Issues in Missouri Health Care 2011

Buying Value:
Improving the Quality of Missourians' Health Care

Acknowledgement

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm, and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, tmcauliffe@mffh.org.

Issue Statement

Missouri spends $31 billion on health care each year, or $5,444 per person,[1] slightly higher than the U.S. average of $5,283. However, higher expenditures do not equate with better outcomes. Missouri ranks in the bottom third of states on key indicators of quality and health outcomes.[2] The residents of Missouri could get better value for their health care dollars with improvements in the quality of care and patient safety. State health policy plays a vital role in making this happen.

Background

Quality care is providing the right care at the right time in the right place. Far too often, patient care fails to meet this standard. Poor quality generally takes the form of overuse, underuse, misuse, or some combination. Some ineffective services are vastly overused, while other types of care that could prevent illness are seriously underused. Medical errors occur in all parts of the health care system, from prescribing contradictory medications to operating on the wrong limb. One third of health care that is delivered in the U.S. is estimated to be of questionable value; nearly half of all Americans do not receive recommended preventive or primary care (45%)[3]; and about 98,000 deaths a year are attributed to preventable medical errors.[4]

Opportunities to Improve Quality of Care in Missouri

Missouri ranks 36th among the 50 states in quality of care according to The Commonwealth Fund, a national health care foundation.[5] Just 42 percent of adults age 50 or older receive recommended screening and preventive care in Missouri. Among adults with diabetes, 44 percent receive recommended preventive care. Children fare better; 77 percent of Missourians aged 19 months to 35 months get all recommended immunizations. In 2003, there were nearly 28,000 preventable hospitalizations and readmissions among Missouri's elderly. On the positive side, Missouri does better than average on the quality of care delivered to patients in the hospital.

Greater use of preventive care

Improving the quality of care can improve health care outcomes and reduce health care spending. The Commonwealth Fund estimated the benefits to Missouri residents if the state's performance on nationally recognized quality indicators matched that of the highest ranked states in the nation:

---

1 Kaiser State Health Facts. www.statehealthfacts.org. Accessed September 17, 2010. Expenditure data include all privately and publicly funded personal health services. Health insurance administration, research, and construction are excluded.

2 Cantor, J.C. et al. October 2009. *Aiming Higher: Results from a State Scorecard on Health System Performance*, 2009. The Commonwealth Fund. http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/2009-State-Scorecard.aspx?page=all. Accessed September 24, 2010.

3 McGlynn, E.A., et al. 2003. The quality of health care delivered to adults in the United States. *The New England Journal of Medicine*, 348(26): 2635-2645.

4 Institute of Medicine. *To Err is Human: Building a Safer Health System.* National Academies of Science Press, Washington, D.C., 1999.

5 Cantor, et al. 2009. Accessed September 24, 2010.

- 183,281 more adults aged 50 and older would receive recommended preventive care such as colon cancer screenings, mammograms, Pap smears, and flu shots at appropriate ages;
- 81,116 more adults aged 18 and older with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications; and
- 18,056 more children aged 19 months to 35 months would be up-to-date on all recommended doses of five key vaccines.

Reduction in avoidable hospitalizations

Improving the quality of health care services in Missouri has the potential to reduce hospital admissions by tens of thousands each year, lowering costs by hundreds of millions of dollars. Improving the state's quality of care to levels similar to that of the highest ranked states could lead each year to:

- 20,911 fewer preventable hospitalizations for ambulatory care sensitive conditions among Medicare beneficiaries aged 65 and older, at a savings of $121 million;
- 5,150 fewer hospital readmissions among Medicare beneficiaries aged 65 and older, at a savings of $60 million; and
- 3,829 fewer long-stay nursing home residents hospitalized, at a savings of $25 million.

Patient Protection and Affordable Care Act: Quality Improvement Initiatives

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions to address quality improvement in the nation's health care system. The ACA supports health care quality by funding research and innovations in patient care, collecting and reporting quality measures, coordinating administrative processes, and piloting payment reforms.

