maryland
health services
cost review commission

TO: Hospital CFOs

FROM: Cait Cooksey, Deputy Director - Hospital Rate Regulation
Prudence Akindo, Associate Director - Financial Methodologies

DATE: July 31, 2026

RE: Operationalizing Carve Outs

This memorandum serves to provide clarification on operationalizing the carve out policy that was approved by the Commission on July 22, 2026. The Carve-out Policy was created in keeping with AHEAD Model specifications which requires revenue associated with certain highly complex, highly specialized innovative quaternary and tertiary care carved out of acute care hospital global budgets. The goal of this policy is to maintain access to care for rare life-threatening conditions in a way that is manageable for hospitals while considering affordability for the system as a whole. Carve-out baseline volumes for Maryland hospitals are set at calendar year 2025 performance inflated to fiscal year 2027 (3-year average for small volume hospitals) and funded at 100 percent of hospital charges. Approximately 8.4 percent of hospital revenues will be carve-out from population-based methodologies and funded through this policy. This is a new approach for the majority of Maryland hospitals, and we will need to work closely with them to properly operationalize the policy.

This memorandum will be broken into four sections.

1. GBR Mechanics

Hospital rate files will reflect the approved carve-outs through the following process: Using a 2025 base year, Staff calculated the percentage of DRGs for In-State and Out-of-State residents by rate center, using total inpatient volumes in calendar year 2025 as the denominator. Staff then applied that percent to the total Rate Order volumes represented on the realignment tab in column E to determine the appropriate amount to carve out from RY 2027 volumes. The realignment tab on column R, represents the carved out volume. Revenue associated with the carve outs will appear on the rate order. Hospitals will be able to calculate the revenue associated with the carve out by multiplying the volumes in column R by the approved rates.

2. GBRs and Unit Rate Compliance

FAQs	HSCRC Response
Will there be any changes to experience data reporting?	Experience data reporting will remain unchanged. Staff recognize the lag between experience and case mix reporting and will work with hospitals to determine the impact on data and any unexpected adverse reactions.
Due to the timing disconnect between charge posting and DRG assignment, what flexibility exists for unit rate and GBR compliance thresholds?	Staff commit to working with the hospitals to understand impact of timing, reporting, and other issues that may have an effect on compliance.
How will hospitals measure and report unit rate and GBR compliance? DRGs are not known until the account is coded (~4 week + delay between discharge & coding completion)	GBR and unit rate compliance will be measured in accordance with the current GBR methodology. Staff are not recommending changes to compliance under GBRs at this time. Staff understand discharge data timing and other factors will play a role in timely compliance monitoring. Staff will work with hospitals through this transition and any other impacts.
How does the need to over/under charge for charges under GBR impact carve out revenue? For example: If a hospital needs to charge below approved rates (undercharge) for revenue under GBR to remain within compliance, the hospital will receive less revenue for the carve out services vs a hospital who has to charge above approved rates to meet GBR.	A settlement will occur at year end and applied to the hospital's GBR to ensure that the hospital receives the appropriate revenue related to charging at approved rates for carve outs is realized. An example of the proposed settlement approach is included in the example table below.
Are the carve outs a pass through or do we only pass through volume and set the charge/case?	Carve out volumes will be charged at the approved unit rate but will not count against
How will we measure supply and drug compliance? Not sure it will be possible to break out supply and drug costs specific to carve out accounts	Staff intend to convene a working group with hospitals to work through the nuance of supplies and drugs.

