Maryland
Hospital Association

June 17, 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, thank you for the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Global Budget Carve-Outs Under AHEAD. MHA appreciates the time staff have dedicated to developing this policy, their engagement with the Volume Subgroup over the past several months, and for responding to feedback from stakeholders on the initial carve-out proposal released at the beginning of the year.

MHA commends HSCRC staff for clearly defining highly specialized and complex care to determine quaternary and tertiary services that are not suitable for population-based methodologies and for recommending the less restrictive list of Diagnosis Related Groups (DRGs). We support the commitment in the recommendation to align this list with the Center for Medicare and Medicaid Innovation's (CMMI) carve out list to the greatest extent possible to reduce administrative complexity and align hospital incentives across payers. We also appreciate the recommendation to carve out all cases assigned to one of the specified DRGs regardless of which hospital provided the service. This feature of the policy will help protect access to highly specialized, complex services for communities across Maryland.

While MHA broadly supports the proposed draft recommendation, we offer the following considerations:

Implementation Timeline
HSCRC staff recommend that highly specialized care be excluded from population-based methodologies beginning July 1, 2026. While academic medical centers have experience with carved out services under the Complexity and Innovation Policy, the proposed policy introduces a significant change for all other Maryland hospitals that have historically had these volumes included in their GBR.

For this reason, MHA respectfully requests that HSCRC consider providing hospitals the option of having the policy apply to them beginning Jan. 1, 2027 instead of July 1, 2026 if it is operationally feasible to do so. This flexibility would allow hospitals the necessary time to

prepare for the carve-out policy and avoid any unintended consequences related to compliance with GBR requirements.

Neonatal Intensive Care Unit (NICU) DRGs
In the draft recommendation, staff expressed an openness to further consider the two NICU DRGs included in the carved-out services (MS-DRG 789 and MS-DRG 790), noting that these services have relatively wide dispersion. Additionally, the MS-DRG system's categorization of neonatal DRGs lacks the specificity and clinical precision of DRGs associated with services more frequently provided to the Medicare population, making it difficult to assess whether cases assigned neonatal DRGs meet the criteria for highly specialized care. MHA supports HSCRC exploring—and collecting stakeholder feedback on—whether it is appropriate to include these DRGs on the list of carve-outs, especially given they account for an estimated 12.3% of total carve-out charges according to MHA's analysis.

Other Considerations
There are several operational and process questions that will need to be answered as the policy is implemented in RY 2027. For example, staff will need to resolve the interaction between the carve-out policy and market shift assessment given these volumes are currently included in GBR. Staff will also need to establish a process for how they would evaluate changes to the carve-out list if the revenue associated with excluded volumes reaches the AHEAD Model Agreement's 15% limit on carve outs. These and other questions could be discussed with stakeholders at future Volume Subgroup meetings.

Finally, MHA supports the recommendation not to categorically exclude the seven low-volume service lines identified as part of the market shift policy approved last fall from global budgets. While excluding these service lines from the market shift evaluation may improve the reliability of market shift assessments, these services generally fail to meet the specified criteria for carve-outs and, in particular, the requirement that they are highly variable and unpredictable.

Thank you for the opportunity to comment on this important policy. We look forward to continuing to work with staff to implement the carve-out policy for complex tertiary and quaternary care services and develop the carve-out policy for select high-cost drugs.

Sincerely,

Patrick D. Carlson
Vice President, Care Transformation & Finance

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