HealthPartners®

Primary Care Total Cost of Care

Provider Reporting Suite &
Patient Support Applications

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HealthPartners Total Cost of Care

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HealthPartners' Total Cost of Care and Resource Use

Summary

HealthPartners' Total Cost of Care and Resource Use (TCOC) measurement approach addresses one of the most fundamental problems related to population health: rising health care costs. This analytical framework is designed to support affordability initiatives, to identify instances of overuse/inefficiency, and to highlight cost-saving opportunities — it is a full population, person-centered measurement tool that accounts for 100 percent of the care provided to a patient. By design, this process measures the cost of that care and also quantifies resources used. When considered together, they facilitate a standardized price-comparison (as total cost is the product of resource use and price).

The TCOC reporting suite supports multiple levels of analysis — users can compare cost, resource, and utilization metrics by provider, by condition cohort, by procedure or by patient. By facilitating these comparisons, TCOC promotes the Institute for Healthcare Improvement's triple aim objectives: improving population health, improving patient experience, and reducing the per capita cost of health care services. TCOC measures were endorsed by the National Quality Forum in January, 2012. Subsequently, measures were re-endorsed in September, 2017.

TCOC is a measure of a primary care provider's risk-adjusted cost effectiveness at managing the population for which they provide care. Measurement begins by coupling administrative claims data with membership eligibility data. To preserve accuracy, this process considers patients (ages >1 to 64) who were active/eligible for at least 9 of the 12 medical months in the measurement period (12-month period, with 3 months of paid claims run out). All administrative claims — for inpatient, outpatient, clinic, ancillary, pharmacy, and all other types of services — contribute to the total cost measure for these continuously-enrolled individuals. Population-level costs therefore reflect a per-member per-month (PMPM) sum, estimated by dividing members' total costs (or paid amounts) by total member months. To account for a member's illness burden, both Total Cost of Care and Total Resource Use measures require the use of a commercial risk adjustment tool. HealthPartners uses Johns Hopkins' Adjusted Clinical Groups (ACG System) to assign each individual a risk score based on diagnoses, age, and gender.

To facilitate peer group comparisons, the TCOC method creates a Total Cost Index (TCI), which compares each provider's risk-adjusted PMPM against the risk-adjusted PMPM for the appropriate peer group (or benchmark). Provider groups with a minimum of 600 attributed members are reported and compared to the thirteen county metro area primary care peer group average (counties including: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Pierce, Ramsey, Scott, Sherburne, St. Croix, Washington, Wright). The peer group average also includes single specialty pediatric and obstetrics and gynecology provider groups. Members are attributed to the provider group that provides the largest percentage of office-based primary care visits as determined by the specialty of the servicing physician during the performance measurement. The types of practitioners include physicians, nurse practitioners and physician assistants with the specialties of family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology. Medical and pharmacy costs for each attributed member are totaled and truncated at $125,000.

HealthPartners calculates Resource Use using its patented Total Care Relative Resource Value (TCRRV) algorithm. TCRRVs quantify resource-use for all procedures and services in a health care system, and are designed to facilitate easy comparisons within and across procedures, peer groups, and health care settings (i.e. inpatient, outpatient, professional, and pharmacy).

Additional information about TCOC measurement and development tools are available online at www.healthpartners.com/tcoc.

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TCOC Attribution Methodology

Total Cost of Care and Resource Use are patient-centered measures and require members be assigned or attributed to a specific unit for analysis. The unit of analysis could be an individual practitioner, provider group, employer group, geographic region or any other grouping of members. When the unit of analysis is a practitioner or provider group in an open access market, a method to attribute a member to a specific practitioner or provider is necessary. While there are a variety of attribution methods that exist to meet varying needs across the country, the method used must be consistent across the population measured.

