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The New Rules of the Health Care Marketplace

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Background

Recently, I read an article in *Harvard Business Review*[1] (HBR) about how "platforming" was transforming traditional models of competition. The authors' example was that of the iPhone – a device that, in just 8 years, had generated 92 percent of global profits in the mobile-phone market while the other major manufacturers (Nokia, Samsung, etc.) had generated none. The authors explained that platforming the iPhone did not rely on the same strategic focuses of a typical, product-based marketplace such as differentiation, brand, logistics, protective regulation, scale, etc. Instead:

> *"Apple conceived the iPhone and its operating system as more than a product or a conduit for services. It imagined them as a way to connect participants in two-sided markets—app developers on one side and app users on the other—generating value for both groups. As the number of participants on each side grew, that value increased—a phenomenon called "network effects," which is central to platform strategy. By January 2015 the company's App Store offered 1.4 million apps and had cumulatively generated $25 billion for developers."*

In other words, whereas typical product-oriented strategies rely on creating value through a classic supply-side, value-chain approach, which involves controlling a set of discrete activities to generate value, platforming creates value by orchestrating the entire network of participants. Instead of focusing on value for the customer, singularly, platforming focuses on demand-side, "ecosystem" value.

In a world in which platforming is made more possible by the free exchange of electronic information, data and volume matter. The number of interactions help you understand more about how to generate value between the participants in an ecosystem. Moreover, traditional models of forces of competition, like those espoused by Michael Porter[2], fail to fully account for how the forces within and external to the ecosystem interact and change the free market dynamics. These forces also shift the ways in which business models are traditionally managed

by moving from a "systems of control" model to more "open systems" centered on boosting overall network performance and the creation of mutual value.

Health Care's Economic Sovereignty

In Paul Starr's book the *Social Transformation of Medicine*[3], the author describes the "sovereignty" of the medical-industrial complex, as he puts it. Essentially, he argues, health care has enjoyed a period of unchecked economic growth[4] that other industries had long confronted, in part because health care was not largely available to most citizens in its early history. In fact, the first efforts to develop national health care in the 1940s by President Harry S. Truman was strongly opposed by the American Medical Association[5] and programs like Medicare and Medicaid were in part developed through government-sponsored industry subsidization like the Hill-Burton Act[6]. This dynamic created unique market conditions in which medicine, in effect, operated under exclusive rules where the producers dictated the value to the market rather than the other way around.

To compare, let's look at the textile industry. As opposed to textiles, the producers of the product being offered in medicine—doctors—have an incredible set of unique skills that are not as easily attained as, in this example, a tailor/automated machinery. Moreover, wherein consumers of textiles have their choice of products over a number of mediums, prices, and geographies, health care is a confusing and asymmetric commercial activity, the margin of which is often increased by poor outcomes due to factors beyond the consumer's or producer's control[7]. Market need in medicine is also defined immediately, manifesting in acute care service and purchased indirectly through insurance or government at a premium. It is this special relationship between producer and consumer, then, that has allowed for a certain amount of historical freedom from the typical systemic thinking that creates value in a traditional market context like manufacturing. That is, of course, until recently with efforts by the federal and state governments in the shift towards value.

The Shift toward Value

Managed Care Plans (MCPs) became a tool of cost management for government as it sought to disrupt the traditional modes of price negotiation in governmental health care spending. By privatizing the management of the program, and offering the incentive of profit through the utilization of management tools of managed care (prior authorization, utilization review, etc.), health care providers would now have to negotiate payment terms with insurance companies whose economic self-interest was built on cost control. This model has certainly gained traction as a viable option in many states, including Ohio where the Ohio Department of Medicaid[8] (ODM) continues to expand the presence of MCPs, covering 86 percent of all beneficiaries.

Continuing to focus on Ohio, we can also look to the state's work around the State Innovation Model (SIM) with Episodes, Comprehensive Primary Care, and even Medicaid expansion as efforts to disrupt this economic "sovereignty" and create a more cost-effective health care delivery system not only in Medicaid, but in the private market as well. If one just looks as

Episodes, for example, one can see the same product-oriented strategy that exists in other parts of the economy, the only difference being a new context.

