COVERED CALIFORNIA BOARD MINUTES
Thursday, January 15, 2026
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Agenda Item I: Call to Order, Roll Call, and Welcome

The meeting was called to order at 11:19 a.m.

Board Members Present During Roll Call:

Craig Cornett
Mayra Alvarez
Kim Johnson

Board Members Absent During Roll Call:

Jerry Fleming

Agenda Item II: Closed Session

A conflict disclosure was performed and there were no conflicts from the Board members that needed to be disclosed. The Board adjourned for closed session to discuss contracting matters pursuant to Government Code Section 100500(j).

The open session was called to order at 12:00 p.m.

Agenda Item III: Board Meeting Action Items

November 20, 2025 Meeting Minutes

Board Comment: None.

Public Comment: None.

Motion/Action: Chairwoman Johnson called for a motion to approve the November 20, 2025, meeting minutes. Ms. Alvarez moved to approve the meeting minutes. The motion was seconded by Mr. Cornett.

Vote: The motion was approved by a unanimous vote of those present.

Agenda Item IV: Executive Director's Report

Discussion – Announcement of Closed Session Actions

Jessica Altman, Executive Director, stated that the Board met in closed session to undertake issues related to contracting. There were no items to report.

Discussion – Executive Director's Update

Ms. Altman announced changes to Covered California's Board meeting schedule, noting that Board member Sumi Sousa has departed. She expressed appreciation for Ms. Sousa's contributions and shared that Covered California will work with the Assembly to appoint a new Board member. Due to quorum concerns, the February Board meeting is canceled, with the next meeting scheduled for March 19th.

Ms. Altman provided an overview of Covered California's current open enrollment data and trends, highlighting significant issues and insights. She reported that plan selections for 2026 are steady compared to the record-breaking year of 2025, but warning signs are emerging, particularly as enhanced premium tax credits (ePTC) have expired, leading to higher consumer costs. This has resulted in an uptick in cancellations, particularly among middle-income individuals earning above 400 percent of the Federal Poverty Level (FPL), where cancellation rates have doubled due to monthly premium increases averaging $500.

She noted that enrollment among lower-income Californians remains stable, supported by the California premium tax credit program, which is offsetting federal inaction for those under 150 percent and up to 165 percent of the FPL. However, a concerning trend is the shift toward Bronze plans, which, while offering lower monthly premiums, come with higher deductibles and out-of-pocket costs, raising concerns about access to care. Ms. Altman acknowledged this as both a challenge and a silver lining, as consumers choosing Bronze plans are prioritizing staying insured despite financial pressures. Ms. Altman emphasized that open enrollment data is still developing, with key milestones such as final deadlines, billing cycles, and grace periods likely to further shape trends.

Board Comments: Mr. Cornett inquired about hospitals' reactions to the data, particularly regarding fears about emergency room strain.

Ms. Altman acknowledged that providers are deeply concerned, especially about the broader implications of changes to Medi-Cal and the shift toward Bronze plans with high deductibles. Ms. Altman highlighted Covered California's reliance on in-person, brick-and-mortar insurance agents rather than the large web-based brokers heavily utilized by the federal Marketplace. She contrasted the federal Marketplace's lack of a comprehensive fraud management system with Covered California's proactive monitoring, identification, and resolution of fraud cases, ensuring systemic fraud does not occur.

Robert Kingston, Director of the Outreach and Sales Division, outlined Covered California's policies and controls to ensure consumer protection and prevent misconduct among enrollment channel partners. He emphasized that enrollers must obtain consumer consent and delegation before taking any action on a consumer's case, using pathways such as the managed delegates feature in the consumer portal, call center authentication, three-way calls with the Agent Service Center, or a one-time passcode system. These processes ensure consumer involvement and consent at every step.

He also highlighted Covered California's strong language in agent agreements and codes of conduct, requiring truthful and accurate information, with noncompliance potentially leading to decertification or referral to the California Department of Insurance (CDI) for further investigation. Additionally, Mr. Kingston described the collaboration with the integrated fraud management team to monitor trends, investigate issues, and take corrective actions as needed, ranging from training to termination.

Katie Ravel, Director of the Policy, Eligibility, and Research Division, discussed Covered California's monitoring and management of duplicate Social Security numbers and duplicate enrollments, emphasizing that these issues are rare and represent less than 1 percent of total enrollment. She explained that most cases stem from consumer confusion, such as applying multiple times due to uncertainty or mistakenly submitting a new application instead of renewing an existing one. This feedback has driven system improvements to reduce consumer burden and prevent duplicate enrollments.

