



# Toward Accountable Care

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## Monarch HealthCare: Leveraging Expertise in Population Health Management

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**ABSTRACT:** Monarch HealthCare, a physician-led independent practice association in Orange County, Calif., is one of the provider groups participating in the Brookings–Dartmouth ACO Pilot Program to form accountable care organizations, which assume responsibility for improving patient care and lowering total costs and, in turn, share in the savings achieved. This case study explores the characteristics of Monarch and its partners, including the insurer Anthem, that have contributed to the development of Monarch's ACO, including: strong executive leadership, trust and transparency in its partnerships, the use of care navigators and physician champions, and economies of scale achieved through the physician network.



### OVERVIEW

This case study examines the progress that Monarch HealthCare, a physician-led independent practice association in Orange County, California, has made in its efforts to become accountable for the quality and overall cost of care for its patient population. Monarch HealthCare is one of the provider groups participating in the Brookings–Dartmouth ACO Pilot Program that are profiled in the Commonwealth Fund case study series *Toward Accountable Care*.

Accountable care organizations (ACOs) have been proposed as a new delivery model to encourage clinicians, hospitals, and other health care organizations to work together to improve the quality of care and slow spending growth. The Affordable Care Act's ACO program is intended to promote better management and coordination of care for Medicare beneficiaries by enabling providers working in ACOs to share in any savings they achieve. However, there is little evidence from the field on how health care organizations progress from traditional payment models toward the ACO model. To better understand this process, this case study documents Monarch HealthCare's journey to develop an ACO.

Monarch is a large, physician-led independent practice association (IPA) localized in three regions: northern, southern, and coastal Orange County. Monarch is developing an ACO with Anthem,<sup>1</sup> in which it will provide care coordination and care navigation support for 25,000 Anthem preferred provider organization (PPO) members in Orange County. In this arrangement, Monarch will serve PPO patients for the first time, having previously served exclusively managed care patients. Monarch's ACO is physician-owned and governed, and will include approximately 500 of its 760 primary care physicians. Monarch was selected as a Medicare Pioneer ACO site in December 2011. (See announcement at: <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.) No patients are currently attributed to specialists, but methods for including them are being explored.

During early implementation, Monarch's ACO is governed by an internal executive steering committee and a joint external steering committee with Anthem. Monarch and Anthem executed a binding letter of agreement, effective January 1, 2011, which outlined the simple shared-savings model for year one of the pilot and allowed the organizations to: share claims data, exchange a care review stipend, and develop a comprehensive five-year ACO contract (Exhibit 1). In May 2011, Monarch launched its ACO by notifying patients that they had been attributed. The final contract will detail the performance-based shared-savings bonus to physicians, the development of an ACO benefit plan, and contract renewal clauses.

Several factors have contributed to the successful development of Monarch's ACO. These include: strong executive leadership, trust and transparency in partnerships, the use of care navigators and physician champions, and economies of scale across the physician network. Monarch has worked to unify diverse physician groups across specialties, regions, and career trajectories; bring hospitals, vendors, and other stakeholders on board; and negotiate ACO contracts with a broader

<sup>1</sup> Anthem was Monarch's ACO payer-partner at the time of the site visit. In October 2011, Anthem discontinued its ACO partnership when Monarch was acquired by OptumHealth, a subsidiary of UnitedHealth Group.

### Exhibit 1. Monarch's ACO Milestones

Nov. 2009	Decided to establish an accountable care organization
Jan. 2010	Selected Anthem as a payer-partner in the ACO
April 2010	Selected as a Brookings–Dartmouth ACO Pilot Program site
Jan. 2011	Monarch and Anthem executed a letter of agreement
April 2011	Hired a senior vice president for accountable care Received historical claims data from Anthem, attributed patients to the ACO
May 2011	Monarch and Anthem released a beneficiary notification letter

payer network to ensure full financial support for the initiative.

This case study describes the progress that Monarch HealthCare, A Medical Group, Inc., located in Irvine, California, has made to become accountable for the overall quality and cost of care for its patient population. It focuses on how Monarch HealthCare embarked on its journey to: 1) to create the capabilities to be accountable for the quality and cost of care received by its patient population, and 2) develop an accountable care organization (ACO) contract with Anthem for this global quality/cost payment model. This case study outlines the key characteristics of the organization and its partners, its rationale for choosing to develop an ACO, steps taken to implement the model, and lessons learned in overcoming challenges and facilitating early changes.

*I'm very excited about that which has been accomplished ... I'm even more excited because I think the best is yet to come. I think that the impact that we are going to have is going to be dramatic—and it's going to be positive.*

Jay Cohen, M.D., executive chairman,  
Monarch HealthCare

**MONARCH HEALTHCARE:  
ORGANIZATIONAL CHARACTERISTICS**

Monarch HealthCare is a physician-owned and operated independent practice association (IPA). It is the largest IPA in Orange County, and the only one with a county-wide presence. Founded in 1994, Monarch is led by Bart Asner, M.D., CEO, and Jay Cohen, M.D., executive chairman, who were among the six founding members. One year after its inception, Monarch was identified as “the fastest-growing medical enterprise in Southern California.”<sup>2</sup> Over its 17-year history, it has maintained stable leadership and consistent growth. Monarch formed a multispecialty group in 2009 and now contracts with more than 2,200 independent, private-practice physicians. Each year it serves approximately 178,300 commercial, Medicare, and Medicaid patients under managed care contracts (Exhibit 2).

Monarch physicians deliver care following the values identified through the acronym “I CARE,” which stands for “Innovation, Communication, Accountability, Respect, and Excellence.” Monarch’s leaders underscored how these core values and an institutional “patients first” philosophy make it well suited to become an ACO.

**Historical Context**

Over the past 20 years, California’s health care market has been characterized by significant consolidation across insurers, hospitals, and physician practices. In Orange County, scores of hospitals merged into just a few hospital systems. Dozens of insurance companies partnered or left the market, and ultimately consolidated into the six major insurers that offer health maintenance organization plans that contract with Monarch: Aetna, Anthem Blue Cross California Care, Blue Shield, CIGNA, Health Net, and PacifiCare/United HealthCare. Independent physicians migrated toward medical groups and IPAs that, in turn, merged with others to form the handful of medical groups and IPAs in the Orange County market. Monarch was formed through the unification of three hospital-based

<b>Exhibit 2. Core Characteristics of Monarch HealthCare</b>
<b>Type:</b> Independent practice association (IPA)
<b>Legal structure:</b> Professional corporation
<b>Location:</b> Irvine, Orange County, Calif.
<b>Patients served annually:</b> 178,300 capitated commercial, Medicare, and Medicaid patients
<b>Physicians, employed:</b> 40 multispecialty
<b>Physicians, affiliated:</b> 760 primary care, 1,470 specialists
<b>Hospitals owned:</b> None, 18 affiliated hospitals
<b>Electronic health record systems:</b> Epic (hospital affiliates) Gaudette, NextGen, Practice Connect

IPAs. Leaders from these entities decided that, rather than compete, they could better serve the needs of the patients and physicians in their communities if they united as a single IPA.

Monarch specializes in providing managed care to seniors, and has a license to take global risk under its own Medicare Advantage plan. Since the HMO model is focused on preventive care, Monarch has a particularly close relationship with its contracted primary care providers. The strength of these relationships will be essential to the formation and continuation of Monarch’s ACO, in which primary care providers play a key role. In Monarch’s early years, some specialists felt alienated by the IPA’s emphasis on primary care. Monarch has since made a concerted effort to build relationships with providers outside of the primary care sphere by aligning incentives through performance-based payment and by employing hospitalists at high-volume hospitals and skilled nursing facilities.

