Effective Strategies for Addressing Overutilization and Abuse of Prescription Drugs in Medicare Part D

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Stacey Plizga: Okay, here to provide participants with an overview of strategies – sorry – to help reduce inappropriate utilization of opioids, from the Medicare Drug Benefit and C&D Data Group, please help me welcome Anna Polk, and Diane McNally.

Anna Polk: Thank you, Stacey. We were joking that she was going to say "Anna" before the presentation, so good job. Hello and good afternoon. My name is Anna Polk. I'm a pharmacist in the Division of Formulary and Benefit Operations. Diane McNally and I are going to be talking to you today about effective strategies to address the overutilization of opioids in Part D. And I apologize, I don't have any Star Wars jokes for this session, so, unfortunately.

To begin, I'm going to provide a brief overview of the CMS policy development in this area, and then discuss the levels for improving drug utilization review controls in Part D, and then show the various strategies that sponsors have used to date. Afterward, I'm going to turn it over to Diane who's going to talk about the impact of this policy and also what's on the horizon.

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The opioid epidemic in this country has become a huge threat to public health, especially as drug overdose deaths in the United States hit record numbers in 2014. From 2000 to 2014, nearly half a million people died from drug overdose. This was not simply the result of illicit drug use either. At least half of these deaths involved a prescription opioid. In fact, since 1999, the amount of prescription opioids sold in the United States has quadrupled.

I'm sure many of you here today have been prescribed an opioid at some point, and many of you may even know someone who's struggled with addiction, and you've seen the devastating effect this has not only on the individual but their loves ones and society as a whole. So it's a huge problem, and it's one that's not going away without a dedicated multifactorial approach. Here, at CMS, we take this incredibly seriously, but we can't solve the problem alone. As Sean stressed this morning, we need to work collaboratively if we are going to make any kind of meaningful impact.

And we've got a polling question for you. In a single day, how many Americans die from an opioid overdose? And so we've got A, 13; B, 54; C, 78; or D, 115. And, as you're making your selections, keep in mind that a similar figure for motor vehicle deaths is 96 per day. And it looks like the most popular answer is D, which luckily is not the correct answer, but it is C, 78. According to the CDC, 78 Americans die every single day from an opioid overdose.

So I know that's a really grim introduction, but I wanted to frame this talk in terms of why we're putting out all this policy and why we continue to talk to you about this. And so what have we done to-date? With the final 2013 Call Letter released in April of 2012, CMS provided comprehensive policy focused on medication safety with a goal to reduce overutilization of opioids, while maintaining access to those in need. Further guidance

was provided in September of 2012 to clarify the limitations and expectations. And then on 01/01/2013 plans were expected to implement several levels of improved formulary management.

And what exactly did those three levels entail? Well, very briefly, level one is referred to as improved use of concurrent claim edits. We also commonly refer to these as safety edits or safety controls. Level two involves the use of formulary management strategies, so things like prior authorization and quantity limits. I am going to be going into detail on these two levels and discuss the strategies that we've seen employed. And then Diane's going to talk to you more about level three, which is the improved retrospective DUR programming in case management.

So let's talk about level one in a bit of detail. This is our concurrent claims or safety edits. And please note that safety edits do not need to be submitted for CMS review and approval, as Marie actually outlined in the previous section. Safety edits could involve point-of-sale edits to prevent early refills or therapeutic duplication. They can also be used in accordance with the FDA-approved label to ensure drugs are used appropriately in terms of age and gender, and to make sure that the dose is appropriate. If a drug has an FDA maximum dose, the safety edit quantity limit can be set at this level.

One other type of safety edit that's particularly relevant to today's talk is point-of-sale edits to take into account the cumulative dose of all opioids being prescribed. We often refer to this type of edit as the cumulative morphine equivalent dose opioid point-of-sale edit. So I'm going to say MED and POS edit frequently on the next few slides so that I don't have to try to get out that whole phrase, but just keep in mind that's what we're referring to. MED is the morphine equivalent dose.