When duplicates are identified, Covered California follows three distinct tracks for resolution. The first addresses cases with multiple enrollments receiving advanced premium tax credits (APTC), giving consumers 30 days to resolve the issue before action is taken. The second involves collaboration with the Department of Health Care Services (DHCS) to resolve cases with overlapping Medi-Cal and APTC enrollments, ensuring consumers clarify income and select the appropriate coverage. The third track focuses on consumers with one subsidized enrollment and another unsubsidized enrollment, typically caused by confusion. While rare, these cases are addressed by notifying consumers and encouraging them to end duplicate plans if unintended. Ms. Ravel emphasized that Covered California's proactive approach ensures proper program integrity while minimizing impacts on consumers.

Ms. Altman discussed Covered California's efforts to improve identity verification processes, emphasizing their dual benefit of enhancing program integrity while improving the consumer experience. Ms. Altman highlighted the importance of remote identity proofing, noting its necessity in an era where personal data, including Social Security numbers, is readily available online.

She explained that Covered California uses identity verification more expansively than the federal Marketplace to ensure accurate identification of enrollees, but acknowledged that previous credit-based identity-proofing solutions often posed challenges for consumers, particularly those without credit histories.

Kevin Cornish, Chief Information Officer of the Information Technology Division, outlined improvements designed to strengthen security while maintaining accessibility. He noted that Covered California has reduced the number of consumers getting stuck during identity verification, addressing a common pain point without compromising program integrity.

Mr. Cornish explained that Covered California replaced its credit-based identity-proofing system, which led 35 percent of self-serve consumers to abandon their applications, with a new Artificial Intelligence (AI) and biometric solution deployed in June 2025.

This new system passively verifies 85 percent of consumers using background data, and for the remaining 15 percent, uses a secondary verification step involving a selfie and document upload. Mr. Cornish also highlighted additional fraud prevention measures, including Intelligent Document Processing for eligibility verification, multifactor authentication to secure consumer accounts, and broader information security upgrades. These efforts collectively enhance program integrity, protect consumer data, and streamline enrollment workflows.

Lisa McCartney, Deputy Director of the Program Integrity Division, outlined Covered California's Integrated Fraud Management Program, highlighting the dedicated fraud team that serves as the central hub for fraud-related issues, addressing complaints received via phone, email, or written correspondence. Ms. McCartney noted that the division monitors agent compliance, issues warnings when needed, and supports prevention through enterprise-wide fraud training, common fraud scenario guidance, and an annual fraud summit. By analyzing consumer data and tracking complaints, Covered California strengthens oversight, improves early detection, and continually enhances its fraud prevention process.

Ms. Altman highlighted two key points regarding fraud and program integrity in the context of federal discussions. She explained that fraud can be perpetrated by various entities, including consumers, agents, and healthcare providers, but much of the federal rhetoric overly focuses on consumer fraud. From Covered California's experience, the vulnerabilities often lie more with professionals seeking income, rather than consumers intentionally accessing ineligible benefits. She also emphasized the distinction between fraud and program integrity, noting that consumer mistakes, such as duplicate cases or income reporting errors, are often mischaracterized as fraud, which oversimplifies the nuanced challenges state marketplaces face compared to the federal marketplace.

Board Comments: Mr. Cornett expressed appreciation for the discussion, particularly the concept of the Fraud Summit. He inquired whether Covered California's robust processes for fraud management are replicable at the federal level and whether the GAO has made any efforts to compare the state marketplaces to the federal marketplace.

Ms. Altman responded by sharing that the GAO has made inquiries into state marketplaces, including audits on issues like duplicate enrollments across multiple marketplaces. While the GAO has sought information from Covered California and potentially other states, their inquiries have not been in the vein of auditing Covered California but rather to understand operational nuances. She noted that Covered California has shared its operational practices with the Centers for Medicare & Medicaid Services (CMS), other states, and the federal Marketplace, and while the federal Marketplace has implemented changes, many of these align with practices Covered California has been using for a longer period.

Mr. Cornett asked for clarification on the proportion of consumers enrolled in federal marketplaces versus state marketplaces.

