Delivering the Next Generation of Health Care

Connecting person to person.
Building healthier communities.
Maximizing effective approaches to care.
Partnering long-term with customers.

CARE IS THE HEART OF OUR WORK™

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AmeriHealth Caritas • Care Is the Heart of Our Work
Value-Based Payment Contracting from a Clinical Perspective

Goals
1. Provide an overview of value-based contracting.
2. Describe how to impact clinical outcomes to improve value-based reimbursement.
3. Establish an understanding of how to share data to improve information availability.
Committed.
Connecting millions of members with critical, high-quality health care services.

Experienced.
Delivering proven, integrated health care services throughout the country.

Multifaceted.
Providing Medicaid, Medicare, behavioral health services, pharmacy benefit management, specialty pharmacy, and third-party management and administrative services.

Rooted.
We began as a mission-driven neighborhood health plan and are proud of our passion to serve those most in need.

Nimble.
Customizing solutions based on our members’ and partners’ needs.

Award winning.
National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction Award recipient.

Evolving.
An industry thought leader giving its customers the edge with innovative, evidence-based products and services.
Developing innovative performance programs
PerformPlus® Value-based Programs

PerformPlus is a portfolio of value-based incentive programs designed to encourage the right care at the right place. Provider groups, hospitals and integrated delivery systems are rewarded for achieving key performance indicators built around adherence to evidence-based clinical practices, achieving targeted quality outcome measures and providing cost-effective, appropriate care.

• Reward program for providers for timely, appropriate ambulatory care and positive patient outcomes; utilizing peer and trend based measurements, including HEDIS measures, to determine outcomes and link to rewards.
• Reimbursement incentives based on performance for closing gaps in care for agreed-upon HEDIS and other quality metrics, including:
  - High-quality and cost-effective care.
  - Member service and convenience.
  - Accurate and complete health data.

More than 40% of our managed care membership across all markets receives care from a provider that participates in one or more of our PerformPlus value-based programs.
Partnering with Health Care Providers for quality improvement

PerformPlus® represents a suite of unique quality incentive programs available to physicians (primary care and specialists), hospitals, and integrated delivery systems. It was developed to reward providers for timely, appropriate care and positive patient outcomes.

As an example, the PerformPlus Shared Savings program addresses the needs of patients across multiple care settings, reducing fragmentation, and duplicative services, and ultimately resulting in better clinical outcomes.

A range of value-based purchasing models

CORE
- Includes PCP value-based models, dental program, and perinatal program.
- Supported by advanced technology and analytic supports.
- Represents “upside only” financial potential.

PREMIUM
- Includes shared savings, specialty, and federally qualified health center (FQHC) programs.
- Designed to support different levels of provider risk tolerance and sophistication.

ELITE
- Features increasing levels of fiscal responsibility and health system risk.
- May include risk-based collaboration and population health management.
- Expands beyond the typical structure of the health system.
Risk Implementation and Scalability

**MLR**
- Quality based guardrails governing risk allocation/sharing.
- MLR targets
- Outcomes capped at upside and downside corridors

**PMPM**
- Cost of Medical Care
  - Member months adjusted to reflect risk burden of the provider.
  - Percentage withheld to level for random variations
  - Quality performance impacts final payout

**Partial Risk**
- Continually enrolled population identified by specific risk stratification
- May exclude non users, maternity members and those with malignancies and catastrophic health conditions
- Outcomes capped at upside and downside corridors

**Actuarially Sound Guardrails**
Achieving growth in our value-based programs

MEMBERS
1,483,587

ACTIVE
788,397

PERCENT BY MARKET
53.1%

As of September 12, 2016
Engaging different types of providers

- 1296 Primary care physician groups
- 11 Nationally recognized integrated delivery systems
- 37 Program partners spanning 6 states
- 24 Community partners programs
- 15 FQHCs
- 11 Specialized medicine provider groups
AmeriHealth Caritas Louisiana (ACLA)

