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Volume Workgroup – Meeting #4 – GBR Carve-outs

July 2026

Agenda

Key Discussion Topics

1. Review updates to the carve-out methodology and resulting carve-out amount based on targeted stakeholder recommendations
2. Discuss key GBR carve-out themes across stakeholder comments and Staff responses
    i. Implementation and timing
    ii. Funding and payment
    iii. Operational mechanics and Compliance
    iv. Alignment with CMMI
3. Final recommendations
4. Next Steps

Status Update and Timeline

Status Update

- CMMI released revisions to financial specifications draft 3.0 this month
  - Final revisions are projected to be released this fall
- The Commission is still in discussions with CMMI regarding carve-outs list alignment. No clinical disagreements on lists from both parties so far
- Staff's original thinking is to make this a prospective adjustment only but are interested in understanding industry needs for funding on a retrospective basis

Projected Timeline

✓ **February 2026**
- HSCRC Proposed GBR Carve-outs Memo sent out to industry with requests for comments
- Stakeholder Comments due back to the HSCRC

✓ **March 2026**
- Volume Workgroup discussing stakeholder comments

✓ **April 2026**
- Volume Workgroup discussing Initial findings
- Review HSCRC potential approach with CMMI

✓ **May 2026**
- **Discuss potential approaches with CMMI**
- **Volume Workgroup discussion – Staff draft recommendations**

✓ **June 2026**
- Present Draft Recommendation at the Commission meeting
- Volume Workgroup discussion – Final Staff recommendations

July 2026
- Volume Workgroup discussing stakeholder comments
- Present Final Recommendation at the July Commission meeting
- FY27 implementation

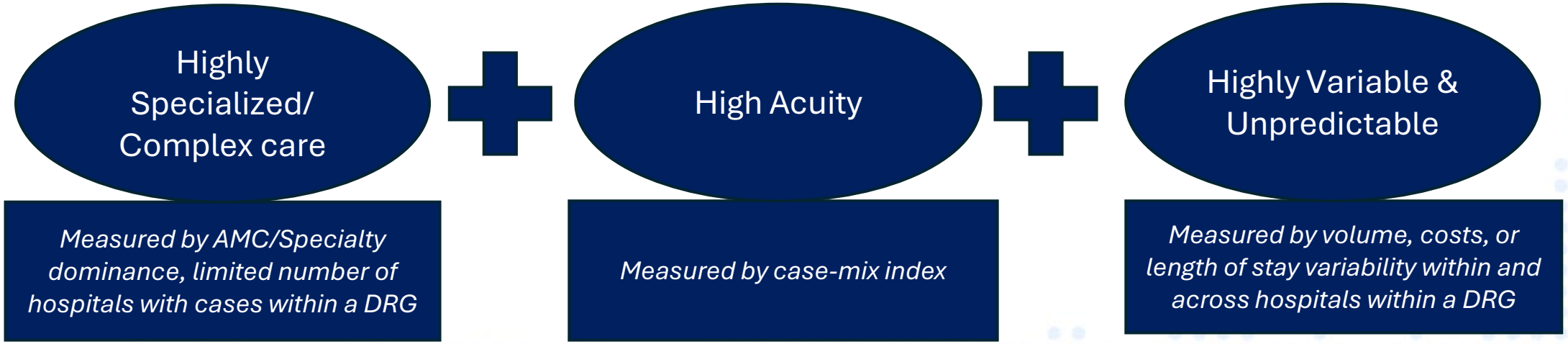
August 2026
- Volume Workgroup discussing additional carve-out operationalization mechanics

Summarized Stakeholder Comments & Staff Responses

Draft Recommendation Refresher: Defining highly specialized care for GBR carve-out consideration

Highly Specialized Care: Highly specialized and complex care refers to **advanced tertiary and quaternary services for rare or life-threatening conditions delivered at the highest levels of care**, defined by staff specifically as, **quaternary and tertiary** care at AMCs (i.e. a limited number of hospitals with advanced resources for treating highly complex cases) and **tertiary** care at MIEMSS-designated and NCI-designated specialty centers (i.e., a limited number of hospitals with specialized programs and resources for treating highly complex cases such as trauma, oncology, and cardiac).

Cases considered for carve-out under this policy must meet all three criteria



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Draft Recommendation Refresher: Defining highly specialized care for GBR carve-out consideration continued….

High acuity ≠ highly specialized

✓

Highly acute AND specialized

Services within areas such as **burn care** and **trauma** can be highly acute and highly specialized, often delivered at a limited number of designated centers

✗

Highly acute but NOT specialized

In contrast, **some cardiac services** can be highly acute but broadly distributed (~24 hospitals), indicating greater volume dispersion; they are relatively accessible rather than specialized

Highly acute and specialized services prioritized for the carve-out **should also be unpredictable or inconsistent** in terms of cost, volume, length of stay, or care pathway. These types of cases are not ideal for a population-based methodology due to their variable nature and therefore Staff has identified them as carve-out eligible

Summary of Public Comments for the Carve-out Draft Recommendation

Key Topics	UMMS	JHHS	Adventist	UPMC	Luminis	MedStar	LifeBridge	MWPH	MHA	CareFirst	Autolus Therap.	Gilead Sciences	Cancer Support Community
Implementation Timing & Readiness	X	X	X	X	X	X	X		X	X			
NICU/ Newborn DRGS	X	X	X		X	X		X	X				
Out-of-State Patients	X	X	X	X		X							
Funding Mechanics & Payment Methodology	X	X			X	X	X			X			
Operational Mechanics, Compliance, and C&I Transition	X	X			X	X	X		X				
Scope of Eligible Services & Applicability Beyond AMCs	X		X	X		X	X		X			X	
Alignment with CMMI & AHEAD Transition	X	X	X			X	X		X			X	
CAR-T and Innovative Therapies											X	X	X

