PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **September 9, 2026 - 7:30 to 9:00 a.m.**

Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:	Angela Brennan, DO *(FF)* Brian Montenegro, MD *(FF)* Michelle Herman, MD *(FF)* Matthew Zavod, MD *(FF)* Teresa Shinder, MD *(FF)* Chester Austin, MD *(C)* John McDermott, FNP *(C)*	Candy Stockton, MD *(E)* Chris Myers, MD, *(E)* Malia Honda, MD *(E)* Karina Gookin, MD *(AU)* Darrick Nelson, MD *(R)* Leigh Vall-Spinosa, MD *(SR)*	Christina Lasich, MD *(SL)* Danielle Oryn, DO *(AL)* Mills Matheson, MD *(OMM)* Derice Seid, MD *(MCC)* Karen Sprague, MSN, CFNP *(WH)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn*	*MCC - Marin Community Clinics* *OMM - Office of Dr. Matheson* *SL - Sutter Health Lakeside* *WH - Winters Healthcare* *AL – Aliados Health*
Members Excused:	Steven Gwiazdowski, MD Zoe Cappe, MD	Betzabel Kunkel, MD			
Members Absent:					
Partnership Staff:	Sonja Bjork, Chief Executive Officer Jennifer Lopez, Chief Financial Officer Wendi Davis, Chief Operating Officer Leigha Andrews, Region Director Vicky Klakken, Region Director Brigid Gast, RN, Sr. Dir., Care Management Aaron Brincko, Sr. Dir., Provider Relations Lisa O'Connell, Dir. Enhanced Health Services Doreen Crume, RN, Mgr. Care Coord. Stephanie Nakatani, Supervisor Provider Relations Representatives	Katherine Barresi, RN, Chief Health Services Officer Robert Moore, MD, Chief Medical Officer Kermit Jones, MD, Deputy Chief Medical Officer Colleen Townsend, MD, Region Medical Director Jeffrey Ribordy, MD, Region Medical Director Bradley Cox, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Matthew Morris, MD, Region Medical Director Lisa Ward, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Marshall Kubota, MD, Associate Medical Director	Irem Conery, Director of Member Experience DeLorean Ruffin, DrPH, Director, Population Health Mohamed Jalloh, Pharm.D., Director, Health Equity Isaac Brown, Sr. Dir., Quality & Performance Improvement Vacant, Director, Quality Management Kristine Gual, Director, Quality Measurement Vacant, Manager of QI Programs Sue Quichocho, Mgr., Quality Measurement Megan Shelton, Project Manager, Quality Improvement Vacant, RN, Director, Utilization Mgmt. (UM) Kevin Jarret-Lee, RN, Assoc. Dir. of UM Robby Potter, RN, Supervisor of Inpatient UM David Lavine, Assoc. Dir. of Workforce Development		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	18/21 – PAC	Committee quorum requirements met (18).	09/09/26

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Executive Officer presented an administrative update on Partnership activities.**
	
	Unsatisfactory Immigration Status (UIS) Transition to Medi-Cal Fee for Service (FFS)
	• Effective January 1, 2027, members in UIS status will transition out of managed care for general Medi-Cal benefits and into the state Medi-Cal fee-for-service delivery system, affecting approximately 85,000 Partnership members.
	• The transition work is substantial and Partnership teams have begun work to minimize disruption to care for affected members.
	• Continuity-of-care planning is being prioritized for members receiving specialty services, chemotherapy, physical therapy, and other active treatments.
	• Additional attention is being directed to members with procedures scheduled after the transition date.
	• Care Coordination staff are using treatment authorization request (TAR) data to identify affected members and active services.
	• Provider participation in state Medi-Cal is being assessed so replacement providers can be located when necessary.
	• Clarification is still being awaited from Department of Health Care Services (DHCS) regarding the state TAR, including how Partnership authorizations will be received and honored as well as what additional provider steps would be required.
	• Although the scale and complexity of the transition is challenging, Partnership experienced a similar transition of approximately 90,000 members to Kaiser under a direct contract in 2024.
	• The present transition is more variable because provider approaches would differ across the state.
	• Partnership intends to transmit TAR information to the state and advocate for a process that minimizes provider burden.
	• Specific state contact information, telephone numbers, websites, and responsible divisions were requested so that providers and referral staff would know where assistance could be obtained beginning January 1.
	• Reliable guidance for specific state contact information, telephone numbers, websites, and responsible division will be translated into clear instructions and distributed to the provider network as it becomes available.
	
