Plan Experience with the 2019 Opioid Safety Edits and the Drug Management Program

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Jonathan Randle, Mutual of Omaha
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Kristen Renkes: And now we have today's final group presentation. They will provide insight and panel members' experience with the new Medicare Part D initiatives including success stories related to engaging providers through case management under the drug management programs and effective plan pharmacist prescriber coordination and communication for the opioid safety edit. Please welcome Adele Pietrantoni, Johnathan Randle, Clay Rhodes, Erin McKenna, and Anne Kane as the Moderator.

Anne Kane: All right. Thank you. Thanks, Kristen.

Okay. So let's get started. This is the last session of the day, so let's talk about opioids. So – Adele, can you click? Thank you.

So today we're going to talk about the 2019 Part D Safety Edits in the Drug Management Program. We're going to talk about innovations and best practices and our outcomes.

And we've invited our plans to come and talk to us about their experiences. But first Adele is going to give us a brief overview of the 2019 Part D Safety Edits and Drug Management Program. Adele, take it away.

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Adele Pietrantoni: Thank you, Anne.

Medicare introduced new policies for prescription opioids, the Part D program, beginning in January 2019. These policies are driven by the goals of patient safety and improved care coordination. They build on prior policies which have shown demonstrated success at reducing overutilization in Part D with minimal complaint volume.

The new policies include improved safety edits when opioid prescriptions are dispensed at the pharmacy. It is common before a prescription is filled for Medicare drug plans and pharmacies to routinely perform additional safety reviews like checking for drug interactions and incorrect dosages.

For opioid prescriptions, these safety reviews also include checking for possible unsafe amounts of opioids, the day's supply of a first prescription for opioids, and concurrent use of opioids and benzodiazepines, which are commonly used for anxiety and sleep, which are at increased risk when taken together. In some cases, the Medicare drug plan or pharmacist may need to first talk to the prescriber before the prescription can be filled as part of their review.

Medicare drug plans also implement drug management programs to help patients who are at risk for prescription drug abuse. Medicare drug plans work with prescribers through individualized case management to help patients use opioids and benzodiazepine safety through better-coordinated care. The program builds on the existing Part D overutilization monitoring system which began in 2013. If needed, after written notice to the beneficiary, a coverage limitation may be implemented. For example, beneficiaries may be required to get these medications only from certain doctors or pharmacies. Beneficiaries have an opportunity to tell the plan which prescribers or pharmacies they prefer

to use or provide additional information if they disagree with the plan's decision.

Beneficiaries, and their prescribers on their behalf, also have the opportunity to appeal these decisions.

The purpose of these policies is not to disrupt needed therapies or to force a one-size-fits-all approach or to create unnecessary burden on patients or their doctors. The approach has been refined over time based on feedback from the public, including patients and doctors, to strike a better balance between access and safety controls. The 2019 policies were tailored to address the distinct populations of Medicare Part D prescription opioid users including new opioid users, sometimes referred to as opioid naïve patients. Chronic opioid users. Users with potentially problematic concurrent medication use. And high-risk opioid users.

These safety edits and drug management programs should not apply to patients with cancer, those in hospice, those who are in palliative or end-of-life care, or those who live in a long-term care facility. Beginning in 2020, we also expect plans to exclude Sickle Cell Disease patients from the opioid safety edits.

And finally, access to medication-assisted treatment such as buprenorphine should not be impacted by these initiatives.

So that concludes the overview of CMS's policies, and so I'll turn it back to you.

Anne Kane: Okay, Adele. Thanks for your insights.

So, we – the Regs allow for the plan to implementate – for plan implementation, and so to that end we wanted to hear specifically from our three health plans that we have represented on the podium here. So,

Johnathan, from Mutual of Omaha, is going to talk about edits and drug management. Clay, from Humana, will talk about outcomes and pharmacy support. And Erin, from Aetna, will talk about patient access.

So, Johnathan, why don't you go ahead and begin? Tell us a little bit about your program.

Johnathan Randle: Okay. Thank you. Thank you for the opportunity to participate on the panel today.

So, Mutual of Omaha is a new entrant into the MA and PDP industry. And so think – and so we're committed to doing our part in aiding our beneficiaries and the industry as a whole and wanted to thank CMS for the opportunity today to participate and also wanted to take the time to thank our fellow panelists for their collaboration and transparency. Because the way we looked at it is simply is more than just rules, and regulations, and process, but this is also about saving lives and doing our part and collaborating as an industry as a whole.

