Maryland
Hospital Association

February 12, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Proposed Hospital Global Budget (HGB) Carve-Outs under the AHEAD Model. MHA appreciates the Commission's interest in engaging with stakeholders on this important policy decision and looks forward to participating in forthcoming work group discussions.

Maryland's experience over the past several years demonstrates the tremendous value of hospital global budget revenue (GBR) in driving care transformation and limiting per-capita cost growth: a legacy that should continue over the next decade under AHEAD. Maryland's experience has also revealed there are certain hospital services that are not suitable for a fixed, population-based payment structure and must be treated separately. As stated in the HSCRC memo, the AHEAD State Agreement allows the state the flexibility to carve out a greater portion of hospital revenue (15%) than under the Total Cost of Care Model (5%). This flexibility provides an opportunity for HSCRC and the hospital field to reevaluate what hospital services should and should not remain under population-based methodologies in future years. The larger allowance for GBR exclusions under AHEAD can support access to a wider range of services that may be unduly limited under a fixed revenue structure, such as complex and highly specialized care. MHA urges HSCRC to adopt a policy that optimizes the increased exclusion allowance to support access to these important services and respectfully asks you to consider:

Alignment of Medicare and Non-Medicare Carve-Out Policies
MHA commends HSCRC for working to advance a policy proposal with an aim of aligning HSCRC-established exclusions with the Centers for Medicare and Medicaid Services' (CMS) methodology for Medicare fee for service (FFS) hospital global budgets. Recognizing that CMS has not yet finalized the financial specifications for PY3 (2028) Medicare FFS HGBs, there should be alignment between the services carved out from Medicare FFS global budgets and those carved out from Medicaid and commercial global budgets to the greatest extent possible. Defining one set of services to be carved out of global budgets regardless of payer will reduce the administrative complexity of an already complicated payment structure and ensure alignment in hospital incentives across payers.

Support Innovation at All Hospitals Where It Happens
Complex, highly specialized care should not be subject to the same volume and revenue constraints as other services. These services have higher associated costs, greater cost variability, and lower volumes, making them less predictable than more routine services from one year to the next. Including these services under a fixed revenue structure that inherently disincentivizes volume growth could unintentionally impede innovation in hospitals and access to cutting-edge care for Maryland's communities. As such, MHA supports the continued exclusion of complex, highly specialized care from Medicare and non-Medicare HGBs under AHEAD to ensure that hospitals are sufficiently resourced to continue providing these services. We urge adoption of an approach that supports innovation at academic medical centers (AMCs) and other hospitals that provide the identified innovative procedures and services.

Further Evaluate the Proposed Carve Out of Low-Volume Service Lines
MHA supports ongoing efforts to refine the market shift policy and more accurately isolate true shifts in volume between hospitals. The analysis presented as part of the market shift policy recommendation approved last Fall determined that exclusion of the identified low-volume surgical service lines could improve the reliability of market shift assessments. While we appreciate this objective, we question whether services excluded from the market shift assessment should be considered exclusions from population-based methodologies given they are still governed by a materiality threshold and subject to a variable cost factor. Before establishing these low volume service lines as a carve-out, HSCRC should first determine whether CMMI would view this accommodation for low-volume service lines under the market shift assessment as an exclusion from HGBs for the purpose of evaluating the state's compliance with AHEAD's requirement that 85% of hospital revenue remain under population-based methodologies. If it is determined that services excluded from the market shift count towards the 15% limit on carve-outs, MHA respectfully asks HSCRC to consider whether this proposal should cede to the priority of other categories of hospital services that are not appropriate for population-based methodologies. This issue could be further explored at a future work group meeting.

Thank you for your leadership on this important policy decision. We look forward to continuing to work with staff over the next several months in preparation for the transition to CMS-led Medicare hospital global budgets starting in 2028.

Sincerely,

Patrick Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
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