The following is an overview of HealthPartners' provider attribution methodology:

Medical Claims Experience Evaluated

- Professional office visits within the last 12 months are considered.
    - Limited to encounters submitted on a 1500 claim form.
    - Only office and outpatient based place of service (POS 11, 19, 22, 50 and 72) visits are included.
    - Includes all types of services, including E&M, labs, immunization administration, etc.
    - Denied claims are excluded.
- Specialty is determined by the servicing practitioner's practicing specialty by NPI submitted on the claim. If no practicing specialty is available for the practitioner at that NPI, a practicing specialty elsewhere within the provider group is selected. If there is still no practicing specialty available for the practitioner, the credentialed specialty (board certification) is used.
- The practitioner must have a primary care related specialty. All other visits are excluded from the attribution process.
    - Primary care includes the following specialties:
        - Adolescent Medicine, Adult Medicine, Certified Nurse First Assistant, Certified Nurse Midwife, Developmental Pediatrics, Family Practice, General Practice, Geriatric Medicine, Gynecology, Internal Medicine, Internal Medicine/Emergency Medicine, Internal Medicine/Pediatrics, Nurse Practitioner, Nurse Practitioner/Emergency Medicine, Obstetrics & Gynecology, Pediatrics, Pediatrics/Emergency Medicine, Practitioner Assistant, Practitioner Assistant (EPN), Practitioner Assistant/Emergency Medicine, Preventive Medicine, Women's Health
- A visit at a provider group where the member was seen by a primary care professional is counted only once, regardless of the number of services performed during the visit.

Attribution Process

- A member is assigned to the provider group that provides the largest percentage of primary care office visits.
    - Each member's qualifying visits are summed to the provider group level.
    - The provider group with the most visits is considered the attributed provider.
    - In the event of a tie, the provider with the most recent visit breaks the tie and is considered the attributed provider.
- The same logic is then applied at next lower level to select the attributed NPI (HPFIN), which is most often at the clinic level, depending on a provider group's enumeration methodology.
- Once the attributed provider group and NPI are selected, the same logic is used to select an attributed physician within that provider group and NPI combination.

Attribution Statistics (approximate average values)

- Primary Care Attributed 70%
- Non-Users 15%
- Non-Attributed 15%
    - Ancillary (PT, Optometry, etc.) 5.0%
    - Specialty (BH, Endo, Card, etc.) 3.0%
    - Pharmacy Only 2.5%
    - Convenience Care 1.5%
    - Emergency Department only 0.5%
    - Other Care or Specialty Unknown 2.5%

Handling of Convenience Care Providers

Convenience care providers are excluded from HealthPartners' primary care attribution as:

- They are not fully managing a patient's overall health, but rather minor acute events.
- Primary Care provider's given "credit" for a reduced total cost of care encouraging appropriate place of service.

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TCOC Suite of Reports – Overview

The NQF-endorsed Total Cost of Care (TCOC) framework is designed to support the Triple Aim by increasing affordability, patient experience, and the overall health of populations. While TCOC is focused on the affordability arm of the Triple Aim, it is best positioned alongside patient experience and health outcome measures. TCOC is a measure of a provider's risk-adjusted cost effectiveness at managing their primary care attributed population. The total cost of a member includes all medical and pharmacy spend. The member's risk score is a measure of their relative expected resource consumption based on their age, gender and diagnosis profile. A provider's average total cost PMPM is risk-adjusted and compared to the metro risk-adjusted average total cost PMPM to create their relative cost position.

The TCOC suite of reports addresses rising health care costs by highlighting cost-saving opportunities, including instances of overuse, inefficiencies, and high prices. The suite includes financials, benchmark opportunity assessments, and supporting member-level data files. In addition, drillable application tools have been developed to accompany the suite of standard reports.

Application

The TCOC suite of reports can be utilized to:

- Create transparency by identifying areas of care and places of service where opportunity exists.
- Review historical care to identify opportunities for process and operational improvements.
- Design targeted improvement strategies to enhance patient care by reducing cost and resource use.

Functionality

The TCOC suite of reports gives the provider the ability to identify cost, price, and resource opportunities by place of service (inpatient, outpatient, professional, pharmacy, and ancillary services). Additional sections of the suite identify performance opportunities by patient management and high cost utilization measures by multiple conditions and procedures. An episode analysis is also included to identify potential TCOC opportunities within the treatment of specific conditions and specialties. The TCOC suite is currently supported by two interactive applications - identification of high risk patients (Patient Management Application), and provider prescribing variation (Pharmacy Application). The applications highlight opportunity areas that the provider can evaluate when developing initiatives to facilitate TCOC improvement. The applications are Excel-based, utilizing pivot table functionality.