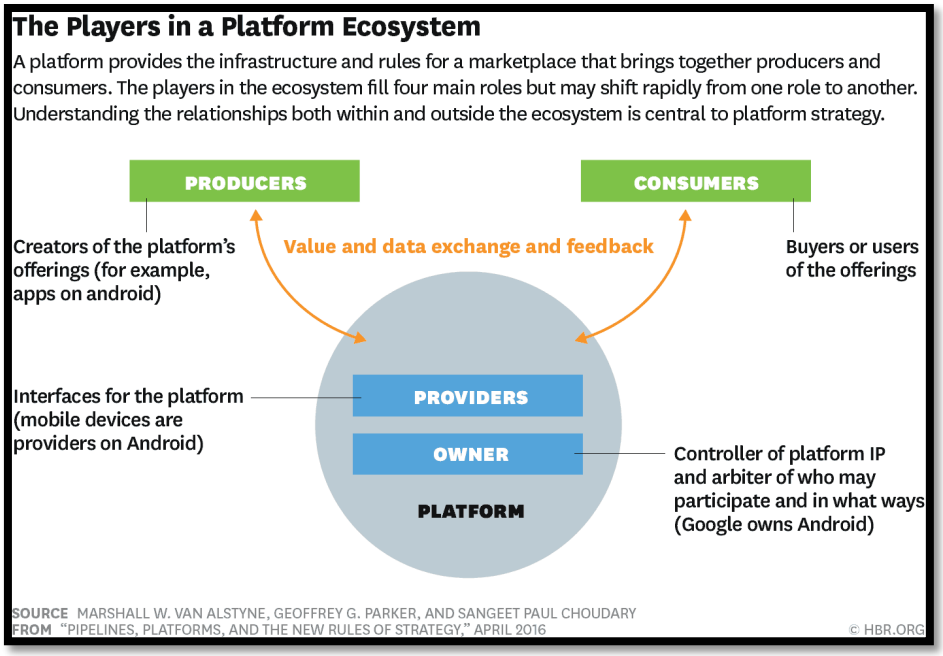
Think of a car. By the time you buy or lease the car, the components are already put together. You are not buying an engine here, a door there - you are buying the entire car. The basis of your consumerism, then, is not based on the discrete parts, but rather the final product and how it compares on price and quality relative to your needs and your budget. In health care, you "buy" each of your "parts" separately. Instead of you making the purchase directly, however, you rely on a third party (insurance, Medicaid), and you are paying for each discrete activity through the utilization of billing codes. Just imagine if you had to buy a car that way – it doesn't make sense and it would be difficult to compare and make good choices. So, in this metaphor, Episodes are like turning a set of those medical services (car parts) into a single product (car) so that the purchasers (insurance) can compare and exert more market pressure to be efficient and high quality.

But, as I have written about before, the story of managed care and bundled payments are not the end of this conversation. Just as the rules of competition changed for cellphones, could the rules for market competition among providers "platform" as well?

Accountable Care Organizations as Platforms

Today, providers are making the shift to value through the traditional models of strategic focus. They focus on the size of their patient population to negotiate prices with insurers. They focus on brand to communicate excellence since many consumers do not see a link between cost and quality[9]. They focus on regulatory advantages[10] to vertically integrate the competition. But this would not be the standard by which value could be achieved if health systems operate as a readily available platform: an Accountable Care Organization.

According to the Centers for Medicare & Medicaid Services[11], "Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their… patients." This medical ecosystem links producers and consumers through a platform which exchanges value, data, and feedback to achieve maximum market efficiency. So, as opposed to separate systems of care delivery, in which data and treatment, codes, and money are siloed and focused on controlling resources for the benefit of each discrete part, an ACO creates a way for these resources to be orchestrated so that value is a mutual activity. Here's the HBR graphic which illustrates this model with the example of mobile providers:



In an ACO, consumers are still consumers – they are the patients. Consumers could be insurance companies, but we can come back to why they may not be the case for platforms in a moment. Producers, then, are the clinicians, social workers (in the case of behavioral health, for example), and others who help the consumers achieve the outcomes they are interested in achieving (like reducing blood pressure). Providers include hospitals, physician practices, Federally Qualified Health Centers (etc.), who help make the connection between the consumers and the producers. This is done through physical space, data management, even malpractice insurance. However, in order for this to be successful, the owners of this process have to be payers. Most notably, because of the historical role it has played in determining access and prices, government has to be the controller/owner of the platform. That brings us to where Medicaid can play a role.

Currently, Ohio Medicaid does not have a formal Medicaid ACO program outside of pediatric pilots called "Partners for Kids" (PFK). With PFK, there have already been some great results[12] with participants like Nationwide Children's Hospital in Columbus where costs grew at roughly 1/3 of managed care and 1/8 of fee for service. And not only has this been a boon to Medicaid and the patients, but it has also led to a margin of 17 percent (the positive difference between revenues and expenses) for Nationwide - nearly 9 percentage points higher[13] than the national average for children's hospitals. Clearly, this system of global payment, with the state as the owner, platforms the market in a way that achieves better outcomes, better margins, and lower costs.

