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# A Quality Strategy to Advance the Triple Aim in California's Medicaid Program

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## Abstract

The California Department of Health Care Services (DHCS) administers the nation's largest Medicaid program. In 2012, DHCS developed a Quality Strategy modeled after the National Quality Strategy to guide the Department's activities aimed at advancing the Triple Aim. The Triple Aim seeks to improve the patient experience of care and the health of populations as well as reduce the per capita cost of health care. An academic team was contracted to assist DHCS in developing the strategy, which also was informed by extensive stakeholder input, an advisory committee, and a comprehensive inventory of DHCS quality improvement (QI) activities. From 2012 to 2018, the strategy included 129 unique QI activities. Most activities were intended to deliver more effective, efficient, affordable care or to advance disease prevention. This qualitative assessment of the DHCS Quality Strategy provides insights that may inform other Medicaid programs or large health systems as they develop quality strategies.

## Keywords

quality improvement, strategic planning, health care reform, health care delivery

Systematic quality improvement (QI) is required to achieve the Triple Aim of (1) improving patient experience (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care.[1] Consistent with this concept, the Affordable Care Act (ACA) mandated the establishment of a National Strategy for Quality Improvement in Health Care (the National Quality Strategy [NQS]). In 2011, in response to this mandate, the Secretary of Health and Human Services submitted to Congress the first NQS.[2] Modeled after the Triple Aim, the NQS had 3 broad aims: to provide Better Care; to foster Healthy People/Healthy Communities; and to advance Affordable Care. To advance these aims, the NQS espoused 6 priorities (Table 1).

Because the NQS had national scope, in 2012, the California Department of Health Care Services (DHCS) began development of a state QI plan, modeled after the NQS but specifically tailored to the activities within the purview of DHCS. It was named the Strategy for Quality Improvement in Health Care (Quality Strategy, or QS). This article describes the process that DHCS took to implement the QS, the resulting QS framework, and DHCS' portfolio of QI activities that were part of the QS.

DHCS administers California's Medical Assistance Program, Medi-Cal. Medi-Cal is the nation's largest Medicaid program by number of members or enrollees. In fiscal year 2018, Medi-Cal's budget was approximately $100 billion, and it provided health insurance for more than 13 million low-income or disabled Californians, or about one third of adults and almost half of the children in the state.[3,4] The Department's experience with implementing a QS may help inform other state Medicaid programs interested in developing a QI blueprint to improve clinical quality and population health.

## Methods

Based on narrative descriptions from those involved in developing the QS and review of internal documents and DHCS QS reports from 2012 to 2018,[5] this article summarizes the process used to develop the DHCS QS and its qualitative outcomes.

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**Table 1.** National Quality Strategy Priorities.

| | |
|---|---|
| 1. | Making care safer by reducing harm caused in the delivery of care |
| 2. | Ensuring that each person and family are engaged as partners in their care |
| 3. | Promoting effective communication and coordination of care |
| 4. | Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease |
| 5. | Working with communities to promote wide use of best practices to enable healthy living |
| 6. | Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models |

## *Background and Context*

The DHCS QS was launched during a time of broad health care reform. Over the years, DHCS has striven consistently to provide the best possible health care and services while being a responsible steward of limited public funds.[6] These sometimes competing goals create a continual state of dynamic tension. In the years leading up to 2012, the confluence of health reforms catalyzed renewed emphasis on quality and outcomes. Following the 2010 passage of the ACA, Medi-Cal implemented "California Bridge to Reform," a Medicaid Section 1115 research and demonstration project intended to improve health outcomes and curb spending as the program expanded under the ACA.[7] It allowed DHCS to enroll uninsured persons in advance of full implementation of the ACA in 2014, transition the most vulnerable members into managed care, and test strategies to strengthen and transform the state's public hospital health care delivery system to prepare for the additional demand for services. The ACA contained provisions designed to improve the quality of disease prevention and health promotion services, patient safety, coordination of care, community health, and service delivery models.[6]

## *Implementation Process*

DHCS senior leadership envisioned the overall framework for the QS. The Office of the Medical Director within the DHCS Director's Office coordinated its development, implementation, and evaluation. To provide thought leadership, technical assistance, consultation, and training to advance the QS, DHCS contracted with the Institute for Population Health Improvement (IPHI), University of California, Davis, because of its demonstrated expertise in QI and health system transformation.[8] IPHI staff were embedded at DHCS and together with internal DHCS staff formed the QS team.