	Community-engagement Requirements and Medical-frailty exemptions
	• Preparation for new community-engagement requirements is occurring concurrently with the transition work.
	• Major eligibility-system changes are being developed by California while additional direction continues to be received from Centers for Medicare & Medicaid Services (CMS).
	• Recent CMS guidance on medical-frailty exemptions was summarized as a three-tier approach.
	  ○ **Tier 1:** Automatic exemptions are expected to be generated from qualifying ICD-10 diagnosis codes without individual clinician letters.
	  ▪ Acute systolic heart failure and alcohol dependence with withdrawal delirium were cited as examples from preliminary federal materials.
	  ▪ California's final Tier 1 list has not yet been determined and will require CMS approval.
	  ▪ State Tier 1 lists will need to be auditable and actively maintained.
	  ○ **Tier 2:** Case-management notes, utilization patterns, and other data could be considered when no single qualifying diagnosis code was present but the record demonstrated that the requirement could not reasonably be met.
	  ○ **Tier 3:** Manual clinical review and supporting documentation will be required for short-term circumstances or cases unresolved through Tiers 1 or 2.
	• Diagnoses could be added when demonstrated that affected members could not meet the requirements and removed when the exemption is not justified.
	• California's implementation approach remains under development because the CMS guidance has only recently been released.
	• During the first year, members are expected to be allowed to self-attest monthly that a medical condition prevents compliance.
	• The final self-attestation form and submission method has not yet been provided.
	• Self-attestation will not be permanent and will need to be completed for each applicable month.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report, Continued	**Community-engagement Hours and Unemployment exemptions** • The federal requirement could be satisfied through either 80 monthly hours or a specified earnings threshold. • Because California's minimum wage is higher, fewer than 80 work hours might be required to meet the earnings threshold. • An automatic county-level exemption was described for residents of counties with unemployment above 8 percent or 1.5 times the federal unemployment rate. • The exemption would be calculated monthly by the state rather than individually claimed. • Administration would be complicated because final unemployment data became available only after the month ended. • The exemption was expected to support retroactive eligibility determinations. • Potential federal enforcement mechanisms were discussed, including concern that delayed Medicaid payments would be especially disruptive.
I.B Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented the following Health Services report.** **Developmental Screening for Children and Follow-up Care** • A partnership between Chapa-De Indian Health and the UC Davis MIND Institute has a promising pilot with lessons that may be useful to the broader network. • A chart review showed recommended developmental screening was completed only in approximately one in three children. • Timely diagnostic follow-up has been difficult to obtain, and the piloted model would allow health centers to assume selected diagnostic functions commonly performed by regional centers in terms of diagnostic workup at various levels. • A webinar on developmental screening and follow-up is planned for September. Organizations are encouraged to send clinical or administrative staff involved in pediatrics or pediatric developmental care. **National Coalition Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set© (HEDIS) results and Statin performance** • Final NCQA/HEDIS results are planned for committee review in October after ratings are available. • Preliminary review had identified four statin-related measures outside the Managed Care Accountability Set (MCAS) as significant contributors to the plan rating. • Statin use among members with conditions including diabetes and coronary artery disease had fallen below minimum performance levels (MPL). • Improving each of the four measures by one performance level could have increased the overall rating by approximately one-half star. • Academic detailing with Partnership Pharmacy staff is available to obtain provider-specific prescribing data and review organizational patterns. • Participation in pharmacy consultation is encouraged because it also supports an existing Quality Incentive Program measure.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**August 12, 2026, PAC minutes were presented for approval.**	**MOTION:** Dr. Montenegro moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Austin. **ACTION SUMMARY:** [17] yes, [0] no, [1] abstentions.	09/09/26 Motion carried.
