American Hospital Association™
Advancing Health in America

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February 23, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Global Benchmark for Efficient Drug Pricing (GLOBE) Model Proposed Rule (CMS-5545-P)

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule on the Global Benchmark for Efficient Drug Pricing (GLOBE) Model.

The AHA supports the administration's goal of lowering drug prices and shares its commitment to make prescription drugs more affordable and easily accessible for patients across the country. As the agency is well aware, drug prices remain high and continue to rise. The average launch price of a new drug in 2024 was $370,000, a 23% increase from the prior year, and the prices for many drugs increase every year, often faster than inflation.[1] A congressional report found that in 2025 alone, 688 drugs — many used to treat conditions like cancer, depression and asthma — experienced price increases above general inflation, with several drugs more than doubling in price.[2] More recently, a report found that drugmakers increased prices for 900 drugs in just the first two weeks of 2026.[3]

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[1] https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-doubled-4-years-focus-rare-disease-grows-2025-05-22/
[2] https://www.sanders.senate.gov/wp-content/uploads/9.29.25-HELP-Minority-Report-Trump-Drug-Price-Increases.pdf
[3] https://www.pharmexec.com/view/companies-raise-list-prices-16-agreements-lower-prices-trump-administration-report

As one of the nation's major purchasers of prescription drugs, hospitals and health systems are acutely aware of this persistent problem and welcome solutions, including testing innovative payment models through the Center for Medicare and Medicaid Innovation (CMMI). While the AHA broadly supports the Administration's objectives as described in the proposed rule, we believe the GLOBE Model as proposed lacks critical operational details that, if not properly clarified, could create additional burden for hospitals and health systems. Moreover, we are concerned that the proposed model could create perverse incentives for drug companies to alter their pricing structure such that it increases acquisition costs for hospitals and health systems – and by extension, limits access to prescription drugs for patients – undermining one of the GLOBE Model's core objectives. In addition, we continue to believe participation in CMMI models should be voluntary and thus encourage the agency to make participation in the GLOBE Model voluntary.

IMPLICATIONS FOR HOSPITAL DRUG ACQUISITION PRICES

As CMS acknowledges in the proposed rule, drug companies are likely to "seek to adjust prices in order to lower the amount of GLOBE Model rebates they owe." The prospect of drug companies adjusting prices has downstream implications for the prices hospitals pay to acquire Medicare Part B drugs. With the sole ability to set and change prices, drug companies could choose to alter their list prices in a manner that has negative consequences for the Average Manufacturer Price (AMP) and Medicaid Best Price that results in higher acquisition costs for hospitals. Moreover, both AMP and best prices have direct implications for 340B ceiling prices, and a lower rebate percentage could result in higher 340B ceiling prices. Over time, if hospitals are subject to higher acquisition prices for Part B drugs, that could make it more difficult for them to obtain and provide those drugs to their patients. Therefore, if the model is finalized, we urge CMS to monitor potential changes to these prices and mitigate any negative impacts to the acquisition prices of Part B drugs for hospitals and health systems.

OPERATIONAL AND ADMINISTRATIVE BURDEN CONCERNS

First, we urge CMS to clarify which drug companies are subject to the model and which are not. The agency states in the proposed rule that it is applicable to all drug companies that manufacture a Part B rebatable drug. However, there have been reports that drug companies that have signed agreements with the Administration may be exempt from participation.[4] It is important for all stakeholders, including hospitals and health systems, to be aware of to which drug companies, and thereby to which drugs, the GLOBE Model would apply.

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[4] https://www.statnews.com/2025/12/23/trump-drug-pricing-deals-medicare-most-favored-nation-demos/

Second, the proposed model would require CMS to establish and maintain a *GLOBE Model Eligible Beneficiary List* based on a geographically randomized sample of approximately 25% of Medicare Part B fee-for-service (FFS) beneficiaries. CMS states that it would update the list on a weekly basis and ensure its accuracy as beneficiaries may become ineligible for a variety of reasons, such as leaving Medicare Part B FFS during the course of the model performance period. We urge CMS to ensure that this list is made available to all hospitals that bill for Medicare Part B drugs as there is no other mechanism outlined by CMS for hospitals to identify which of their Medicare FFS patients are included in the model and which are not. Absent access to this list or any other way to identify GLOBE Model beneficiaries, hospitals could be at risk of collecting the incorrect beneficiary co-insurance amounts. Moreover, it is our understanding that there is no appeals process or other avenue to remedy concerns in circumstances in which CMS may have erred in the identification of a GLOBE Model beneficiary or the calculation of a beneficiary's co-insurance. This could result in the hospital being reimbursed incorrectly, creating significant administrative (and reputational) burdens to rectify. We believe it is important for CMS to provide a path for hospitals to seek review of the agency's calculations if it believes there is an error to ensure that hospitals are not unintentionally under-reimbursed.

Third, the proposed rule does not address how hospitals are to manage the collection of beneficiary co-insurance amounts for any GLOBE Model beneficiary who also has supplemental coverage, such as Medigap coverage. It is estimated that nearly 90% of Medicare FFS beneficiaries have some form of supplemental coverage that covers their co-insurance.[5] Therefore, we respectfully request that CMS clarify this matter and ensure that it provides proper instructions regarding billing for the appropriate co-insurance amounts when a GLOBE Model beneficiary has supplemental coverage.

POTENTIAL TO INCREASE WHITE BAGGING

As CMS acknowledges in the proposed rule, the model may "incentivize the increased use of white bagging" by drug companies as a mechanism to avoid paying GLOBE Model rebates. We agree with CMS' assessment and are concerned by any effort that has the potential to increase white bagging. White bagging is a practice where third-parties require certain prescribed drugs to be dispensed from a specific specialty pharmacy and shipped directly to a practice, hospital, or clinic for patient administration. This practice puts patients' health at risk and disrupts patient care by delaying access to their prescribed medications.[6] For example, this practice is particularly concerning for cancer patients who rely on timely access to their chemotherapy. If CMS finalizes the GLOBE Model, we encourage the administration to establish specific protections to

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[5] https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/#:~:text=In%202023%2C%20most%20(87%25),each%20coverage%20type%20is%20below

[6] https://www.aha.org/system/files/media/file/2021/03/AOMarch8white-bagging-0221.pdf

mitigate against any increases in white bagging that would undermine the agency's goal to improve access to prescription drugs.

We appreciate your consideration of our comments and look forward to working with the Administration on its efforts to lower drug prices for patients and providers. Please contact me if you have any questions, or have a member of your team contact Bharath Krishnamurthy, AHA director of pharmaceutical policy, at bkrishnamurthy@aha.org or Robyn Tessin, AHA director of payment policy, at rtessin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development