**Regional Presence**

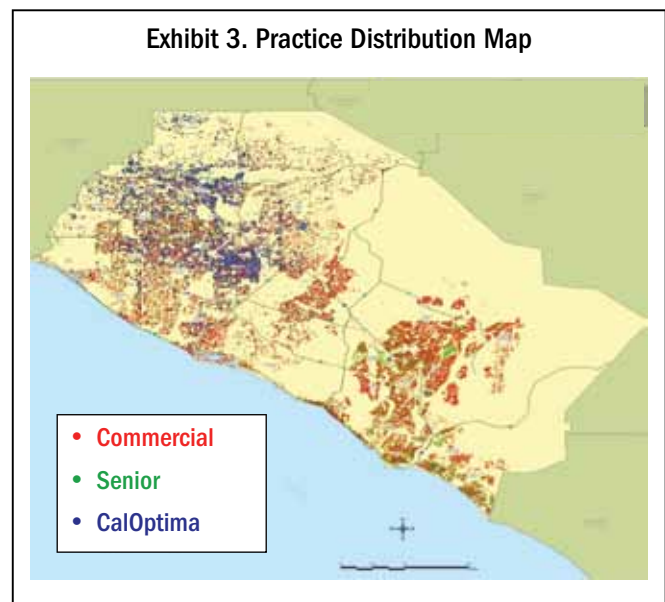
Strength of affiliation among Monarch’s contracted physicians varies across Orange County (Exhibit 3). Monarch has a particularly strong presence in southern Orange County, where there are fewer competing IPAs, larger practices, and more practices contracted exclusively with Monarch. Physicians there tend to be closely tied to Monarch, evidenced by their greater involvement in Monarch-led initiatives and higher usage rates

<sup>2</sup> B. Marsh, “Managed Care, Ill Feelings,” *Los Angeles Times*, Sept. 25, 1995.

of Monarch's care improvement and reporting tools. Although Monarch is affiliated with nearly as many doctors in the northern and coastal regions of the county as in the southern region, practices there tend to be smaller, geographically dispersed, and maintain a more diversified payer mix. As a result, Monarch contributes fewer patients to their panels and is less closely affiliated with these groups. There also is more ethnic diversity in northern and coastal Orange County. Many small IPAs that support the needs of these groups existed prior to Monarch's entry into those markets. Monarch has addressed this by developing materials in a variety of languages and maintaining a presence in those practices.

### Local Market Attributes

There are three competing models of health care delivery in California: the physician-led IPA model, the hospital-led foundation-based model, and the integrated delivery system. As an IPA, Monarch contracts directly with independent physicians, which offers physicians the care management support of a larger entity while maintaining some autonomy. The foundation-based model has emerged because hospitals in California cannot employ physicians. Foundations are nonprofit entities that employ physicians and exist within nonprofit hospital systems.



Prior to 2008, Monarch's HMO market in the southern part of Orange County was the most successful system in the region, and there were few competitive threats to its physician-led model. However, in May 2008, Kaiser Permanente Orange County Irvine Medical Center opened four miles from Monarch's headquarters. Shortly thereafter, Kaiser rolled out a statewide, high-deductible HMO plan, which has enrolled 800,000 members and presented increased competition to physicians, hospitals, and insurance companies in the Orange County market.

As a fully integrated delivery system, Kaiser's model also draws market share from other insurers.

### Study Methods

In late March 2011, a team from The Dartmouth Institute for Health Policy and Clinical Practice conducted a five-day site visit at Monarch HealthCare, A Medical Group, Inc., located in Irvine, Calif. Interviews were conducted with executive leaders, physicians, and directors of technical areas involved in the ACO.

Information in this case study was collected through in-person and telephone interviews with executives and physician leaders. The site visit included focus groups with physicians and administrative staff at nine provider organizations associated with the Monarch ACO, including hospitals, primary care practices, and specialty and multispecialty groups. The site evaluation team attended meetings with the ACO Executive Steering Committee and ACO Physician Advisory Board, as well as the joint Monarch-Anthem-HealthCare Partners ACO Steering Committee.

The case study was informed by a review of internal and external documents, including Monarch's data needs assessment, ambulatory case management tool, adult and pediatric clinical performance metrics, performance quality report card, utilization reports, press releases, steering committee notes, relevant presentation slides, advance directives packet, and confidential elements of its drafted ACO contract.

This has motivated providers and insurers to partner and align incentives to maintain their competitiveness in the market. Although there are still many types of health care entities positioning themselves for leadership in the ACO model in Orange County, Ray Chicoine, chief operating officer, says Monarch’s leadership believes that “physician groups should be the center of the delivery system, and we believe we have the infrastructure, the leadership, and the systems to do that and to do that well.”

**Compensation Methods and Revenue Sources**

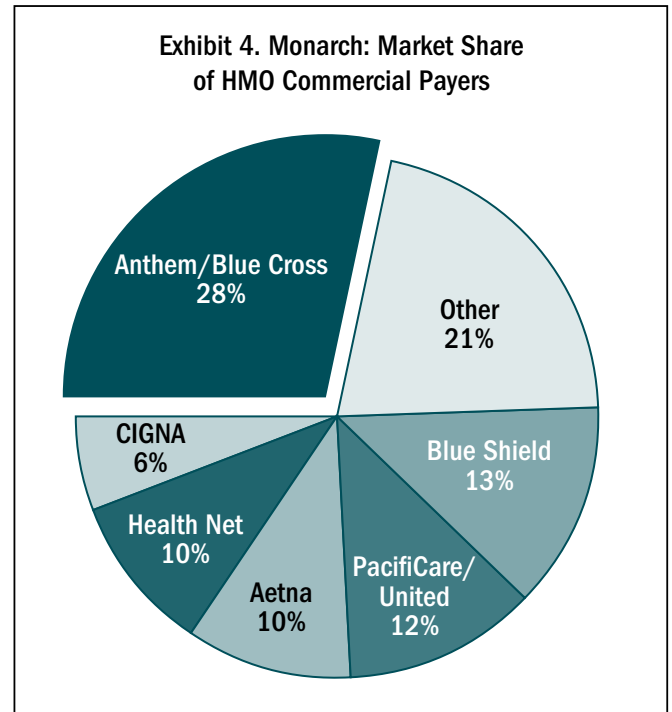
Monarch contracts with all major health plans in California to cover its 178,300 HMO members with professional or full risk capitation on a per-member per-month basis. Its members include:

- 121,500 commercial HMO members,
- 25,500 MediCal HMO members (California’s Medicaid), and
- 31,300 Medicare Advantage members.

Six major payers cover Monarch’s commercial HMO members: Aetna, Anthem/Blue Cross (CaliforniaCare), Blue Shield, CIGNA, Health Net, and PacifiCare/United (Exhibit 4). In January 2011, approximately 25,000 Anthem preferred provider organization (PPO) members were attributed to the Monarch ACO. Given its experience with the full-risk HMO population, Monarch’s developing ACO is well prepared to integrate these patients into the coordinated care model.

**Independent Practice Physicians**

As an IPA, Monarch values physician independence. It typically contracts with physicians and supports them in maintaining their own practices, rather than seeking to employ them. The IPA contracts with more than 2,200 independent, private-practice physicians. As an IPA, it neither owns, nor is it owned by, a hospital system. Independent physicians tend to value their autonomy, but also see the value that Monarch provides as



an IPA. As a uniting organization, Monarch brings together the efforts of disparate physician groups, aligns primary care and specialist physician members in common initiatives, and supports its members in meeting new criteria such as the federal requirements to demonstrate meaningful use of health information technology.

**Employed Physicians**

In 2009, Monarch broadened its physician engagement efforts by employing 12 physicians and two physician assistants in an ambulatory multispecialty practice, Premier Physicians Medical Group. Dispersed among six locations in Orange County, the medical group is a way for Monarch to engage physicians who want to be employed, including those just coming out of residency who may not have the capital to start their own practices. Monarch also employs 24 physician hospitalists and two nurse practitioner hospitalists at six affiliated hospitals and several skilled nursing facilities. Monarch has not made a significant attempt to employ large physician populations.

## **ORIGINS OF ACCOUNTABLE CARE AT MONARCH HEALTHCARE**

Monarch's journey to become accountable for the quality and costs of care delivered to a population of patients is rooted in its 17 years of experience with managed care. Developing an ACO is a natural next step. Its executive leaders believe that creating an ACO is an opportunity to apply the organization's core competencies to a new patient population. Monarch has developed sophisticated tools and infrastructure to manage both the quality and costs of care for a population of patients. These systems facilitate effective communication among providers and identification of high-risk and high-cost patients. They include Monarch's health information technology infrastructure, capabilities to care for a population, quality and performance improvement efforts, and experience with quality-based payment and risk-bearing contracts.