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So this type of edit was introduced by CMS in the 2014 Call Letter, where we strongly encouraged sponsors to develop the ability to implement a plan-level POS edit based upon cumulative MED across the opioid class. We did receive several questions and comments but we didn't receive a complete policy. As you can see, for 2015 we did receive a handful of policies, but still for the minority of formularies. And then in the 2016 Call Letter, CMS continued to urge sponsors to implement at least a soft opioid MED edit, while building the capacity for a more sophisticated edit. With this, we received an increased number of policies, but it was still not to the degree we would have liked. It was still only about a quarter. And, as such, for 2017, we are setting the expectation that all sponsors implement a cumulative MED edit.

We are not setting this requirement without experience, however. When the cumulative MED POS pilot was -- when the edit was first announced, there were several commenters who felt that such edits were premature due to their complexity. So, in order to test this, a pilot project was commenced in 2015 to assess the feasibility and impact of these types of edits. The pilot project included a soft edit where the pharmacist is able to override the edit at the point of sale using an appropriate NCPDP code. This was set at a daily MED of 100 milligrams, which had to occur for at least 60 days.

There were also requirements for the number of prescribers and pharmacies. There was another sponsor who chose to implement a hard edit, which was set at a higher daily MED of 200 milligrams, and this required beneficiaries to request a coverage determination in order for the claims to process. Both edits did include various exclusions for things such as cancer diagnosis, those beneficiaries receiving hospice care, and beneficiaries who had already undergone a determination of medical necessity.

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So what we learned through this process was that sponsors were able to successfully implement both types of edits to address cumulative opioid use. And this was accomplished with minimal impact in terms of access, which is indicated by a lack of any formal complaints throughout the pilot. One plan even used questions from beneficiaries as an opportunity to educate them on the risks associated with opioid use. The participating sponsors felt that their edits were effective. One reported that 19% of beneficiaries receiving an edit did have a change in their opioid regimen moving forward.

It should be acknowledged that these successes were the result of careful planning. Sponsors must do a careful analysis of their population and keep these findings in mind when developing their specific program. And it should also be noted that it did take some time to gain pharmacy and prescriber acceptance of the program. It's critical to notify the pharmacy and provider network in advance of implementation. So, prior to implementing programs for 01/01/2017, it would certainly be advisable to do proactive outreach to those beneficiaries likely to be impacted. And also keep in mind that this will probably need reinforcement.

In order to minimize false-positives, the participating sponsors stressed how important it was to include exclusions. As mentioned before, the exclusions included in the pilot were cancer diagnosis and hospice enrollment, as well as prior determination of medical necessity. So this could have been through the coverage determination process, prior authorization. It could have been through case management, or also the appeals process. Even with these exceptions, however, about 10% of the coverage determinations that they saw did still have a cancer diagnosis associated. Other things to consider when developing a program is to include reasonable allowances for overlapping dispensing dates. And you can also include criterion for a number of prescribers or pharmacies. All of these features will impact the outcomes of the program.

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And so, with this experience in mind and these lessons learned, for 2017 we expect all sponsors to implement a cumulative MED edit. Pharmacy and therapeutics committees should look to their unique experience of opioid overutilization in their respective Part D plans when developing the specifications for their cumulative MED edits. We recommend that when a soft edit is used, the threshold should be set no lower than 90 milligrams MED. And when a hard edit is used, the threshold should be set no lower than 200 milligrams MED.

We do expect sponsors to apply specifications to minimize false positives, as previously discussed. And if the sponsors do decide to include a provider count criterion, we do recommend that two prescribers of the active opioid prescription be set as the threshold at a minimum. I'd like to point out that we expect sponsors to exclude those buprenorphine products indicated for the treatment of opioid use disorder so that beneficiaries are not denied access to these critical medications. With that being said, sponsors may choose to implement an edit for the concurrent dispending of an opioid with buprenorphine for medication-assisted treatment so long as they have the technical capability to only reject the other opioid and not the buprenorphine claim.