Research and Innovations to Improve Quality

- *Private, nonprofit Patient Centered Outcomes Research Institute*: The Patient Centered Outcomes Research Institute is charged with establishing and carrying out a research agenda that serves to advance and improve the quality of health care outcomes research. The Institute will conduct primary research such as clinical trials and systematic reviews and assessment of existing and future research.[6]
- *Center for Medicare and Medicaid Innovation (CMI*): The purpose of the CMI is to "test innovative payment and service delivery models" to reduce program expenditures under Medicaid and Medicare while "preserving or enhancing the quality of care."[7] Among other

6 Section 6301(b) of Patient Protection and Affordable Care Act (ACA).
7 Section 3021 of the ACA.

functions, the ACA directs CMI to develop and test patient-centered medical home models and other approaches that improve care management and coordination between providers.

- *National Strategy for Quality Improvement in Health Care:* The Secretary of the Department of Health and Human Services (HHS) is charged with developing a national strategy for quality improvement with the following requirements included:
  - Have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;
  - Identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;
  - Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques;
  - Improve federal payment policy to emphasize quality and efficiency;
  - Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;
  - Address the health care provided to patients with high-cost chronic diseases;
  - Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections; and
  - Reduce health disparities across health disparity populations and geographic areas.[8]

Collecting and Reporting Quality Measurement

- *Medicaid Quality Measurement Program:* The ACA directs HHS to develop, test, and disseminate quality measures for adults in Medicaid[9] through a process similar to the child health quality measure development process included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The child health quality measures were published in January 2010 and can be used by states to improve pediatric health care quality in the Children's Health Insurance Program (CHIP) and Medicaid programs.[10]
- *Quality Measurement Identification for all public programs:* The Secretary of HHS, in coordination with the Agency for Health Care Research and Quality (AHRQ), is responsible for, on a triennial basis, identifying gaps in quality measures across all public programs and making recommendations for eliminating the gaps.[11]

---

8 Section 3011, ACA.
9 Section 2701(b)(5).
10 A list of the Core set of Pediatric Health Care Quality Measures can be found at http://www.ahrq.gov/chipra/listtable.htm. Accessed September 18, 2010.
11 Section 3013, ACA.

Coordination of Administrative Functions

- *Federal Coordinated Health Care Office:* The ACA requires that the Centers for Medicare and Medicaid Services (CMS) establish a Federal Coordinated Office of Health Care to address care coordination problems associated with dually-eligible Medicare and Medicaid beneficiaries. The goals are to more effectively integrate benefits and improve coordination between the federal and state governments.[12]
- *Interagency Working Group on Streamlining Federal Quality Activities:* The ACA provides for the establishment of an interagency workgroup, headed by the Secretary of HHS, to collaborate on quality, avoid duplication of effort, streamline quality reporting and compliance requirements, and assess alignment of quality efforts in the public and private sector.[13]

Payment Reform

- *Accountable Care Organization (ACO) Incentives Pilots:* The ACA establishes ACO pilot programs for pediatric providers and Medicare, with the goal of improving care coordination and efficiencies of health care services. The ACO pilot includes payment incentives for providers who meet or exceed established quality standards and cost savings goals.[14,15]
- *Other Medicare-specific payment reforms:* The potential exists that payment reforms established by the ACA for Medicare may be transferable to the Medicaid program, such as a provision to develop a value-based purchasing pilot in traditional Medicare (October 2012), a national pilot on payment bundling and care coordination (January 2013), and a provision to pay physicians based on quality standards (January 2015).

States Have Influential Role to Play in Advancing Quality Improvement

States have considerable influence over health care quality through their roles as purchasers of health services, regulators of providers, and supporters of innovation. They can use these levers to improve quality and patient safety, and safeguard the public.

Key strategies states are pursuing to improve quality include:

- Leveraging the purchasing power and opportunities to coordinate quality standards through Medicaid, state employee health programs and other state agency purchasers;
- Engaging providers and consumers by collecting and publicly reporting data on medical errors and adverse events;

12 Section 2602, ACA.
13 Section 3012, ACA.
14 Section 3022, ACA.
15 Section 2706, ACA.

- Promoting adoption of Health Information Technology (HIT) and Health Information Exchange (HIE) so that providers and consumers have safe, reliable systems underlying their decisionmaking; and
- Adopting payment reform approaches in Medicaid such as payment bundling, and ACO pilot programs.