### **Advancing an Effective Health Information Technology Infrastructure**

Monarch has made an institutional commitment to leverage technology to advance clinical practice and the delivery of care. Through their association with Monarch, independent practices have access to resources they may otherwise be unable to afford, such as the NextGen electronic health record (EHR) system. In return, Monarch benefits from having many of its affiliated physicians using the same systems. With these tools in place, Monarch can monitor progress, identify opportunities for improvement, pinpoint waste in the delivery system, and create efficiencies in clinical and administrative processes. These tools include:

- Health Information Exchange (HIE). When it is launched, this Web-based platform will provide internal connectivity between systems that are already in place at Monarch and between Monarch's electronic systems and those of other institutions. This infrastructure was advanced through participation in the Orange County Partnership Regional Health Information Organization, of which Monarch's chief

information officer, Bill Farry, is the chair. The partnership recently received \$795,000 from Cal-e-Connect to expand the regional HIE infrastructure among providers in the county.

- NextGen, which includes an EHR system, practice management system, internal HIE system, and patient portal. Monarch has upgraded the system to meet meaningful use criteria, and is working with providers to ensure compliance. The EHR is linked with laboratories, pharmacies, imaging services, and appointment reminder tools. In place at 40 locations with approximately 150 providers, the system is currently processing approximately 10,000 visits, 9,000 electronic prescriptions, and 5,200 electronic laboratory orders and results per month. Monarch's HIE launched in the fourth quarter of 2011, with connectivity to affiliated hospitals and medical offices. Finally, the patient portal will provide patients with secure access to physicians via e-mail and enable them to request appointments or medication refills and see test results. This system was piloted in June 2011.
- PracticeConnect is a Web-based tool that deploys information to all independent practice providers and enables clinical information-sharing, patient status inquiry, and messaging. It includes chronic care registries and allows electronic submission of claims and authorization requests. It is equipped to identify and notify case managers of high utilization patterns among patients. Monarch providers have been using this tool since 2001. Nearly 90 percent of Monarch's care management referrals are received electronically through PracticeConnect, and it allows them to process roughly 2,000 authorizations per day. PracticeConnect also serves as a connectivity platform for Monarch. It integrates niche products to meet care delivery, analytics, and reporting needs.

Monarch works to ensure consistent and effective application of these tools across its network. It

employs 40 information technology staff, including developers who can customize software.

### **Capability to Care for a Population**

Monarch's approach to managing population health includes: 1) case management, 2) disease management and registries, 3) "Touch Teams," 4) personal health records and advance directives, and 5) use of urgent care and hospitalists. Monarch's experience implementing these programs for its Medicare Advantage population provides important groundwork for future application to the ACO population. It uses a risk-stratification tool to identify high-risk patients who may benefit from case management, disease management, or the Touch Team programs. In the future, it plans to use predictive modeling for more sophisticated identification of high-risk patients.

### **Case Management**

Monarch has extensive experience with case management, particularly in managing transitions of care between outpatient and inpatient settings for frail elderly, who are the highest-risk patients it serves. Monarch does this by using the following "five pillars" as guidelines: 1) reconcile medications, 2) set a follow-up appointment, 3) educate patients about warning signs, 4) use effective patient-physician communication, and 5) use a personal health record. Key players in providing case management include:

- inpatient case managers on site at Monarch's high-volume facilities,
- ambulatory case managers in a centralized office,
- employed hospitalists and nurse practitioners on site at hospitals and skilled nursing facilities,
- patients' primary and specialty care physicians,
- inpatient medical directors, and
- ambulatory care medical directors as well as associate medical directors.

Monarch also has a full-time ambulatory care medical director and 25 associate medical directors (AMDs). The AMDs, all practicing physicians, help Monarch create case management strategies following an episode of care. They conduct utilization reviews and develop evidence-based clinical practice guidelines that are distributed to the physician network. Monarch plans to give AMDs a more prominent role as department chairs to empower them to partner with other physicians from their own specialty to create better models of care.

### **Disease Management and Registries**

Monarch has instituted disease management programs for diabetes and asthma. It encourages primary care physicians to identify patients for inclusion in these programs after a confirmed diagnosis, but patients choose whether to participate. The programs focus on assessment, care planning, and education and coaching. Primary care providers and disease management coaches help patients write self-care management plans, and a case manager is designated for each patient. The plans include recommendations for patients on routine care, sick-day planning, symptom recognition, and early intervention to prevent unnecessary emergency department visits, hospitalizations, and complications of their condition. Monarch plans to expand its disease management programs to include coronary artery disease, chronic obstructive pulmonary disease, and congestive heart failure.

### **Touch Teams**

Monarch's Touch Teams originated from an earlier attempt to establish a high-risk clinic as an intermediate step between the hospital and the primary care physician's office for patients discharged from inpatient stays. Monarch's high-risk clinic allowed patients to see a geriatrician, social worker, and a case manager at the same location. However, patients with complex chronic diseases did not show up in great numbers because of transportation or other psychosocial constraints. Realizing that the most effective way to reach these patients was through home-based care, Monarch created the interdisciplinary Touch Teams.

Team members—an advanced nurse practitioner, case manager, social worker, and pharmacist—coordinate patients’ transition from hospital to home and make home visits. Monarch also hired two full-time social workers to integrate behavioral health clinical services and other community-based services into the overall plan of care for each high-risk patient.

### **Personal Health Record and Advance Directives**

Monarch uses two paper-based tools to improve care transitions: a personal health record and Physician Orders for Life Sustaining Treatment (POLST). The personal health record includes sections on medical history, medications, recent hospitalizations, and emergency or urgent care visits. It also provides information on personal health maintenance. The personal health record booklet is distributed to all members who receive a Touch Team visit. Patients are encouraged to bring this booklet with them on clinical visits. The POLST is available online and in physician offices. It also is included in a packet of information distributed by the Touch Team to patients at high risk for relapse, complications, or accidents. This legally binding document is used for patients to outline their desired course of action in the event that they require life-sustaining treatment such as resuscitation orders, artificial nutrition, and other medical interventions. The completed POLST is signed by the patient and a physician or nurse practitioner and entered in the patient’s medical record.

### **Use of Urgent Care and Hospitalists**

Monarch has taken two approaches to reducing hospital readmissions and emergency department visits: encouraging the use of urgent care facilities and employing hospitalists. Urgent care facilities play an important role in curbing costs because this type of visit is significantly less expensive than a hospital-based emergency visit. Urgent care facilities are often able to address pressing health issues before they escalate into an emergency situation. Monarch developed a brochure to educate patients about each clinic’s location, hours, and clinical capabilities. In 2009, Monarch began employing hospitalist physicians, skilled nursing

facility physicians, and nurse practitioners to improve communication and transitions between inpatient, skilled nursing facility, and outpatient care. Monarch now employs 24 hospitalists, 14 of whom are engaged in a fellowship program to become board certified in palliative care.

### **Performance Improvement Infrastructure**

Monarch looks for opportunities to improve the quality of care delivered to patients, such as reducing hospital readmission rates, developing integrated care teams, and reducing waste.

### **Reducing Hospital Readmissions**

Monarch has identified opportunities to reduce hospital readmissions through the use of “readmission rounds.” Since 2008, a medical director or assistant medical director, hospitalists, and case managers conduct a root cause analysis of every readmission that occurs within 30 days of discharge to determine where the system broke down and how to improve care processes. Monarch’s chief medical officer reported that this initiative has reduced Monarch’s readmission rate substantially over the last two years and led to system-wide changes to improve care transitions and follow-up. For example, Monarch found that a major cause of readmission was that patients did not receive a timely follow-up appointment with their primary care physician. Monarch now proactively calls the primary care offices of high-risk patients to inform them that the patient has been discharged and to ensure a follow-up appointment has been made.

### **Developing Integrated Care Teams**

Monarch also is working on a new initiative to develop integrated care teams that bring together all of the people involved in managing a population of patients. These teams will focus on patients aligned with specific physician practices, according to geography. This will mean that the referrals manager and the case management representative assigned to an integrated care team will be located in one place, and work in collaboration with one of the four primary care assistant medical directors. Monarch sees local integration as



the model for future practice and hopes it will facilitate more effective communication and alignment across specialties, geographic locations, and episodes of care. The integrated care teams will help primary care providers provide coordinated care by strengthening relationships among providers within a geographic area. Monarch sees these integrated care teams as “mini-ACOs” within Monarch.