As already described, the QS team modeled the initial QS on the NQS.[2] The NQS was chosen as a model because it would help ensure that the DHCS QS was aligned with federal goals. Additionally, because the Agency for Healthcare Research and Quality (AHRQ) developed the NQS using an extensive and broad stakeholder engagement process, its contents were judged to be more likely to resonate well among DHCS stakeholders.

Once the draft was complete, the QS team launched the implementation process with 3 concurrent tasks: (1) gather stakeholder input, (2) establish an external advisory committee, and (3) conduct a baseline QI inventory.

*Stakeholder Input.* The draft QS was presented to DHCS leadership and staff and a statewide stakeholder workgroup. More than 5000 internal and external stakeholders also were invited to a QS webinar.[9] The webinar invitation contained the draft QS document, and the webinar covered its contents and implementation process; 181 stakeholders attended. Real-time online polling showed overwhelming support for the proposed goals, priorities, and guiding principles. On a 5-point Likert scale, 98%, 96%, and 93% of respondents reported that they somewhat or strongly supported the goals, priorities, and guiding principles, respectively. Following the webinar, attendees were sent an electronic survey to collect more nuanced feedback. Open-ended questions included, "What is missing from the DHCS Quality Strategy?" and "Is there anything else you would like to add?" Responses expressing concern, confusion, or suggestions were handled with follow-up communication to ensure that the participant's feedback was adequately incorporated into the final draft or to explain why the feedback was not incorporated.

*External Advisory Committee.* To obtain ongoing external guidance, the Medi-Cal Performance Advisory Committee (MPAC) was convened. The MPAC met for a full day 7 times between 2012 and 2014. It consisted of a multidisciplinary group of 9 prominent thought leaders from academia, health plans, hospitals, foundations, and local government. The MPAC provided diverse perspectives to help the QS team make practical, evidence-based recommendations to advance QI and navigate systems change within DHCS.[10]

*Baseline QI Inventory.* As reported previously,[11] the QS team developed a survey to capture information about DHCS QI activities in clinical care, health promotion and disease prevention, and administration. Under each domain, the survey asked participants to report any QI

**Table 2.** Goals and Priorities of the DHCS Quality Strategy.

| | |
|---|---|
| Goals | 1. Improve the health of all Californians<br>2. Enhance quality, including the patient care experience, in all DHCS programs<br>3. Reduce the Department's per capita health care program costs |
| Priorities | 1. Improve patient safety<br>2. Deliver effective, efficient, affordable care<br>3. Engage persons and families in their health<br>4. Enhance communication and coordination of care<br>5. Advance prevention<br>6. Foster healthy communities<br>7. Eliminate health disparities |

Abbreviation: DHCS, Department of Health Care Services.

activities and provide the title, aim(s), baseline metric(s), target metric(s), intervention site(s), start and end dates, lead staff, project partners, funding source for each activity, and other basic information. QI was defined as a process designed to improve the delivery of preventive, diagnostic, therapeutic, and rehabilitative measures in order to maintain, restore, or improve health or health outcomes of individuals and populations.[11] Participants also were asked to identify any quality metrics that were collected but not explicitly linked to any QI activities, perceived gaps in the department's QI activities, and suggestions for future QI activities. Surveys were sent to all 35 offices and divisions within DHCS as well as to 3 other leaders of special subgroups within the organization. All surveys were completed.

Throughout the 3 tasks, the QS team worked to build relationships across DHCS. The QS team learned through the baseline survey and stakeholder outreach that many DHCS division leaders knew little about QI. Terms such as *specific aims* and *objectives* were not readily understood in the context of QI, so definitions were included with the baseline survey to help clarify key concepts. QS team members also personally met with several division leaders to discuss activities in detail and to help determine whether or not they qualified as QI. In several cases, divisions were performing QI activities without realizing it. In several other cases, divisions collected metrics that could be used to inform QI but did not link them to any QI activities. These conversations provided an opportunity to educate DHCS managers and line staff about QI.