And so, these are the edits that we put in place for this year. So as a new entrant, we didn't have the previous experience or have a drug management program put in place, so we relied upon a PBM – collaboration with our PBM heavily on their previous experience and utilizing our kind of customer for – enterprise customer focus approach to figure out what we could do to meet the regulations but also be – have the least amount of disruption to our members' experience.

And so, this is a – just a general overview of kind of the collaborative communication team that we put in place, dedicated team of nurses, managers, case managers, physicians. And then also a specialized case management process that was updated in collaboration with our PBM to ensure that we're meeting the requirements for 2019. And then, in

collaboration with the – with our PBM, detailed reporting that we were able to receive in working with our internal teams and internal partners to ensure that we're getting the necessary data that – to ensure that our patients were being treated properly and that the program was working effectively.

Anne Kane: All right. Thank you, Johnathan. Clay.

Clay Rhodes: So our drug management program is really designed to reduce harm. You know, the beneficiaries are the important piece here. They can certainly have uncontrolled issues with opioids. That's generally the lion's share of the members that come through the analytics for these groups to – to be evaluated.

A lot of these already have other edits in place that, you know, Johnathan just kind of went over, so they're already impacted by many of these edits. But no doubt the intent here is to develop a holistic case management approach around these members, so ultimately the goal there is to – to reduce harm.

Anne Kane: Okay. Thank. Erin?

Erin McKenna: So, I took a little bit different of approach. My colleagues highlighted, really, the drug management program which is, you know, as we shared, really believing it's an industry and CMS is such an important part of that holistic care. My focus, I wanted to talk about the new seven-day opioid naïve edit, and really, the implementation of this – this quality point of sale experience for our – for our members and their pharmacy claims. But also taking into account, you know, it's not just the implementation being ready for the edit, but the proper monitoring that member experience in the early parts of 2019 to make sure that the experience was doing what it was

intended. It was for safety. It was not for creating barriers to care in the opioid-tolerant patient.

So, you know, just highlighting, and I'm sure we all did very similar plan strategies. There was that extensive communication plan, talking with your providers, talking with your pharmacies, certainly having internal staff in those talking to your members to be ready to answer questions and – and to create that seamless experience. You know, certainly testing the logic. Making sure that you could exclude the opioid-tolerant or those with, as Adele had shared, meeting the qualifications to not be considered opioid naïve or – or to be touched by this edit. And also adjusting staffing models. You know, you – anytime you do something new, you're going to experience an increase in pharmacy calls, in member calls, so really making sure that you were ready to service the members on 1/1/19 when these new edits went into place.

We also talked a lot about monitoring that experience early on to make sure that, number one, the edits were performing as expected, and number two, that we were not seeing those that were opioid tolerant having barriers to care.

I'll show you on the next slide in a moment how we did some daily monitoring just to watch that member experience and how that led to us making decisions to do additional communication.

So, we had these daily reports that we started running on 1/1 looking at those that hit the seven-day edit and what was the end result? Were they getting paid claims? Were they getting seven-day edits? Or, for that matter, were they – were they going without a fill at all?

We also were talking very closely with our pharmacy partners really just understanding what was the experience that was happening at the retail

pharmacy. And then really, in those dialogues, realized, you know, we – we needed to do some additional education and really work more closely with our pharmacy partners.

So in this next slide, we really, as I said, we were – we were monitoring how were the claims paying? Through what avenues? Was it coverage determination? Was it calls to our pharmacy help line? Was it being filled just for those seven-day edits? Was it some other avenue that allowed the claim to pay versus those that were – were a walkaway rate? And in those experiences, we were calling and we were learning about the experience.

You know, as we said, the goal was not to prevent claim payment, the goal was really to drive that safety. You know, you think about 1/1, you have a lot of members that are brand new to you so you don't know their history. You may not know their medical yet. You may not know, you know, last year with another plan they were opioid tolerant and really making sure that our pharmacists felt empowered to provide that information to plans was really a key message and one that we delivered a lot during the first part of the – the new year to make sure that they understood, you know, between the state databases, between the fact that while they may have changed insurers, they're going to that same pharmacy and they have that information to be able to partner with a plan to share that information and make sure the patient can continue their – their therapy.

Anne Kane: Okay. So, this is a polling question. What was your plan's most common outcome for a member who experienced a seven-day edit in January? A, script reduced to seven-day supply or less. B, the pharmacy provided information to exclude member from the edit. C, member was directed to coverage determination process. Or D, unknown. So, we don't have any good music for this. Doo-doo-doo.