Care Is the Heart of Our Work

QEP → 531 PCP Groups → 158,002 Members

Perinatal → 38 OBGYN Groups → Managing the delivery of 1,520 Births

PerformPLUS → 2 Shared Savings Plan, 4 Community Partners Program, 4 Behavioral Health → 22,500 Members
Building the ACLA Value Based Network

Current PerformPLUS Partners

- Volunteers of America
- Christus Health
- Franciscan Missionaries of Our Lady
- River Oaks Hospital
- Louisiana Association for Behavioral Health
- PHSC
- Daughters of Charity

In Discussions

- Access Health of LA
- Affinity
- BRFHH (Completed)
- David Raines
- Excelth Family Health Center (Completed)
- Lafayette General Health System
- Pediatric KidMed
- St. Thomas Community Health (Completed)
- Childrens International Medical Group
- LCMC Health Sites
- Capital Area Human Services
- Teche
Transitioning to a value-based system

QUALITY ENHANCEMENT PROGRAM

Focuses on value-based quality measures and primary care provider (PCP) gainsharing.

SHARED SAVINGS

Targets larger health systems and specialized medicine practices to integrate value-based care with a holistic approach.

PREVENTABLE EVENTS

Operates in collaboration with developers of nationally recognized logic for predictive analysis.

PARTIAL RISK

Focuses on specific populations using clinical risk grouping algorithms.

FULL RISK

Includes adjusted value-based measures such as medical loss ratio shares and bundled payments.

GOAL

Incorporates full partnerships — aligned objectives, incentives, and data exchanges.
Classifying alternative payment models (APMs)

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE-FOR-SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE-FOR-SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION-BASED PAYMENT</td>
</tr>
<tr>
<td>A</td>
<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for health information technology investments)</td>
<td>A</td>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
</tr>
<tr>
<td>B</td>
<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>B</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
</tr>
<tr>
<td>C</td>
<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td>C</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>3N</td>
<td>Risk Based Payments NOT Linked to Quality</td>
<td>4N</td>
<td>Capitated Payments NOT Linked to Quality</td>
</tr>
</tbody>
</table>

Figure 1: The Updated APM Framework
<table>
<thead>
<tr>
<th>Quality Enhancement Program (QEP) - PCPs HCP-LAN 2C</th>
<th>Community Partners Program (FQHCs) - HCP-LAN 2C</th>
<th>Woman’s Health Program - HCP-LAN 2C</th>
<th>Cardiology Pay for Performance – HCP-LAN 2C/3A</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality • HEDIS • PCMH Status • Efficiency • Cost Efficiency • Non-Emergent ER Utilization • Improvement Incentive</td>
<td>• Quality • HEDIS • Efficiency • Potentially Preventable Readmissions • Potentially Preventable Admission Rate • Potentially Preventable ER Visit Rate • Administrative Bonus • PCMH Status</td>
<td>• Quality • HEDIS • Efficiency/Transparency • NICU Rates • ONAF forms • Participation Standards &amp; Administrative • Program participation standards • Performance on Access to Care Survey/ • Complaints &amp; Grievances</td>
<td>• Quality • NQF • Cost/Efficiency • Potentially Preventable Readmissions • Potentially Preventable Admission Rate • Potentially Preventable ER Visit Rate • Administrative • “Distinguished Provider” • Medical Home Bonus • Other: EMR, Electronic Claims submission, etc.</td>
</tr>
</tbody>
</table>

**Shared Savings Program – HCP-LAN 2C**

- Quality
  - HEDIS
  - Hospital Safety Measures
- Efficiency
  - Potentially Preventable Readmissions
  - Potentially Preventable Admission Rate
  - Potentially Preventable ER Visit Rate
  - NICU LOS

**Integrated Behavioral Health - HCP-LAN 2C**

- Efficiency measures including potentially preventable ER utilization
- Behavioral Health quality measures such as:
  - Adherence to Antipsychotic Medications for individuals with Schizophrenia
  - Antidepressant Medication Management (AMM)
  - Follow-Up After Hospitalization for Mental Illness (FUH)

