All-State Medicaid and CHIP Call
December 9, 2025

Agenda

- GENEROUS Model
- Recent CMCS Releases –
  - Working Families Tax Cut (WFTC) Legislation Overview CIB
  - Community Engagement CIB
  - CMMI TAF Analytic Research Briefs for the DQ Atlas
- Q&A

GENEROUS - GENERating cost Reductions fOr U.S. Medicaid Model

All State Call

December 2025

Center for Medicare & Medicaid Innovation

Centers for Medicare & Medicaid Services

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Agenda of GENEROUS Model

1. Model Structure & Assumptions
2. Components of the Most-Favored Nation Calculation
3. Model Phases & State Requirements
4. Next Steps

Goal: Help states understand CMMI's new GENEROUS model and identify next steps towards becoming a model participant.

GENEROUS Model – Key Points

The GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model aims to ensure fair and reasonable drug prices for Medicaid through CMS-led negotiations with drug manufacturers to align Medicaid net prices with what certain other countries pay.

PROBLEM

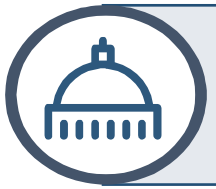
America **pays more for prescription drugs** compared to the rest of the world, which costs states and the federal government billions of dollars.

SOLUTION

Under GENEROUS, for drugs included in the model, participating drug manufacturers will **offer prices based on what other select countries pay** for prescription drugs covered by the Medicaid program.

OUTCOMES

GENEROUS aims to reduce Medicaid spending for drugs included in the model and may **improve access** to these drugs in participating states.



STRATEGY

GENEROUS **increases the sustainability of the Medicaid program through fairer drug prices** and securing greater coverage of needed medications that support our most vulnerable populations

GENEROUS Model – Baseline Assumptions

Manufacturers are interested in offering MFN pricing to state Medicaid programs for drugs where state Medicaid programs may not already have the most advantageous net price.

- States collect **billions of dollars** in Medicaid and supplemental rebates from drug manufacturers.
- States **receive the manufacturer's best "domestic" price** for a Covered Outpatient Drug (COD)*.
- Many states (or their contractors) **negotiate supplemental rebates** with manufacturers for additional rebates.
- States may **pay close to $0** (i.e."penny pricing") for some CODs.
- Some net Medicaid rebate amounts (unit rebate amounts (URA) plus supplemental) **may be better than Most Favored Nation** (MFN **) pricing.

*Under the MDRP, a COD is generally defined as a prescribed drug that is FDA approved and used for a medically accepted indication. See 42 C.F.R. § 447.502

**MFN rebates are those paid to states by manufacturers over and above the Medicaid basic URAs. MFN rebates are based on the MFN country prices. These will be effectuated through a guaranteed net unit price (GNUP) for each COD of a manufacturer that is participating in the model.

GENEROUS Model – Model Structure

Role of CMS

CMMI will negotiate key terms for agreements between states and manufacturers, including clinical criteria

Participant Eligibility

All States and Territories that participate in the Medicaid Drug Rebate Program (MDRP) can participate in the model if they meet requirements.

Manufacturers that participate in the MDRP can participate in negotiations with CMS.

Manufacturers will opt into the model

For certain branded Medicaid covered outpatient drugs.

CMS will negotiate clinical criteria for included drugs

with manufacturers to relieve the burden on states and increase access for beneficiaries.

CMS will calculate the Most Favored Nation (MFN) Price

using data reported voluntary by manufacturers to CMS.

States will choose which CODs to accept

after reviewing the CMS negotiated clinical criteria and MFN price.

GENEROUS Model – Rebate Calculation

CMS would oversee manufacturer calculation of MFN Guaranteed Net Unit Pricing (GNUP)

Pricing Benchmarks:

- The benchmark used for a COD (at the NDC-9 level) will be the second lowest country-specific manufacturer-reported net price, adjusted by gross domestic product per capita using a purchasing power parity method

- MFN countries include the G-7 countries other than the United States (United Kingdom, France, Germany, Italy, Canada, and Japan) plus Denmark and Switzerland.

Manufacturer Incentives:

- Model CODs would have preferred placement on FFS and managed care preferred drug lists (PDLs) with CMS-defined standardized coverage criteria.