Okay, ten seconds. And – it's still moving. I'm going to wait for it to stop moving. Interesting. So, it looks like what we're ending up with is Unknown is – is the highest one. But A, script reduced to seven-day supply or less. And then the next one is member was directed to coverage determination process. And then last is the pharmacy provided information to exclude the member from the edit. Those are really interesting results. Thank you, everybody.

All right. Okay. So now let's talk about our best practices and innovations. We're 11 months in – into the plan year, so Johnathan, do you want to kick it off and tell us about outcome documentation?

Johnathan Randle: (Inaudible) I spoke about earlier, just definitely communication and documentation is key. And so, in collaboration with our PBM, we're able to receive weekly outcome report, monthly dashboard, and then we're able to actually review case files and packages and review evidence of the effectiveness of the program. And I think some of that key collaboration between all stakeholders is imperative to make sure that you're managing the program effectively and that the members are getting the – the best outcomes possible.

And this is just a high-level overview of how that collaboration works between the member outreach, provider, and prescriber outreach, and how our case management team collaborates and works in all these different spaces.

And we had a couple of success stories that I'd like to – to share with you. And so we had the situation where a member was – didn't have – didn't have a provider that they were actively working with from a pain management perspective. And as a result, the case went over to our medical director who chose to restrict all opioids and benzodiazepines. After the initial notice was sent out to the member, they called to discuss

the restriction with us. The member stated that she had not taken opioids for several months after having back surgery. She was given fentanyl and the surgery. And post-surgery she went to rehab. The member reported that she had contract – contacted her surgeon, who reached out to us a few days later – later we were able to reach out to the surgeon who indicated she was still having a complication from the back surgery and the provider is now closely following the patient at that time.

The surgeon verified that the member is no longer taking the opioid medication and is currently managing the pain with over-the-counter meds.

And so the provider was willing to then assume responsibility for the member's pain management and requested no restriction to be placed on the member due to possible future surgeries.

And so, from that communication standpoint, that collaboration, the member ultimately got what they needed without – in a somewhat a seamless manner.

And then the next instance we have, the case management team was able to identify and manage a pain management situation with a member that was also taking opioids and benzodiazepine medicines from several different providers over a six-month period. And after conducting outreach to no avail, the patient was sent to a medical director for review, and at that time it was decided a limitation would be placed to restrict the opioid medication. And during the 30-day waiting period between the patient's initial notice and the implementation of the limitations, it was identified by the case management team that the patient had new claims for opioid medication from a new provider. This provider was contacted where it was discovered that this was a new provider and was an addiction specialist and was currently starting in tapering the patient off of a new

pain man – new pain management regimen and the patient had signed an agreement with that provider. And after discussing with the member in detail and with the new provider, it was determined that no limitations were needed.

And then the last instance that we have, a member was initially excluded from provider outreach. It was identified in a subsequent program that the number of pharmacies and prescribers had increased per recent claims data. And through provider outreach, it was identified that the patient was recently hospitalized due to a surgical procedure which required a variety of inpatient specialists and an increased amount of pain medications. After speaking with the most recent provider for the patient, the case management team learned that the patient was being managed for post-op for six weeks, and the post-op provider agreed to transition the patient back to regular pain management provided that after post-op period to (inaudible) continuity of care.

And so, these are just a couple of examples of success that we felt that we wanted to share. But overall we felt that the communication point and the program that we have put in place produced the desired outcomes to where the members were able to mitigate the disruption to the member and ensure that they are being managed properly.

Anne Kane: Very good. Thank you, Johnathan. Clay, the drug management program.

Clay Rhodes: Like most programs, success really hinges around the communication with the provider. The provider is going to get some information from us considering the case, in form of a letter. And that letter is going to have an opportunity for them to provide feedback to the plan so we can understand the approach moving forward.

However, if the provider doesn't return that feedback for us, there's likely some missing information here, so we're going to do some outreach. A pharmacist specifically is going to outreach via phone call to the provider to understand the particulars of the case and understand, similar to what my colleague Johnathan mentioned, how do we handle, and who's going to manage, the member moving forward?

Ideally we want to get all the information for the response form so the plan itself can help to develop in collaboration with the provider or providers, you know, a harm reduction plan moving forward.

