October 29, 2026

Drug Price Negotiation in the Medicaid Program

Background

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MACPAC

Medicaid and CHIP Payment and Access Commission

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Overview

- Introduction
- Background
  - Medicaid Drug Rebate Program (MDRP)
  - Most Favored Nation (MFN) framework
- Center for Medicare and Medicaid Innovation (CMMI) drug pricing models
  - GENErating cost reductions fOr U.S. Medicaid (GENEROUS) Model
  - Cell and Gene Therapy (CGT) Access Model
  - Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model
- Model interactions with the MDRP
- Next steps

Introduction

- The federal government is directly negotiating drug prices through the MFN framework and three CMMI models that target Medicaid
- MACPAC has initiated work to explore how the MFN framework and CMMI models interact with the MDRP
  - What issues are being addressed?
  - What are the expected outcomes for spending and beneficiary access?
  - What factors influence states' and manufacturers' decisions to participate in these voluntary models?

Background

MDRP

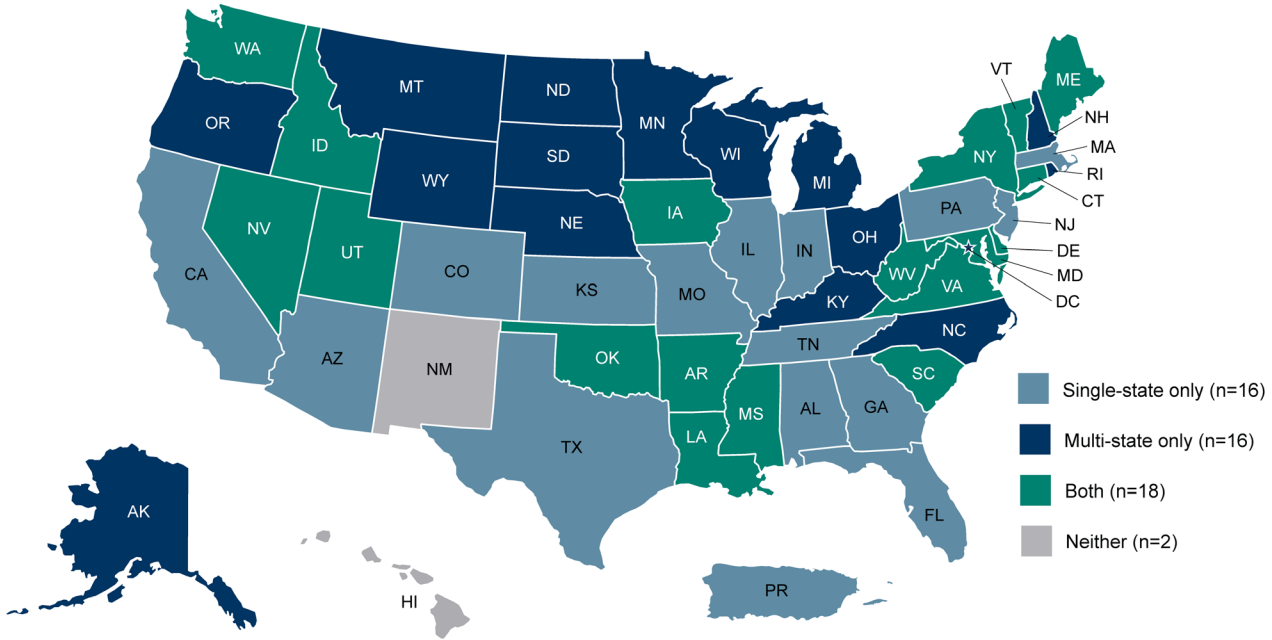
- Outpatient prescription drugs are an optional benefit that all states provide
- Drug manufacturers must provide rebates in order for their products to be recognized for federal Medicaid match
  - Federal rebates are calculated under statutorily defined formulas based on average manufacturer price (AMP)
- States must generally cover a participating manufacturer's products but may limit use (e.g., prior authorization, preferred drug list (PDL))
- Regulatory requirement to pay pharmacy ingredient cost at actual acquisition cost (AAC) plus dispensing fee in fee for service (FFS)

Federal and Supplemental Rebates

- Federal rebate for brand drugs
  - Greater of 23.1 percent of AMP or AMP minus best price
  - Inflationary rebate
- Federal rebate for generic drugs
  - 13 percent of AMP
  - Inflationary rebate
- States can negotiate supplemental rebates with drug manufacturers in addition to the federal rebates
  - Supplemental rebates are often structured as guaranteed net price arrangements and move inversely to federal rebates