This brief summarizes policy options relevant to these key strategies and provides examples in other states along with a summary of Missouri's progress on these fronts.

Leverage Coordinated Approach to Quality

State government is responsible for 25 percent of all health spending in Missouri.[16] As a major purchaser of health care—for state employees, Medicaid beneficiaries, wards of the state, and residents who receive public health services—Missouri has the purchasing power to demand high quality from providers. The state pays for poor quality care when it is the result of overuse, underuse, or misuse of health care services.[17] Missouri can use its purchasing leverage to improve quality and patient safety by rewarding high quality and safe performance, and encouraging correction of poor performance.

Standardize Performance Measures Used for Purchasing High Quality Care

States are leveraging their purchasing power for quality in a variety of ways. Medicaid, state employee health programs, and other state agencies that purchase health services are:

- Building quality and safety standards into their contracts with health plans and providers that include requirements for reporting on quality and safety measures;
- Using standard contracting language, performance measures, reporting requirements, and quality incentives (i.e., pay-for-performance or P4P) to create more value per state health care dollar and create greater efficiencies for providers;
- Issuing joint requests for proposals (RFPs) for health services, which may include managed care, behavioral health, prescription drug benefit management, quality and patient safety data collection and reporting; and
- Forming multi-payer purchasing coalitions with private purchasers to make measurement, reporting, and incentive programs uniform for providers and to establish common benchmarks for improvements in quality and safety.

Align Quality Improvement and Health Outcomes Goals across State Agencies

A state's leverage to drive quality improvements and efficiencies in the health care system is enhanced when an agency has a contract or grant requirement specifically designed to support

16 Kaiser State Health Facts. Accessed September 18, 2010.

17 Hess, C. et al. 2008. *State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health Systems Performance*, National Academy for State Health Policy. www.nashp.org/Files/shapes_report.pdf. Accessed September 18, 2010.

the goals of another state agency or program. For example, a Medicaid program could require health plans to work with local public health departments on strategies to improve immunization rates. Sister agencies can also share data and the costs of data collection and reporting related to mutual health care goals, such as improving immunization and lead screening rates.

The ACA and CHIPRA both provide states with additional structure regarding standardization of quality measurement across populations. Per CHIPRA, HHS established a core set of child health quality measures for states to use in their Medicaid and CHIP programs. In the same manner, the ACA requires the establishment of adult health quality measures for Medicaid.[18]

Reward High Quality

While not a new idea, value-based purchasing efforts are gaining more attention given the provisions included in the ACA. The law directs the Secretary of HHS to develop plans for Medicare value-based purchasing in hospitals,[19] skilled nursing facilities, home health agencies,[20] and ambulatory surgical centers.[21] These initiatives will require standardization of quality measures as well as public reporting. Importantly, these initiatives, along with the ACO, CMI patient care models, and other payment reform pilots, may be directly transferable to Medicaid and have the potential to drive quality improvements for the program's highest expenditure service categories (i.e., aged, disabled, and dual-eligibles).

As the largest purchasers of nursing home care services in their states, Medicaid programs have considerable purchasing power to promote improvements in quality of care provided by their state's skilled nursing facilities. Missouri spends $2.5 billion annually on nursing home care.[22] On average, state Medicaid programs pay 46 percent of the total bill.[23] Georgia, Iowa, Minnesota, Ohio, and Oklahoma have used their purchasing power to implement nursing home quality improvement P4P initiatives, and Virginia is working toward one. The initiatives typically include financial incentives that target improvements in resident outcomes using the Minimum Data Set, staffing-level measures, certification survey deficiencies, and resident/family quality of life surveys.

Potential Strategies for Missouri to Leverage Purchasing Power for Quality Improvement

Building on its efforts to date, Missouri should consider examining other states' multi-purchaser P4P initiatives to gain valuable insights. These include the states of Minnesota, Maine, Washington, and Virginia.