**Partial Risk Model - HCP-LAN 3/4**

- Continually enrolled population identified by specific risk stratification
- Excludes non users, maternity members and those with malignancies and catastrophic health conditions
- Outcomes capped at upside and downside corridors

**Full Risk Model HCP-LAN 3/4**

- Quality based guardrails governing risk allocation/sharing.
- MLR targets
- Outcomes capped at upside and downside corridors
AmeriHealth Caritas FQHC Partnership Strategy

- Leading the way with innovative provider partnership and payment models
- Acknowledges that building effective partnerships with FQHCs is critical to our mission.
- Includes an enterprise-wide strategy for relationship building and innovative value-based contracting
- Our ultimate goal is to help the population that we mutually serve obtain access to care, stay well and build healthy communities
Provider Partnership Opportunities

- Support for Patient Centric Care
  - Integrated care management
  - Integrated behavioral health care
  - Integrated oral care
  - Community outreach teams
  - Community Connectors

- Value-Based Programs for our FQHC Partners
  - Provider Dashboards
  - Robust Analytics and Data Sharing
  - Resource/Support for Success

- HEDIS performance, challenges and strategies for improvement

- Strategies for Dealing with Pain Management and Opioids in the Primary Care Setting
Obtaining positive health outcomes

Preventable events
- Potentially preventable admissions.
- Potentially preventable readmissions.

Condition-based (diabetes, cardiology, asthma)
- Low-density lipoprotein (LDL) lowering drug therapy.
- Left ventricular ejection fracture (LVEF) assessment.
- Warfarin and other approved anticoagulants.
- Heart failure care.
- Diabetes care.
- Beta blocker therapy for systolic pressure.

Preventive
- Chlamydia screening.
- Human papillomavirus (HPV) vaccination for female adolescents.

Maternal
- Postpartum care.
- First trimester prenatal care.
- Frequency of prenatal care.
- Neonatal intensive care unit (NICU) length of stay.

The PerformPlus dashboard provides timely information to monitor our performance and manage our patients, including services provided outside our office.

SUSAN L. WILLIAMS, M. D.
PRESIDENT, CROZER-KEYSTONE PHYSICIAN PARTNERS
Streamlining data through the PerformPlus dashboard

Through our customizable dashboards, AmeriHealth Caritas can quickly develop analyses for internal and external distribution as well as rapidly respond to the changing landscape of value-based purchasing to share detailed and refined data.

Jefferson has been a value-based partner with AmeriHealth for several years. Having access to the PerformPlus dashboard will be a key driver to our success in AmeriHealth’s value-based program. We are able to quickly assess if metrics are within the desired range and generate our own reports to identify improvement opportunities. We rely on the dashboard to help us achieve our targeted goals within the program.

DEBRA TAYLOR
VICE PRESIDENT, PAYER RELATIONS AND CONTRACTING, JEFFERSON HEALTH
Transparency- TREO Dashboard
Dashboards Phase 2

New Design and Differentiated Content

- Allow AmeriHealth to quickly develop analyses for internal and external distribution
- AmeriHealth rapidly responds to the changing landscape of VBP with the development of customizable dashboards sharing detailed and refined data

Dashboard including PICS, MLR, Episodes and More
What’s available on NaviNet at www.navinet.net?

• Real-time eligibility and benefits.
• Provides historic member eligibility information.
• Claim status.
• Monthly panel listing.
• Claims submission – via Change Healthcare Quick Connect.
• Electronic prior authorizations – via JIVA.
Member Clinical Summary and Panel Roster report offer additional information at your fingertips

We’ve added new elements to the Member Clinical Summary. This valuable report now includes the following information about your patients:

- Care Manager name and contact information.
- Observation stays.
- Member restriction information.

The Panel Roster now includes:

- Member restriction information.
- Member language.

