PBM Migration: Lessons Learned in Part D

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Stacey Plizga: Our next session is a panel of speakers from WellCare, who will share key areas of focus relating to Part D that contributed to the overall success in moving from one pharmacy benefit manager or PBM to another. From CMS, I would like to introduce you to Arianne Spaccarelli, who will introduce the WellCare panel.

Arianne Spaccarelli: Hello. I'm Arianne Spaccarelli. It's my pleasure to introduce Michael Yount, Lee Genco, and Laura Hungiville from WellCare. They have joined us today to discuss the lessons learned from transitioning PBMs from 2016. They will be discussing the strategies that they use to promote a smooth transition, and to monitor the transition following January 1, as well as areas of opportunity to improve the future transitions.

In the spring of 2015, WellCare notified CMS central office that they would be transitioning PBMs effective January 1st, 2016. This began a series of meetings and calls with CMS central office and regional staff regarding WellCare's planning for the transition. This early and frequent communication with CMS allowed us to share our experiences and

lessons learned from other large migrations as WellCare planned for and implemented its transition strategy.

From CMS's perspective, the early communication and collaboration with CMS was particularly important because it allowed us to work with WellCare to plan for and mitigate disruptions caused by formularies and the pharmacy network. WellCare representatives will discuss the strategies that they used to prepare for formulary changes, minimize disruption to the network, and communicate with members and providers regarding the changes.

WellCare's experience should be very helpful for sponsors contemplating a PBM transition. Their experiences and lessons learned can also be instructive for sponsors contemplating significant network, formulary, or systems changes, as many of the issues that WellCare dealt with also arise in those context. Their plan in communication and mitigation strategies provide a useful model for any sponsor contemplating a major change in the administration of Part D plan. So please help me in welcoming WellCare's representatives.

Michael Yount: Thank you, Arianne. To start, we have a poll question, and I promise this is an easy one. It's just for the panel to gauge the audience and their experience so you can see, A, I represent a sponsoring organization that includes Part D benefits; B, I represent a sponsoring organization that does not have a Part D benefit; C, I'm a key stakeholder in policymaking and oversight of benefits, for example, CMS, CMS partner, or an advocacy group; or D, none of the above?

Thank you.

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In 2014 WellCare had initiated an RFP process to begin searching for a pharmacy benefits manager. We had both our incumbent PBM, as well as other PBMs respond to that request for proposal, or RFP. And as result of that process, WellCare had elected to change or transition PBMs beginning in benefit year 2016. This was a significant undertaking for not only the organization but for also our outgoing PBM, as well as our incoming PBM, as 3.5 million members, both Medicaid and Medicare would be impacted by this transition in PBMs.

The goal of WellCare as PBMs, as well as the agency, was to ensure that we had mitigated any risk to the beneficiaries, and that we had a project plan initiated and implemented and maintaining that would ensure that any harm to beneficiaries would be reduced, or in the event that there was missteps, they would be identified quickly and then remediated efficiently. Based upon the number of issues, and based upon the number of members impacted, we believe that we had a successful PBM conversion. Lee and Laura will share with you some of those numbers, and some of those results.

The goal today, as Arianne had mentioned, is really threefold. One is to provide you all with some aspects of our work plan, some of what we worked on for nearly 11 months, both internal and external with our PBM partners, as well as with our CMS partners. As well as, two, to discuss with you lessons learned. There were some issues, there were some missteps, and we think we learned from those, and we think you can too. And then third, and maybe this is most important, but to make ourselves available to you.

One of the benefits that we had throughout the process was some conversations that we had with our peers who had recently undergone a PBM conversion and those conversations were transparent and candid,

and they were very helpful to WellCare and, ultimately, to our beneficiaries.

As I had mentioned, there was a significant number of members that could be negatively impacted by this type of transition. WellCare had recognized that potential for significant adverse impact very early on in the process, and we ensured that there was a focus that the beneficiary would receive his or her prescription or his or her therapy in a very timely manner so that there would be no adverse impact. In order to ensure that, we had a number of conversations, both internally, but also externally. We had very early on, I believe it was June, reached out formally to CMS, both at the central office and with our regional account managers and advised them that we would be transitioning the PBM, but more importantly requested and received their partnership and collaboration through that transition period.

In addition to our regional account managers, we had multiple conference calls with the central office staff, and we had calls in which it was not only WellCare representatives and our incoming PBM representatives but also representatives from the central office and regional office staff. As we led off today's presentation, both Judith Flynn and Brenda Suiter talked about collaboration with the regional office staff. I think this is an example of where collaboration not only benefits the agency, as well as the plan, but ultimately benefits the member or the beneficiary.

The discussions: the discussions were transparent. The discussions were candid. WellCare had actually provided to the agency our work plan. That included proposed member communications, and examples or drafts of those types of communications. In response, we received observations and insight from CMS, both at the regional office level and also at the central office level. Recommendations were made, or ideas were given to

us that, quite frankly, we had not thought of. That dialogue was very productive and, again, I think it led -- it was a very key part to our overall success.

In addition to the external communications that we had with our agency partners, we also had a very significant amount of internal communications. There were workgroups established amongst the pharmacy team, with nearly every representative department within WellCare. This was identified as a top-five goal for the organization for 2015, and the focus was put on that.

But, just as importantly, there was a communication from the top. There was a communication from our CEO and from our executive leadership team that, throughout this very long process, if there were any concerns, if there were any deficiencies, if a certain part of the project began to go off track, that the associates were encouraged to raise the concern; that the associates were encouraged to identify that there may be missteps so that we could timely remediate any issues that would come up. That type of transparency, not just external, but internal, was also very key, because it allowed us to have very transparent communications, but also allowed us to identify issues very quickly before we got too far down the road. So that governance or that accountability structure was key.

We also had not only our executive leadership engaged but we had the executive leadership of our incoming PBM engaged as well, and there were frequent conversations between those two groups. And we also had frequent updates that we had provided to our board of directors, both from a compliance risk standpoint, but also from a member risk and operational standpoint.

Laura Hungiville: Hi. I'm Laura Hungiville, and I'm WellCare's Chief Pharmacy Officer. I'm just going to spend a few minutes talking to you about some of the mitigation strategies that we put in place, and then I'm going to turn it over to Lee, who is going to go into the details of our plan, which is probably what is most interesting.

So that executive support that we had at both organizations really was key. And one of the challenges that we put forward was, all right, let's think about anything that could go wrong and let's think of a mitigation strategy, or let's head something off before it happens. So we spent a lot of time evaluating all the changes that were going to be happening to our members, and that happen to them, frankly, every year. You know, a formulary change, network changes, benefit design changes, and then having to show up with a new ID card causes enough confusion. We thought all of these things happening at one time, we want to try and think outside the box, and let's do some creative things, and that's where CMS gave us a lot of insight and reaching out to the peers, as well as our PBM partner, really helped us come up with some unique strategies.

So some of the things that we did, we spent a lot of time with disruption analysis, looking at individuals formulary utilization, looking at the pharmacies that they were getting their prescriptions at, and we spent a lot of effort reaching out to those pharmacies and then looking at the medications to see what can we do, what can we do to minimize this impact. And we made significant changes to our formulary in the fourth quarter in anticipation of the formulary we would have in 2016. This had some financial ramifications from that, so it's certainly something that you need to consider when you're thinking about making these big changes and the investment that you night need to make the really -- have a really smooth transition.

We had emergency fill override processes in place. We have those, and we really beefed up our communication with our call center teams and the training to make sure that when they got a phone call and there was a beneficiary, a member at the pharmacy needing their medication, that they were going to be able to leave that drugstore with it. And so that included both overrides of formularies, and it also meant that overriding for pharmacies that are in the network, which is not something that's very common in the industry. And we were fortunate to have a PBM partner that helped us with that, and a very, very robust communication strategy, which Lee will spend a little bit more time on. We had numerous touches. I don't think that you can communicate enough, and we had some creative reaches to try and make sure that we were getting everyone's attention.

But while this was mainly focused on the beneficiaries and the prescribers, we also spent a lot of time and effort communicating with pharmacies. We reached out to trade associations like NCPA. We talked to legislators in our market. We talked to patient advocates, the SHIP, and reached out to business partners like the SPAP's. So we wanted everyone to understand what was happening, what it would mean to a beneficiary, and what they could help us answer beneficiaries' questions if they got them. And we also spent a lot of time with prior authorization as well. You know, looking to see if there were just exceptions that we needed to make or help people transition going forward.

They told me to be patient. And Mike talked a little bit about peer to peer. And we did engage in dialogue with other health plans that had gone through conversions, and they were very helpful in sharing with us the things that they would have liked to have done differently along the way, and we learned from that, and we hope that we can offer that to the industry as well. So now to the details, I'll turn it over to Lee.

Lee Genco: Thank you, Laura. So first, I want to touch on project planning. We announced our PBM conversion in February of 2015, and one of the first tasks for us was aligning on our critical dates. In order to do that, we had to identify our critical milestones, identification of the key risks, install an oversight process to this project plan, and ultimately, we were able to accomplish an integrative project plan by May, which was just a short three months later. We had over 4,000 tasks, over 200 critical milestones that we put in place.

The governance structure, Michael talked about the amount of different individuals across the organization. We had 19 different work streams across our company. That also included our new PBM that was involved in each of those work streams. Those teams met on at least a weekly basis, and we would get together every two weeks with the leads of each of those 19 work streams to go over project status, and we included other management-level folks in those sessions to provide ready and timely updates to the organization.

Additionally, we had executive engagement through steering committee meetings. We felt it was important to have an internal steering committee meeting among our own executives. But in addition to that, we had a joint executive meeting with our PBM and our executives at our health plan just to make sure the project was staying on track.

One of the more beneficial aspects of the reporting process was a weekly readout. It was an executive summary that we had published for our leaders across the organization that provided line of sight into key issues, what the overall project health was at that given week. We looked at key decisions that were required. By promoting those key decisions, it allowed us to have more timely engagement with our executives and the key

decision-makers so those items could be closed quickly and we could keep things moving along, as well as the identification of any work streams that perhaps had gone off track. They were in yellow or a red status. Those were all called out specifically, along with the path to green; what would it take us to get back -- for that particular work stream to get back on track.

Pre-deployment planning, we went through some exhaustive Q/A and testing, as one can imagine. I would just offer when you're thinking about your test strategy with your PBM, we took a wealth of information from them and test strategies on what they recommended. We then looked at all of our risks that we had identified throughout the course of our project and put test strategies around each of those risks, and then we overlaid that with our own lessons learned from previous Part D annual changes.

We completed an operational readiness assessment. That took place in November, and in December, to get us ready. I'd liken to a pilot that's making a pre-flight check, making sure all the switches are on, the plane is in good working order. We went through that process. And one of the exercises that I found most beneficial was going through catastrophic contingencies. So these are the worst-case scenarios of what could possibly happen.

And I can tell you, we had 27 of them, and if any one of those 27 had not have planned out, we would be up here having a much different conversation with you today. But I bring that up because it was helpful for us in just talking through it and developing the mitigation of each of those critical contingency plans, because it forced us to look closer and just make sure that we had accounted for everything associated to those critical catastrophic contingencies.

And then finally, from pre-deployment we had engagement from -- an outside independent consultant came in and gave us a readiness review assessment in the month of December. Given the timeframes, it was highly driven on process and just making sure that any key identification of risks had not gone unturned.

Post-go-live monitoring, we looked at all the paid and rejected claims. The month of January we had reviewed 3.5 million claims. We focused on transitions, formulary, pharmacy network, of course helpdesk, beneficiary calls, complaints. What I would call out here that was unique in that we work closely with our operations team to really look at the CTMs and grievances that were coming in. We felt it was important not to develop a brand new process for that team, but we wanted to make sure our pharmacy SMEs and the folks that had been engaged in this project were on the frontlines and looking at those individual cases as they were coming in, so we developed a reporting mechanism based on intake, where we were actually reviewing all of those CTMs and grievances on a daily basis, and we would have a team of experts that would go through and review so that we could quickly spot out any trends, any particular issues, and then provide and get ourselves directly engaged back with our operations counterparts in order to provide timely feedback and resolution.

From the reporting perspective, the key performance indicators, the things we were looking at on a daily basis, we actually developed a daily executive dashboard that we were producing, again, too much of the same folks in the project staff. The daily dashboard had the key metrics around call center, pharmacy network, our coverage determinations. We had a number of formulary changes that we were closely monitoring. But one of the areas that was important to us, again, in transparency when we developed this, was having conversations with Arianne and Linda to

really understand what does success look like together and then what are the metrics that we're going to add and put into that? So that conversation proved very helpful for us in development of our dashboard. And what we looked at, ultimately, was the exact same view we provided to CMS for our Medicare metrics.

Now I'm going to talk about our communication strategies, which I think is probably the cornerstone of our conversion, the reason for our success. You know, Arianne mentioned that perhaps you may have other conversions, system conversions, network changes, maybe it's not a PBM conversion but perhaps some of these, you know, things that we had incorporated in our plan might be beneficial to you. So we think about outbound calls or inbound calls. I won't go through all of these in great detail, but I do want to call out whey would consider key differentiators for us in our plan.

From an outbound call perspective, we had all members that received an ID card. Across our enterprise, we had 3.5 million members that were disrupted by the fact that we were going through the conversion. So we used automated calls to these members to make sure they knew, "We sent you a new ID card. It has some very important information called "4RX," make sure you show up at your pharmacy in January and present that new ID card, as well as highlighting some of the key changes that we are going to be producing.

We produced and developed some very scripted messaging for formulary and network. We targeted those members specifically with phone calls. And then here is, again, one of those key differentiators that I would like. And we're going to use this as a best practice, and that is, we looked at ever member that had ever file add CTM in the last two years, and we overlaid that population of members with all of our formulary and network

changes and we created a specialized unit within our call center that made outbound calls to those members, understanding that it might be a little prickly conversation. We're calling to tell them that their drug may not be covered next year. Their pharmacy may not be in the network. But that proved immensely valuable for us, and having those proactive conversations with these members overlaid with all of our other communication plans.

On the inbound call side, CSR training was very important. We wanted to make sure when agents were on the phone and having conversations, that they were educated on all of the changes. We had, for all the members that were going to be impacting -- and I keep referring to the amount of impact -- we had about one in four members that were impacted by a formulary or a network change, so it was significant. We flagged in our core system that these members, the ones that were impacted so that the CSR agent could actually identify that if they happen to be engaged with that member in a conversation. We also had IVR messages, everything from inbound IVR messages around ID cards, formulary changes, and then our pharmacy help desk, we had messaging around our new for RX information.

Now from a digital perspective, you know, Laura mentioned some of the additions we made into our formulary, and that's where we really tried to leverage that as an avenue to let members know that we had made some additions, positive changes that would help us mitigate the abrasion, so that information was on our provider and our member web portals.

On a written communication perspective, we had a targeted network disruption letter. So this letter was developed, told the member exactly what pharmacy they were using and that they would no longer be able to

use that pharmacy, but which pharmacies were in the geographic area, and we had five alternates for the members on this letter.

On formulary changes, very similar approach. We identified the target drug that was being either removed from the formulary or had some additional UM attached to it, and then we put the clinical alternative on that letter and provided those to the beneficiaries.

Another key differentiator for us, and communicated to members, was a EOB insert, so our incumbent PBM helped partner with us and produced an insert. We did a color insert in the members December EOB statement that highlighted the fact that they had received a new ID card and then some of the key change that is were there, so that helped, again, promote some awareness of that last week of December when those EOB statements were coming out.

Postcards was something that we sat here in the audience last year and learned quite a bit about, and the value, so we decided to put that into our strategy, and it also proved successful. We had beneficiary newsletters, provider directories, and a targeted prescriber letter is the other area that I would add that came at the recommendation at CMS; that we think about educating our prescribers on what changes we were going to be doing. So, at Medicare Advantage, we have our own prescribers, but we're also a PDP plan, so that entailed some creative thinking for us and engaging with our prescribers. And then Laura also mentioned the industry trade and advocacy group engagement with NCPA and SHIPs is just a couple of examples on what we did.

Point-of-sale messaging, this is another one that I would put in the key differentiator category. We had point-of-sale messaging with our incumbent PBM that messaged back the new plan BIN/PCN, but also the

RX group information at a member level so that when the pharmacy received the denied claim, they had all the information they needed to resubmit the claim to our new PBM, and that was important for us. What we also did is we tried to identify, where possible, to keep the RX group number from our incumbent PBM, the same for our new PBM, as that just made one less data entry point for the pharmacist to put in.

Pharmacy fax blast notifications, we had a staggered approach. We had our incumbent PBM send out a notification initially that they would no longer be the PBM for WellCare. And then we had our new PBM send out a phased approach of communications welcoming WellCare, and then also getting into the more detailed plan level information in those communications and all the appropriate routing information that they would need.

And we talked about areas of opportunity. This will shift gears a little bit. When we think about all the things that went right and did well, there were certainly areas of opportunity and things that we wanted to call out, sort of risk areas, if you will. First is vendor transition for prior authorizations. For those that are familiar with prior authorizations and loading them in a PBM system, it's complicated. It's very complex. I remember sitting with our regional office, pharmacist, Karla Taylor, and she pulled me aside at the end at the meeting and said, "You know, I've seen plans that have fallen down in the past and this is where that are struggled, was with prior authorization." So we took that to heart and really looked hard at our prior authorization, and we started a clean-up process, actually within our incumbent PBM system, so that we didn't have to make as many drastic changes on PAs. If we could term authorizations at the end of the year, before 1-1-2016, and not have any adverse effect to the beneficiary, let's do that. What we're trying to avoid are authorizations in the new PBM system that aren't necessary and can often create audit risk, in that they

create and become more restrictive than the formulary is. So that was something that was important for us.

What I would recommend out of this is that the control points, when you you're thinking about how to scrub PAs and the volume of PA, understanding the intent of what the original PA was is incredibly important as you're taking it from the your incumbent PBM and loading it into your new PBM. So not to lose sight of that, and then have sort the critical control points around that load process.

Next is a migration timeframe. Our new PBM had -- based on the Central Standard Time Zone, we had claims processing -- not processing for the first hour for our East Coast pharmacies. And I kind of flip back to the critical contingencies, I can assure you that the first few minutes after January 1st were extremely heart wrenching for a lot of folks. But we quickly realized the basis of that, and we were fortunate that we have more people on a conference bridge than we had claims that were actually being processed and not received. So the message here for us, we actually had a conversation with our new PBM, and we should have pressed a little harder on this particular question. We knew that pharmacies had the ability to process on the East Coast to the Central Time Zone adjudication system, but the challenge was the effective dating of the client, so.

Transition period start date: So transition, as we all know, is incredibly important for our members and making sure they have access to those medications. What I would offer here is we developed some enhanced procedures for handling those escalated cases. That took a lot of work and a lot of thought to get that out to our CSRs. We implemented a process whereby members, if they were out of medication, that they had an opportunity and they were impacted and they exhausted their

transition fill, we were giving them an additional transition fill. It was something that we spoke with the agency about and felt that it was important, but it was a manual process. So the oversight to that process was incredibly -- something to think about and make sure you have the right procedures in place and making sure these beneficiaries, when they meet the conditions for these critically urgent meds and they've exhausted their transition fills and have not ultimately received a coverage termination yet, that we're able to give them an additional fill.

Formulary disruption letters -- and this will be the last couple of slides here before we open it up for some questions. Formulary disruption letters, we talked about the targeted nature of these letters. They were extremely complicated when we got into thinking, not only just the volume of letters but also the fact that members needed to be able to comprehend what we were trying to convey to them. Their drug was going to a higher tier. The drug wasn't going to be covered on the formulary. Perhaps it had some increased UM or changes in UM, and then finding the clinically appropriate alternatives for each of those.

We ended up mailing those letters, I would say, mid to late November, which was very late, right around the Thanksgiving Holiday and didn't allow a lot of time for members to react, although we were -- you know, every intent from our communication strategy, starting in October, this particular letter was very late in the AEP period, before the end of December 7th. So the recommendation here, having the benefit of hindsight 20/20, would be to flip the postcard communication, which we mailed in October. As a, hey, we're going to be making some changes, be on the lookout for some future communications, to sending the targeted formulary disruption letter in October, and then sending a reminder communication with a postcard in the month of late November in that same timeframe. So with that, Stacey, I'll open it up to some questions.

Stacey Plizga: Okay. If anybody in our audience has a question, please feel free to go to the microphone in the center of the aisle. All right. I don't see anybody moving out there. So we did receive a question from one of our viewers, and that question is, "Who were the outgoing and incoming PBMs, and what was the name of the consultant used?" What? What did I do?

Lee Genco: Michael, you want to take it.

Stacey Plizga: Did you just answer this?

Lee Genco: No. No. We avoided the topic.

Stacey Plizga: Oh, sorry.

Michael Yount: Yeah, we did avoid the topic. Obviously we had a change in PBMs, and that change was for business reasons, purely business reasons. And maybe I'm going to sound too much like an attorney talking. If anyone would like to ask me after the presentation, I'd be more than happy to disclose who the outgoing PBM was and who the incoming PBM was. I think the key takeaway for this audience is both PBMs were incredibly collaborative through the process and that we had a great deal of transparency, and we also had a lot of communication, so the expectations were very clear. We're very fortunate that our incoming PBM was very responsive to the needs and to the changes and to, quite frankly, the level of detail that WellCare put into this project.

Linda Anders: I just want to add that it was a strong recommendation of CMS's to exclude the names of those folks for a similar reason; that it's not a promotion of a specific vendor for these services but rather the process that we work through together. Had we mentioned their names, we would

have asked them to be part of the panel, and then we would have been bigger than the audience. So just to keep things focused on the purpose of the conversation, that would have just been extra, not noise per se, but another level of topics that we didn't have time to address.

Stacey Plizga: Okay. Thank you. I won't ask any more of those questions. We do have someone in our in-house audience with a question: Please tell us your name and where you're from.

Sarah Lorance: Good afternoon. My name is Sarah Lorance. I'm with Anthem. And this information was exceptionally helpful. I appreciate your willingness to share. My question is when you got to the December/January timeframe, and especially around lag files from your prior PBM to your new PBM, to really ensure those January claims came through the December history and the lag files, can you speak a little bit about what you did in terms of ensuring all of that was timely, and so members balances, et cetera, really carried forward timely for January.

Lee Genco: I'll be happy to take this one. One of those 19 work streams we had was dedicated to loading of these lag files. We also felt it was incredibly important for a claims history to get that information from the incumbent PBM to the new PBM. We started loading claims history in September, so we were very early in the process. We loaded our member eligibility into our new PBM the first week of September. We didn't have 2016 spans in place, but we at least had the membership there so that we could start those activities. So we took a year's worth of claims data and we took it in chunks of a month at a time, and we're sending that data to the incumbent to our new PBM.

Once we got to the nitty-gritty down to December/January timeframes, we moved to a daily load process and making sure that we were handing off

files on a daily basis. At this point, the whole process had become automated between the two PBMs, and there was very little we had to do from a health plan perspective, other than making sure that those files were being transferred and successfully loaded, and that process went on through January. Thank you for the question.

Stacey Plizga: Okay, I do have another question that was received from our viewing audience, and that question is, "What top thing would WellCare do differently?"

Lee Genco: I'd say the hindsight of 20/20, with the member communication letter, the targeted formulary letter being very late in November, we did have a few beneficiaries express some concern and angst that they didn't have enough time to make an appropriate change throughout all of our best efforts to be as transparent with these beneficiaries as we could. That is something that I certainly would -- having the opportunity to do it again, we would mail that targeted disruption letter much earlier in the AEP period.

Stacey Plizga: The next question that I have here, "Of all the recommendations you presented, what was the most effective or most successful?"

Lee Genco: The most successful, outside of the obvious collaboration with CMS, and with our executives, would have to be the communication strategy and, really, the approach, the multi-pronged approach with the different targeted groups. So hitting the beneficiaries, hitting the providers, the pharmacy network, and then also the key stakeholders that were involved in this process, the SHIPs are a huge for us from an advocacy perspective and making sure that they understood, and more or less just promoting awareness of what changes we were making and where they

could go if there were questions; right? CMS didn't have to be the direct line if they had questions. Come to us, we'll help provide an answer.

Laura Hungiville: And I just would add that our messaging was very targeted, so it was, yes, everybody got their ANOC in September, but then we took it a step further, and each letter was customized to individual member. And we didn't just tell that they were going to be disrupted, we told them what they needed to do, and we gave them some alternatives that they could reach out to their physician and discuss.

Michael Yount: Yeah. And through our conversations that we had with CMS, you know, again, it was a very open candid conversation, and the agency said, "Hey, you have a good communication strategy, but you need more." There's always more communication that could be done and based upon the population, based upon how confusing this could be for our members, over-communicate. And so we implemented some communication strategies or methods that we had not done so in the past. Postcards was brought up, and we learned a lot about postcards at this conference last year. That was probably more effective than what we had initially anticipated it would be at grabbing the member's attention and alerting him or her that there were changes on their way.

Linda Anders: From the beginning of your presentation, you talked about upper-level management, senior management buy-in, which, from our perspective, is critical, because they hold the purse strings that allow you to apply the appropriate resources that you might not have been able to otherwise. It's such a large burden to make one change. Then when it's a PBM that's doing multiple delegated functions on your behalf, there are so many moving parts. But having the appropriate people trained at the appropriate time, and getting letters out, it comes down to weeks.

Is this one week better than the other? Is my call center perfect on this day and not the next? And, you know, that was one thing that I think you handled very well, is managing up in your own organization, as well as ours.

Stacey Plizga: Okay. Well, with that, we are just about out of time, so I would like to thank all of our panelists for sharing their experiences and their best practices today.

And it is that time again to evaluate the session. So take out your phones and text your response or go to the pollev link, enter "A" and follow the instructions.