So I'll touch briefly on the technical details for submitting the cumulative MED opioid POS edit program specifications to CMS, but please keep in mind that additional details will be forthcoming. So when you're preparing your formulary files for submission prior to the June 6th, 2016 deadline, please keep in mind that if the only quantity restriction being applied is the cumulative MED edit, quantity limit does not need to be reflected on the HPMS submission. Also keep in mind that the edit is expected to be applied across the entire opioid class. Since it's considered a safety edit, it can be applied regardless of formulary status. In other words, each individual opioid does not need to be included on the formulary in order to be included in the edit.

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In order to allow for more time to fully develop and test these specifications, we're giving Part D sponsors until September 1st, 2016 to submit their information. This information will include documentation on the type of edit being used, hard or soft; the level of MED; any exclusion criteria; and other screening information. A template will be provided to sponsors at a later date that will provide more details.

So we'll move now to level two, which is the Improved Use of Formulary Management Designs. So this includes quantity limits in those instances where there is no clear FDA maximum dose, which is where most of the opioids fall, as well as quantity limits set below the FDA maximum dose. It also includes prior authorization and step therapy criteria.

So, before we get into the levels and the strategies that we see used, I just want to provide a bit of background on the Part D formulary review process. So, much of the data that you will see on the upcoming slides is pulled from HPMS, the Health Plan Management System, which is the system through which formularies are submitted and reviewed. Submissions are based on RXCUIs, which are adopted from the National Library of Medicine's RxNorm system. Each RXCUI represents a distinct brand name, generic name, strength, route of administration, and dosage form. And when submitting formularies via HPMS, each RXCUI has to be flagged with all applicable quantity limits, PA, and step. As such, we can go back and look across all of the submitted formularies and see how often a certain type of UM was used for an individual drug or for a class of drugs.

And also keep in mind when we're working through the next few slides that we're going to be looking at the formulary level or formulary ID level, but an individual formulary could be linked to multiple plans. And so, before we get into all of the details, I wanted to see what you think. Since CMS first released opioid guidance in 2012, up to the present, what do

you think is the percent increase in the use of quantity limits on formulary opioids? So we'll be looking at those formularies submitted just prior to this guidance being released to those most recently submitted in 2016. And it looks like folks are split between 51% and 98%. It's actually 128%. We've seen a huge increase in the use of quantity limits on the opioid class.

So this slide is showing that to you in graph form. In 2012, looking across the opioids present on all Part D formularies, quantity limits were applied 37.7% of the time. After CMS introduced the DUR requirements for the opioid class, which you can see represented by the red arrow there, we saw that increase to 64% for 2013. This has continued to climb steadily up to 86.1% on the most recent submission, which was for 2016. And this table shows you which individual drugs had the largest change in quantity limit rates from 2012 to 2016. You can see the top agents were Oxycodone products, both individual and combinations with acetaminophen, where the rates changed from between 10% and 15% in 2012 all the way up to 83% to 93% in 2016. And you can see a few other agents that were the other biggest changes.

So, next we'll talk about prior authorization. And you can see that compared with quantity limits, it's used much less frequently on the opioid class, whereas before we were in the 80% range, now here we're just in the teens. You can also see that that red arrow, the introduction of this opioid policy, didn't really seem to have much of an effect. We did see a small increase in the use of PA in 2015, but it's likely that this correlated more with the section of the 2015 Call Letter that talked about the appropriate use of PA. This section talked about the transmucosal immediate release fentanyl products specifically. And so we did see a small increase.

And, again, drilling down to the individual agents, you can see those TIRF products, the fentanyl products, were those that had some of the biggest changes. The other agents with the biggest changes were actually either high-risk medications themselves or opioids combined with medications that are considered high risk in the elderly. So, whereas it seems like the change in quantity limits was really driven by this opioid policy, the changes for PA rates seem to be driven by other policy changes.