II.B. II.B.1 II.B.2 II.B.3 II.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – August 2026 • Policies, Procedures, and Guidelines for Action Policy Summary, September 9, 2026 • Credentials Committee Meeting Summary & Credentialed List, July 8, 2026 • Quality Improvement Health Equity Committee Summary, July 21, 2026	**MOTION:** Dr. Austin moved to approve Agenda II.B.1, II.B.2, II.B.5 and II.B.7 with modification to policy MCUP3052, Medical Nutrition Therapy (MNT) Services, to correct CDE (Certified Diabetes Educator) to CDCES (Certified Diabetes Care and Education Specialist), consistent with the Certification Board for Diabetes Care and Education, seconded by Dr. Herman. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
II.C	**PAC Member Nomination of Dr. Harry Ko**	**MOTION:** Mr. McDermott moved to approve Agenda item II.C.A as presented, seconded by Dr. Zavod. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.A	**Enhanced Care Management Quality Improvement Program (QIP) Measure Set Proposal 2027**	**MOTION:** Dr. Austin moved to approve Agenda item VI.A as presented, seconded by Dr. Montenegro **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.B	**Extended Care Center QIP Measure Set Proposal 2027**	**MOTION:** Dr. Montenegro moved to approve Agenda item VI.B as presented, seconded by Dr. Herman. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.C	**Hospital QIP Measure Set Proposal 2027**	**MOTION:** Dr. Shinder moved to approve Agenda item VI.C as presented, seconded by Dr. Zavod. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.D	**Quality Improvement Trilogy** • Closeout Summary of FY 2025-2026 QI Work Plan • Summary of QI Trilogy Documents QI Trilogy Documents • 2025-2026 QI Evaluation • 2026-2027 QI Work Plan • 2026-2027 QI Program Description	**MOTION:** Dr. Herman moved to approve Agenda item VI.D as presented, seconded by Dr. Stockton. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer	**Partnership's Deputy Chief Medical Officer provided a brief report discussing additional Partnership activities.** **DHCS Clinical Efficiency Adjustments — Calendar Year (CY) 2027 Rate Development** **Process: Plan feedback changed the outcome** • Engagement ran from the February 2026 All-Plan CFO meeting through workgroups in March, May, June and July, plus multiple rounds of written feedback. • Three proposed adjustments were dropped and the targeted efficiency level (TEL) was held rather than raised for now. • California Children's Services (CCS) members and long-term care institutional members were added as readmissions exclusions in direct response to plan comment. • De-duplication between inpatient adjustments was accepted as a concern and addressed. **Mechanism: What the target efficiency level does** - DHCS applies Actuarial Standard of Practice (ASOP) No. 49 adjustments only where attainable and achievable • Gross finding - Clinical review identifies inefficient spend – 3.5% of inpatient dollars for readmissions • TEL discount - Only a set fraction is removed. At 50%, half comes out: 1.7% after TEL • Why it exists - A deliberate buffer for review error, misclassification and implementation runway • What is disclosed - The value — 50% across Readmissions, Cesarean Mix and PPA • *What is not* - The derivation. No method is sown for why 50% rather than 35% or 65% **The Central Methodological Issue** Absence of documentation is treated as evidence of avoidability. • The readmissions flag turns on whether an outpatient visit appears in the record — not on whether care occurred. • Encounter completeness is not random. It tracks delivery system structure, Federally Qualified Health Center and subcapitated arrangements. • The base period closed before the standard was set, and submission windows have passed. **Reproducibility: What remains unresolved** • TEL derivation - The 50% value is public. How it was selected is not — and DHCS intends to raise it. • Clinical review standards - No criteria set, reviewer credentials, dual review, or inter-rater agreement reported. • Encounter-level dispute - Policy consultation exists. There is no path to contest a specific flagged admission. • Hierarchy run order - PPA and readmissions can both claim the same admission. Sequence is undisclosed. • Sample versus census - Not stated. Regional figures are smaller subsamples with wider uncertainty. • Operational thresholds **-** Any professional visit exempts a readmission, regardless of relatedness or timing.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer, Continued	**Outcome: Final Decisions for CY 2027** - *DHCS will reevaluate TELs for CY 2028 with a view toward raising them where attainable. Cellulitis, short stay, and Durable Medical Equipment/radiology will not be implemented based on reviewed analyses.*