The QS team approached the process with a supportive and inclusionary attitude, cognizant of the widely varying skill and experience in QI methods. The goal was to simply understand the existing level of QI within the organization and obtain buy-in for the QS initiative. The QS team listened to division leaders without judgment. There were no punitive actions or rewards associated with QI activities. Instead, the QS was presented as an opportunity to showcase existing or develop innovative programs. Where QI activities were lacking, the QS only pointed to an opportunity to implement them. To maintain inclusivity, the QS used a broad definition of QI, encompassing some activities that indirectly affected quality of care, were already at an advanced planning phase, or were administrative tasks that would technically be considered quality control activities. In addition, the QS was promoted as advancing a culture of quality (COQ) that ultimately would improve health for those DHCS served.

## Results

### *Framework*

With input from internal and external stakeholders and MPAC members, the QS team published the inaugural DHCS QS in 2012.[12] It contained a framework for QI. Consistent with the 3 aims of the NQS and the Triple Aim,[1,2] DHCS' QS framework was anchored by 3 linked goals (Table 2). The first 6 of 7 priorities in the QS were similar to those in the NQS. They were relevant to public and private sector care delivery across many patient populations. The seventh priority, Eliminate health disparities, was particularly relevant for the population DHCS serves and was similar to NQS Principle number 3, "a cross-cutting commitment to eliminate disparities due to race/ethnicity, gender, age, socioeconomic status, geography, and many other factors." The order of the 7 priorities did not indicate prioritization.

### *Update Process*

Following publication of the inaugural QS in 2012, the QS team published its baseline QI inventory, which reflected QI activities underway in 2012.[11] Follow-up inventories using similar survey and in-person interview methods as used to collect baseline data continued annually through 2018, with a gap in 2015 because of change in DHCS leadership.[5] The MPAC was discontinued after 2014, also because of change in DHCS leadership. In each updated QS publication, the inventory of activities changed, but the QS framework did not. The contract with IPHI ended in 2018.

## QI Activities

The QS team documented 129 unique QI activities over 6 inventories from 2012 to 2018. The total number of activities was 44 at baseline, grew to 66 in 2013, and remained relatively stable until declining to 46 in 2018. The 2013 inventory documented the greatest number of new QI activities (n = 30), whereas the 2018 inventory documented the least new activities (n = 6; Table 3).

Starting in 2013, the QS organized QI activities under the 7 priorities described in the framework (Table 2), allowing for single QI projects to be classified under multiple priorities. To assess trends in priorities over time, the study team retrospectively classified 2012 QI activities. The 2013 classifications were used for 2012 activities that also appeared in 2013 (n = 36). For the remaining 2012 activities (n = 8), classifications were assigned based on the activity's description. In the years 2014 to 2017, a COQ classification was used to accommodate QI activities focused on the DHCS organization and likely to affect multiple priorities. For example, the COQ section contained the DHCS Kaizen Group, which brought staff together to identify ways to streamline various business processes.

Across all years, most QI activities were classified under priority 2: Deliver effective, efficient, affordable care (39%), followed by priority 5: Advance prevention (21%; Table 4). None of the remaining 5 priorities nor the COQ section individually accounted for 10% or more of the QI activities. Priorities 3: Engage persons and families in their health, 6: Foster healthy communities, and 7: Eliminate health disparities had very few (≤2) QI activities at baseline in 2012.

In the following sections, selected examples are provided of how the 7 priorities in the QS translated into meaningful activities at the patient and population levels.

*Priority 1—Improve Patient Safety.* As part of the broader Public Hospital Redesign and Incentives in Medi-Cal program,[13] the initiative to reduce errors in the ambulatory care setting used hospital-level financial incentives to improve Medi-Cal patient outcomes. Hospitals reported metrics biannually, and performance was determined by each hospital's percentile ranking among all public hospitals nationwide. Underperforming hospitals were financially incentivized to improve their ranking, whereas well-performing hospitals were financially incentivized to maintain their ranking.

*Priority 2—Deliver Effective, Efficient, Affordable Care.* DHCS participated in the California Pharmaceutical Collaborative Clinical Workgroup, a California Health and Human Services Agency-level collaborative. The workgroup's goal was to help lower pharmaceutical costs by developing a coordinated approach to high-cost drugs among state purchasers and payers of pharmaceuticals.

