCPCS code(s) and modifier(s) and the ASC and APC code(s) associated with each service, Treatment, or procedure performed, and any other codes used for billing;

- (m) Whether the practitioner is a salaried employee of the Healthcare Facility where the Treatment episode occurred;
- (n) Whether the Treatment provided was for an emergency;
- (o) The source of the patient (*e.g.*, transfer or referral from another Healthcare Facility, physician, or emergency department), including the identity of any referring or transferring source;
- (p) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (q) The identity of any secondary sources of payment;
- (r) For each product listed in response to Specification 3(p), whether the product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (s) Whether each Person or Entity identified in response to Specifications 3(c) and 3(d) was a participating Provider under the patient’s Health Plan, and if the patient’s Health Plan had different Tiers of participating Providers, which Tier each Provider was in;
- (t) The billed charges of each physician or Mid-level Practitioner (broken out by any codes and modifiers used for billing), the allowed amount under the patient’s Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (u) Any additional amounts paid or to be paid by the patient to any physician or practitioner under the patient’s Health Plan (broken out by any codes and modifiers used for billing), including but not limited to (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (v) Whether the allowed amount identified in response to Specification 3(t) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) the identity of the designated primary Health Plan under this arrangement, and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;

- (w) Whether this Practitioner Treatment Episode is part of a series of Practitioner Treatment Episodes and where this Practitioner Treatment Episode falls in that series; and
 - (x) The patient's status (*e.g.*, any morbidity, mortality, or transfer to another Healthcare Facility for care) at the end of the Practitioner Treatment Episode. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare Facility (including the ZIP code), any Hospital identification number, and the reason for the transfer.
4. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction I11), for each SNF Episode that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the SNF accessed by the patient) or a patient accessing a SNF in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the SNF admission, a unique admission identifier that shall also be included in each record associated with the same admission (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the SNF at which the patient received the care, including the identity of the SNF's owner, the address of the SNF (including the ZIP code), and any SNF identification number used for reimbursement purposes, including Medicare Provider ID or NPI number;
 - (c) The patient's county of residence and the patient's 5-digit ZIP code of residence;
 - (d) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
 - (e) The date of admission and date of discharge;
 - (f) Any codes that are used in pricing and descriptions of those codes, *e.g.*, codes for the level of care provided;
 - (g) The DRG or MSDRG and the MDC associated with the patient's admission;
 - (h) The Resource Utilization Group, version IV ("RUG-IV") associated with the patient's admission;

- (i) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the patient's admission;
- (j) The primary ICD9 or ICD10 procedure code and any secondary ICD9 or ICD10 procedure code(s) associated with the patient's admission;
- (k) Whether the Treatment provided was for an emergency;
- (l) The source of the patient (*e.g.*, transfer or referral from another Provider), including the identity of any transferring or referring Provider;
- (m) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (n) Whether the patient obtained the Health Plan product through an employer, a private exchange, or a public exchange;
- (o) The identity of any secondary sources of payment;
- (p) For each product listed in response to Specification 4(m), whether this product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (q) Whether the SNF identified in response to Specification 4(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the SNF was in;
- (r) The billed charges of the SNF, the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (s) Whether Physician Services were included in the bill or were billed separately;
- (t) Any additional amounts paid or to be paid by the patient to the SNF under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (u) Whether the allowed amount identified in response to Specification 4(r) was determined under a coordination-of-benefits arrangement, and if it was:

- (i) whether the Company was the designated primary payor under this arrangement; and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
 - (v) Any breakdown of the billed charges identified in response to Specification 4(r) by any categories of SNF Services rendered to the patient;
 - (w) Any breakdown of the allowed amount identified in response to Specification 4(r) by any categories of SNF Services rendered to the;
 - (x) The type of admission (*e.g.*, admitted through emergency room, admitted through physician referral);
 - (y) The name, NPI number, employer or Physician Group (including NPI number), and specialty area of practice of each admitting, treating, and referring physician; and
 - (z) The patient's status (*e.g.*, normal discharge, deceased, transferred to another facility) upon discharge. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare Facility (including the ZIP code), any Hospital identification number, and the reason for the transfer.
5. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction I11), for each Hospice Episode that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the hospice accessed by the patient) or a patient accessing a hospice in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episode, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the Hospice Episode, a unique episode identifier that shall also be included in each record associated with the same episode (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the hospice at which the patient received the care, including the identity of the hospice's owner, the address of the hospice (including the ZIP