And then the last piece of the formulary utilization management strategies is step therapy. And you can see that this is used even less often than prior authorization. Now we're down in the 1% to 2% range. And it doesn't seem that the opioid policy had much of an effect on this. And so, with that, I hope you have a better understanding of what folks are doing on their formularies in response to this policy, and I will turn it over to Diane to get into level three.

Diane McNally: Thanks, Anna. I don't know if you all want to get up and stretch. I know you've been sitting a long time. Feel free to. So, again, my name is Diane McNally and I'm from the Division of Clinical and Operational Performance. And my portion of the presentation will discuss the level three drug use review tools, including the beneficiary level opioid -- oops, hold on -- the beneficiary-level MARx opioid POS edits. We'll also discuss the overutilization monitoring system. And then I'll get into some details on the Part D sponsor compliance outreach we performed in 2015, along with some key findings from the outreach and other DUR activities that have been going on for the past couple years. And then I will then end with a discussion of the policy and guidance provided in the 2017 Call Letter.

In the 2013 Call Letter, as Anna talked about before, CMS expressed our concerns that plans could be doing more to address the overutilization of opioids. And as previously described, both level one and two DUR tools,

and as her analysis showed, most formularies have implemented these tools to some extent. The final DUR tool is the level three controls or retrospective DUR with case management. Our guidance suggests that these programs should include the retrospective DUR criteria to identify patterns of inappropriate drug use. This is different than concurrent DUR.

Concurrent DUR identifies overutilization at a single point in time, where retrospective DUR can identify inappropriate patterns over longer periods of time that may not be identified at point of sale. Once overutilization use is identified, case management is employed, which may include a review of PDE claims and outreach to prescribers, providers, and beneficiaries to determine if the drug use is medically necessary. The final step of level three is to assess whether implementation of a beneficiary-level point of sale, which is different than a formulary point-of-sale edit, is necessary to control this individual's opioid use.

Now I'll discuss the beneficiary-level opioid POS edit determination process, which is pretty much driven by the prescriber's response to the Part D sponsor's outreach. If a plan is able to directly communicate with the prescriber, CMS expects the discussion of the complete opioid regimen among all prescribers, not just the certification of what the prescriber wrote. The discussion may go beyond the total morphine equivalent dose or MED, to address the opioids prescribed, including dosage forms, quantities, as well as other concurrent drugs. And, as we all know, benzodiazepine and use of opioids has become a very serious problem and is highly correlated with overdose.

If there are multiple practices involved, the discussion should also attempt to identify a single prescriber willing to manage the patient's pain therapy. What we don't want to see and hope not to see is that the patient is totally discharged from all practices and then they end up seeking care from the emergency room. So we hope plans are trying to help these beneficiaries

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get coordination of care. Plans should continue to monitor their beneficiary's opioid use, also to confirm that decisions were implemented. If the consensus is that a beneficiary-level POS edit is necessary to control the patient's opioid use, then the plan needs to notify the beneficiary and prescribers of the action an agreed upon opioid regimen, along with CMS.

One more. Finally, if none of the opioid prescribers respond to the plan's outreach, the plan should monitor use to see if the use improves, because sometimes just contacting the prescriber will change the beneficiaries use or the prescribing. But it should only be monitored for a short period of time. And if the use doesn't improve, then with input from their P&T Committee, the plan should implement a POS edit that either limits the opioid use or denies coverage for any opioid. If the overutilization does not improve, just monitoring opioid use is not sufficient.

The beneficiary-level opioid POS edit database. Okay, now I'm old-fashioned, no polling. How many are familiar with the opioid POS edit MARx database? A few. I guess everybody online, on the phone knows it. Okay. Originally, when we implemented this policy, plans had to submit to us a letter after they contacted the beneficiary. But now, on February 8th, 2014, the POS edit database within MARx went 'live'. So plans can now send the opioid POS edit information electronically to MARx or enter the information through a user interface. Yes, no more emails, well, at least from me. However, plans still need to send the letter to their regional account manager.