**Table 3.** Unique New and Existing Department of Health Care Services QI Activities by Year, 2012-2018 (No Inventory Was Completed in 2015).

| Year | New[a] | Existing | Total |
|---|---|---|---|
| 2012 | 15 | 29 | 44 |
| 2013 | 30 | 36 | 66 |
| 2014 | 16 | 51 | 67 |
| 2016 | 21 | 40 | 61 |
| 2017 | 12 | 51 | 63 |
| 2018 | 6 | 40 | 46 |

Abbreviation: QI, quality improvement.
[a]For 2012, new QI activities were defined as those with a start date prior to January 1, 2012. For 2013-2018, new QI activities were defined as those not appearing in a prior inventory.

*Priority 3—Engage Persons and Families in Their Health.* DHCS developed the Welltopia Facebook Page, an inspirational, prevention-focused page that created a space for community members to share their ideas about wholehearted living and find information to help reach their full, healthful potential. The success of the Facebook page resulted in the creation of the Welltopia website, a complementary website that linked Medi-Cal members to resources that promoted healthful living and addressed social risk factors of health.

*Priority 4—Enhance Communication and Coordination of Care.* The initiative to improve palliative and end-of-life care practices began with a mission to emphasize the importance of quality of life in the provision of health care by engaging members, patients, and families to ensure personal preferences and values were respected. With a technical assistance grant from the Robert Wood Johnson Foundation, the workgroup published a white paper outlining recommendations for improving access to high-quality palliative and end-of-life care for Medi-Cal members.

*Priority 5—Advance Prevention.* The Medi-Cal Incentives to Quit Smoking project was a $10 million, 5-year research project to reduce smoking prevalence through referrals to a telephone-based quitline.[14] Another major research project was funded by a $7.5 million award of US Department of Agriculture Supplemental Nutrition Assistance Program-Education monies to address overweight and obesity. The formative research phase of the project has been completed.[15] The intervention program, called Koa Family, involves a 6-month program to establish "micro-communities" of mothers supporting one another in healthy living and will launch in the fall of 2019 using a randomized controlled trial design.

**Table 4.** Department of Health Care Services Quality Improvement Activities by Priority and Year, 2012-2018 (No Inventory Was Completed in 2015).[a]

| Year | Priority 1: Patient Safety | Priority 2: Effective, Efficient, Affordable Care | Priority 3: Engage Persons and Families | Priority 4: Communication & Coordination of Care | Priority 5: Prevention | Priority 6: Healthy Communities | Priority 7: Health Disparities | Culture of Quality |
|---|---|---|---|---|---|---|---|---|
| 2012 | 8 | 29 | 2 | 4 | 10 | 1 | 2 | n/a |
| 2013 | 11 | 30 | 6 | 11 | 20 | 5 | 5 | n/a |
| 2014 | 5 | 30 | 2 | 8 | 13 | 3 | 2 | 6 |
| 2016 | 1 | 23 | 5 | 3 | 14 | 7 | 3 | 5 |
| 2017 | 5 | 22 | 4 | 5 | 12 | 7 | 4 | 5 |
| 2018 | 5 | 16 | 4 | 3 | 11 | 3 | 4 | n/a |
| Total by priority | 35 (9%) | 150 (39%) | 23 (6%) | 34 (9%) | 80 (21%) | 26 (7%) | 20 (5%) | 16 (4%) |

[a]Activities by year do not always sum to totals presented in Table 3 because some quality improvement activities were classified under multiple priorities.

**Table 5.** Department of Health Care Services Quality Improvement Maturity Survey 2014-2015: Percentage of Respondents Who Strongly Agree/Agree.[a]