- Staff received comment letters from 13 stakeholders regarding the GBR carve-out draft recommendation
- The comments from stakeholders can be broadly categorized into 8 areas of concern

Comments and Revisions on Carve Out List

NICU / Newborn DRGs

Overall Summary: NICU and newborn DRGs are one of the clearest areas of concern in the comment letters. Multiple stakeholders recommend removing the proposed NICU/newborn DRGs from the carve-out list or evaluating them separately, often noting that MS-DRGs are not sufficiently refined for neonatal complexity and that carve-out treatment could create access, transfer, or financial risks

Staff Response:

DRG	Description	Cases	CMI	AMC %	Specialty %	Total Charges
789	Neonates, Died or Transferred to Another Acute Care Facility	1,341	2.0	26%	39%	$ 84,256,600
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate	2,051	2.2	15%	74%	$ 156,232,136
	Total	3,392				$ 240,488,736

Scenarios	Total carve out charges	% of In-state revenue	# of MS-DRGs Flagged
Less restrictive	$1.9B	9.4%	66
Less restrictive minus NICU DRGs	$1.7B	8.3%	64

Proposed Action: Staff acknowledges the lack of specificity in the two identified NICU DRGs on the carve-outs list (DRGs 789 & 790) given the level of dispersion and volume statewide and have removed those DRGs from the carve-outs list. The staff priority on carve-outs is to maintain access to neonatal services in a way that is manageable for all hospitals and in agreement with Stakeholder comments, Staff believes that NICU DRGs should not be carved out at this time. Removing these DRGs from the carve-outs list should promote continued access

Comments were received from:	Adventist	MHA	JHHS	Luminis	UMMS	MedStar	MPWH

See appendix for comment details

Other DRGs Flagged for Further Investigation

Overall Summary: Staff in the draft recommendation identified the following DRGs as "flagged for further investigation"

Evaluation:

MS-DRG	Description	Cases	CMI	AMC %	Specialty %	Total Charges
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures	621	8.3	20%	0%	118,512,660
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC	280	2.6	28%	33%	16,964,481
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	131	2.5	31%	24%	7,202,700
653	Major Bladder Procedures with MCC	60	3.3	50%	0%	4,855,325

Scenarios	Total carve out charges	% of In-state revenue	# of MS-DRGs Flagged
Less restrictive	**$1.9B**	**9.4%**	**66**
Less restrictive minus NICU, 492 and 515 DRGs	**$1.7B**	**8.2%**	**62**

Proposed Action: Given the level of dispersion associated with DRGs 492 and 515 (35 hospitals reporting cases), staff have removed them from the carve-outs lists. Commenters also did not express opinions in either direction related to these specific DRGs

It is also worth noting that these two DRGs are not included on CMMIs list and for purposes of alignment, should also be excluded from the Staff lists

Staff proposes to maintain DRGs 04 and 653 on the carve-outs lists as these DRGs also exists on CMMI's list

- DRG 04 warrants carve-outs due to the PRE-MDC classification
- DRG 653 meets the carve-out criteria as it tends to be characterized by low and variable volumes and concentrated at AMCs

Out-of-State Patients

Overall Summary: Several stakeholders recommend applying the carve-out methodology consistently regardless of patient residency. These commenters argue that once a service meets the carve-out criteria, reimbursement should follow the characteristics of the service rather than whether the patient is in-state or out-of-state, both to reduce administrative complexity and to support consistent payment for specialized referral care.

Staff Response:

How should out-of-state cases be considered in the carve-out methodology?		Includes out-of-state cases?
AHEAD Test Compliance	The AHEAD test measures carve-out charges relative to in-state revenue. As a result, out-of-state cases do not impact compliance with the 15% threshold	**No**
Carve-out DRG List	The carve-out DRG list is intended to identify DRGs that are a part of the in-state revenue test. Therefore, the DRG selection methodology should be based solely on in-state cases	**No**
Reimbursement	Once a DRG is designated as a carve-out DRG, qualifying out-of-state and in-state cases should be reimbursed consistently	**Yes**

Approach: Generate the carve-out DRG list using in-state cases only, then apply a separate adjustment for qualifying out-of-state carve-out charges. This preserves alignment with the AHEAD test while ensuring consistent reimbursement treatment.

Proposed Action: Staff agree that carve-outs should also apply to Out-of-state volumes however AHEAD Model savings tests as stipulated in the State Agreement will be assessed on in-state volumes only

All out-of-state carve-out volumes will be excluded in the Out-of-State policy

Comments were received from:	Adventist	JHHS	UMMS	UPMC	MedStar

See appendix for comment details

Overview of Updated Carve-out Methodology Updates

Methodology Adjustments

After receiving stakeholder comment letters, Staff made targeted adjustments to the methodology based on the following key themes:

- Removed NICU DRGs (789 and 790) from the carve-out list given limitations in MS-DRG granularity and concerns around accurately capturing neonatal complexity
- Removed two DRGs (492 and 515) which were flagged for further investigation from the carve-out list given their level of dispersion despite volume levels
- Added an adjustment for qualifying out-of-state cases to account for carve-out eligible services provided to non-Maryland residents

Revenue Impact of Methodology Updates

- In-state carve-out amount totals approximately $1.7B across 62 DRGs, representing 8.2% of in-state revenue
- The separate adjustment for qualifying out-of-state cases adds approximately $219M, bringing the total carve-out amount to $1.9B

