FOCUS AREA	CALIFORNIA– MEDI-CAL HEALTHIER CALIFORNIA FOR ALL	NEW YORK – DSRIP 2.0	CMS MEDICARE DIRECT CONTRACTING
Accelerated Managed Care	Continued phase in of mandatory enrollment in Medicaid managed care to high cost, high risk populations such as children with certain conditions such as cystic fibrosis, hemophilia, etc.	Managed Care Organizations (MCOs) seen as an essential participant and funds flow partner for "DSRIP 2.0"	The Direct Contracting Entity (DCE) contracts with CMS for Medicare fee-for-service (FFS) members under capitated model analogous to managed care contracts, with MCOs encouraged to apply*
Quality Measure Standardization	Transition of funds to the established State Quality Improvement Program. New requirements to go from 25th to 50th percentile in quality reporting; all plans required to be NCQA certified	Move away from DSRIP measures and leverage subset of HEDIS	Transitioned to total cost of care and a smaller set of core quality measures focused on beneficiary experience and utilization
Establishment of Regional Markets to Create Competition	Regional managed care capitation rates; County level VBP contracts with MCOs and County Performance Standards	Introduction of regional performance incentive pools	Heavy emphasis on regional benchmarking and payment rates
Premium Risk Transfer to Providers and All Payor Approach	Opportunity for large risk transfer to local entity taking full-risk for a geographic population through full integration pilots (similar to Oregon CCOs); small potential transfer in 1115 Waiver application in 2020 for Global Payment Program for the uninsured	MCOs required to establish downside risk contracts to access MCO incentive funds; proposed funding pools to be used to align attribution and payment to all payor models	Unlike previous ACO models, MDC allows first dollar risk and savings; risk transfer to providers provides flexibility to align models across payors
Funding Social Determinants of Health (SDOH) Through Capitated Payments	Standardize Medi-Cal MCO benefits through defining and allowing "in lieu of services"- flexible, lower cost, effective alternatives to standard clinical care, some of which include SDOH coverage	Establishment of Social Determinants of Health Networks, coupled with MCO incentives to contract with congressional bond offices (CBOs)	Introduction of new benefit enhancement options, including flexibility to provide SDOH benefits that do not count against medical loss ratio (MLR)

* While Medicare Direct Contracting contains features that deliberately expand program eligibility to a larger variety of providers than legacy ACO models, it does not restrict MCO participation as DCEs and encourages their participation in the model.