Data Integrity

The reports are made available to the primary care providers. Additional analysis is provided on a consult basis at the request of the provider or if a metric shows there is a potential cost savings opportunity. All providers have the option to request verification of results either from the Health Informatics, Provider Network Relations and Management or any other HealthPartners' departments. Any data anomalies are addressed through a partnership arrangement with the providers. There is also a detail review of the reports on a yearly basis which includes identification of the top opportunities in a written report.

Relevancy

The TCOC suite of reports is produced quarterly using a rolling 12-month period with three months of paid claims run out. For trending purposes, data from previous years is included for applicable reports. A provider's performance information is based on a primary care attributed population compared to that of a risk-adjusted benchmark. The population is based on the following TCOC methodology:

- Primary Care attributed members where the provider group has the majority of the primary care office visits
- Babies less than one year old and members 65 are excluded
- Members included if they are enrolled for a minimum of 9 months
- Commercial products only
- Total reimbursement capped at $125,000
- Provider groups with a minimum of 600 attributed members are reported

Metric Descriptions

TCOC Indices – Measure the ratio of actual to expected values for the given measurement:

- **Total Cost Index (TCI)** - Reflects the cost effectiveness of managing the patient population.
- **Resource Use Index (RUI) –** Measures the frequency and intensity of services utilized to manage a condition or procedure.
- **Price Index (PI)** – Measures the price structure of the services patients receive from the attributed provider, their referral partners and hospitals as well as more affordable places of service.

Expected Values – is the risk-adjusted benchmarks based on the total of the primary care attributed members.

Risk Adjustment – Expected values are created for the various measures using Adjusted Clinical Groups (ACG) developed by John Hopkins University. Retrospective risk scores are assigned to adjust for variances in illness burden, as well as age and gender.

Methods of Analysis

There are two distinct methods of analysis provided, Total Cost of Care and ETG condition/treatment specific. The TCOC analysis identifies opportunities for the provider's attributed patients based on their ability to manage patient's resource consumption and price from an overall perspective. The condition specific method of analysis identifies opportunities based on how effective a provider is at managing resource consumption and price when a patient is being treated for a specific condition or procedure.

The reason both methods are important is the person centered method will measure the prevalence and volume of the conditions being treated by a patient, while the condition specific method will show variations in how a condition or procedure is performed. For example, a provider can treat all procedures cost effectively, however they could perform more procedures per patient than average which would cause them to be less cost effective from an overall patient management perspective (TCOC).

Since there are two methods of analysis necessary to effectively measure providers, two methods of reporting are needed, the Total Cost of Care method and the ETG condition/procedure method.

Reports Overview

The standard suite consists of twelve reports:

- The **Total Cost of Care Report** provides comparison of a provider's overall performance.
- The **Trended Utilization Report** provides trended performance metrics over a rolling 36 months.

- The **Chronic Conditions Report** provides comparison of a provider's performance for each of eleven specific chronic conditions and for those with none of the specified conditions.
- The **Professional Services Provider Report** provides details on which provider groups provided professional services to a provider's members.
- The **Specialty Care Provider Report** provides details on the top 10 provider specialties by spend, depicting the top 5 providers for each specialty type.
- The **Hospital Services Provider Report** details which hospitals a provider's members used.
- The **Outpatient vs. Ambulatory Surgery Center Opportunity Report** details opportunity for savings by performing outpatient surgery at Ambulatory Service Centers instead of Hospitals.
- The **Percent Generic Report** provides details on generic drug use for a provider.
- The **Top 25 Drugs by Cost Report** gives details on the 25 highest spend drugs as well as total, brand, and generic costs.
- The **TCOC Episode (ETG) Report Section** consists of three reports based on top 10 by spend amount: 1) Condition (ETG), 2) Specialty, 3) Conditions (ETGs) within the major specialties.

Reports Detail

The TCOC reports are generated at the overall provider level and clinic location levels. The measures are relative to the metro primary care network average.