Nearly All States Negotiate Supplemental Rebates

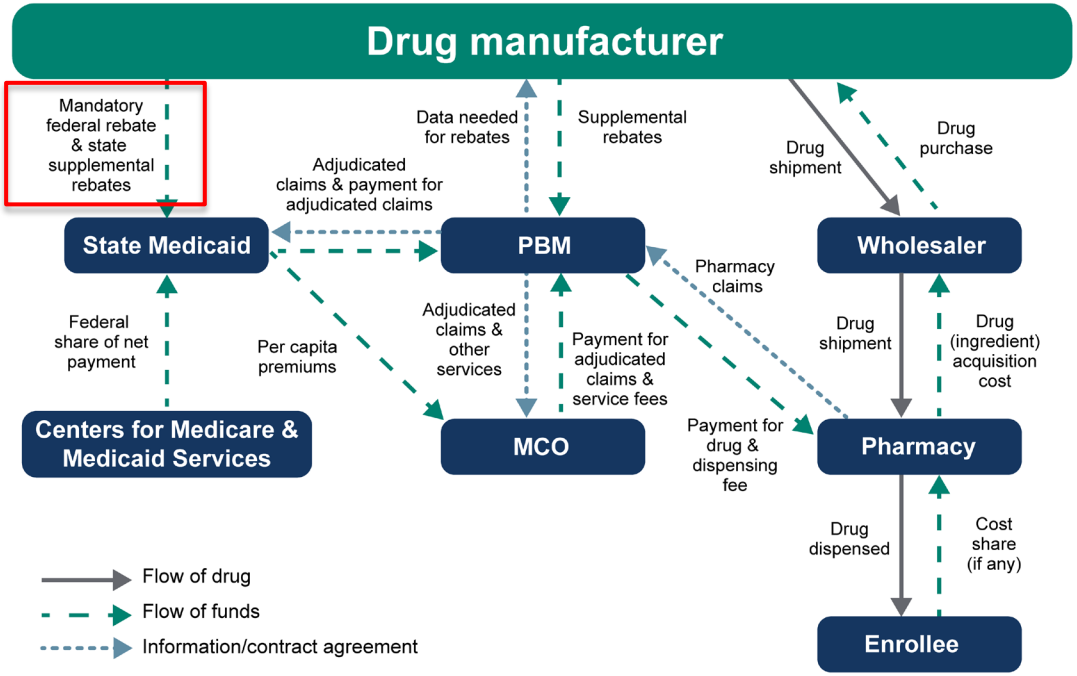
Medicaid Pharmacy Supplemental Rebate Agreements, by State and Territory, 2026



Notes: SRA is supplemental rebate agreement. States may enter into single-state agreements, multi-state agreements, or both. Multi-state agreements are negotiated through interstate purchasing pools, which states join to increase their negotiating leverage. As of June 2026, 34 jurisdictions reported a single-state agreement and 34 reported a multi-state agreement, including 18 that reported both. Hawaii and New Mexico reported no SRA of either type. CMS does not identify which interstate purchasing pool a jurisdiction has joined.

Source: MACPAC, 2026, analysis of Centers for Medicare & Medicaid Services, Medicaid pharmacy SRAs as of June 2026.

Medicaid Drug Payment and Rebate Flow



Notes: PBM is pharmacy benefit manager. MCO is managed care organization. If used, PBMs can process claims, negotiate rebates, provide data needed for rebate administration, and provide other administrative and clinical services. The federal rebates flow from the manufacturer to the state and do not involve either the PBM or MCO.
Source: MACPAC, 2026.