- code), and any hospice identification number used for reimbursement purposes, including Medicare Provider ID or NPI number;
- (c) The patient's county of residence and the patient's 5-digit ZIP code of residence;
 - (d) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
 - (e) The date of admission and date of discharge;
 - (f) The DRG or MSDRG and the MDC associated with the patient's admission;
 - (g) The start and end dates of the benefit period;
 - (h) Number of previous benefit periods;
 - (i) Any codes that are used in pricing and descriptions of those codes, e.g., codes for the level of care provided;
 - (j) Hours treatment if the services are billed on an hourly basis;
 - (k) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the patient's admission;
 - (l) The primary ICD9 or ICD10 procedure code and any secondary ICD9 or ICD10 procedure code(s) associated with the patient's admission;
 - (m) The source of the patient (e.g., transfer or referral from another Provider), including the identity of any transferring or referring Provider;
 - (n) The specific name and type (e.g., HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
 - (o) Whether the patient obtained the Health Plan product through an employer, a private exchange, or a public exchange;
 - (p) The identity of any secondary sources of payment;
 - (q) For each product listed in response to Specification 5(n), whether this product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
 - (r) Whether the hospice identified in response to Specification 5(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the SNF was in;

- (s) The billed charges of the hospice, the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (t) The Claim Pricer Return Code or other codes that characterize adjustments made to the prospective payment;
- (u) The formula used to compute the allowed amount;
- (v) Whether Physician Services were included in the bill or were billed separately;
- (w) Any additional amounts paid or to be paid by the patient to the hospice under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (x) Whether the allowed amount identified in response to Specification 5(s) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) whether the Company was the designated primary payor under this arrangement; and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
- (y) Any breakdown of the billed charges identified in response to Specification 5(s) by any categories of Hospice Services rendered to the patient;
- (z) Any breakdown of the allowed amount identified in response to Specification 5(s) by any categories of Hospice Services rendered to the;
- (aa) The type of admission (*e.g.*, admitted through emergency room, admitted through physician referral);
- (bb) The name, NPI number, employer or Physician Group (including NPI number), and specialty area of practice of each admitting, treating, and referring physician; and
- (cc) The patient's status (*e.g.*, normal discharge, deceased, transferred to another facility) upon discharge. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare

Facility (including the ZIP code), any hospice identification number, and the reason for the transfer.

6. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction I11), for each HHA Episode that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the HHA accessed by the patient) or a patient accessing a HHA in the Relevant Area (regardless of the patient's place of residence):
 - (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the HHA Episode, a unique episode identifier that shall also be included in each record associated with the same episode (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the HHA at which the patient received the care, including the identity of the HHA's owner, the address of the HHA (including the ZIP code), and any HHA identification number used for reimbursement purposes, including Medicare Provider ID or NPI number ;
 - (c) The patient's county of residence and the patient's 5-digit ZIP code of residence;
 - (d) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
 - (e) The start and end dates of the episode;
 - (f) The Home Health Resource Groups ("HHRG") associated with the patient's episode;
 - (g) An indicator for whether the claim is paid on a per visit basis rather than using the HHRG;
 - (h) Any codes that are used in pricing and descriptions of those codes, e.g., codes for the type of services provided during the visit;
 - (i) The number of visits during the episode;
 - (j) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the patient's admission;

- (k) The primary ICD9 or ICD10 procedure code and any secondary ICD9 or ICD10 procedure code(s) associated with the patient's admission;
- (l) The source of the referral (*e.g.*, physician, clinic, HMO, hospital transfer, etc.), including the identity of any transferring or referring Provider;
- (m) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (n) Whether the patient obtained the Health Plan product through an employer, a private exchange, or a public exchange;
- (o) The identity of any secondary sources of payment;
- (p) For each product listed in response to Specification 6(m), whether this product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (q) Whether the HHA identified in response to Specification 6(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the HHA was in;
- (r) The billed charges of the HHA, the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (s) Whether Physician Services were included in the bill or were billed separately;
- (t) Any additional amounts paid or to be paid by the patient to the HHA under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (u) Whether the allowed amount identified in response to Specification 6(r) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) whether the Company was the designated primary payor under this arrangement; and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;