TCOC 3 Year Tend

- Measures TCI, price and resource use indices for the previous 3 years
- Place of service total cost, price and resource use indices are shown for the most recent 2 years (inpatient, outpatient, professional, and pharmacy)
- Overall utilization metric indices are shown for the most recent 2 years
    - Patient management utilization measures: E&M primary care visits, E&M specialty care visits, % of E&M visits for primary care, lab/pathology services, standard radiology services, prescription count and percent generic
    - High cost utilization measures: admit count, IP surgeries count, OP surgeries count, ER visits, high-tech radiology scans in the ER and outpatient setting

TCOC by Chronic Condition Report

- Measures the total cost, price, resource use and overall utilization metrics for the highest resource consuming chronic conditions.
    - Diabetes, Hypertension, Ischemic Heart Disease, Depression, Asthma, Arthritis, Back pain, Hyperlipidemia, COPD, CHF
    - Patient management utilization measures: E&M primary care visits, E&M specialty care visits, % of E&M visits for primary care, lab/pathology services, standard radiology services, prescription count and percent generic
    - High cost utilization measures: admit count, IP surgeries count, OP surgeries count, ER visits, high-tech radiology scans in the ER and outpatient setting
- One Point Index Reduction Impact on Total Costs
    - Savings calculations are shown based on a 1 point (0.01) improvement in the metric index
    - The utilization savings are based on the metro average cost per admit\visit\service
- Place of Service total cost, price and resource use indices are shown for the most recent 2 years (inpatient, outpatient, professional, and pharmacy)

Referral Partner Report

- Identifies the provider's usage of hospitals, surgery centers, free standing imaging centers, specialty providers and ancillary providers
    - Top 15 referral partners by facility
    - Top 15 professional referral partners
    - Cost and quality measures shown when available

Provider ETG Reports

- These reports are based on the episode methodology which measures the effectiveness of a provider at managing the total cost of a specific condition/procedure. It is not an overall patient management measure, but it does measure the specific condition/procedure being treated (e.g.: acute sinusitis).
- Cost performance is measured based on overall Total Cost Index (TCI), Resource Use Index (RUI), and Price Index (PI).
    - These metrics are also displayed by place of service (inpatient, outpatient, professional, and pharmacy
- Utilization metrics at the condition/procedure level
    - Utilization metrics include: E&M visits, Lab visits, High-Tech Radiology scans, IP admits, IP days & length of stay, ER visits, prescription count, and percent generic
- Levels of analysis include all combinations of the following levels:
    - Overall provider
    - Specialty
    - Clinic
    - Physician
    - Condition/procedure (ETG)

Specialty ETG Reports

- A network specialty report that details competition performance overall and within the top ETGs based on resource use
- Overall Resource Use Index by place of service (inpatient, outpatient, professional, and pharmacy)
- Overall utilization metrics at the condition/procedure level
    - Utilization metrics include: E&M visits, Lab visits, High-Tech Radiology scans, IP admits, IP days & length of stay, ER visits, prescription count, and percent generic
- Levels of analysis include:
    - Specialty performance
    - Physician
    - Condition/procedure (ETG)

Report – General Display

SAMPLE MEDICAL GROUP - 201

Total Cost of Care Report - Rolling 12 Months: October through September - 2014, 2015 & 2016

-Risk Adjusted Total Cost of Care Metrics
-Total Spend including Clinics, Hospitals, Rx and Referral Providers
-Attributed, Commercial, Continuously Enrolled, Excluding Babies and 65+
-Total Reimbursement Capped at $125,000

Potential Opportunity (TCI)
Potential Opportunity (Pricing)
Potential Opportunity (RUI)
Potential Opportunity (Patient Mgmt Util)
Potential Opportunity (High Cost Util)

Highlighted cells indicate >= 1.01 after rounding

	Members			Average ACG Score			TCI			Price Indexed to 2016			Resource Use Indexed to 2016		
Provider Group	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016
Sample Medical Group	3,916	4,124	4,474	1.00	1.03	1.08	1.03	1.01	0.95	0.90	0.96	0.98	1.04	1.01	0.97
Metro Total	331,415	358,376	372,110	1.00	1.00	1.01	1.00	1.00	1.00	0.94	0.97	1.00	0.98	0.99	1.00