---

18 Section 2701, ACA.
19 Section 3001, ACA.
20 Section 3006, ACA.
21 Section 10301, ACA.
22 www.statehealthfacts.org. Accessed September 18, 2010.
23 Ellen O'Brien. 2005. *Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net*? http://ltc.georgetown.edu/pdfs/nursinghomecosts.pdf Accessed September 18, 2010.

- *Example:* Minnesota seeks to realize savings to the public by insisting on stringent quality and safety standards in state health contracts. Standards and payment incentives across state agencies, including Medicaid and the state employee health plan, had to align to meet benchmarks of improved patient safety and quality of care by 2010.
    - Study feasibility of requiring state health programs, particularly MO HealthNet and state employee health benefit plans, to issue RFPs with uniform requirements regarding the collection and reporting of quality and patient safety measures.
- *Example:* The Maine state employee plan participates in an ad hoc group that includes five large purchasers from both the public and private sectors. This group has agreed to a set of purchasing principles and RFP language related to patient safety and quality performance.
    - Align goals and requirements of MO HealthNet and other health-related service agencies with state public health priorities.
- *Example:* The Washington Medicaid program jointly supports the state Department of Health's Child Profile health promotional materials and immunization registry.
    - Convene a stakeholders' group to research the cost, benefits, and feasibility of implementing a state P4P initiative that targets skilled nursing homes in Missouri.
- *Example:* Virginia is actively designing a comprehensive Medicaid nursing home P4P program that could be a model for Missouri.[24]
    - The state should also consider examining the potential to pilot ACO and payment bundling models to better coordinate care and reward quality improvements.
- *Example:* Community Care of North Carolina (CCNC) is administered by the state Medicaid agency. Through a performance incentive agreement that is akin to the ACO model, each of the 14 regional physician-led provider networks focuses on care management and shares in the savings that are achieved as a result of improvements in quality and cost reductions.
- *Example:* Missouri physician practices may apply to take part in a federal pilot program on payment bundling for acute inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.[25] One example of bundling in Medicare is a global surgical fee—a single payment covering all preoperative care and postoperative follow-up care, as well as the surgery itself. Another example is the Medicare prospective payment for inpatient hospital services, which covers hospital costs for the duration of a patient's stay.

Missouri's Progress in Leveraging Purchasing Power for Quality Improvement

The Missouri Health Improvement Act of 2007 was designed to be a blueprint for health care reform in the state. The legislation created a Professional Services Payment committee to

24 Medicaid Nursing Home Pay for Performance Working Group Recommendations. http://www.dmas.virginia.gov/downloads/pdfs/pr-MH_facil.pdf. Accessed September 18, 2010.

25 Section 3023, 2013-18, ACA.

develop P4P guidelines. The Missouri Health Improvement Act also created the MO HealthNet Oversight Committee to develop health improvement plans for all managed care participants. Missouri started the Chronic Care Improvement Program (CCIP) in November 2006. The CCIP program paid physicians to complete an initial assessment and manage a care plan for patients with chronic health conditions. The program also provided incentive payments for physicians who achieved certain quality gains. However, despite the program's potential and recognition as a trend-setter among state P4P programs, the CCIP vendor agreement was discontinued in 2009 due to the Medicaid program's severe budget shortfall.

Engage Consumers and Providers by Collecting and Publicly Reporting Data on Medical Errors and Adverse Events

More than 10 years ago, the Institute of Medicine (IOM) published its landmark report, To Err is Human: Building a Safer Health System. The 1999 report revealed that medical errors were the fourth leading cause of death in the United States.[26] Since then, the federal government's response has taken three primary paths:

- Funding systems of measuring and reporting medical errors;
- Increasing consumers' awareness and involvement in their own safety; and
- Denying Medicare payment for certain medical errors, called "never events."

A variety of private organizations also began to address professional training, process improvement, and safety standards.[27]

States have undertaken a variety of strategies to protect the public's health and safety. These include launching patient safety reporting systems, creating patient safety centers, making patient safety part of facility licensure requirements, joining purchaser groups devoted to patient safety, and providing patient safety educational materials to consumers and providers.[28] Some states also choose to publicly release data to improve accountability by informing consumers and payers about the quality of health care facilities.