Updated Draft Recommendation Carve-out Thresholds & Charges Details

Total In-state Carve-out Charges	% of Total In-State Revenue	Number of DRGs
$ 1.7B	8.2%	62

% AMC Contribution to Carve-out Charges	% Specialty Hosp Contribution to Carve-out Charges	% Other Hosp Contribution to Carve-out Charges
61%	23%	16%

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	90%	90%	90%	50%	60%	60%
CMI	-	2.5	2.5	1.5	1.5	2.5	1.5	1.5
Charges in $M	$654.5	$96.5	$568.1	-	$15.4	$295.2	-	$66.5
OOS Charges $M	$219.2							

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Comments on and Considerations for Policy Implementation

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Implementation Timing and Readiness

Overall Summary: Stakeholders are divided on implementation timing. Some support a July 1, 2026, start or a phased approach to begin operationalizing the policy before the 2028 AHEAD transition, while others recommend delaying implementation to allow more time for technical review, operational preparation, and resolution of outstanding policy questions. A subset of commenters specifically tied this timing concern to hospital compliance, revenue monitoring, or financial volatility

Staff Response:

Staff acknowledges the quickness of the carve-outs list generation and implementation and is sympathetic to the industry concerns on readiness and timing however, the State committed to a July 1, 2026, start date.

Staff also perceives that an opt-in opt-out approach to implementation could present challenges related to other volume policy calculations for example the market shift calculation given the variations in associated variable cost factors for GBR versus Carve-out volumes. An opt-in opt-out approach could also inadvertently create an unfair market advantage for early adopters which could affect the AHEAD Savings test

Comments were received from:	Adventist	MHA	JHHS	Luminis	CareFirst	UMMS	UPMC	LifeBridge	MedStar

See appendix for comment details

Funding Mechanics and Payment Methodology

Overall Summary: Stakeholders raise a range of comments on how carved-out services should be funded, with no single alternative approach emerging. Comments include support for using MS-DRGs as a stable basis for identifying cases, as well as objections to paying at 100% of hospital charge per case. They also include recommendations for service-line-specific variable cost factors or rate-center baselines. There are competing views on whether carved-out services should be paid at HSCRC-approved rates or on a DRG basis. Stakeholders also raise concerns about how funding design could affect incentives, predictability, and revenue adequacy

Staff Response:

Staff is not proposing to change the draft recommendation but will like to provide further clarity

Proposed Action: The Staff approach is to identify carve-out volumes using DRG and fund on a unit rate basis as under the current system. Carve-out DRGs are mapped to rate centers and associated rate center revenues and volumes will be deducted from hospital GBRs

Moving to a DRG-based reimbursement would require significant changes to current rate setting practices and places additional burden on the system during the AHEAD transition

From FY 2027 all payers including Medicare, will be charged at the approved unit rate. In CY 2028 when the State transitions to non-Medicare global budgets, hospitals will charge at the unit rates for all payers while Medicare will pay at the DRG level. Payment at 100 percent of hospital charges is consistent with CMS's approach to carve-outs. No impact on the cost shift approved by the Commission in January 2026 is expected, that amount is stated in fixed dollar terms

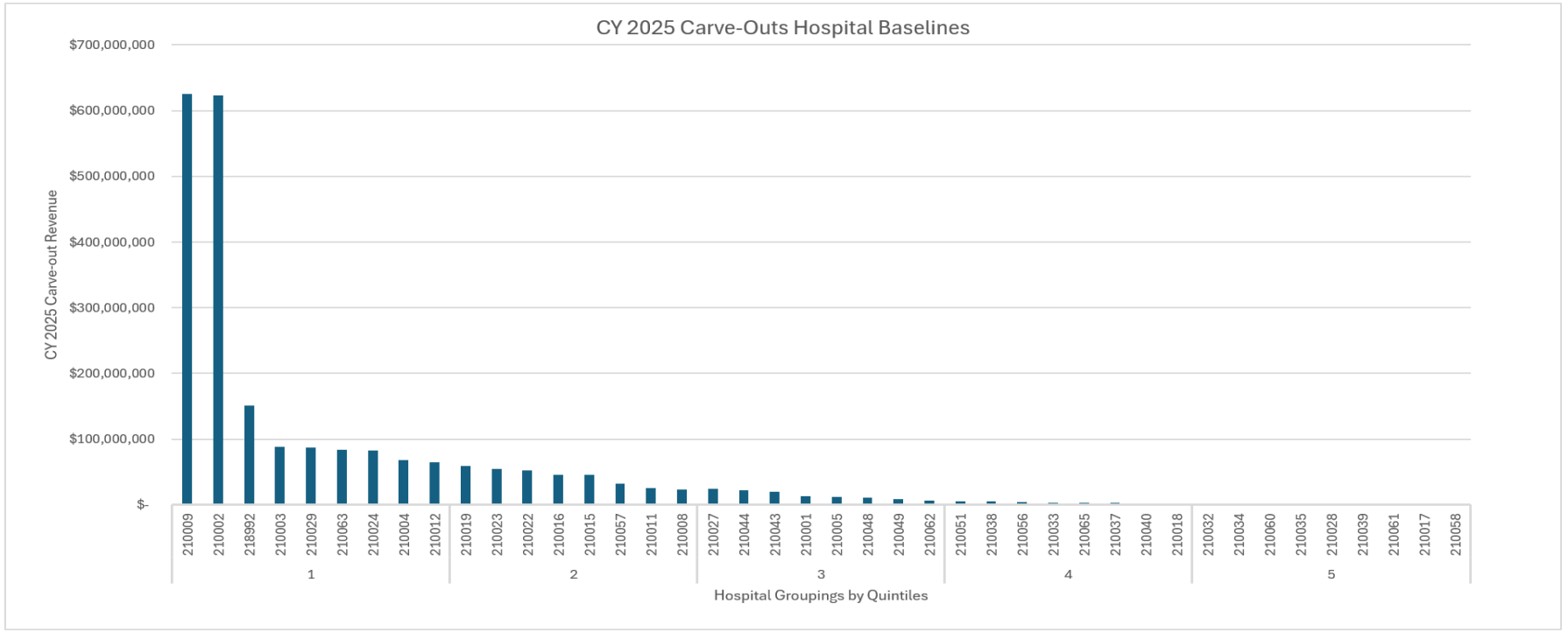
Comments were received from:	CareFirst	Luminis	JHHS	UMMS	LifeBridge	MedStar