Adopted

- Readmissions: 50% TEL
- Cesarean Mix: 50% TEL
- Potentially preventable admissions: 50% TEL, unchanged
- Low acuity non-emergent: Code definitions updates

50% TEL: Readmissions

Physical health admissions within 30 days of a prior discharge, any facility, any diagnostic-related group (DRG).

- Clinical global exclusions removed, plus ages under three and over 84 — now also CCS and long-term care members.
- Not avoidable: unrelated readmissions, elective admits, expired discharge status, against medical advice (AMA) discharge, or any professional visit beforehand.
- Flagged: readmissions related to the index stay with no documented outpatient visit before them.

Region	Before TEL	After TEL
Statewide	**3.5%**	**1.7%**
Bay Area	3.7%	1.9%
South Non-Coastal	3.2%	1.6%
Southern California	3.1%	1.5%
North Non-Coastal	4.4%	2.2%
Coastal	3.8%	1.9%

Impact: Readmissions – Regional Results

Adjustment as a percentage of hospital inpatient dollars. North Non-Coastal carries the highest adjustment of any region — about 45% above Southern California. Limited outpatient infrastructure and use of emergency departments for routine or urgent access were identified as possible contributors.

50% TEL: Cesarean Mix

A benchmarked ratio that re-mixes delivery counts rather than subtracting encounters.

- Statewide cesarean rate is 29.4%. Of those, 10.3% were judged medically unnecessary.
- A portion of potentially avoidable cesareans is shifted to vaginal births, re-mixing the maternity supplemental payment.
- Estimated statewide reduction of $7.3M to CY 2027 maternity supplemental payment dollars.
- Mercer reviewed 437 diagnosis codes against NTSV and accepts eight conditions NTSV does not.

Region	Cesarean %	Avoidable %	PMPD impact
Statewide	**29.4%**	**10.3%**	**-0.7%**
Bay Area	25.3%	8.6%	-0.5%
South Non-Coastal	31.4%	10.3%	-0.8%
Southern California	29.5%	11.0%	-0.8%
North Non-Coastal	29.5%	10.1%	-0.8%
Coastal	26.8%	9.0%	-0.4%

NTSV cesarean rate = Nulliparous, Term, Singleton, Vertex, the proportion of live term singleton births in first-time mothers delivered by cesarean section, a primary cesarean rate measure.