MFN Framework

- MFN pricing is a form of international reference pricing that seeks to align U.S. drug prices with prices paid in comparable countries
- Executive Order 14297 (May 2025) directed the U.S. Department of Health and Human Services (HHS) to communicate MFN policy to manufacturers
  - For Medicaid, the MFN target is the second-lowest net price among G-7 countries plus Denmark and Switzerland
  - Directs HHS to facilitate direct-to-consumer purchasing at MFN prices through TrumpRx
- As of August 31, 2026, 26 manufacturers have signed MFN agreements committing to provide MFN pricing to Medicaid
  - These manufacturers account for about 89 percent of the U.S. branded drug market
- Agreements remain confidential

CMMI Drug Pricing Models

Three CMMI Models Apply Drug Price Negotiation to Medicaid

	GENEROUS	CGT Access	BALANCE
Pricing mechanism	MFN supplemental rebate (second-lowest of eight countries, GDP-adjusted)	Outcomes-based discounts and rebates if therapy underperforms	CMS-negotiated net price and coverage terms
Target drugs	Manufacturer-selected brand drugs	CGTs (initially sickle cell disease)	GLP-1 medications indicated for weight loss
Programs	Medicaid	Medicaid	Medicaid and Medicare Part D
Timeline	January 1, 2026 to December 2030	January 2025 to January 2026; ends December 2035	Medicaid from May 2026; Part D delayed
State participation	All 50 states, DC, and Puerto Rico	32 states, DC, and Puerto Rico	One state (Indiana) confirmed
Stated objective	Lower Medicaid net drug spending	Expand access while protecting taxpayers from paying for failures	Improve metabolic health; lower or maintain net GLP-1 spending

Notes: CMMI is CMS Innovation Center. GENEROUS is the GENErating cost reductions fOr U.S. Medicaid Model. CGT is cell and gene therapy. BALANCE is the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth Model. MFN is most favored nation. GDP is gross domestic product. GLP-1 is glucagon-like peptide-1. DC is the District of Columbia. All three models are authorized under § 1115A of the Social Security Act. GENEROUS participation is as of September 30, 2026.
Source: MACPAC and Urban Institute, 2026.

GENEROUS Model

- Participating manufacturers provide supplemental rebates so that Medicaid's net price for a covered drug reaches an MFN benchmark
  - The benchmark is the second-lowest net price among eight high-income countries, adjusted for gross domestic product (GDP) per capita
- The MFN price and rebate sit outside the MDRP; the MFN price is not included in best price and does not affect the 340B ceiling price
- CMS negotiates uniform coverage criteria with each manufacturer (e.g., PDL placement, prior authorization)
  - States must adopt these terms across FFS and managed care and cannot pursue separate supplemental rebates on those drugs
- States may opt into MFN pricing for a subset of the model drugs

CGT Access Model

- CGTs are often one-time treatments with high up-front costs (over $1 million) and uncertain long-term benefits, creating budget volatility for states
- CMMI negotiates standardized outcomes-based agreements (OBAs) with CGT manufacturers, beginning with gene therapies for sickle cell disease (SCD)
  - Manufacturers pay guaranteed rebates, volume-based rebates, plus outcomes-based rebates if patients do not meet agreed upon benchmarks
  - Manufacturers required to pay for a defined scope of fertility preservation services
- States adopt CMS-negotiated terms and align coverage and billing requirements across FFS and managed care
- CMS centralizes data collection and tracking outcomes against the benchmarks through claims data and designated patient registry
- Uptake of SCD gene therapies has been slow across all payers: about 200 to 300 people treated or starting treatment as of early 2026

BALANCE Model

- CMMI negotiates prices for GLP-1 medications indicated for weight loss in Medicaid, paired with lifestyle support programs*
  - Coverage of weight loss drugs is optional in Medicaid
- States must follow a standardized access policy across FFS and managed care; it acts as a floor, so states may cover more broadly but not more narrowly
- States without GLP-1 obesity coverage would need to expand access, increasing costs