The first through third quarter results should be viewed as preliminary indicators to year end results due to fluctuations in membership and its corresponding impact on continuous enrollment and ACG risk score assignments

TCOC Patient Management Application

The present suite of TCOC (Total Cost of Care) reports includes financials, benchmark opportunity assessments, and supporting data files. The TCOC Patient Management Application (PMA) is designed to translate opportunities into tangible actions that the provider can take to facilitate TCOC improvement. The PMA identifies high-risk patients and high-utilizers by clinic and practitioner. This information can assist the provider in proactively managing patients and redesigning care models.

Application

The TCOC Patient Management Application can be utilized to:

- Identify patients that are at risk of experiencing high costs in the future or have historically utilized a high volume of medical services.
- Create transparency by identifying the clinics and physicians that treat high risk or high utilizing patients.
- Review historical care data to identify opportunities for process and operational improvements.
- Design targeted improvement strategies to enhance patient care and enable proactive patient outreach.

Functionality

The TCOC Patient Management Application is an Excel-based tool, utilizing pivot table functionality. The application gives the provider the ability to easily target at-risk patients through various levels of analysis and to derive manageable patient lists. This output can inform outreach efforts, promote proactive patient management, and support care model evaluation.

The PMA is drillable enabling analysis at the provider, clinic, physician, condition, and patient levels (or any combination of the above). The individual views display predictive cost index (PCI), predicted annual cost per patient, inpatient admit probability, concurrent risk score, and member months for high patient volumes. Within any view, users can double click on a given metric to produce a detailed patient list including all of the patients' relevant information.

Relevancy

To provide the most current information possible, the TCOC Patient Management Application is based on the most current claims data available (rolling 12 months with no paid claims run out). Please note that this differs from the standard TCOC reporting package, which uses 3 months of paid claims run out. The PMA uses the former approach so that the provider has the most current information available to manage their patients.

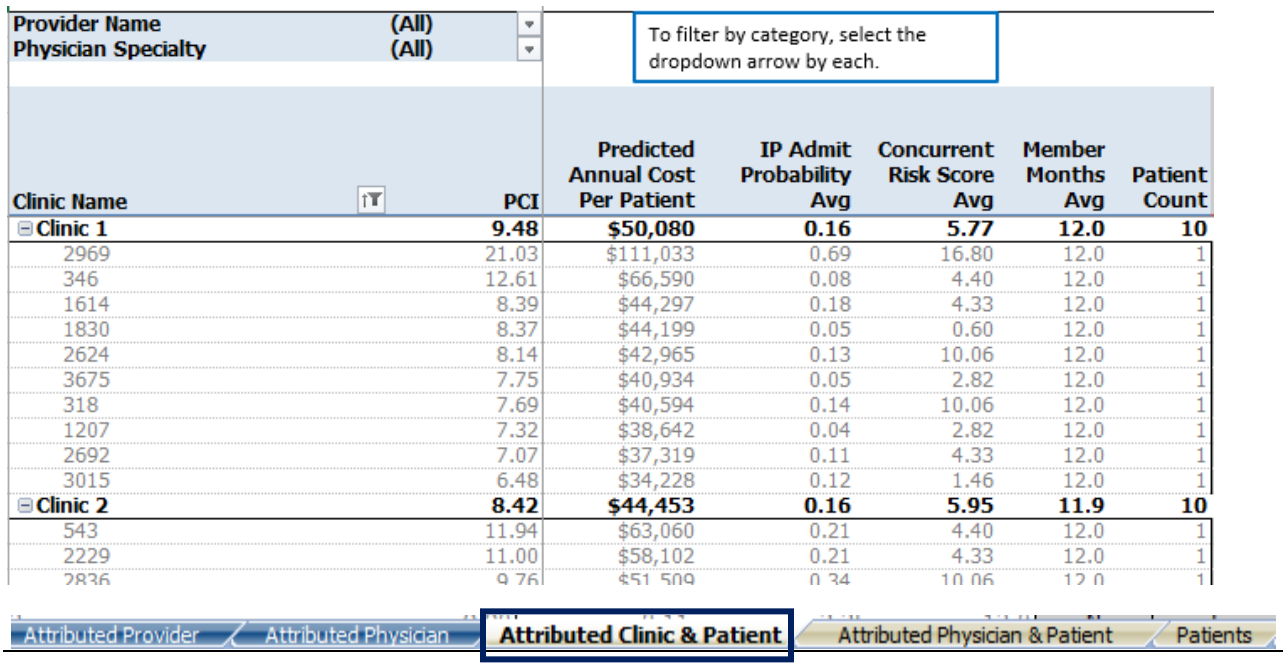
Population Criteria and Data Descriptions