Impact: Cesarean Mix – Results and a Known Gap - Known misclassification: Placenta accreta and partial previa are NTSV-recognized indications but sit in the potentially avoidable pool for CY 2027. DHCS says they are under 1% of cases, were factored into the TEL, and will be added for CY 2028.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer, Continued	**What to prepare for in CY 2028** • TELs are expected to rise where DHCS judges the reduction attainable. A 50% buffer should not be assumed to persist. • Placenta accreta and partial previa move into the medically supported set, modestly shrinking the cesarean adjustment. • Herpesvirus is slated for annual code review. • Cellulitis, Short Stay and DME/Radiology were declined for CY 2027, not withdrawn permanently. • Clinical efficiencies are expected to feature in the forthcoming Hospital Value Strategy, cascading to provider contracting. **Context: NEJM on Pay for Performance** • **R**ethinking the Role of Pay for Performance in Federal Health Care Quality Programs**, (**Chernew and Schneider, 2026) revealed after two decades, pay-for-performance has produced only moderate gains in care processes and outcomes, at substantial administrative cost. • The shortcomings are structural, not fixable by refinement — measurement, scoring and financial incentives each have inherent limits. • Performance tracks patient and social factors absent from risk adjustment, so programs penalize plans and organizations serving marginalized populations. • Payment tied to measures shifts effort toward documentation and scoring rather than care delivery. • Recommended shift: a narrow set of high-impact measures, targeted support for poor performers, and comfort with doing nothing when action will not close a gap. **Summary** • Plan feedback through the workgroup channel changed the outcome — that channel is our leverage for CY 2028. • TEL derivation, clinical review standards, run order and a dispute path remain undisclosed, and TELs are expected to rise. • Penalties tied to imperfect measures burden plans serving marginalized members without clear evidence of better care. • Greater transparency is requested.
IV.A Status Update, Regional Medical	**Partnership's Regional Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • The recent Yolo County Perinatal Care Summit was reported as the second event in a series jointly sponsored by regional directors and regional medical directors. More than 50 participants attended from federally qualified health centers (FQHC), hospitals, community-based organizations (CBO), First 5, Enhanced Care Management (ECM) providers, doula programs, and other local organizations. Networking, service sharing, and exercises following patients through the continuum of care were used to strengthen regional coordination. • Similar summits had previously been held in Solano County and are being planned for additional regions. • Members interested in planning are invited to contact their regional medical director.
IV.B Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • A regional quality meeting was held on September 3, 2026 focusing on updated hypertension-management guidelines, health disparities, promotion, and nursing support for blood-pressure management. • Vaccine uptake is being prioritized through findings from four completed focus groups, with two additional groups scheduled. • Efforts are being directed toward communities with lower vaccination rates and children from birth through age five. • Provider organizations and community-based partners are being engaged. • A Marin/Sonoma Perinatal summit is scheduled for September 25, with approximately 80 participants expected to attend. • Workforce growth is reported through new quality leadership and quality-improvement staff at local health centers and tribal clinics.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
IV.C Status Update, Regional Medical	**No activities to report for Lake, Mendocino, Humboldt, and Del Norte Counties in September.**
IV.D Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities as well as activates located in Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties.** • Graduate medical education leaders are scheduled to meet in Redding to coordinate regional workforce strategy. • Residency-program expansion is creating opportunities for more deliberate recruitment and retention throughout Northern California. • Two psychiatry residencies located approximately 20 miles apart and producing about 14 graduates annually were cited as resources that could be coordinated strategically. • Access and telehealth had been identified as major priorities during a recent regional seminar and workforce discussion, particularly in the Yuba-Sutter area. • Expanded telehealth is expected to support outpatient management of diabetes, chronic heart failure, and other conditions associated with potentially avoidable hospitalization. • The transition to Partnership's trusted hospice network was reported as complete, with 19 contracted providers participating. • A process is being developed to document unavailable contracted hospice providers so that use of noncontracted providers could be evaluated and tracked consistently.
IV.E Status Update, Regional Medical	**Update for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties was combined with Glenn, Butte, Sutter, and Colusa Counties.**
IV.F Status Update, Regional Medical	**Partnership's Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities.** • Plumas District Hospital emphasized Partnership's primary-care-provider calling-center program and hypertension management. • Development of standby perinatal services is continuing following passage of relevant state legislation. A closer facility had been purchased to improve emergency access. A former offsite facility was expected to be repurposed as housing for traveling clinical staff. • Tahoe Forest was reported to have opened a Tahoe City clinic offering urgent and primary care services. • Nevada County's first robotic surgery was performed. • A physician recruitment event is being planned in Grass Valley for residents and practicing physicians. • Reduced infusion-center hours caused by staffing changes are an ongoing access issue, especially for patients requiring recurring treatment. • An academic-detailing event is planned with WellSpace focused on hypertension and diabetes management. • Nevada County reported an approximately 50% reduction in opioid-related deaths over two years. • Patients were reported to be presenting with opioid-withdrawal-like symptoms despite denying opioid use; certain convenience-store products, such as Kratom, are suspected and testing is being pursued. • Clinicians are advised to consider such products when similar presentations occur.
V. Old Business	*No old business.*

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.A Proposed 2027 Enhanced Care Management Quality Incentive Program (ECMQIP) Measurement Set	**Summary of Proposed Measure Changes for Measurement Year 2027** **No proposed changes. Existing measures will be used for measurement year 2027** **Gateway Measure: Timely Reporting** Providers are required to submit three monthly reports on or before their due date. Incentive: $100 per member per month Dollars earned are placed into an incentive pool. • 100% is placed in incentive pool if all reports are received on or before due date. • 50% is placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date. • Reports received after five (5) business days will not be eligible for an incentive pool or participation in program measures.

Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 Days Providers are required to upload a Care Plan and ROI forms into PointClickCare for all ECM enrolled members within 60 days of TAR request date. Targets: • Full credit: > 70% • Partial credit: 60% - 69% No reporting to Partnership is required.	**Measure 2: Depression Screening** Depression screening is required for all ECM enrolled members, ages 12 years and older. Targets: • Full credit: > 90% • Partial credit: 80% - 89% Providers will submit a quarterly screening template.
Measure 3: Blood Pressure Screening Blood pressure screening is required for all ECM enrolled members ages 18 years and older. Targets: • Full credit: > 80% • Partial credit: 70% - 79% Providers will submit a quarterly screening template.	**Measure 4: Timely Review of ED / Admissions Notifications in PointClickCare** **Part 1:** New ECM providers are required to set up the Notification Alerts function in PointClickCare by contacting PointClickCare® for assistance. Targets: Full credit. No partial credit **Part 2:** Providers are required to review ED/Admissions notifications received in PointClickCare® within 72 hours of receiving notifications. Targets: Full credit: > 70% Partial credit: 60-69% No reporting to Partnership is required.

No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.B Proposed 2027 Extended Care Center Quality Incentive Program (EXTQIP) Measurement Set	**Summary of Proposed Measure Changes for Measurement Year 2027** • No changes were proposed to the three gateway measures: CMS Five-Star Overall Rating; California Immunization Registry (CAIR) Enrollment; Quality Assurance and Performance Improvement (QAPI) Plan Submission • A CAIR Connect component was added to Measure 3, Percentage of long-stay residents who needed and got a flu shot and Measure 4, Percentage of long-stay residents who received a vaccine to prevent pneumonia requiring successful entry of care-related data. • All remaining measures were updated per CMS. • **A new Measure 10 was added under the health-equity impact-analysis plan.** **ADD: Measure 10 – Health Equity Impact Analysis and Plan** Facilities are required to submit an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures listed below: • Percent of high-risk residents with pressure ulcers • Percent of residents who lose too much weight • Long-stay residents who needed and received a flu shot • Long-stay residents who received a vaccine to prevent pneumonia • Percent of residents experiencing one or more falls with major injury • Percent of residents who have/had a catheter inserted and left in bladder Points: 10 Target: Full Points No Partial Points *Providers are required to submit analysis and plan by August 31, 2027. Partnership will review and notify facilities if approved or rejected.* *No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**HQIP 2027 Calendar Year Measurement Set (January 1 – December 31, 2027)** Providers have the potential to earn points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

2026 Six-Month Bridge Set July 1 – December 31, 2026	2027 Calendar Year Measure Set Recommendations
Risk Adjusted Domain 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support 10. Increasing Mammography Capacity 11. Vaccines For Children Enrollment **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 14. Hospital Quality Improvement Platform	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support ~~10. Increasing Mammography Capacity~~ ~~11. Vaccines For Children Enrollment~~ 10. Hepatitis B Vaccination 11. ALSO & BLSO Certification Training **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder – 7-Day Follow-up After ED Visit (FUA) **Operations / Efficiency Domain** 14. QI Capacity 15. Hospital Quality Improvement Platform **Patient Experience Domain** 16. Cal Hospital Compare-Patient Experience 17. Health Equity