* The Medicare Part D component of the BALANCE model has been paused

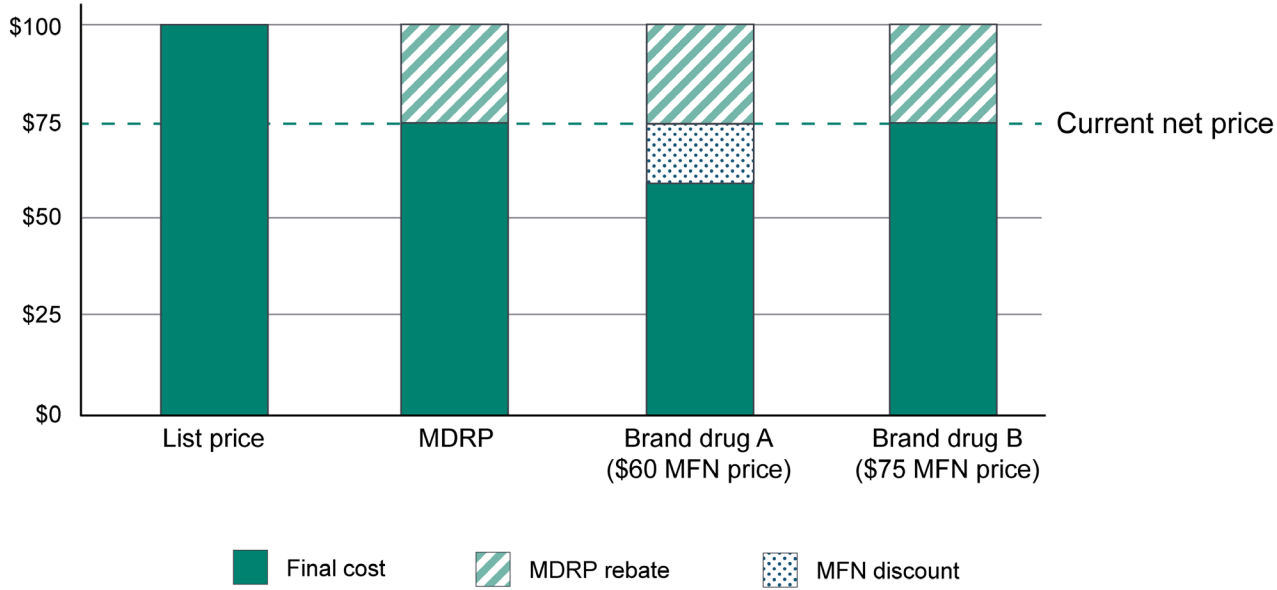
Interactions with the MDRP and Other Considerations

How MFN Pricing Layers onto the MDRP

- GENEROUS operates on top of the MDRP; statutory rebates continue to apply
- The MFN price is a guaranteed net price, effectuated as a supplemental rebate when it is lower than the state's current net price
- States decide drug by drug, weighing whether the MFN price is lower their current net price and how standardized coverage criteria may affect utilization
  - Example: South Dakota projects about $750,000 in annual savings on three products, compared with $150 million in Medicaid drug spending

Whether MFN Pricing Lowers a State's Net Cost Depends on the Drug

Hypothetical Interaction of MDRP Rebates and MFN Pricing on Net Drug Costs for Brand Drugs



Notes: MDRP is Medicaid Drug Rebate Program. MFN is most favored nation. AMP is average manufacturer price. CPI-U is Consumer Price Index for All Urban Consumers. MDRP rebates are calculated as the greater of 23.1 percent of AMP or the difference between AMP and best price, with an additional inflationary component based on the CPI-U. Hypothetical brand drugs with a $100 list price and a $75 net price after statutory rebates.
Source: MACPAC, 2026.

Which Drugs Are Included in GENEROUS is Unclear

- The GENEROUS request for applications appears to include all of a participating manufacturer's brand drugs
- However, company disclosures suggest some manufacturers negotiated terms covering only certain products
  - Pfizer's MFN agreement supersedes GENEROUS where the two conflict
  - Eli Lilly's agreement sets the international price at the active-ingredient level and excludes GLP-1 products from GENEROUS
  - BeOne and BridgeBio have publicly identified products excluded from GENEROUS
- Confidentiality terms in state participation agreements limits what is known about which drugs are included and which one states choose

Considerations for CGT Access and BALANCE

- CGT Access model tries to address challenges of high upfront costs and uncertain long-term benefit through centralized negotiation of guaranteed rebates and OBAs
  - Little information on treatment uptake through the model to date, which may be reflective of the low utilization of these therapies across all payers
  - Centralized data collection (e.g., registry) helps address challenge of tracking outcomes over time, but it will take several years to evaluate the success of the OBAs
  - States may still have challenges covering ancillary costs (e.g., chemotherapy)
- States have expressed little interest in BALANCE to date
  - Optional coverage under MDRP allows states to tightly manage utilization and spending on GLP-1s
  - Expanded coverage under standardized coverage criteria could increase overall spending and strain state budgets

Next Steps

Next Steps

- Staff will convene a panel at the December 2026 meeting
- MACPAC will conduct a technical expert panel (TEP) of federal and state officials, drug pricing experts, manufacturers, and other stakeholders
  - Present key themes from the TEP at the March 2027 meeting
- Staff welcome Commissioner questions and feedback on the background information or any policy topics we should explore

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OCTOBER MEETING

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