- Not have to negotiate additional supplemental rebates with states for drugs with MFN pricing

Implementation:

- Effectuated through SRAs (supplemental rebate agreements) with no interactive effect on the 340B price.

- States are required to participate in both FFS and managed care.

Supplemental Rebate = WAC of the drug – (GNUP plus URA)

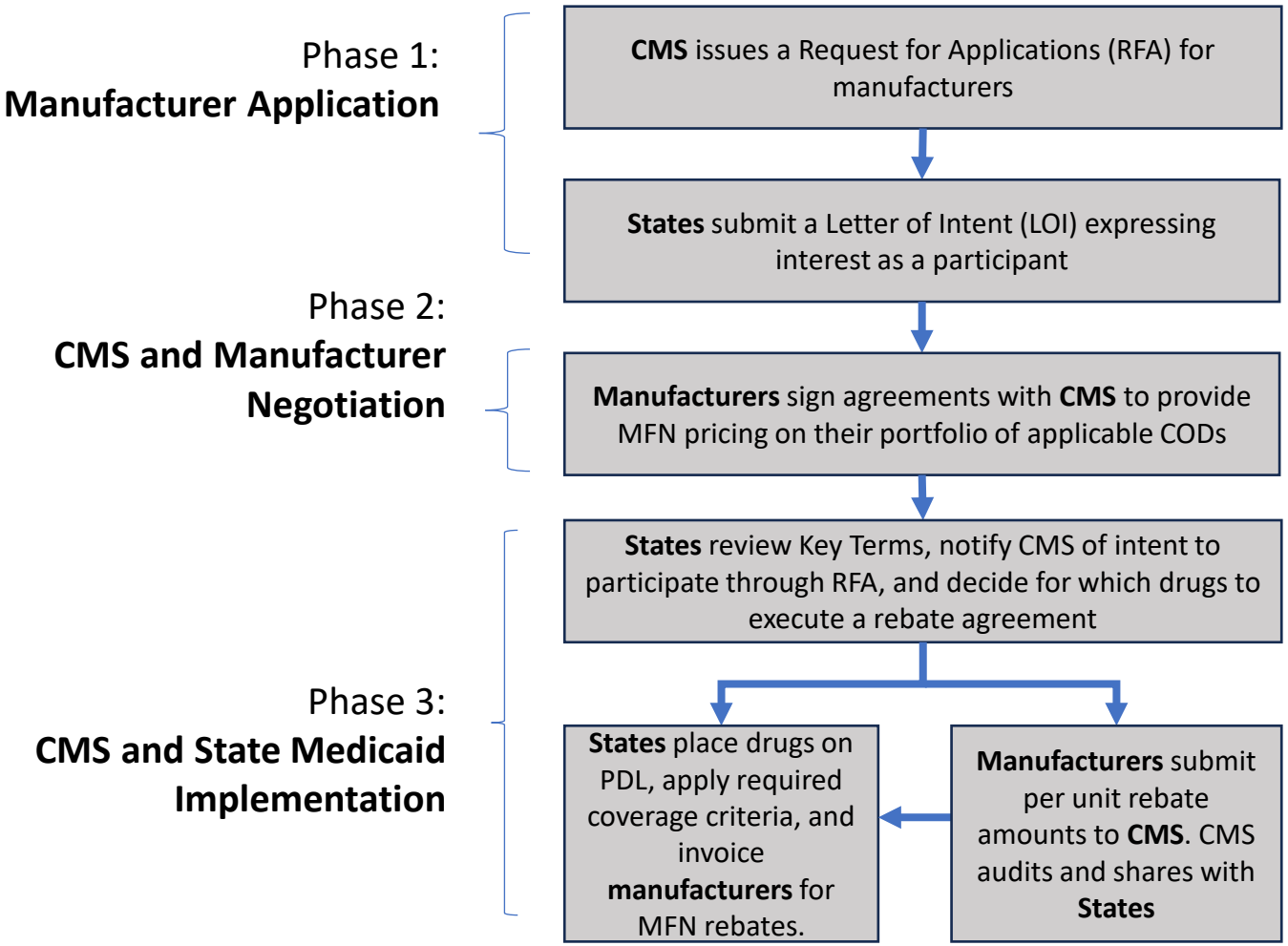
CMS would collect international pricing data from manufacturers