Key: Change to Measure Design || Proposed New Measure || Removed Measures

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**Revisions to Existing Measures** **Measure 8: Expanding Delivery Privileges** - It is proposed that this measure include a partial points option for X-Large size hospitals who are still working on expanding privileges to family physicians and midwives, and it is proposed to change the language from family physicians and midwives to "or" midwives for large and small-size hospitals. The change to "or" is in recognition that for some of our smaller hospitals in rural areas, the resources may not exist to have both provider types. **Requirement Targets** his multi-phase measure began with Phase One in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With Phase One completed in 2024-25, this measure moved into Phase Two for the 2025-26 HQIP Measurement Year. Now, in 2027, the measure requirements are delineated by sizes as noted below: **X-Large Hospitals with >100 LGA Beds:** o Full Points (5 points): By December 31, 2027, hospitals must ensure access to family physicians and certified nurse midwives for deliveries by either employing them directly or maintaining active contracts, as demonstrated, by granted clinical privileges for these providers. Evidence of deliveries from these providers is required. o Partial Points (2.5 points): Phase Two Requirement: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges. **Small & Large Hospitals with between 25 and 99 LGA Beds:** o Full Points (5 points): Small and Large-size hospitals will remain in Phase 2 as follows: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and/or family physicians to hold delivery privileges, must now show evidence that they are actively recruiting these providers and/or share their provider privileges list of midwives and/or family physicians who have been granted delivery privileges. *NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.* **Measure 9: Doula Support -** This measure began in 2025 with Phase 1. It is proposed to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals as noted below. **Specifications** This measure is being implemented over multiple years, starting with Phase One in the 2025-26 measurement year. For 2027, the measure is now in Phase Two of implementation requiring hospitals to work toward actively recruiting and/or allowing doulas who accept Partnership HealthPlan to provide support during labor and delivery. **Phase Two Measure Requirements** 1. Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery, and 2. Hospitals will submit evidence of active recruitment of doulas who are credentialed with Partnership. *NOTE: Hospitals with policy and procedure developed before 2027 allowing doulas to provide support during labor and delivery and that are utilizing them will get full points for the measure.*

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**Revised Measures Continued** **Measure 13 – Substance Use Disorder 7-Day Follow-up After ED Visit (FUA) -** It is proposed to align the Substance Use Disorder Referral measure with the HEDIS FUA measure for 7-Day Follow-up After ED Visits. This will move this measure from focusing on prescribing buprenorphine and MAT to a broader range of services to a broader range of members. This measure will also pinpoint a shorter follow-up window moving from the previous 60-day follow-up window to 7 days. **Specifications** The percentage of emergency department visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up within 7 days of the ED visit (8 days total). **Numerator:** Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 7 days after the ED visit (8 days total). **Denominator:** The number of ED visits for members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose* on or between January 1 and December 1 of the measurement period. Full Points Target (10 pts): > 32.60% Partial Points Target (5 pts): Between 26.90 – 32.5 % Hospital's percentages will be rounded to the nearest 10th. **New Measures/Returning Measures** **Measure 10 - Hepatitis B Vaccination:** It is proposed to remove the VFC Enrollment Measure and replace it with the Hepatitis B Vaccination measure. We have had a similar measure in past years, so it is familiar to our hospitals. Despite changing CDC recommendations, Partnership believes it is important to continue to encourage Hepatitis B vaccination within 24 hours of delivery. **Specification for Hospitals Providing Maternity Services:** Numerator: Newborn Hepatitis B Vaccine entered in CAIR within first day of life Denominator: Newborn births at the hospital between January 1, 2027, and December 31, 2027 **Measure 11, ALSO & BLSO Certification Training measure** was added to encourage Advanced Life Support in Obstetrics (ALSO) for birthing hospitals and Basic Life Support in Obstetrics (BLSO) for non-birthing hospitals. • **Hospitals with Obstetrics**: o Full Points Target (5 pts): 30% of Physicians, i.e. MDs & CNM's and 30% of Nurses working regularly in Labor and Delivery are currently certified in ALSO o Partial Points Target (2.5 pts.): 15% of Physicians, i.e. MDs & CNM's and 15% of Nurses working regularly in Labor and Delivery are currently certified in ALSO • **Hospitals without Obstetrics:** o Full Points Target (5 pts): 30% of ED Clinicians, i.e. MDs & PAs and 30% of Nurses working regularly in the Emergency Department are currently certified in BLSO. Alternative simulation-based trainings in Emergency Obstetrical Care (such as Stanford's GO-MOMS-USA simulation program, done in-person at the hospital) may also be acceptable; they would be reviewed on a case-by-case basis. o Partial Points Target (2.5 pts): 15% of Physicians, i.e. MDs & PA's and 15% of Nurses working regularly in the Emergency Department are currently certified in BLSO.