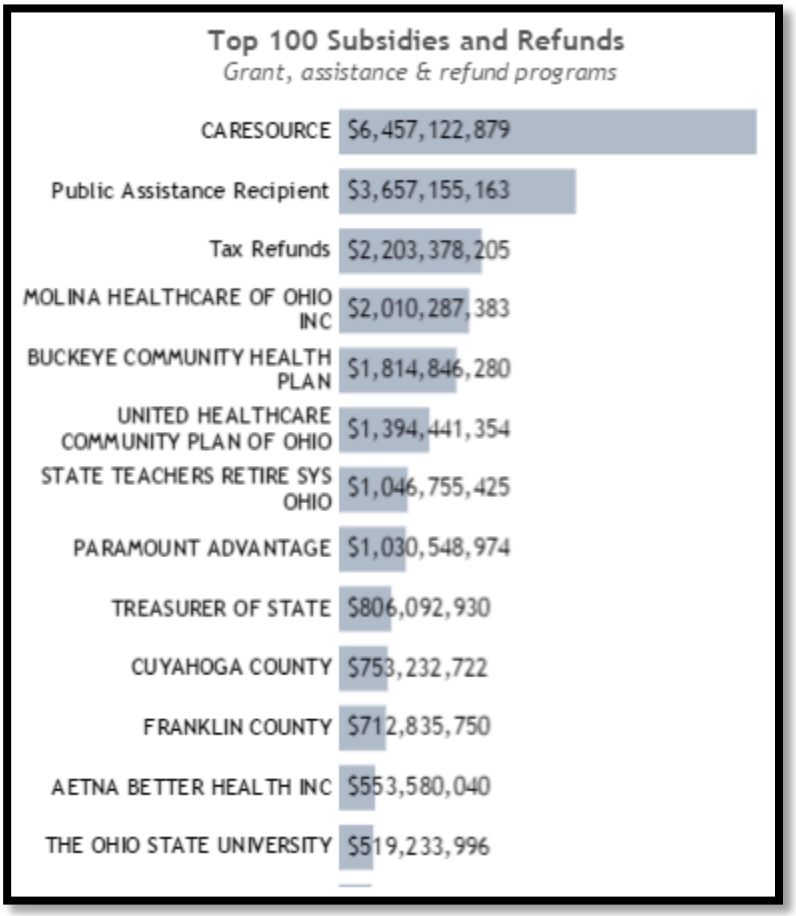
Yes, the state is moving toward global payments, but it is still relying on the expansion of managed care and Episodes to make its first moves to value. And just like when product-oriented systems and platform-oriented systems achieve value through volume and technology,

the expansion of Medicaid and the utilization of electronic health records have helped reduce overall costs by streamlining access to services and the necessary data detail of those discrete interactions. With that said, the adult population still is not organized as a platform. Instead of the state being the main owner in the relationship, MCPs are the owners and none have voluntarily moved toward global, full-risk arrangements that would be needed. Some progress has been made with total cost of care programs like that between MetroHealth and CareSource[14], but no contracts are scaled to a meaningful, "platform-like" level.

What Could Be Next

The Ohio General Assembly (GA) has continued to focus on the issue of cost in Medicaid, and rightfully so. This is the impetus behind the cost-sharing, "skin in the game" policy measures like Healthy Ohio. However, the GA shouldn't look to consumers to achieve value singularly. In fact, in all likelihood, government interventions like Healthy Ohio will perpetuate cost, bureaucracy, and inefficiency in the marketplace. Instead, the GA and the Administration need to continue down a path toward value built around a platform, which relies on participation, not disenrollment, as a cost control.

To start, let's take a look at this chart from Ohio's Office of Budget and Management[15]:



According to the chart, five out of the top seven recipients of Ohio tax dollars are going to privately managed insurance companies participating in Medicaid. This is not to suggest that they aren't achieving efficiencies or quality within the marketplace or that they are not responsible stewards of public funds. Rather, this demonstrates a scalable opportunity for market-oriented innovation where the state can reposition itself as an owner of a platform and place MCPs and health care institutions in a mutual position as providers in a competitive market. This can mean ardently enforcing the standards of at-risk contracts written into the last budget or, if policymakers are willing, defining how health care institutions can platform themselves as ACOs without the plans. In fact, this has already been done with success[16] in several states. With the loss of Managed Care sales tax revenue[17] on the state and local levels, it is certainly worth a conversation.

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