Data Collection Mandates for Providers and Public Reporting

The IOM called on every state government to create a mandatory reporting system to collect information about adverse events that result in death or serious harm. As of February 2008, 39 states and the District of Columbia have implemented legislation or regulations that require hospitals and/or other facilities to report to a state agency on medical errors or adverse events,

---

26 Institute of Medicine. *To Err is Human: Building a Safer Health System.* National Academies of Science Press, Washington, D.C., 1999.

27 For example, the National Quality Forum, The National Committee on Quality Assurance, the Institute for Health Care Improvement, and the Hospital Research and Education Trust.

28 Buxbaum, Jason "Opportunities and Recommendations for State-Federal Coordation to Improve Health System Performance: A Focus on Patient Safety. State Health Policy Briefing. January 2010. National Academy for State Health Policy. http://www.nashp.org/sites/default/files/Patient_Safety_1-12-10.pdf Accessed September 18, 2010.

or that require reporting of judgments or settlements related to physician malpractice.[29] Twenty-six states have a mandate to publicly report data on hospital-based infections. The purpose of public reporting is to stimulate providers to focus on improving care processes to reduce errors that may cause bad health outcomes.

New provisions included in the ACA require physicians and nursing homes to report on Medicare quality measures that will be posted on an HHS website for public comparison. Also, the Secretary of HHS is required to develop a list of quality metrics that must be reported by long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs. The data will be made publicly available by HHS. [30,31,32] Additionally, the law mandates data collection on various metrics to track progress toward the elimination of health disparities.[33]

Not Paying for Poor Quality

The National Quality Forum reached a consensus on 28 "never events"— occurrences that should never happen in a hospital and can be prevented.[34] At least 20 states have passed legislation or are considering policies denying Medicaid payment to hospitals for never events.[35]

Missouri's Progress in Reducing Medical Errors and Adverse Events

Missouri's approach to patient safety has been mostly private and voluntary. The Missouri Hospital Association (MHA), the Missouri State Medical Association (MSMA) and Primaris established the Missouri Center for Patient Safety (MOCPS) in response to recommendations from the Governor's Commission for Patient Safety in 2004. The primary goal of MOCPS is to serve as a central resource of patient safety information for providers, physicians, consumers, and others by:

- Creating and maintaining a voluntary, confidential reporting system that is consistent with national patient safety organization criteria;
- Establishing a focus for improvement activities; and
- Identifying best practices for sharing.[36]

29 Kaiser State Health Facts. Accessed September 18, 2010.
30 Section 10331, AC.
31 Section 6103, ACA.
32 Section 3004, ACA.
33 Section 4301, ACA.
34 National Quality Forum. www.qualityforum.org. Accessed September 22, 2010.
35 #08-004 State Medicaid Director Letter http://www.cms.gov/SMDL/downloads/SMD073108.pdf. Accessed September 18, 2010.
36 Missouri Center for Patient Safety. http://www.mocps.org/about/. Accessed September 24, 2010.

Reporting Hospital-Acquired Infections
The "Missouri Nosocomial Infection Reporting Act of 2004" was passed to decrease the incidence of infections in health care facilities in Missouri. It requires hospitals and ambulatory surgical centers to report specific health care-associated infections to the Missouri Department of Health and Senior Services (DHSS).[37] The Department releases annual public reports based on the information, which identifies individual health care providers.

Reporting Hospital Adverse Events
The Missouri Health Transformation Act of 2008 requires hospitals to report to MOCPS each serious reportable event in health care as defined by the National Quality Forum. MOCPS is required to publish an annual report to the public on reportable incidents. By 2010, hospitals were not allowed to charge for, or bill any entity for, all services related to the reportable incident.

Potential Strategies for Missouri to Improve the Safety and Quality of Patient Care
Building on its efforts to date, Missouri should consider:

- Continuing to move from voluntary to mandatory reporting so that providers and payers can gain a better understanding of quality and safety problems in the system;
- Requiring that errors of a certain type of frequency trigger corrective action plans, and providing DHHS with resources to oversee the appropriateness and effectiveness of corrective actions; and
- Providing DHHS adequate resources to evaluate trends in reporting and outcomes including changes in utilization, readmission rates, and costs over time.