The system also assists plans by alerting any new plans if a new enrollee had an active POS edit during his or her prior enrollment. Prior plans no longer need to alert new plans if any of their enrollees have an active POS edit as long as the POS edit information is submitted to MARx prior

to a beneficiary dis-enrolling. Another advantage of the MARx system and for entering your POS edit into MARx is if the beneficiary is subsequently identified in OMS, if the beneficiary is found in the POS edit database, we will suppress them from future reports.

So the process for submitting a beneficiary-level opioid POS edit to MARx. Once the beneficiary is notified of the edit by mail, the plan is expected to submit the POS edit information into MARx. We clarified in the 2017 Call Letter that the edit information should be submitted within seven business days. And this is important in case the beneficiary dis-enrolls, then the new plan won't know that the person had a POS edit prior. The POS edit information includes, as listed on the slide, demographic information, the HICN, the notification date, the POS edit code, which is either PS1, meaning no opioids are covered, or PS2, when limited opioids are covered.

Plans are also expected to submit to MARx any follow-up decisions, such as a change in the POS edit from PS1 to PS2, adding an implementation date or a termination date, if applicable. Again, the information should be submitted within seven business days of that event. Also, please be careful that the same notification date is used when submitting updated beneficiary POS edit information. I have found in the database, for the same contract, same beneficiary, multiple notification days with the same POS edit.

So, what we suggest to reduce errors is to use the user interface, that way you can see what information was entered prior and you'll get a real-time response for the data you enter. Once the POS edit information is entered into MARx and the edit is not terminated, if the beneficiary dis-enrolls, the new plan will be notified of an active POS edit on the DTRR, or the Daily Transaction Reply Report. With the TRC, Transaction Report Code, of 322. The new contract is expected then to contact the prior

plan's overutilization contact person to request or discuss the associated POS edit documentation, and guidance is provided in the final 2013 Call Letter regarding that. If the new plan decides to continue the POS edit, it can implement the edit and send a notification letter to the beneficiary concurrently, and waiving the 30-day notification requirement.

So what has this policy impact been on so far? As of April 6th, 188 Part D contracts have submitted POS edits for 2,564 unique beneficiaries since the implementation of the policy, which was January 1st of 2013. As you can see, the majority of the beneficiaries are under the age of 65 years, but only a very small percent of beneficiaries dis-enroll shortly following the POS edit notification, 3% within 30 days and 6% within 60 days. And about 8% of beneficiaries with a POS edit switched plans and the gaining plan continued the edit. So most plans don't continue the edit, and hopefully it's because use has decreased to an appropriate level. Concurrently, 57% of the notified beneficiaries have an "active" POS edit, and that is associated with 126 contracts, or about 17% of Part D contracts.

Okay. Another polling question. How many people are familiar with the overutilization monitoring system? All right, a few more. Good. This system was implemented in July of 2013 and its purpose is to ensure that sponsors are compliant with CMS' overutilization policy. Each calendar year quarter, the OMS generates reports for Part D sponsors, identifying their beneficiaries that met CMS' APAP or opioid overutilization criteria during the prior 12 months. So, for example, the April report that just went out last week evaluated data from April 1st of 2015 through March 31st of 2016. Once the reports are released, sponsors have 30 days to submit the outcome of their review for each case identified by CMS in the OMS reports. Plans can also submit, through OMS, the outcome of cases that were internally identified by the plan outside of the OMS criteria. These cases may be excluded from future OMS reports, if applicable.

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And here is the criteria, which I'm not going to read, but in the OMS there are three types of cases, the APAP over-utilizers, opioid over-utilizers, and CPI referrals. We also include cases that we referred to the Medicare Center for Program Integrity that are not under investigation by law enforcement. These cases are then recycled back to the plans for further evaluation and potential case management.