Ms. Altman stated that federal marketplace enrollment is approximately 15 million compared to seven or eight million in state marketplaces. She noted that the federal Marketplace serves the majority of enrollees and states.

Chairwoman Johnson expressed appreciation for the presentation and highlighted the importance of unpacking the nuances between different types of fraud and errors, which are often overlooked in broader conversations. She emphasized the comprehensive processes across areas such as outreach, program integrity, eligibility, identity verification, analytics, and investigations to ensure taxpayers' dollars are used effectively and eligible individuals receive services. She underscored the collaboration with various departments within the California Health and Human Services (HHS) agency, including the DHCS Fraud Integrity Unit, which has 700 members statewide, as well as partnerships with local, state, and federal law enforcement.

Discussion – State and Federal Policy/Legislative Update

Ms. Altman began by providing updates on state and federal policy and legislation, emphasizing the recent reconvening of the legislative session on January 5th and the release of the governor’s budget on January 9th. The budget totals $348.9 billion in spending with a $23 billion reserve. She highlighted the budget’s focus on the impacts of House of Representatives Bill 1 (H.R. 1) across HHS programs, noting the collective harm anticipated from the federal government’s rollback of support for these critical programs. For Covered California specifically, the governor’s budget includes steady funding levels for programs such as the Healthcare Affordability Reserve Fund ($190 million), the $1 California Premium Credit Program ($20 million), gender-affirming care ($15 million), and the Striking Worker Benefit Program ($2 million).

Turning to federal updates, Ms. Altman addressed the ongoing debate surrounding ePTCs. She noted the House's recent vote on a clean three-year extension of the tax credits, which passed with bipartisan support, but the Senate has yet to take similar action. Ms. Altman also shared updates on other regulatory matters and Covered California’s advocacy efforts. She mentioned comments submitted to the National Committee for Quality Assurance (NCQA) regarding AI standards for health plan accreditation and to CMS on digital quality measures. She expressed concern over proposed regulations, including the Department of Homeland Security's public charge rule, which could create fear among immigrant communities and reduce their engagement with healthcare programs. Additionally, she highlighted CMS’s proposed rules that would restrict access to gender-affirming care for youth and use federal financing mechanisms to limit healthcare providers from delivering these services, emphasizing the potential harm these policies could cause.

Discussion – Data and Research

Plan Performance Report: Chelsea Hart-Connor, Health Informatics Lead for the Equity and Quality Transformation Division, presented the Plan Performance Report. She explained that this report, made possible by the Assembly Bill 929 bill, focuses on reducing disparities, improving quality of care, and addressing cost. This year’s report includes new cost measures in aggregate, ensuring compliance with the bill’s requirements, and prioritizes data security to protect members’ confidentiality.

The report transitioned to an interactive Tableau dashboard, providing users with actionable insights and enhanced accessibility through features tailored for different user types, including narrative readers, data point users, and visual users.

Board Comments: Chairwoman Johnson expressed deep appreciation for the work on transparency and the use of dashboards to display information effectively. She commended the variety of visuals provided to present data in different ways and noted that the dashboards are already being utilized by stakeholders to explore opportunities for further insights. She emphasized the value of the dashboards as a tool for the Board to engage in future conversations and thanked the team for their efforts.

Ms. Alvarez expressed deep appreciation for the work on the Plan Performance Report and emphasized its importance in democratizing data, making it accessible and understandable for individuals and advocates alike. She raised a curiosity about how Covered California collaborates with the DHCS to align efforts and provide similar data transparency for Medi-Cal, ensuring that all individuals covered in California benefit from the same level of commitment to data availability. Additionally, she asked about the reasoning and effort behind transitioning the report to a Tableau dashboard, reflecting on the "why" behind this significant initiative.

Ms. Hart-Connor addressed Ms. Alvarez's first question by highlighting Covered California's close partnership with DHCS, emphasizing their regular alignment on measures to reduce fatigue for health plans while focusing on meaningful metrics. Regarding the second question, the presenter explained that transitioning the Plan Performance Report to an interactive Tableau dashboard was driven by the goal of making data more accessible and engaging. The dashboard allows users to extract and explore data more easily, making it a practical and visually appealing tool for driving change.