- (v) Any breakdown of the billed charges identified in response to Specification 6(r) by any categories of HHA Services rendered to the patient;
 - (w) Any breakdown of the allowed amount identified in response to Specification 6(r) by any categories of HHA Services rendered to the;
 - (x) The name, NPI number, employer or Physician Group (including NPI number), and specialty area of practice of each admitting, treating, and referring physician; and
 - (y) The patient's status (*e.g.*, normal discharge, deceased, transferred to another facility) upon discharge. If the patient was transferred to another Healthcare Facility, identify the Healthcare Facility, including the address of the Healthcare Facility (including the ZIP code), any HHA identification number, and the reason for the transfer.
7. Submit (in electronic, machine readable format directly to the Commission representative(s) identified in Instruction I11), for each DME Claim that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the supplier accessed by the patient) or a patient accessing DME in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the DME purchase, a unique identifier that shall also be included in each record associated with the same purchase (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the physician and supplier associated with the claim, including the identity of the employer or owner, the address (including the ZIP code), and any identification number used for reimbursement purposes, including Medicare Provider ID or NPI number;
 - (c) Supplier type code;
 - (d) The patient's county of residence and the patient's 5-digit ZIP code of residence;
 - (e) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
 - (f) The start and end dates of the DME Claim;

- (g) The line miles/time/units/services count associated with the DME (e.g., including number of services, volume of oxygen and drug dose) and the units with which the count is measured (e.g., miles, hours, milliliters, etc.);
- (h) The national drug code(s) associated with the DME Claim;
- (i) The CPT/HCPCS code(s) and modifier code(s), and any other code(s) used for billing the patient's claim;
- (j) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the patient's admission;
- (k) The specific name and type (e.g., HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (l) Whether the patient obtained the Health Plan product through an employer, a private exchange, or a public exchange;
- (m) The identity of any secondary sources of payment;
- (n) For each product listed in response to Specification 7(k), whether this product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (o) Whether the entity identified in response to Specification 7(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the DME was in;
- (p) The billed charges for the DME, the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (q) Any additional amounts paid or to be paid by the patient for the DME under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
- (r) Whether the allowed amount identified in response to Specification 7(p) was determined under a coordination-of-benefits arrangement, and if it was:

- (i) whether the Company was the designated primary payor under this arrangement; and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
 - (s) Any breakdown of the billed charges identified in response to Specification 7(p) DME provided to the patient;
 - (t) Any breakdown of the allowed amount identified in response to Specification 7(p) by any categories of DME;
 - (u) The name, NPI number, employer or Physician Group (including NPI number), and specialty area of practice the ordering physician; and
8. Submit (in electronic, machine readable format directly to the Commission representative identified in Instruction I11), for each IV Therapy Claim that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the Healthcare Facility accessed by the patient) or a patient accessing a Healthcare Facility in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the IV Therapy Episode, a unique IV Therapy Episode identifier that shall also be included in each record associated with the same IV Therapy Episode (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the Healthcare Facility – including the Treatment location's address, zip code, and Healthcare Facility identification number (*e.g.*, tax identification number) – at which the IV Therapy Episode occurred, the identity of the Healthcare Facility's owner, and any codes the Company uses to categorize each Healthcare Facility, including Medicare Provider ID or NPI number;
 - (c) The name, NPI number, and specialty area of practice of each primary physician and Mid-level Practitioner who evaluated or treated the patient;
 - (d) The identity of the employer or Physician Group of the primary physician or Mid-level Practitioner identified in response to Specification 2(c);
 - (e) The patient's county of residence and the patient's 5-digit ZIP code of residence;

- (f) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
- (g) The date of the IV Therapy Episode;
- (h) The CPT/HCPCS code(s) and modifier(s) associated with each Treatment performed, and any other code(s), used for billing;
- (i) The Average Sales Price ("ASP") of the drug administered through IV Therapy Services, if the drug is billed as a percentage markup over ASP, and the percentage markup;
- (j) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the IV Therapy Episode;
- (k) A brief description of the service(s), Treatment(s), and/or procedure(s) performed;
- (l) Whether the Treatment, procedure, or service provided was for an emergency;
- (m) The source of the patient (*e.g.*, transfer or referral from another Provider), including the identity of any transferring or referring Provider;
- (n) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (o) The identity of any secondary sources of payment;
- (p) For each product listed in response to Specification 8(n), whether the product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (q) Whether the Healthcare Facility identified in response to Specification 8(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the Healthcare Facility was in;
- (r) The billed charges of the Healthcare Facility (broken out by any codes and modifiers used for billing), the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (s) A breakdown of the Healthcare Facility's charges by classification of physician services rendered to the patient, by CPT/HCPCS code and modifier or by any other diagnosis and/or procedure codes used by the Healthcare Facility;