3. Example of Settlement Scenario

				Global Budgets			Carve-outs			Settlements		
				A	B	C = A * B	D	E	F = D * E	G = C + F	H = C + (E * D1)	I = G - H
Row	Compliance Scenarios	Revenue center	Service Unit	Unit Rate	Budgeted Volume	Budgeted Annual Revenues	Unit Rate	Baseline Volume	Standard Revenues	Total Revenue	Expected	Settlement
1	Expected	Med.Surg ICU	Patient Days	$ 2,500	2,800	$ 7,000,000	$ 2,500	100	$ 250,000	$ 7,250,000	$ 7,250,000	$ -
				Unit Rate	Actual Volume	Standard Revenues	Unit Rate	Actual Volume	Standard Revenues	Total Revenue	Expected	Settlement
2	Scenario 1	Med.Surg ICU	Patient Days	$ 2,600	2,600	$ 6,760,000	$ 2,600	95	$ 247,000	$ 7,007,000	$ 6,997,500	$ 9,500
3	Scenario 2	Med.Surg ICU	Patient Days	$ 2,300	3,100	$ 7,130,000	$ 2,300	110	$ 253,000	$ 7,383,000	$ 7,405,000	$ (22,000)
4	Scenario 3	Med.Surg ICU	Patient Days	$ 2,600	2,600	$ 6,760,000	$ 2,600	100	$ 260,000	$ 7,020,000	$ 7,010,000	$ 10,000

The settlement will be calculated after fiscal year end, when all final audited data is available. This settlement does not consider the impact of supplies and drugs, as stated above, staff will work with hospitals to develop an appropriate process for them.

4. Carve Out Impact on GBR Policies and Other Items

Policy/Other Items	HSCRC Action
Market Shift	FY 2027 marketshift assesses CY 2025 performance over CY 2024. Baseline volumes for carve-outs will be set using CY 2025 performance and the volume excluded in both Market shift base and performance years when CY 2025 becomes the market shift base. Broader discussions regarding how carve outs and marketshift will interface will be discussed in the fall as part of Medicare Global Budget policy discussions.
Repatriation/Expatriation Adjustment	FY 2027 Repatriation/Expatriation assess CY 2025 performance over CY 2024. Baseline carve-out volumes will be set using CY 2025 performance and the volumes excluded from the assessment periods
Complexity & Innovation	The carve-outs will replace the current complexity and innovation policy. All prospective FY 2027 Complexity and Innovation adjustments will be reversed
Out of State	FY 2027 Out-of-State assesses FY 2025 performance. Baseline volumes will be set using CY 2025 performance and the volumes excluded from the assessment periods.
Deregulation	Carve-outs will not apply. The current Deregulation Policy is an outpatient only assessment.

Surge Funding	FY 2027 Surge funding will assess FY 2025 performance over a FY 2019 base. Depending on the magnitude 1). If small, deduct out the hospital-specific carve-out volume proportion from the final surge allotment 2). If large, create a 2 month lag in experience data reporting to allow hospitals to distinguish between carve-out and GBR volumes. Broader discussions to come this fall as part of Medicare Global Budget policy discussions.
Demographic	Inflate the CY 2025 carve-out baseline by the FY 2027 demographic adjustment. Exclude out actual carve-out volumes from the FY 2027 demographic assessment effective in FY 2028.
Integrated Efficiency	Carve-out volumes will be included in assessment periods.
Quality	No distinction will be made to hospital volumes in quality assessments. Carve-out volumes will still be subject to all quality programs.
Grouper Version Updates	Grouper version updates may change how procedures are classified as carve-outs versus non-carve-outs year-over-year. The grouper release timing (federal fiscal year basis) and the staff monitoring on a calendar year basis could also be problematic. The approved Staff carve-out list was created using grouper v41 while CMMI's list was developed using v43. Staff might need to re-run the carve-out baseline under v43 to align DRGs with CMMI and work with CMMI to establish a process for collaboratively updating the carve-outs list annually.
Inpatient Only List	Staff are aware that there are periodic changes to services that move from the Inpatient Only List to Outpatient. Changes to that list may require review and evaluation of carve-out eligibility.

Staff will work with hospitals to address any unintended consequences of the policy and will remain flexible as the policy landscape shifts under the AHEAD bridge transition.

If you have any questions, please reach out to Cait Cooksey at cait.cooksey@maryland.gov or Prudence Akindo at prudence.akindo@maryland.gov.