While FFS payments can lead to overuse of health care services, capitation payments can incent providers to restrict care. In response to consumer backlash in the 1990s over the perception that managed care led to denials of care, California legislated an Independent Medical Review process, mandated insurance benefits, and network breadth and access requirements for HMO plans. These regulations have helped ensure that consumers are not denied access to services, and that the care provided is comprehensive and timely. However, these regulations have imposed significant costs, and have encouraged the movement of enrollment away from heavily-regulated HMO products to lightly-regulated PPO products and to more self-insured employer arrangements, which are exempt from these state-level regulations.

Lesson Ten: Special attention must be given to establishing ACOs in areas with social and economic challenges.

Statewide physician organization performance measurement in California has uncovered significant variation in the performance of providers, with lower-performing organizations clustered in areas with identifiable sociodemographic and health systems challenges. These variables are interrelated; larger uninsured and Medicaid populations, as well as less consolidation in certain provider markets, lead to lower overall reimbursement, which leaves practices with less capital available for structural and process improvements. Under the new national health reform legislation, coverage will expand most rapidly in these low-income areas, therefore it is important to pay special attention to identifying why quality gaps exist with an eye to setting up high

less reimbursement, more limited trained providers