### **Reducing Waste**

Monarch discovered that it was losing money through systematic inefficiencies, which created costs that did not contribute to improving care. It identifies waste by pulling relevant data from across the network using nearly 20 complementary data systems, as well as actuarial services to compare utilization with peer organizations. Monarch identified systemwide inefficiencies in: duplicative or otherwise unnecessary tests, inadequate communication of information, excessive inpatient bed days, unnecessary utilization of specialists, and overutilization of emergency services. Monarch sees the ACO as creating the incentives to identify and reduce systematic inefficiencies for the PPO population, as it has consistently done for its managed care patients.

### **Experience with Quality-Based Payment**

Monarch has experience with quality-based payment through the Integrated Healthcare Association (IHA) Pay for Performance (P4P) program, which is implemented widely in the state of California. The P4P program has prepared Monarch to implement accountable care, as it requires the institution to monitor performance, publicly report data, and leverage both performance and financial incentives to improve its quality of care. Through the P4P program, participating groups are assessed both on national standards of care and by patients’ ratings of their care experiences. Organization-level data are compiled in a performance scorecard and accessible online through the California Office of the Patient Advocate. The P4P program also prompted Monarch to be an early adopter of health information technology, which further advanced its ability to track and measure performance data.

*The only losers [in the ACO model] are going to be those who rely upon waste in the system.*

Jay Cohen, M.D., executive chairman,  
Monarch HealthCare

As a corollary to this program, Monarch provides physicians with actionable variance data and incentive payments based on their individual performance on Healthcare Effectiveness Data and Information Set (HEDIS) indicators, appropriate urgent care or emergency department utilization, diabetes metrics, generic drug usage, and ambulatory surgical center usage.

### **Experience with Risk-Based Contracts**

The current health care environment in California was shaped by the Knox-Keene Act, passed in 1975. According to a 2001 report from the California HealthCare Foundation, the Knox-Keene Act was developed to apply rigorous licensing standards to MediCal Prepaid Health Plans and address the plans’ weaknesses.<sup>3</sup> Many provisions of the Knox-Keene Act are aligned with the federal HMO Act of 1973. The Knox-Keene Act sets rules for mandatory basic services, financial stability, availability and accessibility of providers, review of provider contracts, administrative organization, and consumer disclosure and grievance requirements. It also created the Department of Managed Health Care, which regulates and licenses risk-bearing health plans. In order to pay provider groups on a capitated basis, plans must be licensed to take on professional and institutional risk. This arrangement has permitted health plans to develop experience managing risk, thereby enhancing their readiness for ACO implementation. As the Knox-Keene Act applies specifically to capitated populations, it is yet to be determined how the PPO population included within ACOs will be regulated.

In April 2006, Monarch created the Monarch Health Plan with the goal of acquiring a license to provide Medicare services. One year later, it obtained

<sup>3</sup> D. L. Roth and D. Reidy Kelch, *Making Sense of Managed Care Regulation in California* (Sacramento, Calif.: California HealthCare Foundation, Dec. 2001), p. 8.

a Knox-Keene license, which allowed Monarch Health Plan to bear institutional risk, a requirement for Medicare contracts. By December 2007, Monarch made a material modification to the business plan in its licensure and expanded its relationship with PacifiCare/United, rather than continuing to pursue a Medicare contract. Under this agreement, Monarch moved from assuming professional shared risk to global risk in January 2008. PacifiCare/United continued to bear risk on the benefit plan and for retaining members. Monarch then partnered with other licensed health plans to take risk and process claims. This allowed Monarch to better coordinate a wider scope of patient services, retain a larger portion of premium dollars, build financial stability, and demonstrate the ability to manage risk. Monarch's leaders see this as a key factor in demonstrating readiness to take on risk in the ACO.

## **MOVING FORWARD WITH ACCOUNTABLE CARE**

Once Monarch made the decision to pursue accountable care, it engaged in three preliminary activities: 1) participation in the Brookings–Dartmouth ACO Pilot Program, 2) establishment of the payer–provider partnership, and 3) involvement in national and state health policy.

### **Participation in the Brookings–Dartmouth ACO Pilot Program**

In the past 10 years, Monarch has exclusively served an HMO population. Its leaders viewed the Brookings–Dartmouth ACO Pilot Program as an opportunity to apply their core competencies in care coordination and population health management to the PPO and Medicare fee-for-service populations, which compose nearly 60 percent of the Orange County market.

The Brookings–Dartmouth ACO Pilot Program was created to support early and successful adoption of ACOs and to provide technical support and direction for advancing the ACO model. In November 2009, Monarch was selected as one of the five ACO pilot

sites based on its readiness to coordinate care; experience identifying and targeting high-risk, high-cost patients; robust IT infrastructure; and institutional prioritization to move toward accountable care.

### **Establishing the Payer–Provider Partnership**

An important early step in ACO implementation is selecting a payer-partner or partners with whom to develop the ACO. The selection of partners is particularly for early adopters that have the potential to set precedent in ACO implementation. “Be very cautious about picking your partners,” said Monarch's executive chairman Cohen. “Because although you may have the right motivation and the right value system and culture, if you partner with an organization that doesn't share those with you, it's going to be a problem.”

Monarch described Anthem as the natural choice for a payer-partner because of the insurer's interest in piloting the ACO in California and its intention to expand it to a national scale. Anthem has a wide state and national network, and the largest share of the commercial market in Orange County. Partnering with Anthem will allow Monarch to reach approximately 25,000 new patients through the insurer's PPO network. Initially, this alliance was forged with Anthem's regional representatives in the California market. However, Anthem's national leadership took an interest in the initiative and provided significant support at the national level to facilitate the partnership. Monarch planned to partner exclusively with Anthem on the ACO in the first year of the pilot, but intends to include Medicare fee-for-service beneficiaries and other commercial payers in the second year.

### **Involvement in National and State Health Policy**

Monarch's leadership viewed the signing of the Affordable Care Act into law in March 2010 as an opportunity to apply the IPA's core capabilities to new models of care. They believed the law's provision on ACOs was particularly aligned with Monarch's strength in care coordination, goal of promoting a

<b>Exhibit 5. Core Characteristics of the ACO</b>
<b>Payer-partner:</b> Anthem
<b>Legal entity:</b> Entity within existing parent organization (professional corporation)
<b>Oversight of ACO formation:</b> HCP-Monarch-Anthem Steering Committee with topic-specific subcommittees
<b>Payment model:</b> Shared savings, no risk in year 1; transition to risk-bearing
<b>Patient attribution model:</b> Anthem ETG (Episode Treatment Group) Method and Brookings–Dartmouth Method
<b>ACO patient population:</b> 25,000 Anthem PPO patients
<b>ACO physician population:</b> 500 PCPs; not currently assigning patients to specialists

physician-led model for delivery system reform, and interest in expanding service to the PPO population. Participation in the ACO pilot program created a platform for Monarch’s involvement in national health care reform, and its leaders contributed to relevant discourse at the state and national levels.

**CREATING THE INFRASTRUCTURE TO BECOME ACCOUNTABLE FOR CARE**

Monarch began working with Anthem in 2010 to develop the infrastructure for the ACO and to agree on a contract that would hold them accountable for the total quality and costs for the PPO patient population. The following section describes Monarch’s development of the ACO infrastructure and contract terms with Anthem including: the type and structure of the ACO, governance and leadership of the ACO, terms of the contract, payment model, patient attribution, benefit design, patient engagement and notification, and physician engagement (Exhibit 5).

**Structure of the ACO**

Monarch’s pilot ACO is built on the single-payer/single-provider model, with Anthem as its designated payer. The ACO is physician-owned and governed, and will include over half of Monarch’s approximately 760 primary care physicians. Physicians in the ACO are identified as Monarch’s primary care providers

who have 20 or more Anthem PPO patients attributed to them through the ACO’s attribution methodology, described below. Monarch anticipates that the ACO will initially cover over 25,000 commercial PPO patients.