CMS would calculate a GNUP based on data

States would invoice manufacturers for both the URA and supplemental rebates

WAC – Wholesaler Acquisition Cost
GNUP – Guaranteed Net Unit Price
URA – Unit Rebate Amount

GENEROUS Model – Model Phases



GENEROUS Model – Additional State Requirements

PARTICIPATING STATES MUST:

- ✓ **Harmonize COD Coverage Policies**
  - Work with State MCOs to align policies.
- ✓ **Invoice Manufacturers for Supplemental Rebates**
  - Invoice manufacturers based on annual GNUP for each COD.
  - Submit invoice data to CMMI for tracking and auditing purposes
- ✓ **Maintain Documentation**
  - Keep records of rebate invoices and collections.
  - Engage in dispute resolution with manufacturers if needed.
- ✓ **Adjust Rebate Invoices**
  - Make necessary adjustments based on updated data from manufacturers
- ✓ **Evaluate the Program**
  - Report data to CMMI for the model evaluation .

States interested in participating in the model may wish to **review their current State Plan Amendments (SPAs)** to ensure that they meet model requirements.

GENEROUS Model – Ongoing Discussions and Alignments

Seeking State Input

We welcome the opportunity to **meet individually with any state** interested in further discussion or to address model concerns.

Each state operates under unique timelines for adopting PDL changes and P&T/DUR Board updates.

Some states have purchasing pool agreements restricting rebate negotiations outside of the pool.

States may need additional time or flexibilities to incorporate managed care into the model.

Contact the model team at GENEROUSModel@CMS.HHS.GOV.