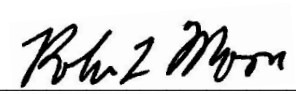
AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**New Measures/Returning Measures Continued** • **Measure 14 - Quality Improvement Capacity:** This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. We had removed this measure for the 6-month bridge set for logistical reasons and propose to bring the measure back for the 2027 calendar year. There are no changes to the measure from previous measurement years. • **Measure 16 - California Hospital Compare:** This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. This measure was removed for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. It is proposed to bring this measure back for the 2027 calendar year. The measure will return in the same form as it was during the 2025-26 measurement year. • **Measure 17 – Health Equity -** This measure is designed to encourage hospitals to work toward reducing health disparities that exist in their area or patient populations. This measure was removed for the 6-month bridge period, and we propose to bring the measure back for the 2027 calendar year. It is proposed that the measure switch from hospitals submitting a CMS Commitment to Health Equity report to submitting a copy of their HCAI Health Equity Report that is required by California Assembly Bill 1204. Hospitals shall submit a copy of their most recently published annual HCAI Health Equity Measures Report to Partnership by December 31, 2027. The submitted report should be the same report hospitals sent to HCAI during the measurement year which was due to HCAI by September 30th. **Removal of Existing Measures for 2027** • **Increased Mammography Capacity** - It is proposed to remove this measure because we cannot continue to ask for increased capacity each year. Capacity at many hospitals increased during the year and a half the measure was in place. • **Vaccines For Children (VFC) Enrollment** - It is proposed to remove the Vaccines For Children (VFC Enrollment) and replace with the Hepatitis B Vaccination measure. This is consistent with what was planned for the measure from the beginning. *No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI. D. Quality Improvement Trilogy	**Trilogy Document Summary** • The Quality Improvement Program Description documents departmental structure, responsible staff, committees, delegated functions, and emerging programs. • The Work Plan establishes annual goals for clinical quality, safety, service quality, and member experience. • The Program Evaluation assesses whether program structures and interventions produced intended results, identifying barriers, and directing future adjustments. • The trilogy package was acknowledged to total approximately 600 pages. • Duplication was being reduced and future documents streamlined without loss of required NCQA content. **FY 2025–2026 Work-plan Closeout** • Of 72 formal FY 2025–2026 work-plan goals, 59 were reported as completed. • Several goals were marked as unmet only because dashboard and reporting workflows were automated or transferred to vendors. • Other goals were delayed because the Health Rules Payor (HRP) claims system remained pending, the Dual Special Needs Program (D-SNP) launch had moved to 2028, or federal rulings had changed QIP requirements. • DataLink participation increased from six practices to more than 30, enabling capture and HEDIS© validation of clinical information not readily visible in claims. • A dental-provider directory was developed with demographics, estimated volume, and other access information. • QIP validation was strengthened so providers would receive credit for all earned incentives. • Approximately 109 mobile-mammography event days and nearly 2,500 mammograms were completed in 2025, with emphasis on rural imaging deserts and previously unscreened members. • The mobile model was being expanded to address cervical-cancer screening and blood-pressure assessment during the same visit where staffing and facilities allowed. • Cozeva was discontinued because scale and functionality were not proportionate to expected initial D-SNP membership. • Future reconsideration could occur as Medicare enrollment and county coverage expanded. *No questions. Entire QI Trilogy package was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

AGENDA ITEM	ADJOURMENT
PAC adjourned at 8:47 a.m.	**Next Physician Advisory Committee announced for October 14, 2026.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on 10/14/2026
Date



Robert Moore, M.D., on behalf of Committee Chairperson

The foregoing minutes were APPROVED WITH MODIFICATION on _____
Date

_____
Robert Moore, M.D., on behalf of Committee Chairperson