**Governance and Leadership**

Two complementary governance structures are involved in overseeing and driving the progress of Monarch’s ACO. These include an internal Executive Steering Committee, which meets weekly, and an external Monarch-Anthem-HealthCare Partners Joint ACO Steering Committee, which meets monthly. HealthCare Partners is another Brookings–Dartmouth ACO pilot program site that began working with Anthem at the same time as Monarch.<sup>4</sup> Additionally, Monarch convenes an ACO Physician Advisory Board, which advises the ACO Executive Committee on physician and patient engagement. A novel addition to the ACO leadership team at Monarch is the senior vice president for accountable care. This position was created to execute Monarch’s ACO strategy in conjunction with the rest of the executive leadership team. This individual is responsible for implementing the ACO business plan, overseeing the project, identifying opportunities to grow the business, and interacting with key stakeholders to ensure effective and efficient progress of ACO implementation.

**Internal ACO Executive Steering Committee**

Monarch’s internal Executive Steering Committee is responsible for both the strategic planning and operating decisions required in establishing and implementing the ACO. Each participant is responsible for a topical subcommittee, through which they incorporate feedback from their respective staff. This subcommittee structure was devised by Monarch’s chief operating officer to divide tasks and increase accountability for the progress of ACO implementation. Each subcommittee reflects key elements of the ACO contract and mirrors the subcommittee structure reporting to the

<sup>4</sup> A case study of HealthCare Partners development of an ACO is available at <http://www.commonwealthfund.org/Publications/Case-Studies/2012/Jan/HealthCare-Partners.aspx>.

**Exhibit 6. Subcommittees of the Monarch-Anthem-HealthCare Partners Joint ACO Steering Committee**

- Attribution
- Clinical operations
- Contracting / Framework
- Cost of care
- HIT / System operations
- Marketing / Sales / Communications
- Medical management delegation
- Performance metrics
- Product development / Benefit design

Monarch-Anthem-HealthCare Partners ACO Steering Committee (Exhibit 6). The internal ACO Executive Steering Committee is advised by an ACO Physician Advisory Board, which is described below.

**Monarch-Anthem-HealthCare Partners Joint ACO Steering Committee**

A parallel structure was adopted in the Monarch-Anthem-HealthCare Partners Joint ACO Steering Committee. One leader from each organization is represented on each subcommittee, and they communicate between the monthly meetings to address standing issues and make progress in developing their contracts. Anthem has a separate contract with each provider organization.

The Monarch-Anthem-HealthCare Partners Joint ACO Steering Committee enables Anthem to address common elements of its partnership with these two ACOs and facilitates cross-fertilization of ideas, collaboration, and troubleshooting among the participants. The potential for Anthem to adopt the ACO on a national scale lends further importance to the Monarch and HealthCare Partners pilots.

**Terms of Contract**

According to one of Monarch’s contracting specialists, developing the ACO provider-payer contract is not an event, “it’s a process, and it takes a long time.” Three core documents were used to develop Monarch and Anthem’s ACO agreement: the guiding principles, the letter of agreement, and the final ACO contract.

The one-page guiding principles document outlines the driving forces in the partnership, such as transparency, objectivity, and a commitment to align incentives and pursue the ACO “for the right reasons.” This document helps Monarch and Anthem understand each other’s interests and needs in this arrangement.

The letter of agreement between Monarch and Anthem was executed in the first quarter of 2011. This 10-page document enabled the organizations to proceed while allowing for flexibility and modification of contract terms as they learned from early experiences. This binding agreement outlined the high-level terms of their working relationship and the trajectory of ACO development over the next five years. It also enabled Monarch to receive from Anthem the historical claims-based data needed for patient attribution and to coordinate care for the attributed population. Transparency of information led Monarch to identify areas of performance measurement that needed to be deferred because of a lack of sufficient data.

**ACO Contracting Process**

Monarch and Anthem’s ACO contracting process over the first two years of ACO implementation is demonstrated in the Monarch-Anthem Contracting Timeline (Exhibit 7). Notably, most of these activities occurred prior to the Centers for Medicare and Medicaid Services’ (CMS) release of the proposed rule for the Medicare Shared Savings Program and were thus undertaken without having a precedent to follow.

Since there was no model for the ACO contract, Monarch and Anthem proceeded by developing hybrids of existing payer–provider contracts, such as the HMO and PPO contracts. Progress on the contract development was maintained through the internal and joint committees and subcommittees. Core elements of

*I do think that’s a critical element of success, having that long-term commitment. But when you’re trying to write a contract that’s going to cover a five-year period and it’s uncharted territory, it makes things very difficult.*

Ray Chicoine, chief operating officer,  
Monarch HealthCare

the ACO contract include: patient population parameters; length and frequency of attribution; performance metrics, baselines, and targets on quality and cost; data collection and reporting; budget development and distribution of shared savings; governance, exclusivity, and length of contract; and transparency and frequency of data sharing.

**Payment Model**

In year one of implementation, neither Monarch nor Anthem is taking on additional risk, but they have agreed on a care management fee and simple shared-savings model. They also agree that for the ACO to be successful, they will eventually need to shift to a risk-bearing model, and aim to phase in a global capitation model over the course of the five-year contract. The move to bear risk may be catalyzed by Monarch’s participation in an ACO arrangement with the Medicare fee-for-service population in 2012.

In the first year of the ACO, the anticipated payment structure for participating primary care physicians has three elements: a base fee-for-service payment, the largest portion; a care review stipend for actively reviewing and coordinating patients’ health care needs; and a performance-based, shared-savings bonus that will supplement up to 20 percent of the physician’s

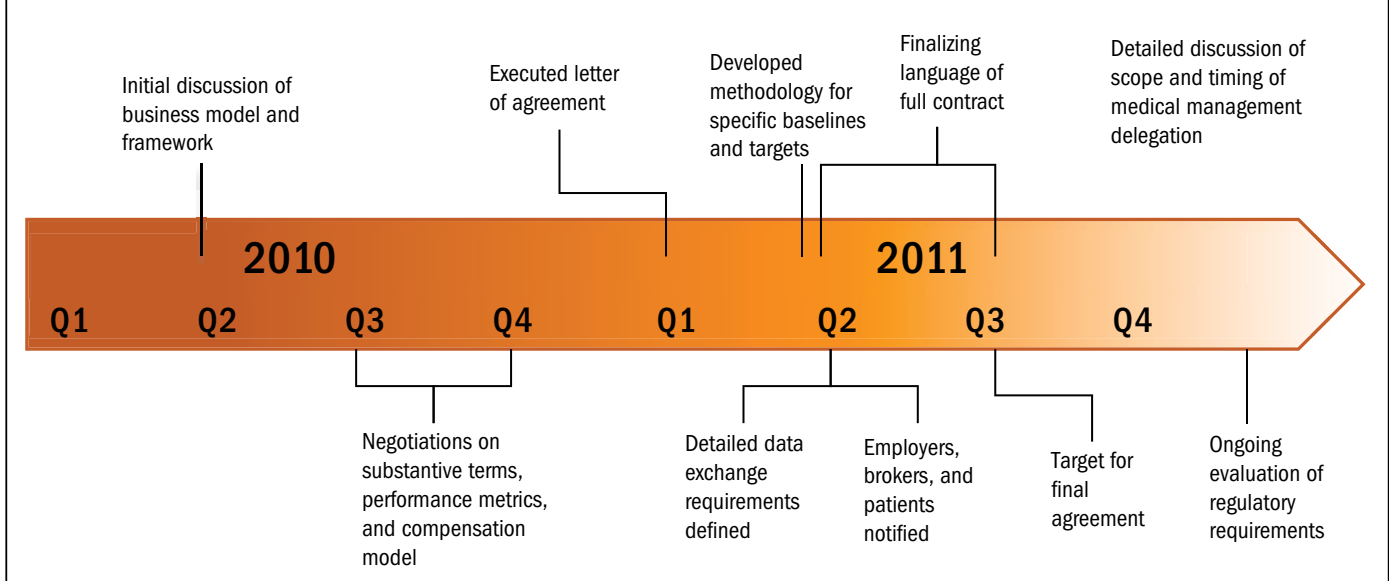
*[In the ACO] you will be valued for preventative care, care coordination, and communication; all the things that you currently do, for which no monetary value is assigned.*

Michael Weiss, M.D., medical director of quality management, Monarch HealthCare

salary. Monarch’s ACO Executive Steering Committee is currently considering how specialists might be included in the ACO. Distribution of shared savings to specialists might be based on engagement and contribution to savings.