Now when we think from a clinical case management perspective, this is all depending on the prescriber's responses in that process I just went through, but we are going to be sending out notification letters to members. But as we're evaluating the data that's coming back, we can choose to close the case, or place the case in a monitoring status so we can evaluate for next program month, next program quarter, do we see a change in the behaviors of the member?

Again, we can work with the provider to establish limits to put in place, whether it's a beneficiary-level edit where we're managing the overall morphine-milligram equivalents per day. Or the lock-in program where managing provider, the pharmacy, and possibly the MME.

And then, at the end of the day we've got to work with the pharmacy specifically to manage their willingness to – to go through all this as well. So there's multiple opportunities here for collaboration with multiple clinicians as well as the member to see success through this program managing folks that are, generally speaking from a data perspective, over utilizing opioids.

And from an outreach to the member, or beneficiary in this instance, again I mentioned this is a case management control program early on. This is really where a lot of interaction and education can go on with the – with the member. Where they're not just getting letters. They're not just picking up prescriptions at the pharmacy and, you know, getting that do you have any questions type of thing. We can do some real true interactions with the – with the members through this process. Now, it does take time. You know, they are going to receive a letter. They've got 30 days to respond and then we've got 60 days to – to make a determination after that. So, in many cases, behaviors do change in that 30 and 60 days, so those conversations can take place, and then nothing really happens from a – a implementation at a point-of-sale or in-the-system perspective. It's just ongoing monitoring.

Now from an opportunities perspective, we've got some – some gaps as far as how do we improve some of these contact rates and engagement? Whether it's the provider, the member, or the pharmacy, we're doing a really good job here, as well as the provider themselves. But there's always some opportunity to continue to make that efficient.

The engagement piece on the member is really the most – I'd say the largest opportunity for us here. For them to understand that everything is, you know, just working as planned is one thing. But the other pieces for them to understand, there is always that opportunity for harm. Whether they're taking it as they have been prescribed for months, years, etc., it's a really good opportunity for that consultation to happen with a clinician and the member when they're on the phone.

And then, ultimately reducing that time to implementation. So we can catch an event from a preventative standpoint versus after the fact in a retrospective standpoint.

Best practices. What we have found is pharmacists making these outreach, whether it's to the provider or the member. Having some additional training. We – we refer to folks, the Society of Health Systems Pharmacists, they have a great pain management certification training that all of our pharmacists go through. It's a nice 21-hour CE, so for folks that want to continue to engage in members and providers and have some certification, additional training, this is a great program for folks to go through. Or simply just to refresh as they start to specialize in this area.

Utilizing different channels of communication. We mentioned letters, calls. I think the previous group that was one the stage talked about that member preference. It's really engaging in the member preference here as well.

And then, lastly, it goes down to that technique that you're utilizing from a intervention and interview perspective. And what's really neat right now is the motivational interviewing that a lot of clinicians, social workers are going through to make sure that they get that motivational piece in there because it really does engage the member and we see change from a behavior perspective when folks are engaged this way.

Anne Kane: Great. Thank you. Erin?

Erin McKenna: Thank you.

So, there was a recent poll study of over 500 physicians. Seventy percent said that they could use more education on both treatment of pain protocols as well as tapering. And 75% felt that they needed more education regarding substance use disorder behaviors, recognizing them and intervening.

We've been in the business for a while of helping to be part of the solution. Through prevent, support, and intervening, we've often been looking at, both our data and through conversation, what can we do to take that next big step? How can we be a partner, you know, with our prescribing community, with our members to really make a difference in – in the safe use of opioids?

So, last year we launched in November, and really are still in the pilot process of this, of launching, it's now in five states, where we're going out and detailing not on a drug, but on pain treatment. We're working closely with our providers, and – and having those dialogues about all of those key topics that they're wanting to hear. We're presenting evidence-based medicine and – and studies about not only opioids, but also alternatives to opioid therapies. Really the message is, it's meant to be the safe use when an opioid needs to be used, how do you do it safely? There's CE credits. There's a lot of great conversation, you know. And at – at first when we were offering this as – as anybody who's done detailing can probably say, your biggest challenge is getting in the office. At this point in time, we've gone to over 6,000 offices, and I would say our early indicator of success is, number one, we're being invited back. And number two, through word of mouth we're actually being invited into other practices to really have this meaningful conversation.

So it's a – it's an exciting and novel way that – that, you know, we really, as an industry, and – and taking what we've learned so far, to say how do we – how do we take it to that next level, and so I was really excited to be able to share that with this panel today. You know, the education, it's – we also talk about tapering. And, you know, there's a lot of concern over tapering these days and how you do it right and slowly tapering and that continued monitoring from the physician, recognizing side effects. A lot of

really great, helpful information in these interactions as well as leave-behind packets.