See appendix for comment details

Establishing Carve-out Baseline Volumes

Overall Summary: Staff in the draft recommendation proposed that carve-out volumes be based on CY 2025 performance inflated to FY 2027, but use of a 3-year average for small volume hospitals

Evaluation:



Small volumes hospitals as shown on the graph will include those hospitals in the bottom two quintiles (Quintiles 4 & 5). These hospitals have shown consistently low carve-out volumes since CY 2023. While some variation exists in assessment periods, hospitals in the bottom two quintiles tend to stay consistent

Carve-out DRGs are mapped to rate centers and associated rate center revenues and volumes will be deducted from hospital GBRs. For these small volume hospitals, the baseline will follow the same cadence but on a 3-year average basis i.e., CY 2023 – CY 2025 performance inflated to FY 2027

Comments were received from:	CareFirst	Luminis	JHHS	UMMS	LifeBridge	MedStar

See appendix for comment details

Operational Mechanics, Compliance, and C&I Transition

Overall Summary: Many commenters emphasize that important technical and operational questions remain unresolved. Stakeholders raise concerns about compliance monitoring, reconciliation, interaction with other HSCRC policies, transition from the Complexity & Innovation policy, revenue monitoring, and how the policy would function in practice once implemented. Several recommend further technical evaluation or workgroup discussion before or during rollout.

Staff Response:

HSCRC Policies	Proposed Action
Market Shift Adjustment	FY 2027 Market Shift assesses CY 2025 performance over CY 2024. Baseline carve-out volumes for carveouts will be set using CY 2025 performance and the volume excluded in both Market Shift base and performance years
Repatriation/Expatriation Adjustment	FY 2027 Repatriation/Expatriation assess CY 2025. Baseline carve-out volumes will be set using CY 2025 performance and the volumes excluded from the assessment periods
Complexity and Innovation Policy	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 (OOS) Policy	FY27 Out-of-State assesses FY2025 performance. Baseline carve-out volumes will be set using CY 2025 performance and the volumes excluded from the assessment periods
Deregulation Adjustment	Carve-outs will not apply. The current Deregulation Policy is an outpatient only assessment
Surge Funding Policy	FY 2027 Surge funding will assess FY 2025 performance over a 2019 base. Depending on the magnitude of carve-out volumes 1). If small, deduct out the hospital-specific carve-out volume proportionally 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
Demographic Adjustment	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
Integrated Efficiency Policy	Carve-out volumes included in assessment periods
Quality Pay for performance programs	No distinction will be made to hospital volumes in quality assessments. Carve-out volumes will still be subject to assessments in all quality programs

Staff anticipate revisiting all of these policies in the fall of 2026 as part of the planning process for the transition to Medicare Hospital Global Budgets in 2028; specific details regarding the treatment of the carve outs will be incorporated in this process

Comments were received from:	MHA	JHHS	Luminis	UMMS	LifeBridge	MedStar

See appendix for comment details

Operational Mechanics, Compliance, and C&I Transition Cont….

Overall Summary: Many commenters emphasize that important technical and operational questions remain unresolved. Stakeholders raise concerns about compliance monitoring, reconciliation, interaction with other HSCRC policies, transition from the Complexity & Innovation policy, revenue monitoring, and how the policy would function in practice once implemented. Several recommend further technical evaluation or workgroup discussion before or during rollout.

Staff Response: Compliance Example

			Global Budgets			Carve-outs			Settlements		
Compliance Scenarios	Revenue center	Service Unit	Unit Rate	Budgeted Volume	Budgeted Annual Revenues	Unit Rate	Baseline Volume	Standard Revenues	Total Revenue	Expected	Settlement
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
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
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)
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

Proposed Action: Carve-outs are not subjected to compliance corridors, but actual rates and unit rates charged on the carve-out volumes will still need to be reconciled at year end. In order words, GBR volumes and carve-out volumes will be charged at the same rates. So, if a hospital undercharges its rates, it also undercharges its carved-out rates. At year end, a reconciliation must be done to calculate the amount of revenue that would have been charged had the carved-out rates been charged at actual and the resulting value applied as settlements to the GBR. HSCRC staff is committed to working with hospitals in the first year of operation to review and determine charging appropriateness and any additional considerations. Reconciliations will only apply to non-Medicare volumes in CY 2028

Comments were received from:	MHA	JHHS	Luminis	UMMS	LifeBridge	MedStar

See appendix for comment details

Scope of Eligible Services & Applicability Beyond AMCs

Overall Summary: Stakeholders comment extensively on which services and providers should fall within the carve-out framework. Several support expanding carve-outs beyond academic medical centers to include qualifying services delivered at specialty and community hospitals, while others request inclusion of specific service lines such as structural heart, complex brain cases, limb-lengthening, psychiatric, and rehabilitation services. Some also seek clarification that listed DRGs should apply consistently across hospital types. The common theme is that eligibility should be driven by the characteristics of the service rather than solely by provider type.