Based on the agreement with Anthem, the ACO will need to meet a threshold performance level, called a “quality gate,” in order to receive shared savings. The quality gate measures are primarily based on HEDIS performance measures. Physicians have experience with several of these measures, which are already part of the California IHA metrics and Monarch’s physician performance incentive program. Beyond the quality gate, there are additional efficiency metrics that are intended to generate specific savings. A draft of the proposed metrics is provided in the [Performance Measurement](#) section below. The final metrics and benchmarks will be included in the ACO contract.

**Exhibit 7. Monarch-Anthem Contracting Timeline**



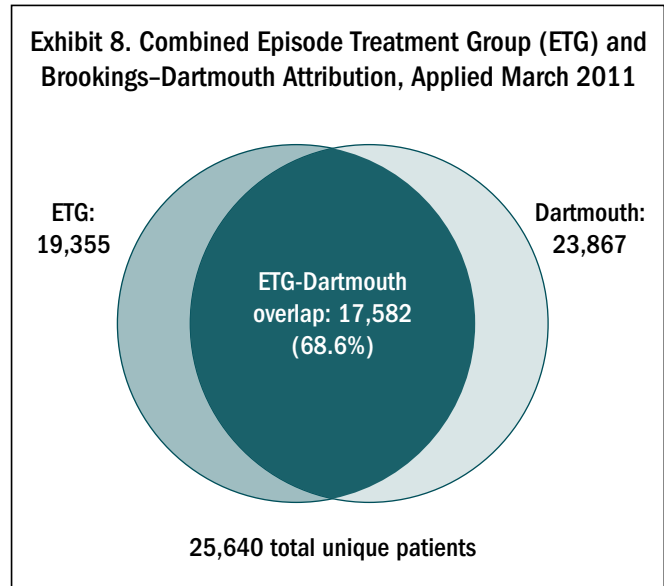
Source: Monarch HealthCare, 2011.

The percent of potential shared savings linked to quality has not yet been determined, nor have the target and benchmarks for performance been established. Although the targeted budget for the total cost of care is still under development, Anthem has projected a potential 3 percent to 7 percent reduction in the trend in the total cost of care in 2012. Anthem has provided two years of historical claims data to Monarch as one method of determining the budget.

**Patient Attribution**

The ACO patient population is defined as those who live in or around Orange County, are covered by Anthem’s PPO plan, have historically utilized physicians in Monarch’s network, and are among 20 or more patients who have been attributed to the same physician. Additional patients are added to the pool as a result of patient movement and family member additions. This attribution process was achieved through a data-sharing agreement established in the letter of agreement between Anthem and Monarch, which allowed Anthem to share the historical claims data used to identify patients’ visit patterns to primary care physicians in the ACO.

For the purpose of attributing patients in the first year and calculating shared savings, Anthem will employ the Episode Treatment Group (ETG) attribution model. The ETG model creates episodes of care by collecting all inpatient, outpatient, pharmacy, and ancillary services for a patient into clinically homogeneous, mutually exclusive, and exhaustive categories. It also assigns patients based on the plurality of allowed charges to either a primary care physician or specialist. For purposes of continuity across the Brookings–Dartmouth pilot sites, Anthem and Monarch also use the Brookings–Dartmouth attribution model in year one of the pilot. Unlike the ETG model, the Brookings–Dartmouth methodology assigns patients prospectively based on historical care patterns, specifically the plurality of outpatient evaluation



and management visits.<sup>5</sup> Based on a March 2011 application of each methodology, there were 19,355 patients attributed to the ACO using the ETG method, and 23,867 patients attributed using the Brookings–Dartmouth method. There were 25,640 unique patients attributed between these two methods, with 17,582 patients, or 68.6 percent, overlap (Exhibit 8).

**Benefit Design**

In 2012, Anthem plans to introduce an ACO product geared toward PPO patients. Because beneficiaries will select the ACO product as they would any other plan, it will eliminate the need for patient attribution. Such a plan would likely allow patients to voluntarily align themselves with a primary care provider. This alignment would allow Monarch to better leverage its care coordination tools for the PPO population, while still providing the freedom of provider selection. Anthem currently has more than 300,000 PPO patients in Orange County. Early estimates suggest that up to one-third of these patients will eventually be eligible for participation in Monarch’s ACO. This would give an additional 100,000 patients access to the care coordination benefits provided by Monarch.

<sup>5</sup> J. P. W. Bynum, E. Bernal-Delgado, D. Gottlieb et al., “Assigning Ambulatory Patients and Their Physicians to Hospitals: A Method for Obtaining Population-Based Provider Performance Measurements,” *Health Services Research*, Feb. 2007 42(1 Pt. 1):45–62.

## Patient Engagement and Notification

In order to engage patients in the ACO, Monarch and Anthem sent a cobranded notification letter in May 2011 to all patients who had been attributed to the ACO using the dual ETG-Dartmouth attribution methodologies. This letter notifies patients of: 1) Monarch and Anthem's collaboration in the ACO, 2) changes that they can expect as a result of the ACO, and 3) where to go for more information.

The letter conveys that the Monarch-Anthem ACO partnership is designed to better manage and improve patient health, coordinate care, and control health care costs. It introduces beneficiaries to the concept of a "care navigator," who will help to coordinate the care of PPO patients in the ACO. The letter describes the care navigator as "A caring and knowledgeable professional who will work closely with your doctor's practice to assist you when you have complex questions about your treatment plan... [and] help you understand the often confusing array of health care options." Care navigators are not required to have a medical or nursing degree, but they must be familiar with the health system and skilled at customer service.

Patients are instructed to access these benefits by visiting their Monarch-affiliated doctor and using their new ACO member ID card that identifies them as an ACO beneficiary. Patients can opt out of the ACO by continuing to use their existing Anthem insurance ID card. Patients retain freedom of physician selection within the Anthem PPO network. Monarch received approximately 50 responses to the notification letter in the month following the communication. Most respondents had either received the letter in error or were seeking clarity on the purpose of the program; very few had a negative response to it.

## Physician Engagement

Monarch has identified effective physician engagement as an essential element in early ACO implementation. As an IPA, Monarch has the ability to make some decisions on behalf of its affiliated physicians. It does, however, recognize the need for broad physician

support when instituting programs that will change the way care is delivered, as independent physician practices have the right to decline patients from Monarch.

To promote physician engagement and test new ideas, Monarch's ACO Executive Steering Committee assembled an ACO Physician Advisory Board from across their three regional service areas. Developing this decentralized physician leadership structure is intended to prepare Monarch's wider network of physicians for ACO implementation. The Physician Advisory Board members will be equipped to explain the ACO model to develop understanding and support among their staff and colleagues. The board's primary function is to inform the ACO implementation process. Its members were initially tapped to participate in a physician focus group, which guided early decisions on how to convey the ACO concept to providers. They were chosen because they are respected by their peers, have expressed an interest in health care reform, and have a large proportion of Monarch patients on their panel. The Physician Advisory Board includes predominantly primary care physicians, but Monarch has identified the need to engage specialists in both the process of developing the ACO and the final product.

Monarch took a multilateral approach to presenting the ACO to physicians. The ACO was initially introduced to physicians in a letter sent to the network. Leaders then presented the concept to physicians at Monarch's general membership meeting and addressed how this would affect their practices. Monarch's network managers also have hosted ACO-specific meetings with subsets of the IPA's physician population.

Monarch's executive leaders noted that it is a delicate task to communicate with physicians about a program that might change the way they practice. The executive chairman, Cohen, counseled his staff to be "careful in how you communicate what the physicians can expect. Be very thoughtful in setting expectations. Make sure that you have systems in place that will enable the doctors to easily track their progress on quality measures. Then develop your message such that they understand how vital it is for them to participate."

## **MONITORING PROGRESS TOWARD ACCOUNTABLE CARE**

The ability to provide accountable care is inextricably linked to the ability to measure progress. A strength of the ACO model is its dual emphasis on the quality of care, which is addressed through care improvement programs and performance measurement, and the cost of care, addressed through efforts to improve efficiency and measured by calculating the overall cost of care.