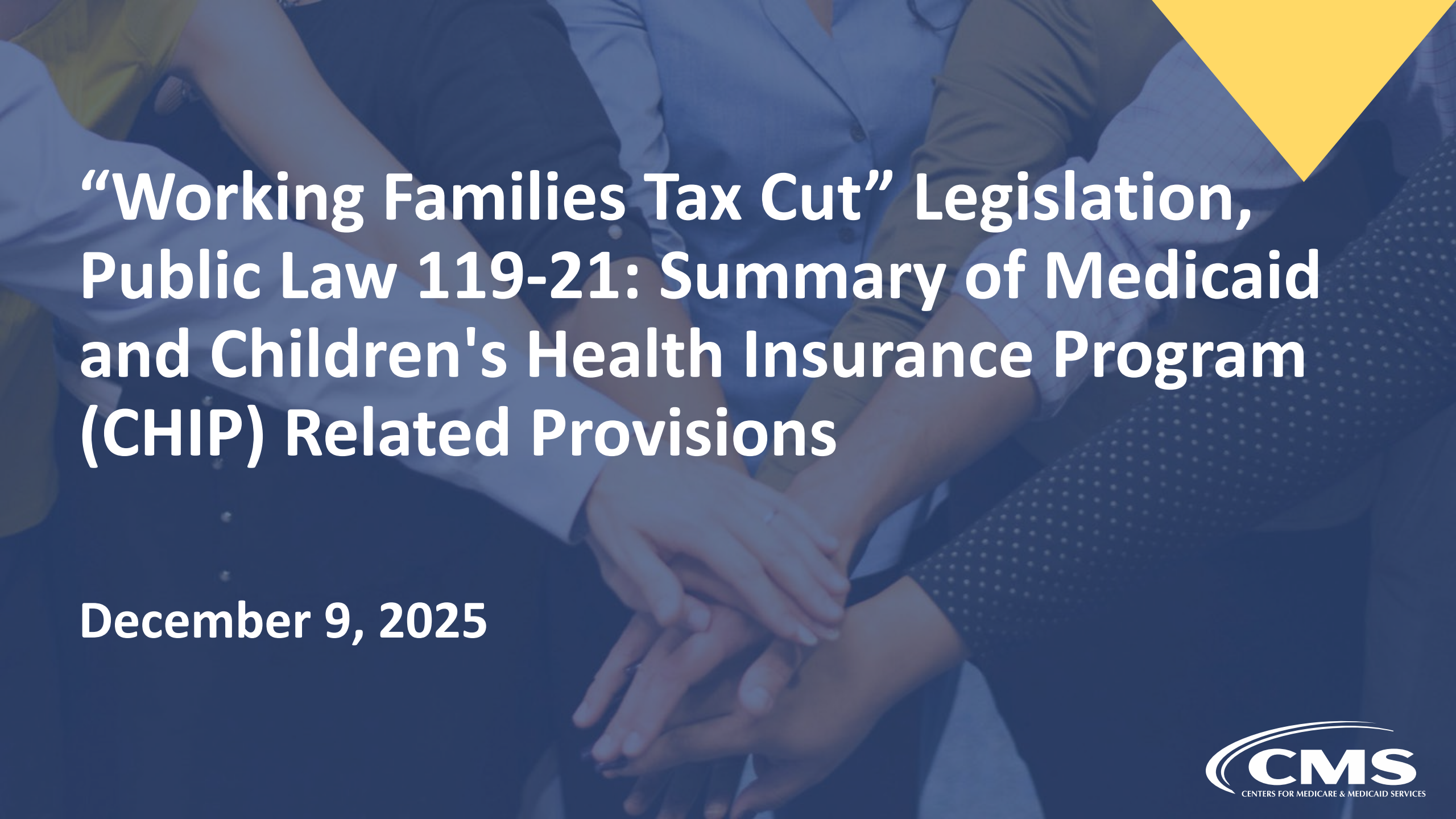
GENEROUS Model – Next Steps

We want to hear from you! Interested states should submit a Letter of Intent as soon as possible to GENEROUSModel@CMS.HHS.GOV.

- **November 2025** Manufacturer RFA Released; State Letter of Intent Released
- **December 2025** State RFA Released; Manufacturers can start negotiations with CMS
- **January 2026** Model Begins; States can begin to submit RFAs
- **March 31, 2026** Deadline for Manufacturer RFAs to be submitted to CMS
- **June 30, 2026** Deadline for Manufacturer to Sign agreements with CMS
- **August 31, 2026** Deadline for States to Sign agreements with CMS and supplemental rebate agreements with manufacturers
- **December 2030** Model Ends. Agreements terminate.

QUESTIONS?

We want to hear from you! Interested states should submit a Letter of Intent as soon as possible to GENEROUSModel@CMS.HHS.GOV.



“Working Families Tax Cut” Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions

December 9, 2025

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Overview of Releases

- On November 18, 2025, CMCS issued two releases related to the implementation of Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation:

    1. CMCS Informational Bulletin: *"Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions*
    2. Overview Slide Deck: *Working Families Tax Cut Legislation*

- These releases are intended to provide general information on the Medicaid and CHIP related provisions contained in the WFTC legislation. The CIB and slides provide an overview of each Medicaid and CHIP provision in the legislation, including key statutory and regulatory citations, as well as the effectives dates of those provisions.

- These releases are part of a series of guidance documents that CMCS expects to issue to support WFTC legislation implementation.

- CMCS has also launched a new subpage on Medicaid.gov to serve as a "one-stop shop" for all things related to implementation of the WFTC legislation.

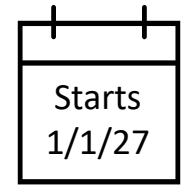
Source: CMCS CIB, "Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions. Hereinafter referred to as "the CIB."

CIB Content Overview

- **Summary of Working Families Tax Cut Legislation Provisions**
  - Subchapter[1] A – Reducing Fraud and Improving Enrollment Processes
  - Subchapter B – Preventing Wasteful Spending
  - Subchapter C – Stopping Abusive Financing Practices
  - Subchapter D – Increasing Personal Accountability
  - Subchapter E – Expanding Access to Care
  - Chapter 4[2] – Protecting Rural Hospitals and Providers
  - Tax-Related Provisions
- **Appendices**
  - Appendix A – Key Dates
  - Appendix B – Opportunities for Additional Financial Support for States
  - Appendix C – Applicability to the Territories
  - Appendix D – Applicability to American Indians and Alaska Natives
  - Appendix E – Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs
  - Appendix F – Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program

1. The references to “subchapters” are to subchapters of chapter 1 of subtitle B of title VII of Public Law 119-21.
2. Specifically, chapter 4 of subtitle B of title VII of Public Law 119-21.