- (t) Any additional amounts paid or to be paid to the Healthcare Facility by the patient under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
 - (u) Whether the allowed amount identified in response to Specification 8(r) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) the identity of the designated primary payor under this arrangement, and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
 - (v) Whether this IV Therapy Episode is part of a series of Treatment Episodes and where this Treatment Episode falls in that series; and
9. Submit (in electronic, machine readable format directly to the Commission representative identified in Instruction I11), for each Independent Laboratory Claim that occurred in the period January 1, 2011 to the present, and that involved a patient residing in the Relevant Area (regardless of the location of the Healthcare Facility accessed by the patient) or a patient accessing a Healthcare Facility in the Relevant Area (regardless of the patient's place of residence):
- (a) A unique patient identifier, different from that of other patients and the same as that for different inpatient admissions, Outpatient Episodes, Practitioner Treatment Episodes, SNF Episodes, Hospice Episodes, HHA Episodes, DME Claims, IV Therapy Claims, and Independent Laboratory Claims for the same patient (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3); and, if the Company is providing data in multiple records for the Independent Laboratory Service, a unique Independent Laboratory Service identifier that shall also be included in each record associated with the same Independent Laboratory Service (to protect patient privacy, the Company shall mask personal identifying information, such as the patient's name or Social Security number, pursuant to Instruction I3);
 - (b) The identity of the Healthcare Facility – including the Treatment location's address, zip code, and Healthcare Facility identification number (*e.g.*, tax identification number) – at which the independent laboratory service occurred, the identity of the Healthcare Facility's owner, and any codes the Company uses to categorize each Healthcare Facility, including Medicare Provider ID or NPI number;

- (c) The name, NPI number, and specialty area of practice of each primary physician and Mid-level Practitioner who ordered the Independent Laboratory Service;
- (d) The identity of the employer or Physician Group of the primary physician or Mid-level Practitioner identified in response to Specification 2(c);
- (e) The patient's county of residence and the patient's 5-digit ZIP code of residence;
- (f) The patient's gender, age (including age in days if the patient is less than one year old), race, and ethnicity;
- (g) The date of the Independent Laboratory Service;
- (h) The CPT/HCPCS code(s) and modifier(s) and the ASC and APC code(s) associated with each Independent Laboratory Service performed, and any other code(s), used for billing;
- (i) The primary ICD9 or ICD10 diagnosis code and any secondary ICD9 or ICD10 diagnosis code(s) associated with the Independent Laboratory Service;
- (j) A brief description of the Independent Laboratory Service(s) performed;
- (k) Whether the Independent Laboratory Service provided was for an emergency;
- (l) The specific name and type (*e.g.*, HMO, POS, PPO, etc.) of the Health Plan product – including the name of the sponsor or patient employer for Self-Insured Health Plans – that was the principal source of payment;
- (m) The identity of any secondary sources of payment;
- (n) For each product listed in response to Specification 9(1), whether the product was offered through a managed care contract with Medicare, Medicaid, or other public health insurance program;
- (o) Whether the Healthcare Facility identified in response to Specification 9(b) was a participating Provider under the patient's Health Plan and, if the patient's Health Plan had different Tiers of participating Providers, which Tier the Healthcare Facility was in;
- (p) The billed charges of the Healthcare Facility (broken out by any codes and modifiers used for billing), the allowed amount under the patient's Health Plan, the amount actually paid by the Health Plan, and whether the amount actually paid by the Health Plan includes any adjustments under any stop-loss provisions;
- (q) A breakdown of the Healthcare Facility's charges by classification of Physician Services rendered to the patient, by CPT/HCPCS code and modifier or by any other diagnosis and/or procedure codes used by the Healthcare Facility;

- (r) Any additional amounts paid or to be paid to the Healthcare Facility by the patient under the patient's Health Plan (broken out by any codes and modifiers used for billing), including (and listed separately):
 - (i) The Deductible amount,
 - (ii) The Copay amount, and
 - (iii) The Coinsurance amount;
 - (s) Whether the allowed amount identified in response to Specification 9(p) was determined under a coordination-of-benefits arrangement, and if it was:
 - (i) the identity of the designated primary payor under this arrangement, and
 - (ii) what the allowed amount would have been absent the coordination-of-benefits arrangement;
 - (t) Whether this Independent Laboratory Service is part of a series of Treatment Episodes and where this Treatment Episode falls in that series; and
10. Identify capitation, risk-sharing, bundled payment, ACO payment, value-based payment, lump-sum payment, increased reimbursement or bonuses for meeting quality objectives, or any reimbursement contracts other than fee-for-service with providers now in effect or that were in effect at any time since January 1, 2011 in the Relevant Area, and for each such arrangement provide the following information (in electronic, machine readable format directly to the Commission representative identified in Instruction I11):
- (a) The name and a brief description of the arrangement;
 - (b) Eligibility requirements for participating in the arrangement;
 - (c) The areas or populations to which the arrangement applies;
 - (d) Whether the arrangement is intended to supplant or complement any of the Company's fee-for-service reimbursement models (e.g., per-diem, DRG-based, percent-of-charges, etc.)
 - (e) A unique identifier for the arrangement;
 - (f) The number and dollar value of Claims or Episodes that are covered by the arrangement;
 - (g) The total bonuses, penalties, and other payments or deductions associated with the arrangement that are not already reflected in the claims data for each time period for which the bonuses, penalties, payments, or deductions are normally assessed and for each provider participating in the program as well as the Tax

