http://www.nytimes.com/2013/08/28/business/economy/lessons-in-maryland-for-costs-at-hospitals.html?_r=0

**The New York Times, August 8, 2013**

# Lessons in Maryland for Costs at Hospitals

By **EDUARDO PORTER**

CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive elsewhere: as much as possible, keep people out of hospitals, where the cost of health care is highest. Here, the experiment seems to be working.

Hospital admissions here are down 15 percent. Readmissions have fallen, too. In 2011, 16 percent of people who had been discharged went back into the hospital. Now, that figure is 9 percent. Many patients report that they are happier with the care.

And Western Maryland has reaped financial rewards. In the fiscal year ending in June, the system made an operating profit of $15 million on about $370 million in revenue, said Barry P. Ronan, the chief executive. That's a spectacular return, given that the average margin at hospitals across the state is a meager 0.8 percent.

Western Maryland's initiatives to take charge of people's health, rather than simply provide services for a fee, fit a core objective of federal health care reform: changing hospitals and related facilities into something resembling an Accountable Care Organization.

Yet the innovations taking place in this corner of Appalachia rest on a policy that the architects of President Obama's health care reforms never tried to emulate. Indeed, this innovation was only possible because in Maryland, hospital fees are subject to government price controls.

Western Maryland Healthcare System is one of 10 rural hospitals that agreed with the state's Health Services Cost Review Commission to accept a guaranteed budget every year to take charge of the health care of the community they serve.

If revenue comes in under the budget one year, the hospitals are allowed to increase prices the next to make up for the deficit. If revenue exceeds the budget, however, they must reduce prices to give the surplus back.

The system, adopted by Western Maryland in 2010, helps spur innovation. But it was only possible because Maryland has a commission that sets the fee that hospitals can charge patients regardless of whether they are covered by Medicare or private insurance, or are uninsured. Everyone pays roughly the same.

Price controls are not unique to Maryland. Medicare has regulated prices for decades. Other states — including New York, New Jersey and Connecticut — experimented with them in the 1970s, only to drop them in the 1980s and ’90s when, for a time, managed care seemed to keep a lid on prices. In West Virginia, price controls have been in place since the 1980s.

Maryland has the longest track record, however. Price controls were put in place in the mid-1970s, when hospital costs had been rising at an alarming pace.

They addressed “the price dominance of hospitals, which are often monopolies or oligopolies and have a lot of price-setting power,” John Colmers, who heads the commission, told me.

At a stroke, the controls turned hospitals into something like public utilities — with regulated prices and a low but stable profit. Four decades on, the state’s experience offers fairly solid evidence that the hospital-as-utility model can work.

Not only could it help usher in changes called for by the Affordable Care Act, as it has at Western Maryland, it could also address head-on Obamacare’s main weakness, providing a direct means to rein in the cost of care.

From 1977 to 2010, Maryland’s price-regulated hospitals experienced the slowest rise in costs per patient in the country, according to the commission. Before the advent of price controls, the cost per each patient admitted into a Maryland hospital exceeded the national average by 26 percent. In 2011, it was 4 percent lower.

What’s more, costs are more evenly spread. On average, hospitals across the country charge private patients about 44 percent more than patients on Medicare and Medicaid. The uninsured — who don’t have the clout to negotiate lower fees — must pay a sticker price that includes a 220 percent markup over costs, on average.

This, hospitals say, makes up for uncompensated care and the fact that Medicare and Medicaid pay almost 8 percent less than cost.

In Maryland, Medicare and Medicaid get only a 6 percent volume discount compared to private payers. And the sticker price markup over costs is only 33 percent. All hospitals contribute proportionately to a pot to cover uncompensated care — and this cost is incorporated into their regulated rates.

Unsurprisingly, health insurance in Maryland is among the cheapest in the country. Health plans

that will operate on the new health exchanges created under the federal reforms will charge among the lowest premiums of any state.

Could price controls work nationwide? Studies have found that they helped manage costs in other states that later abandoned them, including New York, Massachusetts and New Jersey.

They didn't work everywhere, however. Maryland hospitals bought into the system because Medicare accepted paying the higher rates set by the commission as long as increases in the cost per patient — measured from the base year of 1981 — came in lower than Medicare's national average. This provided hundreds of millions in extra revenue from the federal government.

But in Washington State, regulation couldn't keep costs down in the face of resistance from the hospital industry. And even Maryland's regulations have had trouble controlling the volume of care.

The commission has no control over physicians' decisions, the primary drivers of health expenditures. It hasn't figured out how to transport the global budget used in Western Maryland to urban settings, where hospitals could cut costs simply by encouraging patients to go to the hospital down the block.

Indeed, Maryland's cost controls are an example of how difficult calibrating regulation could be.

As Maryland's hospitals have done a better job keeping healthier people out, they have ended up with sicker, more expensive patients, raising their unit cost. At hospitals like Western Maryland, a fixed budget means that each person kept out of the hospital automatically raises the cost of each patient in it.

This is threatening the Medicare waiver, which relies on keeping costs per patient low. It has forced the commission to authorize very small price increases of late. “Hospitals have taken it in the stomach in the last four years,” said Carmela Coyle, president of the Maryland Hospital Association.

The problems seem fixable, though. Global payments might be brought to urban areas by defining the population each hospital must serve and shaping compensation schemes for patients who are treated elsewhere. Mr. Ronan at Western Maryland suggests that global payments could be extended to physicians, too.

Maryland is now negotiating a new measure with the federal government to keep the Medicare waiver — one that will take account of the growth of hospitals' total costs, rather than the cost per patient.

The rewards seem worth it. Robert Murray, a former head of Maryland's rate-setting commission, estimated that if every hospital in the nation followed Maryland's price guidelines, we would have saved $2 trillion between 1976 and 2008 in lower hospital costs.

Given that health care consumes 18 percent of the nation's economic output, Maryland's experiment seems worth a try.

*E-mail: eporter@nytimes.com;*