Support Health Information Technology and Exchange

Electronic health information systems have the capacity to improve the delivery and coordination of care, reduce medical errors, and provide a mechanism for tracking and assessing performance. The federal government, private sector, and many states are active—although not always well coordinated—in advancing new information systems and technologies in the health field.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided funding for Medicaid Health Information Technology (HIT) and Health Information Exchange (HIE) plan development to encourage providers to be "meaningful users" of health information technology. The federal government is projected to spend almost $300 million in support of HIE activities in 2009 and 2010. The ACA also provides significant funding for various HIT initiatives and establishes the CMI to test various models of patient care that leverage HIT and HIE to promote coordination.

37 Missouri Department of Health and Human Services. http://www.dhss.mo.gov/DataAndStatisticalReports/2009NosocomialReport.pdf. Accessed September 24, 2010.

States' Involvement in Supporting Health Information Exchange and Health Information Technology

Most states have public health information systems that integrate data from multiple sources. Immunization and vital statistic data are most common. Other data systems may include newborn screenings, laboratory, hospital discharges, hospital emergency services, and cancer registry. States can leverage financing of HIE and HIT through:[38]

- Demonstration or pilot initiatives;
- Encouraging or requiring use of health information exchange and technology in their purchasing roles; and
- Accounting for HIT-related costs in their payment policies. ARRA specifically provided for incentive funding to providers as they adopt electronic health records that meet certain meaningful use criteria, including improved quality, safety, efficacy, and care coordination.[39]

More than 190 electronic HIE initiatives are functioning across all 50 states. Of these, 57 HIEs reported being operational in 2009. Others are developing and revising legal structure through laws and regulations. The most significant challenge for all state efforts is addressing privacy and confidentiality issues.[40]

Progress in Missouri to Support HIT and HIE

The Missouri Health Information Technology Task Force report of 2006 provided a comprehensive assessment of the opportunities, challenges and status of HIT and HIE in Missouri, along with numerous recommendations.[41] The Missouri Health Improvement Act of 2007 established a Healthcare Technology Fund to support technological approaches to improving patient care and administrative efficiencies. In 2010, Missouri initiated its statewide HIE. The goal of the HIE is to "create a policy, technical, and financial foundation for providers to become meaningful users of electronic health records and to support health information exchange in Missouri."[42] Missouri's Medicaid program plays a leading role in this process and is undertaking significant efforts to develop a state Medicaid HIT Plan that ensures the Medicaid program is strategically integrated with statewide HIE networks and services. MO HealthNet also contracts with a HIT vendor to implement electronic health records and e-prescribing for participating Medicaid providers.

---

38 Hess, C et al. 2008.

39 ARRA, Section 4201, 2009.

40 e-Health Initiative. 2000 HIE Survey. http://www.ehealthinitiative.org/sites/default/files/file/2009%20Survey%20Report%20FINAL.pdf. Accessed September 24, 2010.

41 *Missouri Health Information Task Force Final Report*. September 2006. http://www.dhss.mo.gov/HealthInfoTaskForce/Report.pdf. Accessed September 18, 2010.

42 HMO-HITECH Governance Workgroup. http://dss.missouri.gov/hie/leadership/pdf2010/gov100505agenda.pdf. Accessed September 18, 2010.

Potential Strategies for Missouri to Use HIT/HIE to Improve the Safety and Quality of Patient Care

Building on its efforts to date, Missouri should consider:

- Using the newly created public-private HIE organization to set priorities for following through on the recommendations outlined in the 2006 HIT Task Force report;
- Coordinating HIT and HIE investments in the state (e.g., Healthcare Technology Fund, MO HealthNet, and private sector), to align quality measures for public reporting and performance-based contracting; and
- Using upcoming ACA provisions, such as the physician quality-based payment policies[43] (January 2015) as an opportunity to support providers in adopting HIT in health care practice.

43 Section 10327, ACA.