### **Performance Measurement**

In order to determine clinical effectiveness in the ACO, Monarch must apply valid, meaningful measures that yield actionable data.

#### **Brookings–Dartmouth Performance Metrics**

Brookings–Dartmouth ACO performance measurement specifications were not finalized when the pilot began. A Performance Measurement Technical Workgroup, with representatives from each participating payer and provider group, offered input on the feasibility of collecting proposed measures and their usefulness and relevance to the quality of care. The workgroup identified measures and specifications in three categories: a claims-based starter set (including utilization test measures), clinically enriched measures (which rely on data extracted from clinical data systems, as well as administrative claims data), and patient-reported measures (including patient experiences of care and patient-reported outcomes).

#### **Quality Gate and Efficiency Scorecard**

In order to determine shared savings, Monarch and Anthem collaborated to define a quality gate and an efficiency scorecard. As described above, the quality gate is the minimum performance threshold that must be achieved by participating providers in order to receive a bonus. It is established to ensure that the quality of care is not jeopardized for the sake of cost savings. The quality gate is based on the quality of both physician and hospital performance, with physician performance weighted at 70 percent and hospital performance at 30 percent (Exhibit 9). The ACO intends to use these metrics in the first year of the ACO. The

precise thresholds and target will be determined in the final ACO contract. Over the five-year pilot, Monarch intends to transition from process measures to outcome measures.

The draft efficiency scorecard (Exhibit 10) identifies aggregate utilization and costs associated with efficiency measures. Once the ACO passes the quality gate, the efficiency scorecard will be used to determine the savings that will be shared between Monarch and Anthem. Monarch recognizes that there may be savings generated in other areas that are not specifically identified in the scorecard but are captured in the global cost of care.

#### **Sharing Performance Data**

In agreeing to participate in the Brookings–Dartmouth ACO pilot, Anthem and Monarch agreed to share performance data at the ACO, practice, physician, and patient levels (Exhibit 11). Monarch received two years of historical claims data from Anthem on their PPO population. In April 2011, Anthem shared with Monarch the first current claims file on the ACO attributed population. Claims data will be transmitted on a monthly basis in the first year of the pilot, and Monarch is receiving daily inpatient patient census reports on attributed members. Information transmitted includes: admission date, provider, diagnosis, daily level of care, and discharge date.

Currently, Anthem processes claims for patients attributed to the ACO and has shared these data with Monarch under their letter of agreement. Anthem plans to delegate medical management to Monarch in the third quarter of 2011. This will enable Monarch to more closely monitor patients' utilization of services and reduce the lag that occurs when transmitting data. Monarch is prepared to play this role, as it has prior experience processing claims in a delegated model with their HMO population.

Physicians in the ACO will receive data modeled on those which are provided to physicians in the HMO. Examples include clinical performance scorecards on quality metrics, emergency department utilization reports, generic drug prescribing utilization reports, and patient experience reports.



### Exhibit 9. ACO Shared-Savings Quality Gate

<b>Physician quality: 70%</b>	
Preventive measures	IHA - Breast cancer screening
	IHA - Childhood immunization status (MMR and VZV)
	IHA - Chlamydia screening in women
Diabetes	IHA - HbA1c screening
	IHA - LDL screening
	IHA - Nephropathy monitoring
Cardiology	IHA - Cholesterol management LDL screening (patients with cardiovascular conditions)
Imaging	IHA - Use of imaging studies for low back pain
Pediatrics	IHA - Appropriate testing for children with pharyngitis
	IHA - Appropriate treatment for children with upper respiratory infection
Pulmonary	IHA - Avoidance of antibiotic treatment of adults with acute bronchitis
Medication management	IHA - Medication monitoring (ACE/ARBs, digoxin, diuretics)
<b>Hospital quality: 30%</b>	
Joint Commission / CMS National Health Quality Measures	Acute myocardial infarction set
	Congestive heart failure set
	Pneumonia set
	Surgical care improvement program set
American College of Cardiology Metrics	Percutaneous coronary intervention mortality
	Vascular access injury
	Door-to-balloon for ST-elevation myocardial infarction at 90 minutes
Society of Thoracic Surgeons Metrics	Deep sternal wound infection
	Prolonged ventilation
	Operative mortality for coronary artery bypass graft surgery
	Surgical reexploration
	Preoperative beta blocker
National Healthcare Safety Network	Central line infections
	Ventilator-associated pneumonia
	Catheter urinary tract infection
Patient satisfaction	CAHPS or local market survey

IHA = Integrated Healthcare Association; CAHPS = Consumer Assessment of Healthcare Providers and Systems.  
Source: Monarch Healthcare, 2011.

**Exhibit 10. ACO Shared-Savings Efficiency Scorecard**

Measure	Specification
Inpatient bed days	Bed days per 1,000 (excluding pediatric and maternity)
Emergency department	Aggregated total—avoidable visits per 1,000
Prescription medications	Generic prescribing rate
Utilization and costs	Length of stay (medical surgery)
	Admissions per 1,000 (medical surgery)
	Days per 1,000 (medical surgery)
	Healthcare Effectiveness Data and Information Set (HEDIS)—all-cause readmission rate
Imaging	Cost per-member per-month (medical surgery)
	Spine magnetic resonance imaging scans per 1,000
	Spine computer tomography scans per 1,000
	Abdominal computer tomography scans per 1,000

Source: Monarch Healthcare, 2011.

**Public Reporting**

Monarch publicly reports annual group-level IHA quality and patient experience metrics to the California Office of the Patient Advocate (OPA). OPA publishes this information online, and it is used in a scorecard that rates all California medical groups on national care standards and patient ratings of their care. In the 2011 rankings, Monarch scored three out of four points in each category. Among the 24 medical groups ranked in Orange County, only one organization scored four points on either category.

Monarch does not publicly report performance on other metrics, such as outcomes or cost of care, but it would be prepared to share group-level data if required by a payer, such as CMS. Hospitals affiliated with Monarch do publicly report data on

process-of-care measures, use of medical imaging, and patients’ hospital experience for Medicare patients. Data on these measures are collected via Medicare patient records, claims, and responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

**LESSONS LEARNED**

Monarch executive chairman Cohen advised that leaders of prospective ACOs should do a “gut check” in determining their readiness to face the challenges of this process. Monarch’s experience in overcoming these challenges and building on its early successes offers lessons for other health care organizations considering development of an ACO.

**Exhibit 11. Monitoring and Sharing Performance Data**

Level	Access to Data	Content	Purpose
ACO	Anthem, Monarch, Brookings–Dartmouth	Aggregate quality, utilization, and cost data based on the entire ACO patient population	Pass the quality gate, and determine amount of shared savings based on the efficiency metrics
Practice	Anthem, Monarch	Aggregate efficiency and clinical performance	Drive competition for performance
Physician	Respective attributed physicians	Individual efficiency and clinical performance	Determine performance to qualify for shared savings
Patient	Anthem, Monarch, attributed physicians	Individual historic visit patterns and current claims	Attribution, identification of high-risk patients

Source: Monarch Healthcare, 2011.

## Challenges

### Unifying Support for the ACO Across Diverse Groups of Physicians

In order for the ACO initiative to succeed, Monarch will need broad support from physicians throughout its network. There is diversity among Monarch's physicians on several fronts, including by region, career trajectory, and specialty. As described above, physician practices in the Northern and Coastal regions of Orange County tend to be smaller, geographically dispersed, and maintain a more diversified payer market in comparison with contracted practices in the Southern parts of the county. Monarch has developed a Medical Leadership Council of physicians to represent the interests of their regional peers and define the IPA's guidelines to advance health care practices.

In addition, physicians in the Monarch network are at different phases of their professional development, with differing expectations of their professional role. Generally, physicians who have been in the workforce for a long time are more resistant to change, and have responded to this reform effort by attempting to "wait it out" as they prepare for retirement. Physicians who have recently begun practicing are more likely to be interested in an employed model, to participate in reform efforts, and to select different specialties. Monarch continues to address this challenge by looking for meaningful incentives for all physicians.