Identification Number (TIN) and any other provider codes (e.g., the NPI number) that would allow us to match the provider to the providers in specifications 1-9;

- (h) The formula used to compute the bonuses, penalties, and other payments or deductions associated with the arrangement;
 - (i) Any additional data, e.g., quality scores, required to replicate the calculation of the bonus or penalty using the relevant formula and the claims data.
11. Describe, for each Health Plan (such as HMO, POS, PPO, etc.) offered by the Company in the Relevant Area for each year beginning January 1, 2011:
- (a) The name of the product as it is referred to in the Company's data provided in response to Specifications 1-10;
 - (b) The counties in which the product is or was offered;
 - (c) The identity of each participating Provider, including the Provider's affiliation with a Hospital, Hospital System, or other larger entity (i) for each physician or Mid-level Practitioner, the Provider's specialty, employer, type of affiliation with the Hospital or Hospital System (such as employed, member of physician hospital organization, member of clinically integrated network, professional service agreement), and indicate whether the affiliated Hospital or Hospital System negotiated rates on behalf of the Provider; and (ii) for each Provider, a description of any Provider-Tiering or preferred-provider designation pursuant to a Steering Program; and
 - (d) The services or procedures covered by the Health Plan and, for each service or procedure:
 - (i) All Deductible amounts, Copay amounts, Coinsurance rates, or out-of-pocket maximums that apply and how these differ across tiers or between preferred and non-preferred Providers pursuant to a Steering Program; and
 - (ii) Any other inducements offered to Health Plan patients to use certain Providers.
 - (e) The number of covered lives in the Health Plan, stated separately for each 5-digit ZIP code in the Relevant Area, if possible;
12. Identify the code definitions used in the Company's responses to Specifications 1-11 of this Order (e.g., DRG, MSDRG, MDC, ICD9, ICD10, CPT, ASC, APC, and version number), including the date on which any change to any of these code definitions was implemented by the Company in the period from January 1, 2011 to the present. If the Company used or uses one or more proprietary procedure coding systems in the period from January 1, 2011 to the present, provide for each such system:

- (a) The time period during which the Company used the system,
 - (b) A master list of the system's codes,
 - (c) A brief description of each code, and
 - (d) Each code's associated weight value, if this value was or is used for billing.
13. Submit all of the Company's fee-for-service contracts now in effect or that were in effect with Mountain States Health Alliance, Wellmont Health System, and Ballad Health in the Relevant Area at any time since January 1, 2011, including any amendments or modifications thereto.
14. Submit all of the Company's capitation, risk-sharing, bundled payment, ACO payment, value-based payment, lump-sum payment, increased reimbursement or bonuses for meeting quality objectives, or any reimbursement contracts other than fee-for-service now in effect or that were in effect with providers at any time since January 1, 2011 in the Relevant Area, including any amendments or modifications thereto.
15. Submit all information described in Instructions I6 and I7 below, and any additional instructions necessary for the Commission to use or interpret the data and information submitted in response to this Order.
16. Submit the name(s) and title(s) of the person(s) responsible for preparing the response to this Order and a copy of all instructions prepared by the Company relating to the steps taken to respond to this Order. Where oral instructions were given, identify the individual who gave the instructions and describe the content of the instructions and the person(s) to whom the instructions were given.

DEFINITIONS

For the purposes of this Order, the following Definitions apply:

- D1. The term “the Company” means [COMPANY DESCRIPTION]; its domestic and foreign parents, predecessors, divisions, subsidiaries, affiliates, partnerships and joint ventures; and all directors, officers, employees, agents, and representatives of the foregoing. The terms “parent,” “subsidiary,” “affiliate,” and “joint venture” refer to any person in which there is partial (25 percent or more) or total ownership or control between the Company and any other person.
- D2. The terms “and” and “or” have both conjunctive and disjunctive meanings.
- D3. The term “Claim” refers to any individual occurrence of a particular medical service at the level of detail at which the Provider bills the Company.
- D4. The term “Coinsurance” refers to the set percentage of covered charges (*i.e.*, the charges recognized by the Health Plan) that a Health Plan enrollee must pay out-of-pocket for each episode of healthcare covered by the enrollee’s Health Plan. The term also has any other meaning that the Company ascribes to it in the ordinary course of business.
- D5. The term “Copay” refers to the set fee that a Health Plan enrollee must pay out-of-pocket for each episode of healthcare covered by the enrollee’s Health Plan. The term also has any other meaning that the Company ascribes to it in the ordinary course of business.
- D6. The term “Deductible” refers to the set amount that a Health Plan enrollee must pay out-of-pocket each year for healthcare services before the enrollee’s Health Plan benefits go into effect. The term also has any other meaning that the Company ascribes to it in the ordinary course of business.
- D7. The term “Durable Medical Equipment” (DME) means equipment which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury and can withstand repeated use.
- D8. The terms “each,” “any,” and “all” mean “each and every.”
- D9. The term “Entity” means any natural person, corporation, company, partnership, joint venture, association, joint-stock company, trust, estate of a deceased natural person, foundation, fund, institution, society, union, or club, whether incorporated or not, wherever located and of whatever citizenship, or any receiver, trustee in bankruptcy or similar official or any liquidating agent for any of the foregoing, in his or her capacity as such.
- D10. The term “Episode” refers to any individual occurrence of a particular medical service.

- D11. The term “Fully-Insured” refers to any arrangement by which a Health Plan is directly responsible for paying the Provider claims generated by the healthcare consumption of its members.
- D12. The term “General Acute Care Inpatient Services” refers to the provision of Inpatient Services (including any Physician Services that may be provided on an inpatient basis) for medical diagnosis, Treatment, and care of physically injured or sick persons with short-term or episodic health problems or infirmities, excluding non-acute long-term services (*e.g.*, skilled nursing care).
- D13. The term “Health Plan” means any health maintenance organization, managed healthcare organization, preferred provider arrangement or organization, managed healthcare plan of any kind, Fully-Insured health benefit plan, Self-Insured health benefit plan, other employer or union health benefit plan, Medicare, Medicaid, TRICARE, or private or governmental healthcare plan, or health insurance of any kind.
- D14. The term “Healthcare Facility” means any location where Relevant Services are delivered, on an inpatient or outpatient basis, including, but not limited to, Hospitals, ambulatory surgery centers, urgent care centers, physician offices, locations where radiology services or imaging services are delivered, or clinical laboratories.
- D15. The term “Home Health Agency Services” means health care services provided by an entity that is primarily engaged in providing skilled nursing care and other skilled health care services like physical and occupational therapy, speech language therapy, and medical social services to individuals in private homes.
- D16. The term “Hospice Services” means health care services designed to provide palliative care for the terminally ill focused on maintaining quality of life rather than curing the patient.
- D17. The term “Hospital” means a facility that provides General Acute Care Inpatient Services, collectively or individually.
- D18. The term “Independent Laboratory Services” means diagnostic laboratory tests for nonhospital patients.
- D19. The term “Inpatient Services” refers to the provision of medical services that require at least one overnight stay at a Provider or at least 24-hour nursing care, including any Physician Services rendered as part of the inpatient Treatment.
- D20. The term “Intravenous Therapy Services” means the administration of medication through a needle or catheter directly into a vein.
- D21. The term “Mid-level Practitioner” means a nurse practitioner or physician assistant.
- D22. The term “Outpatient Episode” means any Practitioner Treatment Episode that involves only the delivery of one or more Outpatient Services.

- D23. The term “Outpatient Services” refers to the provision of medical services, including physician services, that do not require an overnight stay at a Healthcare Facility or 24-hour nursing care.
- D24. The term “Person” includes the Company and means any natural person, corporate Entity, partnership, association, joint venture, government Entity, or trust.
- D25. The term “Physician Group” means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, or employees, or in which only one physician practices medicine.
- D26. The term “Physician Services” refers to services provided by a physician, Mid-level Practitioner, or Physician Group.
- D27. The term “Practitioner Treatment Episode” means any individual occurrence when a patient visits or receives a Treatment from a physician or other medical professional for medical care at one specific location, regardless of whether the Treatment involved Inpatient Services or Outpatient Services.
- D28. The term “Provider” means any Entity that provides the Relevant Service. The term “Provider” includes but is not limited to Hospitals, freestanding outpatient facilities, Physician Groups, individual physicians, and other Healthcare Facilities.
- D29. The term “relating to” means in whole or in part constituting, containing, concerning, discussing, describing, analyzing, identifying, or stating.
- D30. The term “Relevant Area” means [RELEVANT AREA DESCRIPTION].
- D31. The term “Relevant Services” as used herein means, and information shall be provided separately for, each of the following: (1) General Acute Care Inpatient Services, collectively and individually; (2) Outpatient Services, collectively and individually; (3) Physician Services; (4) Skilled Nursing Facility Services; (5) Hospice Services; (6) Home Health Agency Services; (7) Durable Medical Equipment (DME); (8) Intravenous Therapy Services; and (9) Independent Laboratory Services.
- D32. The term “Self-Insured” refers to any arrangement by which an employer or other Health Plan customer is directly responsible for paying Provider claims generated by the healthcare consumption of its employees or other members. The term includes and refers to, without limitation, Administrative Services Only (“ASO”) arrangements.
- D33. The term “Skilled Nursing Facility Services” means health care services provided by professional staff (e.g., registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, audiologists, etc.) to treat, manage, observe, and evaluate patients at a facility that meets criteria for Medicaid and Medicare reimbursement for nursing care.