The PMA includes all active HealthPartners' members, including members greater than 65 years old and babies. The following metrics as well as member months are included on each of the five summary views (all pivot tables).

Predictive Cost Index (PCI)	A member's predicted cost for the next 12 months indexed to the average cost of the HealthPartners' metro primary care attributed commercial population.
Predicted Annual Cost Per Patient	The predicted annual cost for a member in the next 12 months.
IP Admit Probability Hospitalization	Represents the probability that a member will have an acute care inpatient hospitalization in the next 12 months.
Concurrent Risk Score	Ambulatory Care Group (ACG) risk score of a member based on the previous 12 months of claims experience relative to HealthPartners' primary care attributed commercial population.
Member Months	Number of medical months the member was covered by HealthPartners insurance in the reporting period (more member months means higher reliability can be placed on the metrics).

Reporting Level Summary View

Each summary level displays the metrics by the overall total and the top 10 subcomponents where applicable. The summary views are built off of the "Provider Group Data" tab (far right, not shown) which represents all the patient data within the PMA. Additional cost metrics, patient conditions, and provider information are included to assist with identifying patient opportunities.



Provider Name	(All)	To filter by category, select the dropdown arrow by each.				
Physician Specialty	(All)					
Clinic Name	PCI	Predicted Annual Cost Per Patient	IP Admit Probability Avg	Concurrent Risk Score Avg	Member Months Avg	Patient Count
Clinic 1	**9.48**	**$50,080**	**0.16**	**5.77**	**12.0**	**10**
2969	21.03	$111,033	0.69	16.80	12.0	1
346	12.61	$66,590	0.08	4.40	12.0	1
1614	8.39	$44,297	0.18	4.33	12.0	1
1830	8.37	$44,199	0.05	0.60	12.0	1
2624	8.14	$42,965	0.13	10.06	12.0	1
3675	7.75	$40,934	0.05	2.82	12.0	1
318	7.69	$40,594	0.14	10.06	12.0	1
1207	7.32	$38,642	0.04	2.82	12.0	1
2692	7.07	$37,319	0.11	4.33	12.0	1
3015	6.48	$34,228	0.12	1.46	12.0	1
Clinic 2	**8.42**	**$44,453**	**0.16**	**5.95**	**11.9**	**10**
543	11.94	$63,060	0.21	4.40	12.0	1
2229	11.00	$58,102	0.21	4.33	12.0	1
2836	9.76	$51,509	0.34	10.06	12.0	1

Attributed Provider | Attributed Physician | **Attributed Clinic & Patient** | Attributed Physician & Patient | Patients

TCOC Pharmacy Management Application

HealthPartners' Total Cost of Care (TCOC) reporting suite includes financials, benchmark opportunity assessments, operational applications and supporting data files. The TCOC Pharmacy Management Application (RxMA) is designed to translate opportunities into tangible actions that the provider can take to facilitate TCOC improvement, specifically related to pharmacy costs. The RxMA identifies generic and brand prescription utilization and the dollars spent by physician specialty, physician, and drug. Patient level information is not included in this application as the intended intervention is designed to be at the physician level rather than direct patient education.

Application

The Pharmacy Application can be utilized to:

- Create transparency by identifying what areas of care have a higher utilization of brand prescriptions and of which specific drugs.
- Review pharmacy data to identify opportunities for process and operational improvements.
- Design targeted improvement strategies to enhance generic prescription utilization where appropriate.