Example Section



Section 71112. Reducing State Medicaid Costs

Shortens the retroactive eligibility period in Medicaid, for applications made on or after January 1, 2027:[1]

- The retroactive eligibility period for individuals enrolled in the Medicaid adult group[2] will be limited to one month prior to the month of application.
- For all other individuals, the retroactive eligibility period will be limited to two months prior to the month of application.
- States retain the option to provide retroactive CHIP eligibility, but cannot begin the coverage any earlier than two months prior to the month of application.[3]

Applicable to all states, DC, and the territories

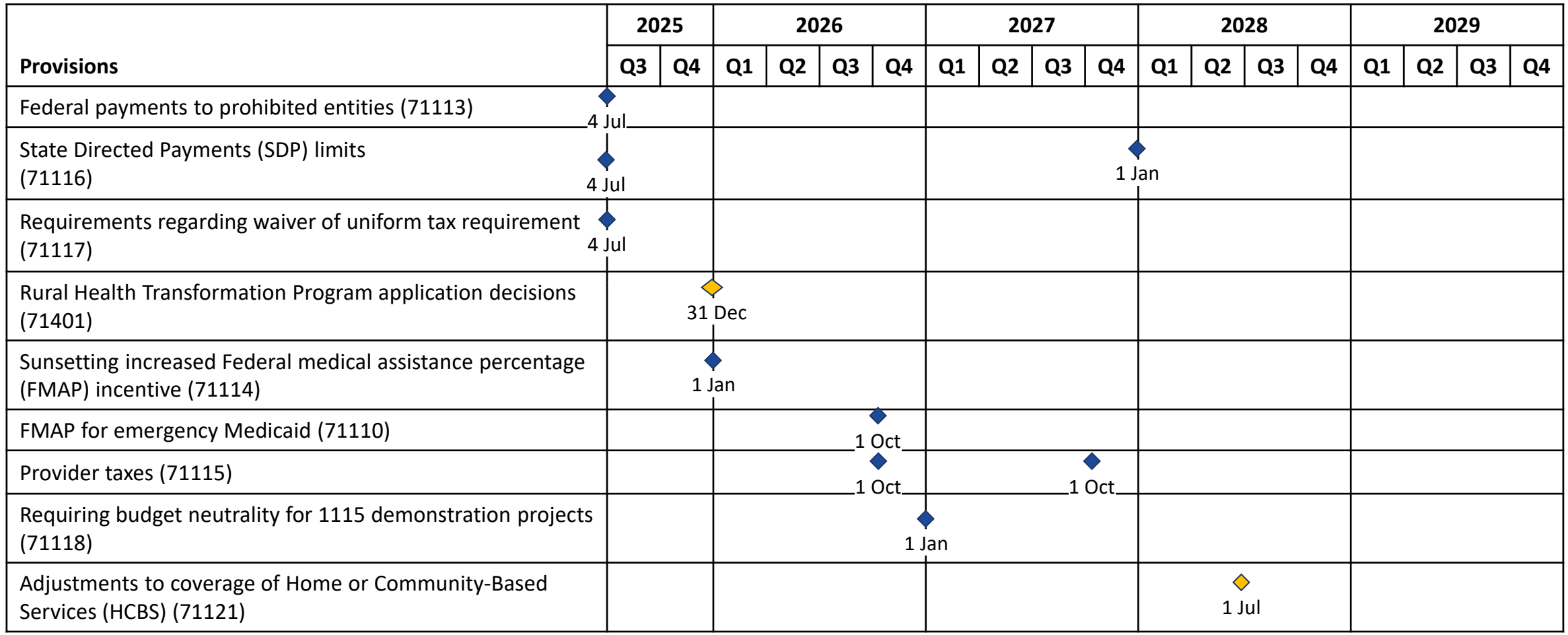
1. Amends sections 1902(a)(34) and 1905(a) of the Act.
2. Under section 1902(a)(10)(A)(i)(VIII) of the Act.
3. Amends section 2102(b)(1)(B) of the Act by adding a new paragraph (vi).