So, what's happened to date? So what impact have we observed since CMS released its policy on improving drug utilization review controls in Part D? As reported in the 2017 Call Letter, overall, Part D has seen a significant drop in the number of beneficiaries identified as APAP and opioid over-utilizers. This slide illustrates the change observed in the opioid use.

In particular, the Part D program has experienced a 47% drop in potential opioid over-utilizers from 2011, which was prior to the policy release, through 2015. An even larger decrease of 57% was observed in the percent of opioid users identified as over-utilizers or outliers. This decrease occurred while the percent of opioid ever-users used one or more claim -- had one or more claims, remained constant, even as the number of Medicare enrollees increased, suggesting that the decrease in outliers is not due to an increase in enrollment or a decrease in the number of opioid users.

At this time, we would like to thank Part D plans for your hard work in helping us to reduce opioid over-use in Medicare. So give yourself a pat on the back.

Okay. Now, even though we have seen a decrease in outliers, in 2014 we were very concerned that a majority of the responses submitted to the over-utilization monitoring system by Part D plans were, "Does not mean

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internal criteria and over-utilization resolved," and we would get that repeatedly for the same bene, which didn't make a whole lot of sense. So we conducted an outreach program in May of 2015 for two things, two goals; assess sponsors' compliance with CMS over-utilization guidance and determine if revisions in the policy guidance and/or the over-utilization criteria was needed. We selected eight parent organizations from the October 2014 OMS cycle who had high rates of specific or repeat responses, and those who had no or low rates of beneficiary level POS edit submissions.

The outreach asked the parent organization to answer a general question regarding their internal criteria and over-utilization policy, and specific questions regarding individual beneficiaries identified in OMS. And on the slide are those questions. In general, what are your internal criteria for identifying potential opioid over-utilization? More specifically, which criteria were not met for the tickets provided, and please provide a detailed response.

In conclusion, we found that most sponsors were compliant with CMS guidelines. And we also were able to identify opportunities to modify opioid over-utilization criteria in an effort to reduce false positives.

Some of the reasons that plans gave why the beneficiary did not meet internal criteria or the over-utilization resolved were the following: The prescriber or the pharmacy count was not met. Some of the sponsors were able to identify physicians that were in the same practice. CMS will be working on that in the future, but at this time, we have to use the NPI which is unique to prescriber. And some plans also would group chain pharmacies and count them as a single pharmacy. The second one was situational acute events. The patient would go have a dental procedure or a surgery, and that might increase the number of prescribers, and even the dose. Plans also considered consistent opioid regimens with no

evidence of early refills as appropriate, and the over-utilization decreased during more recent months. Since the OMS criteria looks back at 12 months of PDE data, use that occurred earlier in the year would be flagged despite recent use that was below the criteria threshold.

Potential lack of POS edits: Plans that is lack a POS edit felt that direct communication with prescribers and follow-up monitoring was sufficient and would often impact the member's opioid use. In addition, sometimes the high number of prescribers was due to a lack of coordination of care, and if a prescriber was willing to coordinate care, there was no reason to implement a POS edit.

So, based on the outreach findings, CMS sees its next step to analyze options to modify the opioid criteria, including shortening the review period, and averaging the opioid MED with consideration of the new CDC guidelines for the treatment of non-cancer pain. Our goal is to report any potential opioid criteria changes in the 2018 Call Letter to allow for comments.

So our over-utilization policy that was reported in the 2017 Call Letter: So given the changes observed in the Level 1 and 2 DUR formulary analysis, and decreases observed in the number and percent of opioid and APAP over-utilizers we reported the following policies: Opioid use monitoring; as stated before, we will investigate the OMS opioid over-utilization modifications and changes in how prescribers are identified. Within OMS, we have added the contract-level opioid high daily dose rate, which is calculated as the number of opioid days greater than 120 milligram MED per 1000 opioid days prescribed.