Ms. Altman added that the creation and application of the Plan Performance Report aligns with Covered California's strategic plan, particularly its pillar to serve as a catalyst for change. She emphasized the importance of stratified data in advancing equity, especially during a time when such transparency is declining at the federal level. Ms. Altman highlighted Covered California's role in demonstrating how data can be utilized effectively and encouraging others to follow suit. She noted that impactful initiatives like fraud management and health informatics often go underappreciated in government, but investing in them can lead to significant change. She expressed hope that the dashboard inspires others to use the data and apply similar approaches in their own work.

Public Comment: Anete Millers, representing the California Association of Health Plans, expressed gratitude for Covered California’s presentation and its ongoing investments in program integrity, including advancements in identity verification, duplicate coverage tracking, and strengthened enroller controls.

Alicia Emanuel, representing the National Health Law Program and the Health Consumer Alliance, expressed gratitude to Covered California and its team for their hard work amidst numerous challenges. She highlighted concerns regarding the 50 percent increase in user-generated plan cancellations.

Cary Sanders, representing the California Pan-Ethnic Health Network, expressed gratitude for the outreach and enrollment report, noting the significant impact of Congress's failure to approve ePTCs on enrollment, particularly among communities of color who are disproportionately losing or not signing up for coverage.

Diana Douglas, representing Health Access, thanked Covered California for its report and highlighted concerns about the enrollment impacts from the loss of federal ePTCs, particularly the increase in coverage drops and the shift to Bronze plans. Ms. Douglas also commended Covered California's efforts to address fraud and modernize identity verification, noting the importance of ensuring transparency and functionality in the process.

Doreena Wong, representing Asian Resources Inc., noted that many community members are still waiting to renew their coverage, hoping for the renewal of federal ePTCs. Ms. Wong also praised Covered California's Navigator program for its consumer-focused approach, and emphasized Covered California's role as a model for other states in fraud prevention and program integrity.

Agenda Item V: Covered California Policy and Action Items

Discussion – 2027 Qualified Health Plan Issuer Certification Process and Contract Discussion

2027 Qualified Health and Dental Plan Certification Application: James DeBenedetti, Director of the Plan Management Division, explained that Covered California conducts major contract overhauls every three years, with minor changes in the interim years, and this year falls into the latter category. Regarding the certification application process, returning applicants can complete an abbreviated application, while new applicants must submit the full version. Health plans interested in joining for 2027 must apply, and the public comment process resulted in only three requests for clarification, which were addressed. The certification selection criteria remains unchanged and is key for any health plan seeking to join.

2027 Qualified Health and Dental Plan Issuer Model Contract: Mr. DeBenedetti outlined minor updates to Covered California's contracts for 2027, including adjustments related to privacy and security based on federal guidance, which received no significant pushback from carriers.

Taylor Priestly, Director of the Equity and Quality Transformation Division, discussed proposed changes to Attachments 1 and 2 of Covered California's Health and Dental Plan contracts for 2027, focused on quality, equity, and value. The Dental Plan contract amendments aim to address disparities in utilization, particularly between Dental Health Maintenance Organization and Dental Preferred Provider Organization plans, by introducing differentiated improvement targets based on plan type and a performance threshold of 70 percent utilization, above which financial penalties would not apply. Public comments highlighted concerns about the high threshold, but Covered California remains committed to improving data completeness and member engagement strategies.

Turning to the Health Plan contract, Ms. Priestly explained that unanticipated substantive changes were proposed in response to the NCQA overhaul of its Health Equity Accreditation, now called Health Outcomes Accreditation. The new program removes key elements related to multicultural populations, culturally and linguistically appropriate services, diverse workforces, and gender identity, which Covered California views as critical for advancing health equity.

Consequently, the requirement for plans to maintain this accreditation will be removed, and Covered California will introduce explicit contract language to ensure plans maintain a diverse workforce and provide culturally and linguistically appropriate services. Additionally, a 70 percent performance threshold for pediatric oral health measures will be implemented to align standards between health and dental contracts. Despite concerns about NCQA's new accreditation model, plans have embraced current requirements, and Covered California is committed to ensuring its standards exceed external benchmarks in promoting equity and quality.

Board Comments: Chairwoman Johnson expressed gratitude for the emphasis placed on linguistic and cultural competency, highlighting the importance of being explicit in addressing these areas. She commended the additional work and effort dedicated to ensuring these competencies are prioritized.

Public Comment: None.

