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Developing Aligned ACO and CIN Boards within the Health System's Broader Governance Structure

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Over the past decade, many health systems have pursued value-based care strategies that include the design and launch of, or alignment with, an outcomes-oriented organization such as an accountable care organization (ACO) or clinically integrated network (CIN). Governance of these entities is critical in achieving the goals of aligning incentives between hospital and physician participants.

ACOs and CINs are organized for the distinct business purpose of improving clinical quality and outcomes, resulting in the reduction of healthcare costs (and creation of shared savings). In many cases, these entities are operated as joint ventures between health systems and physician organizations. Creating purposeful synergy between the ACO/CIN and the health system governance structure can enable success and help to avoid misaligned strategies.

Key Board Takeaways

Health systems should have a quarterly governance review checklist that ensures:

- Governance groups, such as councils and committees, are acting in accordance with their charter
- The board of the ACO/CIN includes members of the health system (investor) leadership team or board, and is supporting the interests of the health system
- Performance reporting is active, reflects the quality or cost objectives of the ACO/CIN, and is aligned to support health system performance KPIs
- The health system actively communicates and coordinates with the ACO/CIN, either clinically or financially

A Primer on ACO and CIN Structure

Both ACOs and CINs represent collaborative, but often independent, groups of healthcare providers who voluntarily choose to work in a coordinated way to drive quality care and outcomes for patients. When organized correctly, and formal/contractual participation agreements exist, it grants independent providers more freedom to communicate and coordinate.

Specifically, ACOs represent a payment mechanism offered by CMS (and some commercial insurers) that focuses on shared savings. CINs represent a formal structure for clinical integration for a health system with otherwise independent providers and may span multiple independent health systems (multi-system CIN). Traditionally, a CIN can also act as an ACO, but an ACO may or may not technically qualify as a legally designated CIN. Both entities can collect and distribute financial incentives to providers who contribute towards success measures. They are also capable, where applicable, of repaying penalties that may be incurred if success is not reached.

For the purpose of discussing governance of these groups, we can think of them as similar structures.

ACO and CIN Governance

Driving forward an agenda of improved quality, resulting in reduced costs, requires these entities to execute on well-designed internal management structures—usually represented by a leadership council and operational subcommittees. Senior executives and physician leaders work together to set priorities and lead the work of the subcommittees. While subcommittee structures may vary depending on the goals of the entity,

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these groups typically manage various agendas:

- Quality and care transformation, including identification of key performance indicators (KPIs), focused performance improvement goals, and specialty-specific transformations
- Financial management, including payer relations, financial impact analysis, and incentive distribution
- Network development, including member enrollment, member remediation, and communication
- Information technology, including adoption of technologies, clinical systems outreach, and reporting

Subcommittees should include representation from the leadership council as well as directors and physicians with operational responsibilities in the related areas.

Proactive Design of Governance Elements

Successful governance processes, including strong alignment between ACO/CIN and health system boards, requires proactive design. From the ACO/CIN entity conceptual stages through activation and ongoing operations, several key elements should receive additional attention by the governance architects, including:

- **Development of governance documents:** As the ACO/CIN structure is being established, diverse input is needed to create fully customized leadership groups and subcommittees. Each of these groups should work based on an initial charter, outlining the group's purpose, goals, membership structure, specific authority, timeline, and meeting agenda. As part of the charter development process, and occasionally discussed explicitly in the charter, it is important to identify related but separate functions of the ACO/CIN with the functions of the health system. For example, the specific purview, goals, and authority of an ACO/CIN quality subcommittee function may have similarities to a health system quality program/quality leader, but the ACO/CIN quality objectives are typically aligned with payer quality measures, and the health system quality objectives most often ensure Joint Commission compliance and enforcement of medical staff standards.
- **Co-resourcing of board members:** While both the ACO/CIN and health system governance groups should be empowered to act with a degree of independence, aligning key leaders and stakeholders of the health system and physician members (within the executive structure of the ACO/CIN governance councils) ensures alignment and encourages proactive bilateral communication. Applicable physicians and directors from member health systems should comprise subcommittees. When inaugural organizations are investing directly in the new entity, especially when multiple health systems work together to form a CIN, the appointment of the CIN executive council is often proportional to the investment of the founding health systems.
- **Shared goal setting and supporting processes:** With the goal of an ACO/CIN set to improve quality and decrease cost in compliance with payer criteria, the underlying objectives and supporting processes may share common elements. Through direct collaboration and coordination, the health system and ACO/CIN ensure that the goals and processes do not create conflicting priorities amongst the medical staff and enable a shared focus on common performance indicators. Over time, this includes the use of shared KPIs, performance reporting, and group review of ACO/CIN performance.

Health System Board Perspective

As health systems invest in outcome-oriented entities, both through time and expense, they become a participating member (and investor) in the new organization—an entity with its own governance processes and objectives. The health system should leverage the investments they make to ensure ongoing alignment, both with the entity itself and with other investors (e.g., independent health systems, physician groups, etc.) as applicable.

To maximize the impact of an ACO/CIN entity, the health system board and leadership team should monitor the impact of the ACO/CIN on health system KPIs, and actively communicate and coordinate with the ACO/CIN. Because the intent of an ACO/CIN structure is to improve the coordination among healthcare delivery partners, the health system should be encouraged to share information and align strategies that drive patient outcomes or reduce the costs of care, via established clinical or financial integration pathways.

When successful, the ACO/CIN entity should pay dividends to the health system by way of improved quality and financial improvement in CMS and other payer programs. As with any investment, without ongoing active participation by the health system board, prior investments may become at risk of underperformance. While an ACO/CIN board does not report directly to the health system board, co-resourcing, purposeful design, and regular review will ensure ongoing alignment and success.

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