- D34. The terms “Tier” and “Tiering,” with respect to Providers, refer to the classification of some or all of a Health Plan’s in-network Providers into two or more Tiers based on each Provider’s costs, quality, other attributes, or some combination of the foregoing, such that each Health Plan member faces different out-of-pocket costs across the various Tiers for the same Treatment, service, or procedure.
- D35. The term “Treatment” is defined as any individual occurrence when a patient receives medical attention (such as a diagnosis, clinical procedure, surgery, imaging service, rehabilitation session, visit, or any other medical assessment, care, procedure, or action) from a physician or other medical professional at one specific location, including a physician office.
- D36. Any word or term that the Company considers vague or insufficiently defined has the meaning most frequently assigned to it by the Company in the ordinary course of business.

INSTRUCTIONS

For the purposes of this Order, the following Instructions apply:

- I1. All references to year refer to calendar year. Where data/information is requested, provide it separately for each calendar year; if calendar year data/information is not yet available, provide the data/information for the calendar year to date. If calendar year data/information is not kept by the Company, supply the Company's fiscal year data/information, indicating the 12-month period covered, and provide the Company's best estimate of calendar year data/information.
- I2. In order to comply in a manner consistent with the Commission's Rules of Practice, 16 C.F.R. § 2.7(k), the Company shall schedule a teleconference, within 14 days after receiving this Order, with the Commission representative identified in Instruction I12 of this Order to confer regarding production format and method. Upon request, an extension of no more than 30 days for the teleconference may be granted in writing by a Commission official.
- I3. To protect patient privacy, the Company shall mask personal identifying information, such as the patient's name, Social Security number, patient medical record number, or insurance ID, by substituting (a) a unique patient identifier that is different from that for other patients and the same as that for different admissions, discharges, or other treatment episodes for the same patient; and (b) a unique inpatient admission or outpatient visit identifier.
- I4. The Company shall submit data in delimited text or Microsoft Excel format. Other formats should be discussed with the Commission representative identified in Instruction I11 of this Order.
- I5. The Company shall encrypt all data and information before producing it to the Commission. Using NIST FIPS-Compliant¹ cryptographic hardware or software modules is strongly encouraged. All submissions in electronic format shall be produced in the following manner:
 - (a) For any submission over 10 gigabytes, use IDE and EIDE hard disk drives, formatted in Microsoft Windows-compatible, uncompressed data; data can be provided on a FIPS-Compliant encrypted hard drive.

¹ The National Institute of Standards and Technology (NIST) issued the Federal Information Processing Standard (FIPS) Publications 140-1 and 140-2 that details certified cryptographic modules for use by the U.S. Federal government and other regulated industries that collect, store, transfer, share, and disseminate sensitive but unclassified information. More information about FIPS 140-1 and 140-2 can be found at <http://csrc.nist.gov/groups/STM/index.html>.

- (b) For any submission under 10 gigabytes, use CD-R, CD-ROMs, and DVD-ROM for Windows-compatible personal computers, and USB 2.0 Flash Drives are also acceptable storage formats.
- (c) **All information produced in electronic format shall be scanned for and free of viruses. The Commission will return any infected media for replacement, which may affect the timing of the Company's compliance with this Order.**
- (d) **The password for the encrypted data and information shall be provided separately, via email, to the Commission representative identified in Instruction II of this Order.**

However, the Company may produce any data/information responsive to this Order using the Commission's secure file transfer protocol ("FTP"). For instructions on using this FTP, please contact the Commission representative identified in Instruction II2 of this Order.