Discussion – Presentations by Qualified Health Plan Issuers on Quality Transformation Initiative Experiences

Ms. Priestly briefly introduced presentations from three participating health plans, which will share their experiences with Covered California's Quality Transformation Initiative (QTI) following the completion of year 2 scoring and assessments. Health plans were asked to discuss topics such as changes in governance and accountability, resource reallocation, the evolution of quality initiatives, provider engagement and feedback, and priorities for year 3 of QTI.

Monica Baldzikoski, Manager in Quality Improvement from Valley Health Plan, shared her positive experiences with Covered California's QTI. She highlighted how the initiative has pushed the health plan to grow by adding 5,000 providers to its network, nearly doubling its staff, and launching its first pay-for-performance program. Additionally, the initiative spurred efforts to improve data collection and fostered greater member and provider outreach.

She also outlined barriers the health plan faces, such as challenges in obtaining supplemental data from independent providers, who make up about half of their Covered California network and are not part of larger groups or the Independent Practice Association. These providers often cannot participate in pay-for-performance programs, requiring creative solutions to support them and collect data. Another challenge involves gaps in benefits under certain metal plans, such as blood pressure cuffs and blood sugar test strips not being covered, which complicates efforts to support members in meeting QTI measures like controlling high blood pressure and hemoglobin A1C.

Board Comments: Chairwoman Johnson expressed interest in hearing about Valley Health Plan's focused efforts and strategies to improve colorectal cancer screenings and childhood vaccinations. She noted these areas of particular importance to the Board and invited insights into current and future initiatives to increase performance in these measures.

Ms. Baldzikoski shared Valley Health Plan's strategies for improving colorectal cancer screenings and childhood vaccinations. For colorectal cancer screening, the plan partnered with Exact Sciences to implement the Cologuard outreach program. Regarding childhood vaccinations, while Valley Health Plan's Covered California population is too small to count for the QTI measure, their efforts under Medi-Cal include leveraging insights from Covered California's clinical retreat for clinicians.

Mr. Cornett inquired about Valley Health Plan's limited footprint in Santa Clara County and asked for more details on their strategies for engaging providers within that region and asked for clarification on the addition of 5,000 providers to the network.

Ms. Baldzikoski explained that Valley Health Plan has been engaging its independent providers in Santa Clara County by leveraging her nurse team to visit offices with a health equity focus. She confirmed the provider figure but noted that some of the network was reduced after leaving Monterey and Salinas, highlighting that access remains their biggest challenge. She emphasized their ongoing goal to continue increasing provider numbers despite these challenges.

Katie McMahon, Associate Vice President for Quality at Molina Healthcare of California, shared the organization's journey and successes under the QTI. Molina's initial focus was on building collaboration, strengthening processes, and creating pathways to quickly surface and address barriers. Key drivers of improvement included expanding resources and tools, enhancing vendor partnerships, increasing member and provider engagement, and implementing structured progress tracking through monthly milestone reviews. These efforts led to doubling the number of measures meeting their goals from year one to year two, including significant improvements in challenging metrics like colorectal cancer screenings.

She emphasized the organization's deepened provider engagement and expanded access options, including in-home, mobile, and community-based care, which have helped close care gaps effectively despite challenges with a dispersed member population. Looking ahead to year three, Ms. McMahon outlined priorities such as reducing disparities, improving hard-to-move measures requiring deeper member engagement, and expanding alternative access options and community-based events. She highlighted the anticipated impact of their mom and baby journey initiative now that partners are fully integrated.

Board Comments: Ms. Alvarez expressed concern about Molina Healthcare's ongoing challenges with childhood immunizations, noting their performance remains below the 25th percentile. She asked Ms. McMahon about the plans to address this gap, particularly in light of the broader challenges around childhood vaccinations and preventive care.

Ms. McMahon acknowledged the difficulties tied to their dispersed network and the challenge of engaging providers who may only have a single Molina Marketplace patient in their panel, making it hard to meet childhood immunization metrics in value-based contracts. To address this, Molina brought on an alternative access provider, certified through the Vaccines for Children program, to offer vaccinations at home or through quality events. Ms. McMahon also highlighted Molina's mom-baby journey initiative, which incentivizes providers to engage members from pregnancy through the child's first two years of life. This approach aims to build lasting relationships, increasing the likelihood of adherence to vaccination schedules.

Chairwoman Johnson emphasized the importance of continuing efforts to improve vaccinations statewide, noting the partnership between Covered California and state entities and the role of science and evidence-based approaches in combating federal policy shifts. She asked Ms. McMahon how Molina Healthcare addresses local variations across the counties it serves while maintaining statewide accountability targets.

