



Government & External Affairs
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January 26, 2021

Liz Richter, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5528–IFC
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–5528–IFC - Most Favored Nation Model published in Vol. 85 (229) Federal Register 76180-76259 on November 27, 2020.

Submitted electronically via <http://www.regulations.gov>

Dear Acting Administrator Richter:

UnityPoint Health appreciates the opportunity to provide input in response to the Center for Medicare & Medicaid Services (CMS) interim final rule on the Most Favored Nations (MFN) Model. With more than 400 physician clinics, 40 hospitals, 16 home health locations, 7 Community Mental Health Centers and 4 accredited colleges, UPH is one of the nation's most integrated health care systems. Our more than 32,000 employees provide care throughout Iowa, western Illinois and southern Wisconsin. UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 7.9 million patient visits annually.

UPH respectfully offers the following comments.

Most Favored Nations (MFN) Model

CMS seeks comment on the MFN Model, a new Medicare payment model under section 1115A of the Social Security Act. The MFN Model will test whether more closely aligning payment for Medicare Part B drugs and biologicals with international prices and removing incentives to use higher-cost drugs can control unsustainable growth in Medicare Part B spending without adversely affecting quality of care for beneficiaries. This 7-year demonstration will impact 50 separately payable single-source drugs and biologicals representing the highest annual spend under Medicare Part B and comprising roughly 75% of Medicare Part B drug spending.

Comment: UPH is deeply concerned with the ever rising cost of pharmaceuticals. We agree that rising drugs costs have disproportionately grown over time and represent an increasing percentage of the Medicare Part B spend. We are also concerned that escalating costs may hamper access to care and we support efforts to lower program expenditures and out-of-pocket costs for beneficiaries. That said, as a health care provider, we also recognize the importance of Part B drugs for the continued health and well-being of our beneficiaries, and we understand that

there are associated research and development costs to bring new and improved drugs to market. With this backdrop, **we urge CMS to withdraw this rule at this time.**

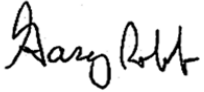
We have several reasons for requesting a withdrawal.

- The MFN Model is misdirected. We do not believe that the MFN Model will change drug manufacturer pricing behavior. As structured, the MFN Model does not directly address the high drug prices set by manufacturers, but instead reduces reimbursement to Medicare providers in the hope that manufacturers will reduce domestic drug prices in response. Rather than holding manufacturers accountable, this Model shifts cost reduction burdens to health care providers. Without ensuring that manufacturers reduce their prices, this proposal would require providers to risk catastrophic financial losses to continue providing patients with drugs for which there may be no suitable alternatives.
- The scope of the MFN Model is flawed. By limiting reform efforts to Part B, this Model misses an opportunity to take to a comprehensive approach to drug pricing reform. This topic deserves a harder and larger look.
- The Interim Final Rule was drastically changed from its proposed version. The International Pricing Index Model (as named under the proposed rule) was posted more than 2 years ago. Stakeholder engagement on this Model during that time was limited, yet the Model was released in current form with significant revisions. In addition, the effective date was proposed to be January 1, 2021, less than 60 days after its publication in the Federal Register. In the absence of a legal challenge with an injunction, we would now be commenting on a rule that had already taken effect, signaling a desire of the agency not to seriously consider stakeholder input.
- The MFN Model further erodes payments to 340B hospitals and negatively impacts safety net patients. This Model further threatens the viability of safety net hospitals participating in the 340B Drug Pricing Program. CMS estimates that average payment to 340B hospitals under the MFN Model could be as low as Average Sales Price (ASP) – 65%. This reimbursement places us in an upside-down position, in which we are reimbursed far below our costs for drugs subject to the Model. Our hospitals have seen the financial cuts related to reduced reimbursement under Outpatient Prospective Payment System as well as the Health Resources and Services Administration’s reluctance to stop drug manufacturers from illegally withholding 340B pricing at contract pharmacies. UPH has worked very hard to find ways to continue providing the patient services our communities need; further cuts to the benefits we see from the 340B Drug Pricing Program, especially of the magnitude of this proposal, will likely have a negative impact on the services we provide to our communities.

As an alternative to this rule, we encourage CMS to consider enacting drug pricing reform under the guise of drug pricing transparency, which focuses on pricing accountability from drug manufacturers and Pharmacy Benefit Managers. This first step could help guide CMS in determining future steps to curb the escalating trend of drug prices, without adversely impacting patient access.

UPH is pleased to provide input on this interim final rule. To discuss our comments or for additional information, please contact Cathy Simmons, Government & External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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