| Domain | Question | 2014 | 2015 | Difference (95% CI) | *P* |
|---|---|---|---|---|---|
| Organizational culture | Staff members are routinely asked to contribute to decisions at DHCS | 49.2% | 56.5% | 7.3% (−1.2%, 15.8%) | .094 |
| | When trying to facilitate change, staff have the authority to work within and across program boundaries | 45.5% | 47.6% | 2.1% (−6.4%, 10.6%) | .629 |
| | The key decision makers in DHCS believe quality improvement is very important | 74.8% | 81.1% | 6.3% (−0.8%, 13.4%) | .081 |
| | DHCS currently has a pervasive culture that focuses on continuous quality improvement | 45.9% | 58.8% | 12.9% (4.4%, 21.4%) | .003 |
| Capacity/ Competency | The leaders of DHCS are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act | 35.1% | 42.5% | 7.4% (−0.9%, 15.7%) | .082 |
| | DHCS has a quality improvement plan | 68.9% | 71.7% | 2.8% (−5%, 10.6%) | .482 |
| | DHCS currently has a high level of capacity to engage in quality improvement efforts | 44.8% | 52.2% | 7.4% (−1.1%, 15.9%) | .090 |
| Alignment and spread | Job descriptions for many individuals responsible for programs and services at DHCS include specific responsibilities related to measuring and improving quality | 37.2% | 43.4% | 6.2% (−2.2%, 14.6%) | .147 |
| | Customer satisfaction information is routinely used by many individuals responsible for programs and services | 33.7% | 44.9% | 11.2% (2.9%, 19.5%) | .009 |
| | DHCS currently has aligned our commitment to quality with most of our efforts, policies, and plans | 54.0% | 59.5% | 5.5% (−3%, 14%) | .203 |

Abbreviation: CI, Confidence Interval; DHCS, Department of Health Care Services.
[a]Two-sided *P* value based on 2-sample test of proportion conducted using Stata 14.2.

*Priority 6—Foster Healthy Communities*. The California Asthma QI Initiative's goal was to reduce asthma-related emergency department visits, hospitalizations, and direct health care costs by strengthening linkages between health systems and those conducting asthma home visits. The workgroup formed through this initiative developed a competency-driven, evidence-based curriculum that built skills for effective asthma management in accordance with the National Asthma Education and Prevention Program Guidelines for the Diagnosis and Management of Asthma.

*Priority 7—Eliminate Health Disparities*. DHCS began publishing Health Disparities Fact Sheets in 2012 to highlight health inequalities among Medi-Cal subpopulations for 33 key health indicators identified by a governor-convened, statewide blue ribbon panel called the Let's Get Healthy California Task Force.[16]

## Organizational Impact

To identify organizational features that enhance or impede QI and measure possible changes in DHCS culture, the QS team administered an organizational QI maturity survey in January 2014 and 2015. The survey consisted of a 10-question subset of the valid and reliable QI maturity survey developed to evaluate the Robert Wood Johnson Foundation Multistate Learning Collaborative.[17] The Minnesota Public Health Research to Action Network developed the 10-question subset to represent key domains of QI maturity.[18] Questions were comprised of statements with 5-point Likert scale responses ranging from *strongly agree* to *strongly disagree*. The survey was distributed to DHCS executive staff during staff meetings (n = 37 in 2014, n = 42 in 2015) and emailed to managers and supervisors (n = 224 in 2014, n = 223 in 2015). DHCS management reported high levels of agreement that key decision makers believe QI is very important and that DHCS has a QI plan. From 2014 to 2015, statistically significant ($P < .05$) increases were observed for 2 items: (1) DHCS has a pervasive culture that focuses on continuous QI and (2) customer satisfaction information is routinely used by many individuals responsible for programs and services (Table 5).

DHCS leadership used the QS to highlight the department's innovative work to the state legislature, the Centers for Medicare & Medicaid Services (CMS), and other stakeholders. However, the primary purpose of the

QS was to serve as a strategic document. It provided a system for identifying gaps and opportunities for new QI activities. At baseline, priority areas 6 and 7 (fostering healthy communities and eliminating health disparities) had no exclusive QI activities, and, as a result, several were developed. The QS provided the impetus to develop activities in underrepresented areas—it allowed gaps in health care quality to be recognized and filled. The QS also provided the framework to create a sub-strategy within each priority area. For example, priority area 5, Advance Prevention, resulted in a portfolio of activities to address the leading causes of preventable mortality, including a hypertension control learning collaborative,[19] and projects aimed at reducing obesity,[15] alcohol abuse, and smoking.[14] The QS also allowed new activities to address emerging topics (eg, the opioid epidemic) to be readily integrated into an existing organizational framework. Because it mirrored the NQS, the DHCS QS easily connected to national-level QI activities. For example, in August 2013, DHCS presented the QS at an AHRQ national webinar as a case study of how the NQS could be adapted for use by states. In addition, federal dollars funded many of the QI activities, and DHCS QI activities often paralleled national QI activities.