Another opportunity when we're talking about opioids is talking about x-waivers and MAT therapy, and really starting to overcome some of those barriers, answering physician questions, and encouraging considering applying for that MAT therapy, x-waiver, going through the training to really engage our providers to be part of the solution.

Anne Kane: Okay. Thanks, Erin. So now our last section is talking about outcomes and results. (Inaudible). Thank – yeah, thank you.

So Johnathan's going to talk about some trends, and then we'll have another polling question.

Johnathan Randle: Okay. And thank you, again.

And so, as we noticed kind of from the discussion points and some of the stories that I've shared, that most members who are sent out for evaluation to DMP don't actually meet the criteria. And this suggests to us and everyone else in the industry what to expect most individuals using opioids do so for legitimate reasons, however, additional attention may need to be paid to ensure that adequate medic – medical documentation is put in place.

And generally, most overutilization concerns have been resolved through discussions with the providers. The lock-ins are rarely needed. Regardless, they are valuable for prescribers with members – with member health and safety concerns that are put in place. And as you will note from the stories that were shared, most concerns related to patient overutilization can be addressed through enhanced or more detailed communication with the prescriber and the patient.

Clay Rhodes: All right. A polling question. A little bit of a clinical one out there to keep you awake. When should the antagonist naloxone be co-prescribed? Subsequent or concurrent alcohol use? Concurrent use with benzodiazepines? Tricyclics, skeletal muscle relaxants, and gabapentinoids? Treatment of opioid use disorder with either buprenorphine or methadone? Concurrent history of smoking, COPD, or other? And, all the above.

Okay. (Inaudible.)

Well, no matter which way you answer, you're probably somewhat right. But the right answer here is E, all the above.

Anne Kane: Okay. Thank you.

Clay Rhodes: All right. From our outcomes perspective, the ideal state is that we come to an agreement with the member and the provider on the approach for their pain therapy. And this could be an opportunity for coverage limitations.

Now, generally speaking, our goal is to have a bidirectional conversation to think through optimization of the member's, or beneficiary's, drug regimen. Generally speaking, this may approach tapering protocols, whether it's benzodiazepines or opioids, and we want to be there with the provider along the way. It's a challenge. But that's a positive outcome for us when we're engaged in this challenge as well as other clinicians out there in the retail sector, hospital sector, etc.

And then lastly, the reason why we had that polling question, is to drive that opportunity to get folks naloxone in hand. Very similar to folks who have allergies needing an epi pen. We've got to get this in the hands of – of folks that, unfortunately, things can happen, and they've got a rescue agent on board. So that – that is one of the outcomes that the DMP is

providing for us, these three in particular, where we're having conversations around tapering. Conversations around limitations of coverage. And then adding on naloxone where it's appropriate.

Erin McKenna: So I think this slide doesn't really just speak to Aetna data but really, I think if you look at your own data, what you're going to see is that year-over-year success story. It's not one particular program that is really driving what we would deem success.

So here, we're really looking at, in – in our data population, and this isn't normalized for membership growth, this is just showing in our population that we have managed since we're back to, I think showing on the slide, July of 2016, what we're seeing in our – in our data trends, looking at members who on a continuous basis are using six months' of opioid totaling 90 MME or greater. Really seeing that – that trend downward.

And I want to also highlight, I mean, we have not removed appropriate utilizers out of this. We are really just – this is an all-in, so, you know, our cancer patients are still in here, our end-of-life care are still in here. And – and even outside of those kind of what we would call like CMS exclusions from these types of programs, I mean there – there are patients that, indeed, the right dose is – is still at 90 MMEs. For whatever their pain condition.

One of the other pieces of data that I didn't put on this slide, though, was really looking at the number of providers being part of that care, and – and I'm sure you see it as well in your data, that when patients are on high dose, it's most often one provider office, one provider. So, getting to that safer opioid utilization is really a great story that I think we can all see in our data results.

We also monitor our MAT therapy and see growth in prescribing per thousand, which I think, again, kind of tells the story that what we're doing, you know, as – as plans, as CMS, as, you know, all the different programs really that are out there to help be part of the solution, are working.

All right. Would you advance that? Thank you.

Anne Kane: All right. We're to the questions section of our presentation, and here's all of our email addresses. And feel free to reach out to us. And so we'll turn it back over to Kristen.