- I6. Each submission responsive to this Order shall be accompanied with a letter that includes all of the following:
 - (a) Volume name;
 - (b) A description of encryption software/hardware used;
 - (c) The total number of files; and
 - (d) A list of data fields in the Order in which they appear in the data files.
- I7. Each data submission responsive to this Order shall be accompanied by a description of each data field, a data dictionary that specifies what the values of each data field signify, and an identification of the field(s) that respond(s) to each subpart of Specifications 1-12 of this Order.
- I8. The Company shall submit documents as instructed below absent the written consent by a Commission official.
 - (a) Documents stored in electronic or hard copy format in the ordinary course of business shall be submitted in electronic format provided that such copies are true, correct, and complete copies of the original documents:
 - (i) Submit Microsoft Access, Excel, and PowerPoint in native format with extracted text and metadata;
 - (ii) Submit all documents other than those identified in subpart (a)(i) in image format with extracted text and metadata; and
 - (iii) Submit all hard copy documents in image format accompanied by OCR.

- (b) Documents responsive to this Order, regardless of format or form and regardless of whether submitted in paper or electronic form:
 - (i) Shall be produced in complete form, un-redacted unless privileged or as required by I3, and in the order in which they appear in the Company's files, and shall not be shuffled or otherwise rearranged. For example:
 - (1) If in their original condition papers were stapled, clipped, or otherwise fastened together or maintained in file folders, binders, covers, or containers, they shall be produced in such form, and any documents that must be removed from their original folders, binders, covers, or containers in order to be produced shall be identified in a manner so as to clearly specify the folder, binder, cover, or container from which such documents came; and
 - (2) If in their original condition electronic documents were maintained in folders or otherwise organized, they shall be produced in such form and information so as to clearly specify the folder or organization format;
 - (ii) If written in a language other than English, shall be translated into verbatim English, with the English translation attached to the foreign language document;
 - (iii) Shall be produced in color where necessary to interpret the document;
 - (iv) Shall be marked on each page with corporate identification and consecutive document control numbers; and
 - (v) Shall be accompanied by an affidavit of an officer of the Company stating that the copies are true, correct, and complete copies of the original documents.
- I9. If the Company is unable to answer any question fully, supply such information/data as is available. Explain why such answer is incomplete, the efforts made by the Company to obtain the information/data, and the source from which the complete answer may be obtained. If books and records that provide accurate answers are not available, enter best estimates and describe how the estimates were derived, including the sources or bases of such estimates. Estimated data should be followed by the notation "est." If there is no reasonable way for the Company to make an estimate, provide an explanation.
- I10. In order for the Company's response to this Order to be complete, the attached certification form must be executed by the official supervising compliance with this Order, notarized, and submitted along with the responsive materials. No official of the Company need appear to testify with the responsive materials, but the Commission reserves the right to have a Company representative testify as to the adequacy of the return at a later date.

- I11. The responses to Specifications 1-12 of this Order shall be addressed to the attention of “BE Data Support Center” and delivered, between 8:30 a.m. and 4:30 p.m. ET on any business day prior to and including the return date stated on the face of the attached Order, to BE Data Support Center, Federal Trade Commission, 600 Pennsylvania Ave., NW, Room H-285, Washington, DC 20580. For courier delivery, contact Kevin Richardson at (202) 326-3481, krichardson@ftc.gov; or Constance Herasingh at (202) 326-2147, cherasingh@ftc.gov. Please notify Mr. Richardson and Ms. Herasingh by email in advance of each delivery. Any password(s) necessary to access the response to the Order shall be emailed to Mr. Richardson and Ms. Herasingh.
- I12. Any questions that you have relating to the scope or meaning of anything in this Order or suggestions for possible modifications to it should be directed to Stephanie A. Wilkinson at 202-326-2084, swilkinson@ftc.gov. The responses to Specifications 13-16 of this Order shall be addressed to the attention of Ms. Wilkinson and delivered between 8:30 a.m. and 4:30 p.m. ET on any business day prior to and including the return date stated on the face of the attached Order, to the Federal Trade Commission, 600 Pennsylvania Ave., NW, Washington, DC 20580. Please notify Ms. Wilkinson by email in advance of each delivery.

CERTIFICATION

This Special Report, together with any and all appendices and attachments thereto, was prepared and assembled under my supervision in accordance with instructions issued by the Federal Trade Commission. To the best of my knowledge, the information is true, correct, and complete, subject to the recognition that, where so indicated, reasonable estimates have been made because books and records do not provide the required data. Where copies rather than original documents have been submitted, the copies are true, correct, and complete.

TYPE OR PRINT NAME AND TITLE

(Signature)

Subscribed and sworn to before me at the City of _____,

State of _____, this _____ day of _____, 20__.

(Notary Public)

My Commission expires: