Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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About the Newsletter

HIT Perspectives is published by Point-of-Care Partners. Individuals at the leading management consulting firm assist healthcare organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. The team of accomplished healthcare consultants, core services and methodologies are focused on positioning organizations for success in the integrated, data-driven world of value-based care.

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1 Part 1: Connecting Patients With the Costs of Their Medications

By Jocelyn Keegan, Payer Practice Lead, and Pooja Babbrah, PBM Services Practice Lead

The soaring cost of specialty medications and the increasing complexity of health benefits means that consumers are asked to bear a larger share of the cost of their medications, yet most don't know how that will affect their pocketbook or their health care. More than ever, consumers need to know upfront about drug prices, payer requirements, pharmacy options and potential out-of-pocket costs. At the same time, connecting patients with the costs of their medications is part of consumer-directed care and price transparency at the point of prescribing.

But that's easier said than done. Physicians may be unaware of the need for prior authorization (PA) when prescribing expensive specialty medications, often because of data-related issues in the formulary and benefit (F&B) file used for electronic prescribing (ePrescribing). Since they don't have all the facts at their fingertips — and don't really trust what they do have — prescribers frequently order medications that are not on formulary, have higher copayments or generally are unaffordable. Patients' out-of-pocket costs are often unknown until they are hit with sticker shock at the pharmacy.

All of this often results in a variety of problems related to unaffordable medications, including reduced speed to therapy, abandoned prescriptions, disruptions in care, medication nonadherence, and unnecessary doctor visits and emergency department and hospital admissions.

The industry response. The industry is aware of these issues and is taking action through the development of two new transactions: the real-time pharmacy benefit check (RTPBC) and the real-time medical benefit check (RTMBC). They represent continued forward movement toward connecting patients with the costs of care.

- **RTPBC.** The real-time pharmacy benefit check is an emerging transaction that focuses on pricing transparency for the patient at the point of prescribing, which is driving adoption.

  With the RTPBC, the prescriber and patient can have up-to-date information about a drug that is being prescribed as part of the ePrescribing process at the point of care through the electronic health record. The RTPBC lets the prescriber know in real time if the drug is covered, the copay amount for the drug and any plan restrictions. Potential alternatives can be provided if the drug is not covered. The prescriber also will know whether the drug requires PA, helping the physician obtain faster approval and improve speed to therapy.

  At the same time, all this information helps the consumer better understand the potential out-of-pocket financial obligations associated with certain drug choices. It also can help direct the consumer to a specific site of care — or site of administration, in the case of many specialty medications — that is covered by insurance. This dialog between the prescriber and patient, facilitated by the RTPBC, is an important way to engage patients in their care and improve outcomes.

  An RTPBC standard is under development by the National Council for Prescription Drug Programs (NCPDP). Even though the federal government has not yet adopted an RTPBC standard, several vendors are offering RTPBC connectivity due to the value of the transaction. For example, there were 3.1 million RTPBC transactions in 2017 through Surescripts. This growing transaction volume indicates the RTPBC's value to patients, payers and prescribers in better connecting consumers with the costs of their medications.

- **RTMBC.** Work on a related transaction area that Point-of-Care Partners is calling the real-time medical benefit check is just getting off the ground. It is needed because roughly half of prescriptions today are for drugs, devices and procedures covered under patients' medical benefit. These can also be a huge hit to consumers' pocketbooks if their costs are not known at the point of the prescribing. That said, the development and widespread adoption of the functionality required to support RTMBC is on a longer horizon due to the nascent efforts to expose medical payer systems to support specialty pharmacy.

Connecting patients with the costs of their prescriptions.

In addition to development of the RTPBC and RTMBC, what else can be done to better inform patients about the costs of their prescriptions? Here are some thoughts.

1. **Accelerating specialty pharmacy automation.** Specialty pharmacy is largely not yet computerized, relying heavily on antiquated phone-, fax- and paper-based processes. Work is underway to change that. The industry is taking steps to automate the complex processes used for filling specialty prescriptions, building on standards and implementations for ePrescribing. These also complement other efforts to automate various aspects of specialty pharmacy, such as patient enrollment. NCPDP has a new specialty pharmacy workgroup to identify issues that can be addressed through standards development. These efforts should increase momentum to accelerate specialty pharmacy automation, which in turn will drive adoption of the RTPBC and development of the RTMBC. It also will drive adoption of electronic prior authorization (ePA).

2. **Adoption of the ePA standard.** The time is right for adoption of the ePA standard from NCPDP. ePA is a tightly related, complementary transaction to the RTPBC and RTMBC. ePA allows the prescriber to electronically request a PA from the payer, a process that takes seconds versus the time-consuming manual method. The payer's response also is received in seconds, benefiting patient costs and speed to therapy depending on whether the drug is covered. It is already being used by many in the industry and increasingly is becoming mandated by states. The newly enacted **SUPPORT for Patients and Communities Act (HR6)** calls for the government to adopt an ePA standard. Its use will be required for drugs covered under Medicare Part D beginning on January 1, 2021. This needs to be done sooner rather than later so an implementing regulation can be issued with enough time for stakeholders to comply. Adoption of this standard will help improve the patient experience and speed to therapy, as well as help drive the use case for the RTMBC and medical prior authorization.

3. **Enhanced consumer communications.** Paying attention to the consumer and providing high-quality experiences are parts of payers' business models, especially those transitioning to value-based care. They are metrics on which providers are rated by payers and how certain public payers, such as Medicare Advantage plans, are rated as well. As a result, consumers must be given meaningful and transparent pricing information for their costs of care. Payers must evaluate and improve how they communicate drug pricing information to consumers. The same goes for pharmaceutical manufacturers.

4. **Improved data quality.** Payers also must improve their data quality so patients and providers can make informed decisions about which medications will work best and what affordable alternatives may be available. As mentioned previously, there are problems with the quality and accuracy of the F&B files used in ePrescribing. These data quality issues must be fixed if the information is to be used — and trusted — by prescribers.

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Development of the RTPBC and RTMBC represents a beginning of the end of the decades-long disconnect in drug costs for patients. Realization of the benefits of integrating these transactions into ePrescribing will take time but there is a huge potential on the horizon to improve the patient's experience and avoid cost-related disruptions in care. •

Want to know more? Reach out to us at **jocelyn.keegan@pocp.com** *and* **pooja.babbrah@pocp.com**

2 Part 2: High Impact: Opioid Legislation Effects ePrescribing, ePA and PDMPs

By Tony Schueth, Editor-in-Chief

Sweeping new legislation was signed into law on October 24, pulling together 70 bills from both sides of the aisle to address various aspects of the opioid epidemic. The new law is the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the **"SUPPORT for Patients and Communities Act" (aka HR6** and Public Law 115-271). Among its dozens of treatment, prevention and enforcement provisions are several that directly impact electronic prescribing (ePrescribing), electronic prior authorization (ePA) and prescription drug monitoring programs (PDMPs).

ePrescribing. Section 2003 mandates that prescriptions for all controlled substances covered under Medicare Part D must be transmitted electronically beginning on January 1, 2021, with a few exceptions. Requiring electronic prescribing of con-

trolled substances (EPCS) will give a needed shot in the arm to use of this transaction. That is because we expect prescribers who are required to use EPCS for Part D prescriptions will ePrescribe controlled substances for commercial lives as well. In addition, private payers and states are likely to follow suit and require EPCS for all controlled substance prescriptions, not just a subset.

Although EPCS adoption has lagged generally, it has shown strong growth in states where EPCS has been mandated. This trend will spread nationwide as a result of this new national mandate. We know that physicians respond to mandates. For example, Surescripts data shared at the last National Council for Prescription Drug Programs (NCPDP) meeting show EPCS jumped in response to mandates in Maine and Connecticut, rising from virtually zero in January 2018 to nearly 50% by mid-September in Maine and 43% in Connecticut.

Now physicians (the vast majority of whom treat Medicare patients) will have to get onboard. The impact of adoption should be minimal. Virtually all electronic health records (EHRs) — the most frequently used method for ePrescribing — are already compliant with EPCS standards required by the **Drug Enforcement Administration (DEA)**.

At the same time, the costs of prescriber adoption — a major barrier — are coming down, and the widespread availability of biometric authentication on computers and smart phones is helping to ensure security. The DEA has already approved biometrics as an authentication method for sending controlled substance prescriptions electronically. The new law calls for updated guidance on their use as part of Section 2003.

Electronic prior authorization. ePA has been around for a while but has not experienced the adoption uptick originally expected. The new law should change that. Section 6062 mandates that all covered Part D drugs requiring prior authorization (PA) must be electronically submitted to Part D sponsors and processors electronically — and responded to electronically — by January 1, 2021. Those ePA transactions must use an as yet-to-be named standard specified by the Secretary of the Department of Health and Human Services (DHHS). In addition, facsimiles, proprietary payer portals that do not meet standards specified by the Secretary, or electronic forms don't count as complying with the law.

All covered Part D drugs requiring prior authorization (PA) must be electronically submitted to Part D sponsors and processors electronically — and responded to electronically — by January 1, 2021.

A potential challenge is that a standard has yet to be named by the Secretary. There is a choice of two. There is the ePA standard from the NCPDP, which is part of NCPDP's SCRIPT standard used today for ePrescribing. The second is the ASC X12 278, the Health Care Review and Response transaction. The 278 is among the suite of standards named under the Health Insurance Portability and Accountability Act, but so far has not been widely implemented. Resolution concerning use of one or both standards is likely to come from the National Committee on Vital and Health Statistics (NCVHS). NCVHS is the federal advisory group charged with recommending health data standards to DHHS after consulting various stakeholder groups, including those mentioned in the legislation. This needs to be done sooner rather than later so an implementing regulation for NCVHS' recommendation can be drafted and issued with enough time for stakeholders to comply.

The lack of a named ePA standard has several consequences. The first is that many states will have to change their legislation to comply by specifying use of the ePA transaction, whatever DHHS decides to use, and eliminate the use of facsimiles, noncompliant provider portals and electronic forms. So far, slightly more than half the states have adopted or are considering legislation or regulations addressing ePA. However, many don't specify a standard and only require an online system to receive PA requests electronically — the details of which can vary from state to state.

A second issue is that this standards vacuum will lead to more retrospective PA. Retrospective PA is better than fax, phone and paper but nonetheless a burdensome, usually propriety process in which PA is sought after the prescription has been rejected at the pharmacy by the payer. Retrospective PA frequently results from missing or incomplete data in the current ePrescribing process. In an EHR, ePA is triggered based upon an indicator, or flag, in the formulary and benefit (F&B) file provided by the payers and

pharmacy benefit managers. However, the PA flag is frequently not populated by commercial payers. Even when the flag is provided, the need for PA is not always accurately presented. These inaccuracies, plus the traditional manual paper and fax-based PA process, result in delays and frustration.

Innovative solutions are on the horizon. Artificial intelligence (AI) is one that some organizations are testing to predict if a PA will be required. Another is the real-time pharmacy benefit check (RTPBC), which provides real-time patient-level information at the point of prescribing, pulled directly from the payer's claims system, which is where the most accurate and timely information is stored. It enables the prescriber to see patient-specific plan restrictions (such as PA and step therapy), true out-of-pocket costs for a medication (specific copay/coinsurance amount) and specific deductible information. This will prevent dispensing delays caused by inadvertent prescribing of a drug that is not covered by the patient's insurance or requires an expensive copayment. Even with these innovations, the need for F&B files will not go away with the advent of RTPBC. Rather, they will evolve to support RTPBC by consistently alerting prescribers of the need to perform a PA due to due to mitigating factors, such as noncovered drugs. Thus, eligibility-informed formulary is still important because it helps determine whether a PA is needed. The bottom line is that payers must address the shortcomings in F&B data at the same time as they are innovating with AI and RTPBC.

A third issue is that the law speaks to ePA for medications covered under a patient's pharmacy benefit. However, a significant number of prescriptions for drugs and medical devices are covered under the patient's medical benefit. The industry is working to address the gap for medical ePA, but this effort is in its early stages. (**Click here for our article on the need for medical prior authorization.**)

PDMPs. PDMPs are state-specific databases of controlled substance prescriptions. Electronic consultation of PDMPs before the prescriber "writes" the prescription is viewed as an effective way to prevent drug diversion, overprescribing and doctor shopping – and is required in many states.

The SUPPORT for Patients and Communities Act has numerous provisions related to making PDMPs more interoperable. Under Sections 7161 and 7162, states, the District of Columbia, US territories and others will be eligible for grants to implement, enhance and improve various PDMP functionalities. These include improved and interoperable sharing and accessing of controlled substance prescribing data across the states; integration of PDMP data into EHRs and the "health IT infrastructure" workflow; and "integration of automated queries into clinical workflow to improve the use of such data analytics by practitioners and dispensers." Other interoperability-related provisions include sharing dispensing data across state lines in real time and linking PDMP data with other data systems within the states, such as those for coroners, the Department of Veterans Affairs and the Department of Indian Affairs.

Receipt of the grant money requires that a state must have a PDMP program in place, which likely puts additional pressure on Missouri as the sole state without a true statewide PDMP program. These provisions will require states to revisit their legislation to sync up with requirements in the SUPPORT for Patients and Communities Act. We expect states will also revisit legislation due to Section 1016. This addresses PDMP data sharing for Medicaid, granting authority for state laws to permit sharing of data among providers, as permitted by state law.

The statute also allows the DHHS Secretary to issue guidelines specifying a uniform electronic format for the reporting, sharing, and disclosure of information pursuant to PDMPs.

The requirements in these sections are to be overseen federally by Centers for Disease Control and Prevention, in coordination with the Office of the National Coordinator for Health Information Technology. Timing and amounts of the grant awards were not specified. Many of the activities are suggested but not required, which begs the question of whether they actually will be implemented without a real mandate in place. •

Want to know more? *The SUPPORT for Patients and Communities Act has numerous other provisions of interest to stakeholders, including expanding use of telehealth in Medicare for substance abuse treatment and expanding eligibility for medication therapy management for beneficiaries at risk for substance abuse. Contact Keith Fisher (keith.fisher@pocp.com), who co-leads our Regulatory Resource Center (RRC). We can provide a complete look at the act's provisions, as well as explain the depth of information available from the RRC on laws and regulations pertaining to ePrescribing, ePA, and other topics of interest. Drop me a line (tonys@pocp.com) if you'd like to know more about the changing health IT landscape and what it means for your organization.*

3 Part 3: Looking Back at 2018 Predictions: How'd We Do?

By *Tony Schueth*, *Editor-in-Chief*

Every January for the past several years, we've made predictions about key trends that should affect health information technology (health IT), electronic prescribing (ePrescribing) and the exchange of various types of health data in the coming year. We thought it might be interesting to circle back and see how our predictions panned out. Here's the rundown of predictions for 2018, where things landed and how we graded ourselves.

1. Biosimilars. We got ahead of the curve on this one. Biosimilars are poised to take off because insurers, the government and other health care stakeholders believe biosimilars will offer comparable clinical utility at a lower cost versus reference drugs. Five biosimilars were **approved by the Food and Drug Administration (FDA) in 2018**, the same number as 2017. Regulatory and competitive barriers continue to be addressed. The FDA is working on one of the biggest remaining barriers: drug manufacturers' extending patents to stifle competition on branded drugs. This is important because a number of drugs are scheduled to come off patent, opening the door for biosimilars.

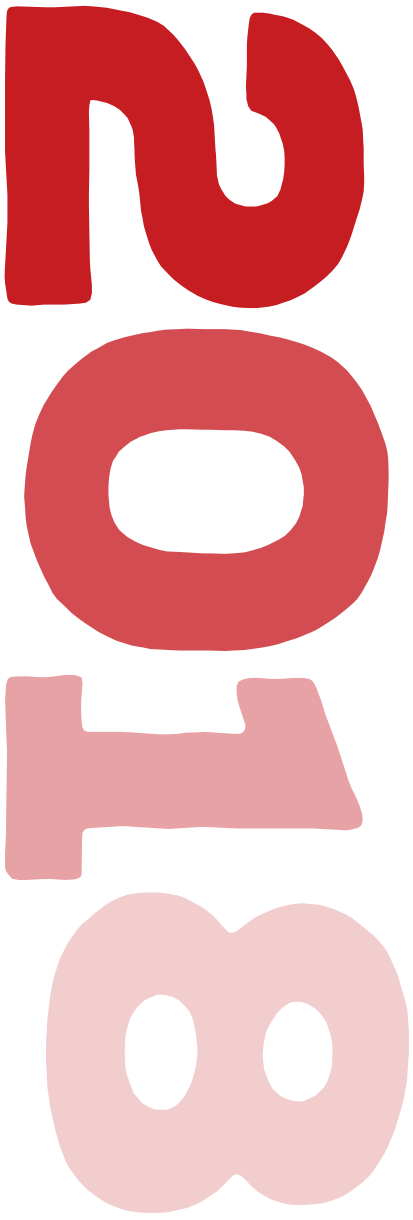
Grade: Way ahead of ourselves.

2. Blockchain. A data structure of **ordered "blocks"** that cannot be changed, deleted or otherwise modified, blockchain was widely hyped as a trend in 2018. As we reported in January, just about every large health care organization reported actual and expected investment in blockchain technology.

That said, its use didn't exactly trickle down to the health IT ecosystem as soon as we expected. However, **startup applications are springing up like mushrooms**. Examples include using blockchain in electronic health records (EHRs) to help track patients through their entire postacute care journey, health data analytics (using blockchain as a service) and managing personal health records.

Grade: Way ahead of ourselves.

3. Electronic prescribing of controlled substances (EPCS). Earlier in the year, we predicted that EPCS will experience an accelerated uptick in adoption in 2018, along with the rapid increase in controlled substance prescription volume seen over the past couple years. That is coming to pass, according to unpublished Surescripts data. At the last National Council for



Prescription Drug Programs (NCPDP) workgroup meeting, they showed new EPCS transactions jumped from 5 million in January to around 10 million at the end of the summer. About a quarter of prescribers using Surescripts' network now are active EPCS users, growth that has increased by over 50% in just the past month. This is due to several factors. The first is state legislation. EPCS transaction volume initially was driven by mandates in four states (New York, Minnesota, Connecticut and Maine). Active EPCS prescribers jumped in response to mandates in Maine and Connecticut, whose requirements recently went live. They rose from virtually zero in January 2018 to nearly 50% by mid-September in Maine and 43% in Connecticut.

Volume will likely respond upward even more quickly in the next couple of years as 11 more states will require EPCS for some or all controlled substances within the next few years; five more have similar bills pending in their legislatures. This is putting pressure on providers to adopt EPCS in response to the opioid epidemic. Providers are finally beginning to invest in and use EPCS infrastructure because it's time and, in part, it will help them meet required quality reporting targets for Medicare and other payers. Vendors are ready, so preparedness that is no longer problematic. **The costs for prescriber adoption** — a major barrier — are coming down.

However, EPCS will get a huge boost in the next couple of years from legislation that was unknown in January: the newly enacted **SUPPORT for Patients and Communities Act (HR6)**. It requires that all scheduled drugs covered under Medicare Part D must be electronically prescribed beginning January 1, 2021. **(Click here for our analysis of the legislation in this issue of *HIT Perspectives*.)** We expect this, in turn, will push private payers and states to adopt similar requirements. It is likely that physicians who are required to use EPCS for Part D prescriptions will use EPCS for all prescriptions. The act's regulatory mandates will push physicians to adopt EPCS sooner rather than later.

Grade: On target.

4. **ePA.** We predicted in January wider adoption of electronic prior authorization (ePA) for pharmacy transactions. To be sure, progress was made but many unknowns still remain. For example, a couple dozen states require support of ePA, with many specifying use of the ePA standard from the NCPDP. Several other states are working on ePA legislation, but requirements vary across jurisdictions and are not all standards based. How that affects adoption has yet to be determined.

At the same time, progress was made by pharmacies and payers in terms of commitment to ePA implementation. According to CoverMyMeds, all pharmacies are committed to an ePA solution in 2018, as are 96% of payers and 80% of EHRs.

That said, adoption by health care providers is still not what it could be. For example, 70% do not know that prior authorization (PA) is needed when prescribing certain medications. That is because the field is frequently not populated by commercial payers in the formulary and benefit (F&B) files used for ePrescribing. The reasons for this omission are not fully understood. A workaround is on the way in terms of the real-time pharmacy benefit check (RTPBC). The RTPBC's response to a prescriber's inquiry will indicate if PA is needed. However, the RTPBC is a fairly new transaction. The breadth and depth of its adoption are unknown.

There also was continued movement in 2018 toward automation and standardization of electronic medical prior authorization. (**Click here to read more about it.**) There is growing interest in medical ePA because of the intensive paper-based process for PA on specialty drugs covered under the medical benefit.

Grade: Somewhat ahead of ourselves.

5. **FHIR.** The health IT world is still, well, on fire due to the accelerating adoption of FHIR (the Fast Healthcare Interoperability Resource). This draft standard will be finalized as a **blockchain in electronic health records (EHRs)** toward the end of this year. Widely deployed in draft standard format across EHRs, vendors and providers, FHIR provides normalized data formats and elements (known as "resources") and **application programming interface(s)** (API) for exchanging data with EHRs. FHIR differs from previous standards because it uses existing common, modern, Web-based suites of API technology. A driving force for promoting payer adoption of FHIR is the DaVinci Project, which got off the ground midyear. **DaVinci is a multistakeholder group** that is developing value-based care use cases for data exchange that leverage the FHIR standard. We're honored to be its program management organization.

Grade: On target.

6. Information blocking. Information blocking has been all the buzz for the past couple of years. It resulted in requirements in the 21st Century Cures Act prohibiting the practice. We included it as a trend for 2018 because of an anticipated regulation spelling out the details. So far, that regulation has not been promulgated — we suspect, in part, because the government had difficulty defining it. Frankly, a lot of what some people call information blocking is really not so much a technology challenge as a business one. The competitive nature of health care delivery is primarily what prohibits the exchange of clinical information — competitors don't want to make it easy for patients to seek care outside their networks.

Grade: On target.

7. Interoperability. As just about every item on this list indicates, interoperability is no longer just a buzzword. The public and private sectors both saw significant progress in exchanging clinical and administrative data in 2018. We noted in January that an emerging area of emphasis is improving patients' access to their data. This is top-of-mind at the Centers for Medicare and Medicaid Services (CMS), which rolled out its **MyHealthEData** initiative and **Blue Button 2.0**. On the private side, Apple debuted its new **"Health" application (app)** for users of newer iPhones and iPods. Users can download their records from a certain number of participating provider organizations such as Cleveland Clinic. While consumers are rapidly adopting the Apple app, beneficiary uptake of BlueButton 2.0 is minimal, although over 1,200 developers are interested. This captures the current state of interoperability: many are interested in various facets and progress has been made, but significant adoption challenges remain.

Grade: On target.

8. Medication adherence. Medication adherence is a long-standing problem that emerged from the shadows in 2018. Payers, in particular, called it out as a driver of health care costs and poor patient outcomes, which resulted in growing demand for drug price transparency at the point of prescribing. We made progress in 2018 in better understanding the problem and creating new and improved solutions. Efforts also ramped up to better connect patients with the costs of their expensive specialty medications, thus reducing noncom-

pliance, poor outcomes and unnecessary costs.

Grade: On target.

9. **Patient identifier.** It seems as though everyone keeps talking about the need for a universal patient identifier, which is key for achieving interoperability. It is needed to accurately associate patients with their records among various providers and within and across payers and health systems. While many efforts are underway to develop a patient identifier, none have emerged a clear winner. Meanwhile, the government still is prohibited by statute from developing an individual patient identifier. Patient identification is one use case in which Blockchain makes sense for exchange of patient clinical information. **Grade: Slightly ahead of ourselves.**

10. **PDMPs.** Prescription drug monitoring programs (PDMPs) are state-run databases of prescriptions for opioids and other kinds of controlled substances, depending on the locality. As such, they are viewed as key to addressing the opioid crisis by preventing drug diversion, doctor shopping and opioid overprescribing. States worked in 2018 on legislation surrounding use and interoperability of PDMPs, including mandates to consult the PDMP before creating or filling prescriptions for all or some scheduled drugs; requiring better interstate data sharing; and removing barriers caused by varying state laws concerning who can access PDMP data and under what circumstances. Section 7162 of the newly enacted SUPPORT for Patients and Communities Act is devoted to improving PDMP interoperability. In the near future, this also will help drive interoperability, including better integration of PDMP data in the workflow.

    Grade: On target.

11. **RTPBC.** The real-time pharmacy benefit check provides more accurate information in real time to the health care provider directly from the pharmacy benefit manager, based on patient-level plan data. Work continued by NCPDP in 2018 on developing standard formats and one implementation guide for the real-time exchange of pharmacy benefit data. In the absence of a standard, several proprietary solutions have entered the market. Their transaction volume is rapidly increasing, indicating value. At the same time, the RTPBC is viewed as a method for creating drug pricing transparency at the point of prescribing. This should lead to improved patient satisfaction and medication adherence, which are key metrics for value-based care organizations. All these drivers indicate accelerating adoption and usefulness of the RTPBC in the near-term.

    Grade: On target.

12. **Specialty pharmacy automation.** Standardized specialty pharmacy automation continued to make progress in 2018. NCPDP created a specialty pharmacy workgroup, which will identify challenges to automated data exchange in specialty pharmacy and how they might be addressed through the NCPDP standards-setting process. A separate workgroup is working on an enrollment standard for specialty pharmacy — a needed building block for end-to-end automation. Stakeholders continue to push for specialty pharmacy automation to improve speed to therapy and better manage the use of high-cost specialty medications.

    Grade: On target.

13. **Virtual visits.** Telehealth continues to be one of the fastest growing segments of health care. In 2018, the virtual doctor was in — providing diagnosis, treatment and remote patient monitoring to patients all over the country, not just in rural areas. The **percentage of health care organizations using telehealth** rose from 63% in 2015 to 74% in 2018, a statistic that continues to increase daily. Usage barriers continued to be addressed, including cross-state licensing for doctors and reimbursement under Medicaid and Medicare. An example is the new provisions in the SUPPORT for Patients and Communities Act, which expands telehealth services in Medicare for substance abuse treatment. A new telehealth CPT code for remote patient monitoring (99091) was added in 2018 to facilitate Medicare payment and billing. CMS also is **proposing to expand telehealth coverage** for Medicare Advantage plans. Virtual visits skyrocketed by hospitals, physicians and pharmacies. Patients linked up through the Web and their smart phones.

    Grade: On target. •

Keep up with the trends at Point-of-Care Partners (POCP). Our **Regulatory Resource Center (RRC)** *tracks state and federal legislation and regulations related to opioids, ePA and other topics of interest. Contact Keith Fisher (***keith@pocp.com***), who is the center's co-lead. POCP subject matter experts can update you on the health IT landscape, breaking developments and where things are heading in the future. Drop me a line (***tonys@pocp.com***) and I'd be happy to put you in touch.*