Kristen Renkes: Thank you.

Okay. Could you discuss the percentage of providers who work with plans on implementing tools to manage opioid utilization or overall engagement of providers with the drug management program?

Clay Rhodes: I think engagement really overwhelmed us a little bit. When we think through the providers that are really jumping in and working with us on this. Greater than 50% of providers are engaged here. Thirty-three percent of them, or about a third, they'll work with us, but ideally they're suggesting that the member has got appropriate pain medication regimen. And about a fifth of them are working with us directly to make changes. Generally speaking, like I mentioned earlier, that's where they're doing some tapering opportunities, moving on to MAT therapy or non-pharmacological changes.

Kristen Renkes: Okay. And, what drove your decision to utilize the 200 MME edit and what has been your experience using this?

Johnathan Randle: Well, as I indicated, as a new entrant into the industry this year, we greatly collaborated with our PBM in making that decision. And so, what

we observed from the rest of the industry and working with our PBM is that there has been somewhat of a struggle with how to ensure access for patients based on medical necessity without further contributing to the challenges associated with opioid utilization. And based on our internal clinical analysis, we believe the 200 MME threshold would help us both in the pharmacies identify potential high doses of opioids while ensuring continued access to opioid therapy. And, when the edit was put in place, like any other edit, we did experience some disruption, however, we communicated with the pharmacies early and often to ensure that they were aware of the edit and would be implemented, and to provide guidance on what to do to minimize patient disruption. And, as with any other aspect of a DMP program, frequent communication and collaboration is key and critical.

Kristen Renkes: And, can you tell me more about your physician detailing program?

Erin McKenna: Sure. So, you know, as in any detailing, we're -we're out there. We – we certainly leveraged our data to find where we felt we had the most opportunity. As an MAPD plan, you – you have access to your medical information as well as the pharmacy information and really looking to where you have those partnerships and those collaborations with physicians and those that you can see prescribing opioids to really became that perfect area to say where are we going to launch these, what – what areas. So, just like any detailing, going to the physician, physician office, setting up appointments, getting in there. Typically the first appointment is – is a good half-hour discussion, you know, really – really going through a lot of the evidence-based medicine. Talking about, you know, different types of – of pain common in a Medicare population and alternatives to opioids, you know, for new starts especially, you know, or how to use opioid in combination with other therapies. Promoting that safe use, you know, and when appropriate, to talk about tapering, to talk

about non-pharmacy interventions in – in pain. And – and really with that tapering, I think, you know, there's a lot of concern with how do you do it right, how do you do it safely. You know, we – we know as clinicians, too, going too abruptly with a taper can – can create a significant medical event. So, following guidelines. Creating those tapers. And routine monitoring after the fact. You know, as – as you're moving down and tapering, what are the side effects? How – how is the patient, the member, doing in this taper? And, you know, it's not always a cookie-cutter answer, right? You've got to look at the patient and how are they doing, and is it ready to take the next step. So a lot of great conversation that happens in that early education. And then, you know, obviously our services for follow-up questions and such are certainly offered there. It – it's not a one-and-done conversation. It's certainly an open-door policy to continue to – to be partners with our prescribers.

Kristen Renkes: Okay. And seeing no questions from our audience, I – oh, do we have one?

Hello?

Hi.

Yvonne Zachman Fiedler: I'm Yvonne Zachman Fiedler from PWC. So, how proactive are you finding that your PDMs are as implementing these processes? Are they really leading the way or are the health plans leading the way? And like, can we have some examples of interactions with them?

Johnathan Randle: Well, I would definitely say, in regards to PBM collaboration, we're extremely collaborative with the PBM. And I would definitely say, as being new into the marketplace, our PBM is definitely leading the way for us and we're collaborating with them and taking a lot of advisement from

their previous experience, industry experience and collaboration or data that they've taken from a spectrum of clients.

Erin McKenna: We have a really great relationship with our PBM. And early on, as we were talking about the early implementation of the seven-day edit, we were sharing what we were seeing and certainly leveraging that partnership as we were talking to our providers as we were helping to kind of get that message out, certainly leveraging our PBM efforts so that we weren't just solving one problem but really trying to help be an overall driver of change.

Kristen Renkes: Any further questions from the audience? Okay. Thank you so much for your participation in this panel discussion. I will set you free.

Anne Kane: Thank you.

Kristen Renkes: Thank you so much.

Thank you.

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