## Discussion

Following the NQS model, the DHCS QS established organization-wide QI goals and priorities. The QS offered a means to highlight and systematize DHCS QI activities while also helping to identify and fill gaps in quality health care delivery. The baseline QI inventory found many QI activities, at differing levels of maturity, underway at DHCS and integrated them into a formal framework. The QS provided organizational support for new QI activities to fill the remaining gaps identified by the framework. The framework remained essentially unchanged from 2012 to 2018, proving sufficiently flexible to adapt to a rapidly changing health care environment. Individual QI activities were added, dropped, or changed over time, yet all were intended to help achieve the foundational 3 linked goals and 7 priorities. As can be seen in the example QI activities for each priority, QI activities included efforts to improve the quality of health care across all 3 interdependent aspects of the Donabedian model: structure, process, and outcomes.[20]

DHCS based its QS on the NQS but featured important differences. The NQS established indicators for each priority and tracked progress on those indicators over time, highlighting select QI activities that support each indicator.[21] Conversely, the DHCS QS identified a portfolio of QI activities for each priority, with each QI activity linked to its own indicators. This arrangement was meant to reduce performance pressure for DHCS program administrators and create an open door for participation in the QS. The QS was not intended to be a compliance document nor create additional burdens.[22] However, the lack of priority indicators limited quantification of QI progress. Thus, this review of the DHCS QS was limited to tracking the number and types of QI activities over time and to assessing organizational culture through a QI maturity survey.

Changes in QI maturity from 2014 to 2015 suggest that DHCS organizational culture increasingly embraced QI. There was expressed room for improvement in many areas, particularly in the domain of alignment and spread, or the extent to which QI supports the organization and the extent to which QI is diffused throughout the organization.[17] Most QI activities were focused on priority 2, delivering effective, efficient, affordable care and priority 5, advancing prevention. Priority 2 had a very large scope, which accounts for a large number of activities. In contrast, leaders in the Office of the Medical Director and IPHI, with the support of the department's director, actively sought increased attention to disease prevention to better advance population health. The total number of QI activities grew quickly, stabilized through the first 5 years of QS publication, then declined in the final year of the IPHI contract. However, it is difficult to interpret this finding given the large variability in scope of QI projects and ongoing changes in policy priorities.

Compared with typical organizational strategic plans,[23] the QS as a QI blueprint demonstrated unusual support from organizational leadership, managers, and line staff. From the outset, the director of DHCS encouraged transparency and engagement in the QS. Thus, executives, managers, supervisors, and line staff in the department felt free to share both support and concerns for all policies and programs. To the study team's knowledge, there were no strongly negative sentiments expressed for the QS, either verbally or in writing. Although this is unusual for such a large planning process, the team believes that the QS was not viewed as a traditional strategic plan. Instead, it was perceived as a statement of the important activities and policies of the department aimed at addressing needs of Californians. In addition, staff in the director's office attempted to minimize the reporting burden while encouraging the submission of important updates.

Organizational support for the QS also may be related to its nonthreatening nature. The QS served as a framework for organizing existing QI projects and developing new projects to fill gaps but was not used to strategically discontinue projects. From 2012 to 2018, all DHCS QI projects that ended did so according to their own time line. Although the portfolio of QI projects featured in each QS certainly was reflective of leadership interests, the QS itself was not used to allocate QI resources. For

this reason, the QS may fall short of being a true strategic document used for making difficult choices. Over time, the QS came to be seen as a place to showcase innovative programs. IPHI staff, without active outreach, would receive updates on QI activities between formal annual reporting periods near the end of the year. In addition, references to the QS were made in policy documents and public engagement over 6 years.

In November 2018, a new governor was elected, who appointed a new Secretary for the Health & Human Services Agency. In which direction the new administration goes with regard to the QS is not known at the time of writing this report. However, current CMS regulations (42 CFR Part 438, subpart D) mandate a state quality strategy for any state Medicaid program that contracts with managed care plans.

This assessment of the DHCS QS is primarily qualitative and dependent on narratives of the participants who developed the QS. The intent is to provide an accounting of the experience that may inform similar initiatives elsewhere.[24] Opinions of the QS from other stakeholders (eg, providers, patients, external policymakers) were not collected, and this is a limitation in interpreting the findings. Nonetheless, the study team believes that this experience may inform decision making of other state Medicaid programs that are considering developing a quality strategy.

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