See the NaviNet Enhancements Training Guide (PDF) to learn more about the new screens.
The Member Clinical Summary (MCS) is a snapshot of a patient’s relevant clinical data and demographic information all displayed in a single user-friendly report and contains:

- Demographic information (Member and PCP)
- Gaps in care
- Medications that have been filled within the past 6 months
- Office visits within the past 12 months
- Chronic conditions
- ER visits within the past 6 months
- Observation stays within the past 6 months
- Inpatient admissions within the past 12 months
- Imaging services received within the past 6 months
- Available lab data for tests within the past two years
- EPSDT and immunization services (for pediatric patients)
- Patient-specific critical screening services (based on diagnosis compared to clinical recommendations)
- Care Manager’s name and contact numbers (when applicable)
- Member restriction information if a member is “locked-in” to a PCP or pharmacy
The Clinical Report Inquiry is a snapshot of a patient’s relevant clinical data and demographic information all displayed in a single user-friendly report and contains:

- Admit/Discharge Reports
- Care Gap Query
- HEDIS Improvement Campaign Query
- Member Alert Standalone Care Gap Request
- Missing and Overdue Care Gaps Adolescent Only
- Missing and Overdue Care Gaps Adult Only
- Missing and Overdue Care Gaps All Members
- Missing and Overdue Care Gaps Pediatric Only
- QEP ER Utilization Report
- QEP Hospital Admission Report
- QEP Perinatal Report
- QEP Report Card
- QEP Specialty Usage Report
- Single Service Care Gap Query
Care Gap Query v. 1.0.2

Instructions
Please enter your search criteria, and click "Search". * Indicates Required Fields.
NOTE: if your browser has an active popup blocker you may need to turn it off to receive the report.

Provider/Member Information
* Choose a Provider Group [Group Name - PIN]
Choose a Provider [Provider Name - PIN]

Report Criteria

Conditions
- All
- Asthma
- Coronary Artery Disease
- Critical Quality Incentive
- Diabetes
- EPSDT
- Heart Failure
- Hypertension
- Medication Adherence
- Preventive Health Screens
- Preventive Health Vaccine
- Preventive Health Vaccines
- Sickle Cell Disease (SCD)

Status
- M
- O
- P
- A
- D
- I
- L
- R

Age Ranges
- All
- < 12 yrs
- 12 - 21 yrs
- > 21 yrs

Select Sort Op
* Member Last Name

Select Report Type
- PDF
- Excel or CSV (Downloadable)

Last Update: 04/17/2013 v.1.0.2

Search Exit Clear
ACLA Support for Practice Transformation – 2017 and Beyond

Addition of Practice Transformation Specialist to support practice transformation and enhanced performance in a value-based purchasing environment

- Assessing organizational/practice readiness for transformation, change management and practice improvement opportunities
- Understanding how information is captured and analyzed, which data analysis techniques are best for various situations, and how to use data to improve performance. Optimizing health information technology for performance monitoring and population management
- Creating an infrastructure for continuous improvement by identifying and developing suggestions for provider participant’s improvement plans and assisting providers in developing, implementing, monitoring, and tracking of improvement activities
- Facilitating development of a goal-oriented plan for interim monitoring of process
- Identifying and cross-pollinating best practices

In addition to helping our providers navigate through our existing resources, the Practice Transformation Specialist will also help to identify and fill any gaps in how we support practices during the transformation continuum.

Specific responsibilities of the Practice Transformation Manager include:

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Additional Opportunities for Innovation in 2017

Framework for ACLA Approach:

- Risk-adjusted non-fee-for-service based payment and practice transformation support
- Value-Based performance incentive payment methodology
- IT Operations Manager Service Departments
- Practice and member-level cost and utilization data at regular intervals for all practices
- Practice Transformation Support
- ACLA CPC+--like program will be modeled after CMS framework, with modifications specific to ACLA population.