Staff Response:

Staff would like to further emphasize that it is the list of carve-out services that counts versus the methodology used to generate the list. Also, the staff methodology defines specialty by DRG MDC as the dominant criteria prior to assessing dominance within specialty state resource providers.

Staff would also like to emphasize that the final list of carve-out eligible services is applied consistently across all hospitals in the State so all hospitals will carve-out DRGs identified on the carve-outs list that occur at their hospitals

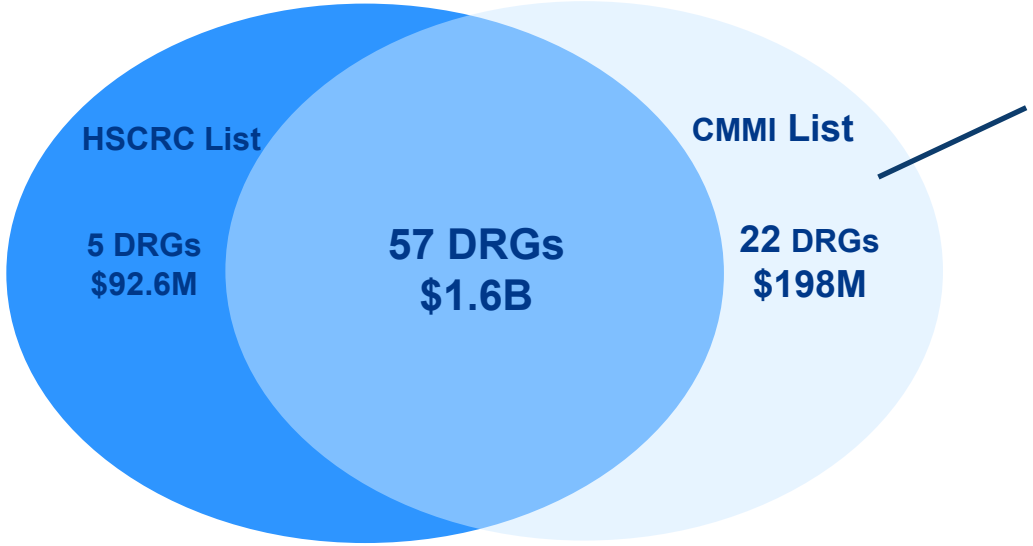
Comments were received from:	Adventist	MHA	UMMS	UPMC	LifeBridge	MedStar	Gilead

See appendix for comment details

Alignment with CMMI & AHEAD Transition

Overall Summary: Many stakeholders recommend aligning Maryland's carve-out policy as closely as possible with CMMI under AHEAD. Commenters emphasize that consistency across State and Federal methodologies would reduce administrative burden, improve predictability, and help hospitals prepare for the CY 2028 transition. Some specifically recommend reconciling to a CMMI-aligned list before implementation or preserving the FY 2027 framework as the basis for the future AHEAD exclusion list.

Staff Response:



- Includes spinal fusion DRGs which CMMI has indicated refinements that will exclude
- Includes two cardiac defibrillator DRGs (226 & 227) with no statewide volumes
- MCC/CC DRG variations between the CMMI and HSCRC list is strictly driven by the algorithm

Proposed Action: Staff acknowledges stakeholder concerns on alignment with a CMMI list for simplicity and consistency. Staff would like to confirm that there is currently an 85 percent match in charges across 57 DRGs identified by the Staff and CMMI lists

CMMI has noted that their list is strictly algorithm driven. The Staff list is defined using all-payer data while CMMI's list is defined using Medicare data which could explain some of the variation in identified DRGs. CMMI acknowledges this and is open to evaluating their list further making accommodations for DRG mis-matches. There is no clinical disagreement between the two lists currently.

CMMI has indicated flexibility in refining their list for purposes of alignment and are open to further discussions around collectively updating the carve-out lists annually

Comments were received from:	Adventist	MHA	JHHS	UMMS	LifeBridge	MedStar	Gilead

See appendix for comment details

CAR-T and Innovative Therapies

Overall Summary: A subset of commenters focuses specifically on preserving or expanding carve-outs for CAR-T and other innovative therapies to support access across settings. These stakeholders emphasize that financial barriers under global budgets can delay treatment, reinforce AMC concentration, and limit access for patients who live farther from major academic centers. The common recommendation is a setting-neutral framework that maintains carve-out treatment for CAR-T as Maryland transitions under AHEAD.

Staff Response:

Staff agrees with stakeholders and will like to re-iterate that the staff priority on carve-outs is to protect access to care for rare life-threatening conditions in a way that is manageable for all hospitals while considering affordability for the system. CAR-T is an innovative therapy which Marylanders should have access to and hospitals providing this care regardless of type should equally be reimbursed accordingly

Comments were received from:	Autolus	Cancer Support Community	Gilead

See appendix for comment details

Next Steps

1. Present the final recommendation on carve-outs at the July Commission meeting
2. Share hospital calendar year data with hospitals by DRG and rate center
3. Convene an August Volume Workgroup meeting to discuss additional operationalization mechanics
4. Continue conversations with CMMI to
    i. Continue conversations with CMMI to
    ii. Formalize a standard process for updating the carve-outs list

Appendix A. Detailed Stakeholder Comments

Implementation Timing and Readiness

Overall Summary: Stakeholders are divided on implementation timing. Some support a July 1, 2026 start or a phased approach to begin operationalizing the policy before the 2028 AHEAD transition, while others recommend delaying implementation to allow more time for technical review, operational preparation, and resolution of outstanding policy questions. A subset of commenters specifically ties this timing concern to hospital compliance, revenue monitoring, or financial volatility.

Organization	Summary of Comments
Adventist	Adventist HealthCare (Adventist) supports implementation effective July 1, 2026 and, if statewide implementation is not feasible, suggests an optional pilot approach.
MHA	Maryland Hospital Association (MHA) requests that HSCRC consider allowing hospitals to opt into the policy beginning January 1, 2027 instead of July 1, 2026 if operationally feasible.
JHHS	Johns Hopkins Health System (JHHS) supports the July 1, 2026 effective date but suggests voluntary implementation on July 1, 2026 for systems that are ready and statewide implementation on January 1, 2027 for systems needing additional time.
Luminis	Luminis Health (Luminis) recommends delaying implementation until January 1, 2027 at the earliest because the review and implementation timeline is too compressed.
CareFirst	CareFirst says implementation should be delayed by at least six months so stakeholders can assess the financial and operational implications of the policy.
UMMS	University of Maryland Medical System (UMMS) supports implementation on July 1, 2026 and argues the policy should be implemented now to ensure hospitals are adequately reimbursed for high-acuity care.
UPMC	UPMC Western Maryland (UPMC) supports July 1, 2026 implementation for AMCs already familiar with carved-out services, but requests the option of January 1, 2027 implementation for other hospitals newly subject to carve-outs.
LifeBridge	LifeBridge Health (LifeBridge) recommends delaying the effective date until January 1, 2027 to allow communication with clinical stakeholders and a transition period for monitoring and financial recording changes.
MedStar	MedStar Health (Medstar) recommends delaying implementation until July 1, 2027 and says more time and due diligence are required to avoid unintended consequences.

NICU / Newborn DGRs

Overall Summary: NICU and newborn DRGs are one of the clearest areas of concern in the comment letters. Multiple stakeholders recommend removing the proposed NICU/newborn DRGs from the carve-out list or evaluating them separately, often noting that MS-DRGs are not sufficiently refined for neonatal complexity and that carve-out treatment could create access, transfer, or financial risks. MWPH is the strongest opposing voice, arguing that carving out the identified NICU DRGs would threaten both neonatal care pathways and a critical hospital revenue stream.

Organization	Summary of Comments
Adventist	Adventist recommends removing the two NICU MS-DRGs from the carve-out list and evaluating NICU separately. They note that MS-DRGs are not well suited to identifying highly specialized neonatal care and that moving NICU services fully to volume-based reimbursement could jeopardize access.
MHA	MHA supports further consideration of the two NICU DRGs and notes that the MS-DRG system lacks the specificity and clinical precision needed to assess whether neonatal cases meet the criteria for highly specialized care.
JHHS	JHHS says NICU MS-DRGs should not be included in the carve-out list because MS-DRGs do not adequately differentiate more complex from less complex neonates and APR-DRGs are more appropriate.
Luminis	Luminis supports further study of the two NICU DRGs rather than including them in the carve-out list now, stating that the current MS-DRG structure may not be sufficiently refined to account for complexity and intensity of care.
UMMS	UMMS recommends removing newborn cases from the carve-out methodology. They note that inclusion would increase the carve-out percentage by over 1% and that the newborn MS-DRG definitions capture more standard-of-care cases than the carve-out is intended to include.
MedStar	MedStar says NICU services need further evaluation; the letter supports staff's intent to include NICU services conceptually but says MS-DRGs are not designed for this patient population and recommends considering an alternative methodology.
MWPH	MWPH asks that DRGs 790 and 789 not be carved out and instead remain in hospital global revenue budgets, noting that approximately 24% of its annual net revenue comes from neonates and 200–250 of these cases transfer from acute care hospitals each year, making the carve-out a financial threat to its broader services.

Out-of-State Patients

Overall Summary: Several stakeholders recommend applying the carve-out methodology consistently regardless of patient residency. These commenters argue that once a service meets the carve-out criteria, reimbursement should follow the characteristics of the service rather than whether the patient is in-state or out-of-state, both to reduce administrative complexity and to support consistent payment for specialized referral care.

Organization	Summary of Comments
Adventist	Adventist recommends applying the carve-out policy uniformly regardless of patient residency, arguing that different reimbursement rules for in-state and out-of-state patients create unnecessary administrative complexity and payment variation.
JHHS	JHHS recommends applying the carve-out methodology to all volumes regardless of state of origin, arguing that the AHEAD 15% limit is measured on in-state revenue only and that a bifurcated approach would create unnecessary operational and compliance complexity.
UMMS	UMMS says the carve-out policy should include both in-state and out-of-state patients because identification of excluded GBR cases should occur before separating revenue into carve-out volume and hospital global budget volume.
UPMC	UPMC advocates including out-of-state volumes in carve out methodology because about 20% of its specialized service volumes come from Pennsylvania and West Virginia.
MedStar	MedStar says the draft's in-state limitation is inconsistent with the intent of carving out high-cost and unpredictable services from hospital global budgets and recommends expanding the policy methodology to out-of-state patients.

Funding Mechanics and Payment Methodology

Overall Summary: Stakeholders raise a range of comments on how carved-out services should be funded, with no single alternative approach emerging. Comments include support for using MS-DRGs as a stable basis for identifying cases, as well as objections to paying at 100% of hospital charge per case. They also include recommendations for service-line-specific variable cost factors or rate-center baselines. There are competing views on whether carved-out services should be paid at HSCRC-approved rates or on a DRG basis. Stakeholders also raise concerns about how funding design could affect incentives, predictability, and revenue adequacy..

Organization	Summary of Comments
CareFirst	CareFirst recommends using DRG payments for carve-out services rather than the older HSCRC rate-setting approach, arguing that DRG payments better align incentives and would help avoid creating a third payment system under AHEAD.
Luminis	Luminis opposes funding 100% of hospital charge per case, recommending service-line-specific variable cost factors and standardized charge-per-case caps. Luminis also recommends retrospectively adjusting revenue for CON-approved carve-out projects, citing its 50% VCF open-heart program as underfunded, and emphasizes that methodology is as critical as the carve-out list itself.
JHHS	JHHS proposes establishing baselines at the rate-center level using CY 2025 experience and FY 2027 approved rates rather than embedding CY 2025 rates with a uniform inflation assumption.
UMMS	UMMS supports using MS-DRGs in the carve-out policy and sunsetting the current Complexity & Innovation policy because a DRG approach provides greater stability and operational consistency.
LifeBridge	LifeBridge recommends developing a process to monitor real-time growth in carve-out / excluded cases and any associated unintended lower-complexity volume movement, allowing for a more responsive market-shift adjustment funded at a 100% variable cost factor.
MedStar	MedStar says carved-out services should continue to be paid at HSCRC-approved rates, not on a DRG basis. The letter opposes creating a new all-payer DRG case-rate system during the AHEAD transition.

Operational Mechanics, Compliance, and C&I Transition

Overall Summary: Many commenters emphasize that important technical and operational questions remain unresolved. Stakeholders raise concerns about compliance monitoring, reconciliation, interaction with other HSCRC policies, transition from the Complexity & Innovation policy, revenue monitoring, and how the policy would function in practice once implemented. Several recommend further technical evaluation or workgroup discussion before or during rollout.

Organization	Summary of Comments
MHA	MHA says operational and process questions remain, including how the carve-out policy will interact with market shift and how HSCRC would evaluate changes to the carve-out list if excluded revenue approaches the AHEAD 15% cap.
JHHS	JHHS requests clarification on the transition from the Complexity & Innovation policy, including how current C&I revenue will be assigned to carve-out cases, how retrospective FY 2025 and FY 2026 C&I adjustments will be calculated, and how year-end global budget compliance will be determined in the transition year.
Luminis	Luminis says technical and operational questions remain related to implementation, compliance monitoring, and reconciliation, and argues these issues should be addressed before implementation to avoid financial volatility and administrative burden.
UMMS	UMMS recommends convening a workgroup to address rate mechanics and other policy impacts so staff and hospitals can develop an agreed-upon implementation and management approach.
LifeBridge	LifeBridge cites the need for a transition period to change revenue monitoring and financial recording practices.
MedStar	MedStar says numerous implementation questions remain, including effects on Market Shift, Repatriation/Expatriation, Out-of-State, Deregulation, and Efficiency, supply and drug compliance, unit rate pricing, coding delays, and possible reporting requirements.

Scope of Eligible Services & Applicability Beyond AMCs

Overall Summary: Stakeholders comment extensively on which services and providers should fall within the carve-out framework. Several support expanding carve-outs beyond academic medical centers to include qualifying services delivered at specialty and community hospitals, while others request inclusion of specific service lines such as structural heart, complex brain cases, limb-lengthening, psychiatric, and rehabilitation services. Some also seek clarification that listed DRGs should apply consistently across hospital types. The common theme is that eligibility should be driven by the characteristics of the service rather than solely by provider type.

Organization	Summary of Comments
Adventist	Adventist strongly supports inclusion of structural heart procedures, explaining that these programs require specialized teams, major infrastructure investment, and high-cost implantable devices.
MHA	MHA supports not categorically excluding the seven low-volume service lines identified in the market shift policy, stating those services generally fail to meet the specified carve-out criteria and should not automatically be treated as carve-outs. MHA also supports applying carve-outs based on defined DRGs regardless of which hospital provides the service.
UMMS	UMMS says the carve-out policy should apply to all hospitals, noting that over $800 million (42%) of this highly complex care is provided outside AMCs. UMMS also recommends adding all complex brain cases—specifically MS-DRGs 024, 026, and 027—because those DRGs are highly concentrated at trauma-designated centers and are highly variable.
UPMC	UPMC Western Maryland supports continued inclusion of cardiac / structural heart MS-DRGs because those services are highly acute, highly specialized, and difficult to control.
LifeBridge	LifeBridge Health says the revision to include cardiac valve procedures appropriately recognizes highly specialized, technology-intensive procedures with costs driven by patient acuity, implant expenses, and continuous innovation. LifeBridge Health also requests inclusion of non-cosmetic limb-lengthening procedures at Sinai Hospital, arguing that they meet the criteria for highly specialized services and are performed almost exclusively at Sinai Hospital.
MedStar	MedStar argues that if hospital volumes are complex, expensive, and unpredictable, they should be carve-out candidates regardless of where the service is provided and says DRG selection should be held to the same site-neutral standard as the ultimate funding rather than relying on AMC cell dominance or special designations.
Gilead	Gilead asks HSCRC to clarify that all DRG carve-out list cases, including Pre-MDC MS-DRG 018, will be removed from the global budget regardless of whether care is delivered at an AMC, specialty hospital, or community hospital, and flags language in the draft recommendation as potentially narrowing the policy more than intended.

Alignment with CMMI & AHEAD Transition

Overall Summary: Many stakeholders recommend aligning Maryland's carve-out policy as closely as possible with CMMI under AHEAD. Commenters emphasize that consistency across State and Federal methodologies would reduce administrative burden, improve predictability, and help hospitals prepare for the CY 2028 transition. Some specifically recommend reconciling to a CMMI-aligned list before implementation or preserving the FY 2027 framework as the basis for the future AHEAD exclusion list.

Organization	Summary of Comments
Adventist	Adventist supports alignment with CMMI's final carve-out methodology and recommends that Maryland seek alignment where practical while preserving flexibility to refine policy before Medicare Hospital Global Budgets begin in 2028.
MHA	MHA supports aligning the carve-out list with CMMI's carve-out list as much as possible to reduce administrative complexity and align incentives across payers.
JHHS	JHHS says the policy should prioritize alignment between State and Federal methodologies and supports maintaining a single, reconciled carve-out list across HSCRC-administered and CMS-administered global budgets in CY 2028 and beyond.
UMMS	UMMS says the carve-out methodology should align with CMMI's planned definition under AHEAD to reduce administrative burden and maintain consistency across multiple regulatory frameworks.
LifeBridge	LifeBridge recommends that, at the appropriate time, HSCRC align its exclusion list with the services ultimately finalized and included on the CMMI exclusion list.
MedStar	MedStar recommends aligning with CMMI under AHEAD everywhere possible and adopting a CMMI-aligned list from the start to avoid two rounds of rebasing and sustained unpredictability and also recommends aligning HSCRC's approach for inpatient psychiatric and rehabilitation services with CMMI for consistency under AHEAD.
Gilead	Gilead asks HSCRC to preserve an access-protective, setting-neutral carve-out framework through the AHEAD transition and use the FY 2027 framework as the basis for a targeted CY 2028 exclusion list.

CAR-T and Innovative Therapies

Overall Summary: A subset of commenters focuses specifically on preserving or expanding carve-outs for CAR-T and other innovative therapies to support access across settings. These stakeholders emphasize that financial barriers under global budgets can delay treatment, reinforce AMC concentration, and limit access for patients who live farther from major academic centers. The common recommendation is a setting-neutral framework that maintains carve-out treatment for CAR-T as Maryland transitions under AHEAD.

Organization	Summary of Comments
Autolus	Autolus Therapeutics (Autolus) supports extending the global budget carve-out for CAR-T to all hospitals, arguing that it reduces financial pressure, supports site-of-care flexibility, and helps avoid delays in treatment.
CSC	Cancer Support Community (CSC) requests a carve-out for CAR-T therapies regardless of treatment setting, arguing that patients outside the Baltimore–Washington corridor face significant travel, logistical, and caregiver burdens when CAR-T remains concentrated at AMCs.
Gilead	Gilead supports finalizing a setting-neutral carve-out for CAR-T, including Pre-MDC MS-DRG 018, and says access to innovative therapies should not depend on whether a patient can travel to or be treated at an AMC.

Appendix B. Carve-out DRGs

Carve-out DRGs

MS-DRG	DRG Description
1	Heart Transplant or Implant of Heart Assist System with MCC
2	Heart Transplant or Implant of Heart Assist System without MCC
3	ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
5	Liver Transplant with MCC or Intestinal Transplant
6	Liver Transplant without MCC
7	Lung Transplant
8	Simultaneous Pancreas and Kidney Transplant
10	Pancreas Transplant
11	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC
12	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC
13	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC
14	Allogeneic Bone Marrow Transplant
16	Autologous Bone Marrow Transplant with CC/MCC
17	Autologous Bone Marrow Transplant without CC/MCC
18	Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis
20	Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC
23	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
25	Craniotomy and Endovascular Intracranial Procedures with MCC
28	Spinal Procedures with MCC
29	Spinal Procedures with CC or Spinal Neurostimulators
31	Ventricular Shunt Procedures with MCC
140	Major Head and Neck Procedures with MCC
143 ★	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC
212	Concomitant Aortic and Mitral Valve Procedures
215 ★	Other Heart Assist System Implant
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization without CC/MCC
219	Cardiac Valve and Other Major Cardiothoracic Procedures without CardiacCatheterization with MCC

★ *Not included on CMMI's list*

Carve-out DRGs

MS-DRG	DRG Description
220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC
221	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization without CC/MCC
228	Other Cardiothoracic Procedures with MCC
231	Coronary Bypass with PTCA with MCC
232	Coronary Bypass with PTCA without MCC
233	Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC
234	Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC
235	Coronary Bypass without Cardiac Catheterization with MCC
236	Coronary Bypass without Cardiac Catheterization without MCC
266	Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC
267	Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC
268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
270 ★	Other Major Cardiovascular Procedures with MCC
319	Other Endovascular Cardiac Valve Procedures with MCC
405	Pancreas, Liver and Shunt Procedures with MCC
650	Kidney Transplant with Hemodialysis with MCC
651	Kidney Transplant with Hemodialysis without MCC
652	Kidney Transplant
653	Major Bladder Procedures with MCC
829	Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with CC/MCC
834	Acute Leukemia with MCC
837	Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC
838 ★	Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or HighDose Chemotherapy Agent
846 ★	Chemotherapy without Acute Leukemia as Secondary Diagnosis with MCC
927	Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
955	Craniotomy for Multiple Significant Trauma
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC

★ *Not included on CMMI's list*