Further, primary care physicians, specialists, and hospitalists have different incentives to participate in an ACO. Monarch has not fully engaged specialists in the early implementation of the ACO, but the specialists are very interested in how the ACO will affect their own practices. Some specialists at Monarch also expressed doubt that the financial incentives would be significant enough to support the substantial work required in this initiative.

The Physician Advisory Board will be instrumental in championing and conveying the ACO model to all of Monarch's physicians. The success of this group will be determined by its ability to bring together physician leaders to align incentives and communicate the benefits of the ACO to their peers.

### Developing an ACO as an Early Implementer

Inevitably, there is a challenge to being an early implementer of an ACO since there are no precedents to follow in formulating the ACO contract, arranging support structures, or quantifying and calculating costs of implementation. Monarch has trained its customer service staff on how to field ACO-related questions. It has developed educational tools on the ACO for physicians and patients, a beneficiary notification letter, and other communication tools. A significant effort is required to develop and produce these materials for the first time. As a designated Brookings–Dartmouth ACO pilot site, Monarch is connected with a group of peer organizations, has access to the wider Brookings–Dartmouth ACO Learning Network, and receives technical support and guidance from the Brookings–Dartmouth team. Through this network, Monarch has gained insights from others' experiences and shared lessons.

### Success Factors in Early Stages of ACO Development

Several factors have contributed to the successful development of an ACO at Monarch. These include:

- strong executive leadership,
- trust and transparency in partnerships,
- use of care navigators,
- physician champions of the ACO, and
- economies of scale.

These elements are not unique to Monarch, but the way these factors converge in a single organization to fulfill the goals of the ACO is distinctive of Monarch's environment, history, and organizational decisions.

### Strong Executive Leadership

The development of the ACO created changes in Monarch's leadership roles. Monarch's executive chairman invested a substantial portion of his time in ACO development and hired a full-time senior vice president for accountable care to oversee internal and external ACO efforts.

Monarch has also acted as a leader among its peer institutions. Its executives have presented at peer-learning conferences, actively participated in efforts to develop ACO performance metrics, and committed themselves to maintaining equal footing in the organization's relationship with both HealthCare Partners and Anthem in collaborative efforts.

Monarch has designed a strong internal governance structure, which ensures progress toward goals, accountability for deliverables, and a coordinated approach to advancing the ACO initiative. Executive leaders have a highly visible presence within the organization, and are considered widely accessible to employees.

### **Trust and Transparency in Partnerships**

Throughout early implementation, Monarch has touted trust and transparency as the cornerstones of the ACO. It has tried to maintain these principles in advancing the ACO pilot in all of its partnerships with patients, physicians, and payers. Monarch strives to maintain a track record of building trust with the HMO population, and hopes to build that same relationship with PPO patients. It has demonstrated transparency to patients by being the first of the Brookings–Dartmouth pilot sites to notify patients that they had been attributed to the ACO. In the letter, patients were notified of how the ACO will and will not affect their ability to freely choose their physicians. Monarch's leaders are also committed to publicly reporting performance data.

To build trust among physicians participating in the ACO, Monarch assured them that their performance will be accurately and fairly measured. Monarch has actively engaged in vetting the performance metrics that will be used in the pilot.

Finally, trust and transparency in the ACO are essential in establishing a solid foundation with a payer partner. Chicoine, the chief operating officer, said that Monarch's ACO contract negotiations with Anthem have required "unprecedented levels of transparency" with respect to data, commitment to participate, future plans for the ACO, strengths, and weaknesses.

### **Use of Care Navigators**

The care navigator program was launched in May 2011, when patients were notified by Monarch and Anthem of their attribution to the ACO. Several of Monarch's physician and executive leaders portrayed the use of care navigators as a key to success in the ACO. Like case managers, care navigators provide nonclinical case management services. They differ from Monarch's existing case managers in two primary ways. First, they only serve the PPO population introduced through the ACO, whereas case managers serve the HMO population. Second, they will assist members in understanding their benefits (i.e., claims and eligibility) and how the benefits affect care (i.e., the cost and effectiveness of various treatment options). As nonclinical members of Monarch, care navigators are housed in the Customer and Member Services Department.

### **Physician Champions of the ACO**

Monarch has developed processes for engaging and developing physician leaders. The executive team has been working to create a curriculum on leadership development, which currently entails three levels of involvement. The first happens in the Physician Advisory Council, which includes network physicians who have demonstrated interest in improving the delivery system. The council is designed to cultivate their interest and understanding of Monarch's institutional values, approach, and priorities. The second level of involvement, the Medical Leadership Council, is a select group of physicians who represent Monarch's three regions: northern, southern, and coastal Orange County. Formed in 2002, the council exists to define guidelines to advance health care practices. Monarch looks for physicians who are respected in the medical community, dedicated to improving the practice of medicine, and interested in engaging with Monarch to guide and communicate the strategic direction of the organization. The ACO Physician Advisory Board, a third level of physician involvement, is essential to the success of the ACO. Physicians on the advisory board inform the strategic direction of the pilot, represent the interests of participating physicians, explore ways to

include non-ACO physicians, and champion the ACO model among their peers.

### **Economies of Scale**

Monarch's large size relative to other IPAs in Orange County enables it to leverage economies of scale. The ACO strengthens Monarch's network of physicians and countywide delivery system for patients and payers. Physicians throughout Monarch's network conveyed concern that smaller practices will not be able to keep up with the larger groups. This has been an incentive for many physicians to join the Monarch IPA. Physicians are able to practice more efficiently by sharing staff, overhead, EHR systems, and diagnostic equipment and by combining efforts to report on HEDIS and other performance measures. Monarch's extensive care management infrastructure and EHR capabilities allow independent physicians to better care for their patients without having to provide up-front capital to fund these resources themselves.

Despite the economy of scale that Monarch lends independent practitioners, some physicians still question whether the IPA is big enough to compete with larger entities, such as Kaiser's fully integrated,

multistate network. This question remains to be answered as the industry evolves, but Monarch hopes to see physician groups as the center of the current delivery system reform.

### **CONCLUSION**

With a strong foundation in population health management, Monarch had already established many of the tools for delivering accountable care. The ACO will enable Monarch to expand its services to a PPO population for the first time. As the ACO evolves, Monarch will need to address existing and potential challenges, such as competing with other care delivery models, strengthening relationships with specialists, and determining how to best manage the care of PPO patients. It has built readiness for ACO implementation through its care coordination infrastructure, health information technology, and experience with quality-based payment. Leveraging its strengths and mitigating existing challenges will enable Monarch to advance toward achieving the triple aim of providing better care for individuals, improving the health of populations, and reducing per-capita costs.

For a complete list of case studies in this series, along with an introduction and description of methods, see <http://www.commonwealthfund.org/Publications/Case-Studies/2012/Jan/Four-Health-Care-Organizations.apx>.

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Stephen M. Shortell, Ph.D., M.P.H., M.B.A., is dean of the University of California, Berkeley, School of Public Health, and the Blue Cross of California Distinguished Professor of Health Policy and Management and Professor of Organization Behavior at the School of Public Health and Haas School of Business. A leading health care scholar, Dr. Shortell is the recipient of many awards, including the distinguished Baxter-Allegiance Prize for his contributions to health services research. An elected member of the Institute of Medicine of the National Academy of Sciences, he is preparing to launch the third round of the National Survey of Provider Organizations. He is also conducting research on the evaluation of quality improvement initiatives and on the implementation of evidence-based medicine practices in physician organizations.

Elliott S. Fisher, M.D., M.P.H., is director of the Center for Population Health at The Dartmouth Institute for Health Policy and Clinical Practice. He is the director of the Dartmouth Atlas of Health Care and a member of the Institute of Medicine of the National Academy of Sciences. Dr. Fisher's research has focused on exploring the causes of the twofold differences in spending observed across U.S. regions and health care systems, on understanding the consequences of these variations for health and health care, and on the development and testing of approaches to performance measurement and payment reform that can support improvement. His current policy work has focused on advancing the concept of accountable care organizations (ACOs) and includes codirecting, with Mark McClellan, a joint Brookings–Dartmouth program to advance ACOs through research, coordination of public and private initiatives, and the creation of a learning collaborative that includes several pilot ACO sites across the United States.

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