Key Practice Criteria (Core):

- Must Use CEHRT
- Assigning patients to provider panel
- Providing 24/7 access for patients
- Supporting quality improvement activities
- Comprehensiveness & Care Coordination
- Care Management
- Patient and Family Engagement
- Planned Care and Population Health Management

In 2016, ACLA submitted an application for participation in the CMS CPC+ Innovation Program. Although Louisiana was not selected, ACLA is evaluating roll-out of a CPC+--like model. CMS has also announced “round two” of the CPC+ program.
ACLA is in negotiation with a leading software vendor for episodic payment analysis in 2017. Using the results of the network analysis, we will implement pilot programs in 2017 in order to identify best practices and value-based opportunities when implementing episode of care payment design in the LA Medicaid market.

Value Based Continuum.

**Bundled Payments**
- Continually enrolled population identified by specific risk stratification
- May exclude non-users, maternity members, and those with malignancies and catastrophic health conditions
- Outcomes capped at upside and downside corridors

**Full Risk**
- Quality based guardrails governing risk allocation/sharing
- MLR targets
- Outcomes capped at upside and downside corridors

**Partial Risk**
- Continually enrolled population identified by specific risk stratification
- May exclude non-users, maternity members, and those with malignancies and catastrophic health conditions
- Outcomes capped at upside and downside corridors
Increasing access to data and reports

319 External users

127 Unique provider groups

50% Deployed essential data and reports for over 50% of membership for quality and cost tracking and transparency

"The Community Partners Program provides us with current, user-friendly data that is easy to access and download. While the program offers a complete incentive, it also provides the tools to do focused patient care management."

Marcella Lingham, Ed.D.
Executive Director, Quality Community Health Care
Expanding program throughout our health plans

Active states as of September 2016

- District of Columbia
- Pennsylvania
- Michigan
- Louisiana
- South Carolina
Characteristics of a Successful Practice

- Quality focused
- Electronic health record
- Risk stratified patient population
- Call Center
- Navigator or Care Manager
- ADT notification of care transitions
- ED visit and hospital discharge follow-up
- Co-location of services (behavioral health, dental, podiatry, optometry, pharmacy)
- Specialized services (infectious disease, cardiology)
- Day of Wellness
### Case Study of Population Health Data

#### Members < age 12 with Missing or Overdue Services

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Dental Visit 2 to 21 Years</td>
<td>242</td>
</tr>
<tr>
<td>Annual Developmental Screen</td>
<td>146</td>
</tr>
<tr>
<td>Annual Hearing Test</td>
<td>192</td>
</tr>
<tr>
<td>Annual Vision Screen</td>
<td>278</td>
</tr>
<tr>
<td>Chicken Pox Vaccine</td>
<td>13</td>
</tr>
<tr>
<td>Controller: Controller and Rescue Ratio</td>
<td>2</td>
</tr>
<tr>
<td>Diphtheria/Tetanus/Pertussis Vaccine (DTaP)</td>
<td>47</td>
</tr>
<tr>
<td>H Influenza Type B Vaccine</td>
<td>22</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>36</td>
</tr>
<tr>
<td>Hydroxyurea Therapy</td>
<td>5</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>21</td>
</tr>
<tr>
<td>Measles Mumps Rubella Vaccine</td>
<td>14</td>
</tr>
<tr>
<td>Past-due Refill: Hydroxyurea</td>
<td>1</td>
</tr>
<tr>
<td>Past-due Refill: Inhaled Corticosteroid</td>
<td>12</td>
</tr>
<tr>
<td>Penicillin Prophylaxis</td>
<td>1</td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine</td>
<td>48</td>
</tr>
<tr>
<td>Polio Vaccine</td>
<td>31</td>
</tr>
<tr>
<td>Primary Care Visit 1 to 2 years</td>
<td>13</td>
</tr>
<tr>
<td>Well Child Visit 18 Months and Younger</td>
<td>34</td>
</tr>
<tr>
<td>Well Child Visit 3 to 6 Years</td>
<td>164</td>
</tr>
<tr>
<td>Well Child Visit 7 to 11 Years</td>
<td>198</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1520</strong></td>
</tr>
</tbody>
</table>
# Case Study of Population Health Data

