AHA Warns CMS GLOBE Model Could Raise Hospitals' Drug Acquisition Costs

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The American Hospital Association is warning CMS that its proposed GLOBE drug pricing model, designed to tie Medicare Part B rebates to international drug prices, could unintentionally raise hospitals' acquisition costs and disrupt patient access.

In a letter to CMS Administrator Mehmet Oz, the AHA said that while it supports the administration's efforts to lower prescription drug prices, it believes the model omits key implementation details and could create unintended downstream consequences.

Specifically, the group raised concerns about which manufacturers and drugs would be subject to the international benchmark, how CMS would address the potential expansion of "white bagging" -- in which drugs are shipped directly to hospitals by specialty pharmacies -- and whether manufacturers might restructure pricing to increase hospitals' purchase costs.

Additionally, AHA reiterated its longstanding position that participation in Center for Medicare and Medicaid Innovation (CMMI) models should be voluntary, arguing that making these demonstrations mandatory exposes providers to financial and administrative risk without sufficient safeguards.

"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," the AMA said in a press release Monday.

In December, CMS proposed the Global Benchmark for Efficient Drug Pricing (GLOBE) model, which would tie Medicare Part B drug inflation rebates to prices paid in 19 other industrialized countries, including Canada, France, Germany, Japan, the United Kingdom, Australia and Switzerland. If a manufacturer's U.S. price exceeds the international benchmark, the company would owe additional rebates to Medicare.

The administration estimates the model would save nearly $12 billion in Medicare Part B spending over seven years, from Oct. 1, 2026, through Sept. 30, 2033, while lowering beneficiary out-of-pocket costs without harming access or quality of care.

The model would apply to a subset of high-spending, single-source Part B drugs and would affect approximately 25% of traditional Medicare Part B fee-for-service beneficiaries selected based on geographic criteria.

CMS would exclude drugs already subject to Medicare's negotiated maximum fair price, as well as vaccines, radiopharmaceuticals, certain oral drugs, compounded products and intravenous immune globulin.

A primary concern raised by AHA -- and one CMS acknowledged in the proposed rule -- is that requiring manufacturers to pay higher rebates could backfire if drugmakers respond by adjusting pricing structures to reduce their exposure. Because manufacturers control list prices and discount arrangements, AHA warned hospitals could ultimately face higher acquisition costs for certain Medicare Part B drugs. Such changes could have ripple effects on pricing metrics used in Medicaid and the 340B drug discount program, AHA says, undermining the administration's stated goal of improving affordability and access.

“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,” the release said.

The association also urged CMS to clarify which manufacturers would ultimately be subject to the model.

While the proposed rule indicates the model would apply broadly to manufacturers of selected Part B drugs, there have been reports that certain drugmakers entering voluntary pricing agreements with the administration may be exempt. AHA said stakeholders need greater transparency regarding which companies and products would fall under the international benchmark.

Beyond concerns about the pricing structure, AHA raised operational questions about how hospitals would identify beneficiaries in the model’s geographically randomized cohort.

CMS has proposed maintaining and updating a list of eligible beneficiaries, but AHA said hospitals need clear, real-time access to that information to avoid collecting incorrect coinsurance amounts. The group also expressed concern that the proposed rule does not outline a formal appeals process for hospitals in cases where CMS may misidentify a beneficiary or miscalculate cost-sharing obligations.

Additionally, AHA said CMS should clarify how reduced coinsurance would be handled for beneficiaries with supplemental coverage, such as Medigap plans.

The letter also warns that the model could incentivize increased white bagging practices -- a practice in which drugs are dispensed by a specialty pharmacy and shipped directly to a provider for administration to a specific patient, rather than being purchased and stocked by the hospital. AHA argues that expanded white bagging can disrupt care coordination, delay treatment, and create safety concerns, particularly in oncology settings.

If the model is finalized, the group urged CMS to implement safeguards to prevent an expansion of such practices.

“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,” the release said.

The hospital industry’s warning comes as the Trump administration continues to advance a broader “most favored nation”-style drug pricing strategy across multiple Medicare programs. CMS has proposed a parallel GUARD model targeting certain high-cost Medicare Part D drugs, while also encouraging voluntary pricing agreements aimed at aligning U.S. drug prices more closely with those paid in other wealthy nations.

Senior officials reinforced that broader push this week at the National Association of Benefits and Insurance Professionals (NABIP) conference in Washington, DC, where CMS Deputy Administrator and Chief Policy and Regulatory Officer John Brooks defended the administration’s effort to use international benchmarking to curb what he described as post-Inflation Reduction Act “instability” in Medicare drug markets.

At the same event, FDA Commissioner Marty Makary praised the administration’s TrumpRx initiative and argued that the United States shoulders a disproportionate share of global pharmaceutical research and development costs. In separate remarks, Makary said the administration’s trade and pricing strategy is intended to rebalance global spending while preserving incentives for innovation.

CMS Administrator Mehmet Oz has also promoted codifying the GLOBE model to “lock in” projected savings, though that effort has faced skepticism from some congressional Republicans who have expressed concern about expanding federal authority over drug pricing.