For acetaminophen we will continue to monitor, and if you haven't opened your April OMS packages released last week, good news, APAP reports are gone. However, we did move the APAP monitoring to the patient

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safety reports in the form of a contract-level APAP high daily dose calculated rate similar to opioids, which is the number of APAP days greater than four grams per 1000 APAP days prescribed. And in 2017, we see the APAP rate will probably be included in the patient safety outlier report. So if you plan is an outlier on number of days on this rate, then you'll show up in that report.

Additional priorities: Despite the overall positive results, we need to remain diligent in improving opioid use, so we are shifting from a retrospective DUR focus to concurrent DUR tools with the implementation of either a soft or hard POS cumulative MED edit, which Anna has previously described. In fact, one of the contractors who implemented a hard edit observed a reduction in cases referred for case management. The soft opioid POS claim edit, following the initiation of buprenorphine for opioid use disorder, as long as Buprenorphine is denied, again, as Anna mentioned before.

For submitting and updating POS edits to MARx, we clarified in the Call Letter that timely means seven business days, so please, I hope that is not too burdensome. We remind plans that formulary structures should not impede medication assisted treatment for opioid use disorders. And finally, sponsors should review their utilization management process to ensure that methadone is not the preferred opioid for pain management. Methadone is frequently associated with overdose, and the CDC guidelines now recommend that methadone only be prescribed by a pain specialist.

So, in conclusion, Part D plans should congratulate yourselves. Improved opioid and APAP utilization controls are moving opioid over-utilization rates in the right direction, and we thank you. Cumulative opioid MED POS edits with exclusions are possible and are effective in reducing opioid use. And as Anna mentioned before, you know, it's important to

query your database, query your beneficiaries and see how best to implement that.

CMS is pleased that the majority of studied Part D parent organizations are compliant with CMS opioid criteria, and, also, sponsors use beneficiary-level POS edits sparingly following case management. Whether the current level is appropriate will require additional analysis, but overall, we are seeing a decline in opioid over-utilizers based on this current metric. Finally, I want to leave you with some additional resource links and the CMS mailboxes that you can use for questions.

So, the first link is the improving drug utilization controls in Part D. Anything that has to do -- any memos, the Call Letters, or reports that have to do with MARx, the over-utilization monitoring system and DUR tools, retrospective DUR tools, can be found on this website. So go there first. Next is the link to the plan communication user guide and that provides detailed instructions how to submit a beneficiary level opioid POS edit to MARx. The next link is to formulary guidance. Guess what that's for; formularies. And the final link is the link to CDC's new guidelines for general practitioners on prescribing opioids for the treatment of chronic non-cancer pain.

And if you have any specific questions, you can send them to these mailbox. Again, the first one is for formularies. The Part D OM is for MARx questions, anything that has to do with opioid over-utilization. And for patient safety, if you have any questions on OMS or your patient safety packages, you can e-mail the patient safety acumen website. Thank you all for your attention, and I guess if we have any questions?

Stacey Plizga: Okay. Unfortunately, we are out of time right now for questions. But Anna and Diane will be back at the end of the day for the Open Q&A Session,

so I would like to thank them for their strategies to improve medication use.

Okay, here we are again. If you would like to evaluate session five, go ahead and either text in "A" or put that in the pollev website.

And look at that, it is time for an afternoon break. We will take a 15-minute break, and we will return here promptly at 2:30. And, remember, if you have any questions, go ahead and send them in through that SurveyMonkey link and we will address them, either during the sessions or at the end in the Open Q&A Session. Thank you.

[AFTERNOON BREAK]

Welcome back everyone. We are going to get started. We have a couple panels yet today. So if you can please have a seat. And those of you in our viewing audience, thank you for hanging in there with us on the webcast. And thank you to those of you who are in the audience for being on time.