Ms. McMahon explained that Molina uses regionally-based teams for provider and community engagement, complemented by a health equity team stationed in contracted counties. Through member surveys and testing changes, such as adjusting outreach materials or imagery, the team ensures that statewide strategies are adapted to local needs and resonate effectively with the population in each region.

Dr. Edward Sheen, Chief Quality and Population Health Executive with L.A. Care Health Plan, shared the organization's experiences and successes with Covered California's QTI. Dr. Sheen outlined L.A. Care Health Plan's holistic and aggressive performance improvement strategy, anchored by eight core pillars, including enhancing data analytics, expanding access to care, deepening provider engagement, improving member experience, and addressing staffing and organizational needs. Over the past two years, L.A. Care Health Plan has achieved year-over-year improvement in QTI measures, projecting for the first time to exceed the 66th percentile across all four measures and eliminating financial sanctions. Specific successes include increased performance in diabetes management, blood pressure control, colorectal cancer screenings, and childhood vaccination rates. Efforts such as sending FIT and Cologuard kits to members and leveraging data analytics have improved engagement, while regular provider meetings and new clinical initiatives have strengthened provider relationships.

Looking ahead to 2026 and beyond, Dr. Sheen emphasized L.A. Care Health Plan's commitment to addressing challenges such as federal healthcare cuts, vaccine hesitancy, and disparities in care access. He highlighted efforts to expand alternative care options like virtual visits, home care, and mobile clinics, as well as initiatives to improve population health, including updates to Childhood Immunization Status Measure 10 policies to combat vaccine hesitancy and extend vaccination timelines. Dr. Sheen reaffirmed L.A. Care Health Plan's dedication to advancing health equity, particularly through Covered California's move to stratify QTI performance by race and ethnicity, and emphasized the need to better understand and motivate members while enabling providers to deliver more effective care.

Board Comments: Mr. Cornett acknowledged Dr. Sheen's comments on strategies to engage providers and improve relationships, noting their importance. He raised a question about L.A. Care Health Plan's reliance on a single clearinghouse for provider payments during the Change Healthcare cyber attack a few years ago, which caused delays and challenges for providers. He asked if this issue had been corrected, emphasizing the risks posed by cyber attacks.

Dr. Sheen responded by stating that L.A. Care Health Plan is actively working to improve resiliency and strengthen key infrastructure to address such vulnerabilities, however, the issue has not been fully resolved yet but remains a high priority for the organization.

Ms. Alvarez asked Dr. Sheen to elaborate on L.A. Care Health Plan's new member incentives and educational efforts around home visiting, noting its impact as a strategy integrated into existing programs.

Dr. Sheen explained that home visiting rates for Covered California members have not reached desired levels. While there is no specific incentive for home visits, members can earn incentives for actions like colorectal screenings or vaccinations, with multiple options for completing these, including visiting a primary care physician, attending a mobile clinic, using virtual care, or opting for a home visit. Dr. Sheen emphasized the importance of offering alternative care options to ensure members maintain access to care in the current climate.

Public Comment: Ms. Millers expressed gratitude to Covered California and health plan colleagues for their leadership and insightful presentations on advancing quality improvement.

Tory Robinson, representing Blue Shield of California, commended the Covered California team for their structured approach to driving rapid quality improvement across the state.

Discussion – California Alignment for Hospital Quality (Cal HQ)

Ms. Priestly shared details about Covered California's involvement in the Cal-HQ initiative. Cal-HQ seeks to align hospitals across California on quality improvement efforts, building on successful past initiatives like Smart Care California, which reduced Nulliparous, Term, Singleton, Vertex C-section rates and demonstrated the power of statewide alignment. The initiative focuses on improving patient care, accelerating access to performance data, and fostering collaboration among hospitals to create a network of excellence.

Covered California's new health plan contract for 2026 emphasizes cross-plan collaboration and support for hospitals, moving away from payment-based requirements and focusing on quality outcomes. The initiative plans to facilitate peer-to-peer learning among hospitals, a proven strategy in ambulatory care but less common in hospital settings. Ms. Priestly expressed enthusiasm for the initiative's potential to drive meaningful improvements in hospital quality, thanking the audience for the opportunity to share this promising effort.

Board Comments: None.

Public Comment: None.

The meeting adjourned at 3:30 p.m.