Functionality

The RxMA is an Excel-based tool, utilizing pivot table functionality. The application is drillable enabling analysis at the provider group, physician specialty, physician, drug class, and individual drug levels (or any combination of the above). The individual views display the percent of generic prescription use and count, the percent of brand prescription use and count, the cost per prescription, and the total dollars spent. Within any view, users can double click on a given metric to produce a detailed list including all of the relevant information for the selected category or level.

The application serves as an interactive, drillable tool to accompany the standard TCOC reporting package, specifically the "Percent Generic" and "Top 25 Drugs by Cost" reports. However, please note that the time period differs between the standard package and the tool (see Relevancy). Total counts and dollars will differ between the standard reports and the tool.

Relevancy

To provide the most current information possible, the RxMA is based on the most current claims data available (rolling 12 months with no paid claims run out). This differs from the standard TCOC reporting package, which uses 3 months of paid claims run out. The RxMA uses the former approach so that the provider has the most current information available to manage their patients and prescribing patterns.

Data and Field Descriptions

The RxMA includes members using the same attribution method as the standard TCOC reporting package, but applies the method using most current information available. The following fields are included:

Pharmacy Application Overview and Dictionary

Application Functions	Instructions
Selection criteria	To change criteria select down arrow and make selection
Adding criteria	Any criteria can be included in the display window (row labels)

Field Name	Field Definition
Fill Year_Qtr	Year and quarter that the prescription was filled
Attributed Provider Group	Attributed Provider Group: Provider Group Name - member is attributed to the provider group and meets TCOC report criteria (age 1-64, continuously enrolled 9 mo.) Not a TCOC Member - member is attributed to the provider group, but does not meet TCOC report criteria
Prescribing Physician Primary Group	Provider group associated with the prescribing physician's primary practicing location
Prescribing Physician Location	The prescribing physician's primary practicing location Primary Clinic is shown if clinic is owned by Attributed Provider Group Primary Provider Group is shown if clinic is not owned by Attributed Provider Group Unknown location - physician practices at a non-contracted entity or has not billed a medical claim
Prescribing Physician Specialty	Prescribing physician specialty classification Specialty - prescribing physician is within the attributed provider group Blank - prescribing physician is NOT within the attributed provider group
Prescribing Physician Name	Prescribing physician's last name and first name Physician name - prescribing physician is within the attributed provider group Non-Business Entity Physician - physician is NOT within the attributed provider group
Therapeutic Class	Class of medications that are used to treat similar medical conditions
Drug Product Name	Base drug product name
Brand Generic Flag	Brand or generic drug indicator
Formulary Flag	Formulary or non formulary indicator
Rx Count	Script count in the form of 30 day supply
Total Spend	Total reimbursement which includes plan paid and member liability

Reporting Level Summary View

The application includes five summary views (pivot tables) all displayed in a similar fashion as below. Each view has selection options that limit the data and is displayed by the row label categories.

ATTRIBUTED PROVIDER GROUP	(All)
PRESCRIBING PHYSICIAN PRIMARY GROUP	(All)
PRESCRIBING PHYSICIAN LOCATION	(All)
PRESCRIBING PHYSICIAN NAME	(All)
DRUG PRODUCT NAME	(All)

	GENERIC				BRAND			
Therapeutic Class	Rx %	Rx Count	Total Spend	Cost/Rx	Rx %	Rx Count	Total Spend	Cost/Rx
DIABETES	60.00%	14,000	$140,000	$10	40.00%	10,000	$4,800,000	$480
CHRONIC INFLAMMATORY DISEASE	55.00%	1,500	$127,500	$85	45.00%	1,000	$4,400,000	$4,400
STIMULANTS	75.00%	11,000	$1,485,000	$135	25.00%	3,500	$1,697,500	$485
ASTHMA	50.00%	9,000	$135,000	$15	50.00%	8,500	$1,402,500	$165
ONCOLOGY	92.00%	1,400	$245,000	$175	8.00%	120	$900,000	$7,500

Overview and Data Dictionary | Pharmacy - Clinic | Pharmacy - Physician | Pharmacy - Drug Class | Pharmacy - Drug