Members > 21 with Missing or Overdue Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEi/ARB Therapy (CAD)</td>
<td>3</td>
</tr>
<tr>
<td>ACEi/ARB Therapy (HF)</td>
<td>1</td>
</tr>
<tr>
<td>Adolescent Well Care</td>
<td>30</td>
</tr>
<tr>
<td>Adults Access to Care</td>
<td>390</td>
</tr>
<tr>
<td>Annual Dental Visit 2 to 21 Years</td>
<td>31</td>
</tr>
<tr>
<td>Anticoagulant Therapy (HF)</td>
<td>3</td>
</tr>
<tr>
<td>Antiplatelet Therapy (CAD)</td>
<td>21</td>
</tr>
<tr>
<td>Beta Blocker Prior MI (CAD)</td>
<td>3</td>
</tr>
<tr>
<td>Blood Glucose Monitoring</td>
<td>178</td>
</tr>
<tr>
<td>Breast Cancer Screen</td>
<td>140</td>
</tr>
<tr>
<td>CARE FOR OLDER ADULTS ADVANCE CARE PLANNING</td>
<td>7</td>
</tr>
<tr>
<td>CARE FOR OLDER ADULTS FUNCTIONAL STATUS ASSESSMENT</td>
<td>3</td>
</tr>
<tr>
<td>CARE FOR OLDER ADULTS MEDICATION REVIEW</td>
<td>7</td>
</tr>
<tr>
<td>CARE FOR OLDER ADULTS PAIN ASSESSMENT</td>
<td>7</td>
</tr>
<tr>
<td>Cervical Cancer Screen</td>
<td>624</td>
</tr>
<tr>
<td>Chlamydia Screen in Women</td>
<td>31</td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td>428</td>
</tr>
<tr>
<td>Controller: Controller and Rescue Ratio</td>
<td>11</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>135</td>
</tr>
<tr>
<td>Diabetes HbA1c Test</td>
<td>57</td>
</tr>
<tr>
<td>Diabetes Microalbumin Test</td>
<td>22</td>
</tr>
<tr>
<td>Event Cholesterol Test (CAD)</td>
<td>11</td>
</tr>
<tr>
<td>Glaucoma Screening in Older Adults</td>
<td>5</td>
</tr>
<tr>
<td>Hepatitis A Vaccination Series</td>
<td>129</td>
</tr>
<tr>
<td>Hepatitis B Vaccination Series</td>
<td>105</td>
</tr>
<tr>
<td>Hydroxyurea Therapy</td>
<td>12</td>
</tr>
<tr>
<td>LDL Lowering Drug Therapy (CAD)</td>
<td>23</td>
</tr>
<tr>
<td>Lipid Test (CDC) - for Diabetes</td>
<td>62</td>
</tr>
<tr>
<td>Lipid Test (CMC) - for Coronary Artery Disease</td>
<td>19</td>
</tr>
<tr>
<td>LVF Assessment (HF)</td>
<td>31</td>
</tr>
<tr>
<td>Past-due Refill: Inhaled Corticosteroid</td>
<td>18</td>
</tr>
<tr>
<td>Past-due Refill: Oral Antidiabetic -biguanide</td>
<td>17</td>
</tr>
<tr>
<td>Past-due Refill: Oral Antidiabetic - Sulfonylurea</td>
<td>6</td>
</tr>
<tr>
<td>Past-due Refill: Oral Antidiabetic - Thiazolidinedione</td>
<td>1</td>
</tr>
<tr>
<td>Past-due Refill: Renin Inhibitor</td>
<td>58</td>
</tr>
<tr>
<td>Past-due Refill: Statin</td>
<td>35</td>
</tr>
<tr>
<td>Pneumococcal Vaccination 2 Part Series - 23 Valant Pneumococcal</td>
<td>812</td>
</tr>
</tbody>
</table>

**Notes:**
- The counting of services includes only the ones with missing or overdue services.
- Services marked with red text are not included in the counting due to various reasons.
More than 30 YEARS of making care the heart of our work.

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