Examples of Appendices

Appendix A: Key Dates-- Eligibility and Enrollment Provisions in WFTC Legislation

Provision	2025		2026				2027				2028				2029			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Moratorium on Rules (71101, 71102, 71111)	4 Jul																	
Alien Medicaid eligibility (71109)					1 Oct													
Reducing duplicate enrollment (71103)							1 Jan										1 Oct	
Ensuring deceased individuals do not remain enrolled (71104)							1 Jan											
Eligibility redeterminations every 6 months for expansion adult group (71107)							1 Jan											
Medicaid community engagement requirements (71119)							1 Jan											
Reducing state Medicaid costs (71112)							1 Jan											
Ensuring deceased providers do not remain enrolled (71105)											1 Jan							
Revising home equity limit for Long-term Care (LTC) (71108)											1 Jan							
Modifying cost sharing requirements (71120)														1 Oct				
Payment reduction for erroneous excess payments (71106)																		1 Oct

Appendix A: Key Dates-- Financing and Care Delivery Provisions in WFTC Legislation



Appendix C – Applicability to the Territories

Subchapter A Provision	Applicable to Territories?
71101	Does not affect regulations that impact the territories
71102	Affects regulations that apply to the territories
71103	Requirement to establish process to obtain address information by January 1, 2027, does not apply to territories; otherwise applies
71104	Does not apply
71105	Applies
71106	Does not apply
71107	Does not apply
71108	Applies
71109	Applies
71110	Applies

Subchapter B Provision	Applicable to Territories?
71111	Affects regulations that apply to the territories
71112	Applies
71113	Applies

Subchapter C Provision	Applicable to Territories?
71114	Does not apply
71115	Does not apply
71116	Does not apply
71117	Does not apply
71118	Applies

Subchapter D Provision	Applicable to Territories?
71119	Does not apply
71120	Does not apply

Subchapter E Provision	Applicable to Territories?
71121	Applies

Chapter 4 Provision	Applicable to Territories?
71401	Does not apply

Next Steps

CMS recognizes that the provisions of this law represent significant programmatic changes that will require substantial planning, coordination, and resources at both the federal and state levels.

- CMS intends to issue additional detailed guidance in the coming months addressing specific provisions of the WFTC legislation.

- The agency stands ready to provide the technical assistance and support that states need during this implementation period.

- States requiring technical assistance or having questions regarding implementation should send an email to **MedicaidReforms@cms.hhs.gov**.

https://www.medicaid.gov/medicaidreforms

Working Families Tax Cut Legislation

Public Law 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, includes significant eligibility and financing reforms in Medicaid and the Children's Health Insurance Program (CHIP) and focuses on the connection of health to work through community engagement. Specific eligibility reforms are aimed at ensuring lawful enrollment in Medicaid and CHIP. The financing reforms are focused on ensuring that states contribute their full commitments to finance Medicaid and reducing financing loopholes. Community engagement has potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation, build confidence, and achieve prosperity. These provisions reflect a commitment to safeguarding Medicaid and CHIP for the most vulnerable Americans now and in the future.

Resources

- Rural Health Transformation Program

This webpage is home to the Center for Medicaid & CHIP Services' (CMCS) guidance and technical assistance documents that support the implementation of the Medicaid and CHIP provisions of the WFTC legislation. CMCS expects to provide additional detailed guidance addressing specific provisions and implementation requirements. CMCS also plans to undertake rulemaking as required under the law or as otherwise warranted.

Overview Resources

- Public Law 119-21 – which CMS refers to as the "Working Families Tax Cut" legislation, was signed into law on July 4, 2025.
- WFTC Legislation CMCS Informational Bulletin – provides summary information on the Medicaid and CHIP provisions in the law.
- WFTC Legislation Overview Slide Deck – provides summary information as outlined in the WFTC Legislation CMCS Informational Bulletin.

Section 71119: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

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Overview of Section 71119

- Community engagement requirements apply in any state and the District of Columbia that elects to provide coverage to the adult group under the state plan or to certain individuals through certain section 1115 demonstrations.
  - The provision is not applicable to the U.S. territories, regardless of whether they elect to cover the adult group.
- The requirement to condition Medicaid eligibility on demonstrating community engagement begins January 1, 2027, unless a state opts to implement them sooner.
  - Before effectuating the community engagement requirement, states must engage in outreach to applicable individuals on how to comply, consequences of non-compliance, and how to report a change in status.
- The community engagement requirements cannot be waived under section 1115 demonstration authority.

Section 1902(xx) of the Act.

Definition of Applicable Individuals

- Community engagement requirements apply to "applicable individuals." Applicable individuals must demonstrate compliance with community engagement requirements as a condition of Medicaid eligibility.

- Applicable individuals are generally those:

  - Eligible for or enrolled under the state plan in the adult group described in §1902(a)(10)(A)(i)(VIII) of the Act; or

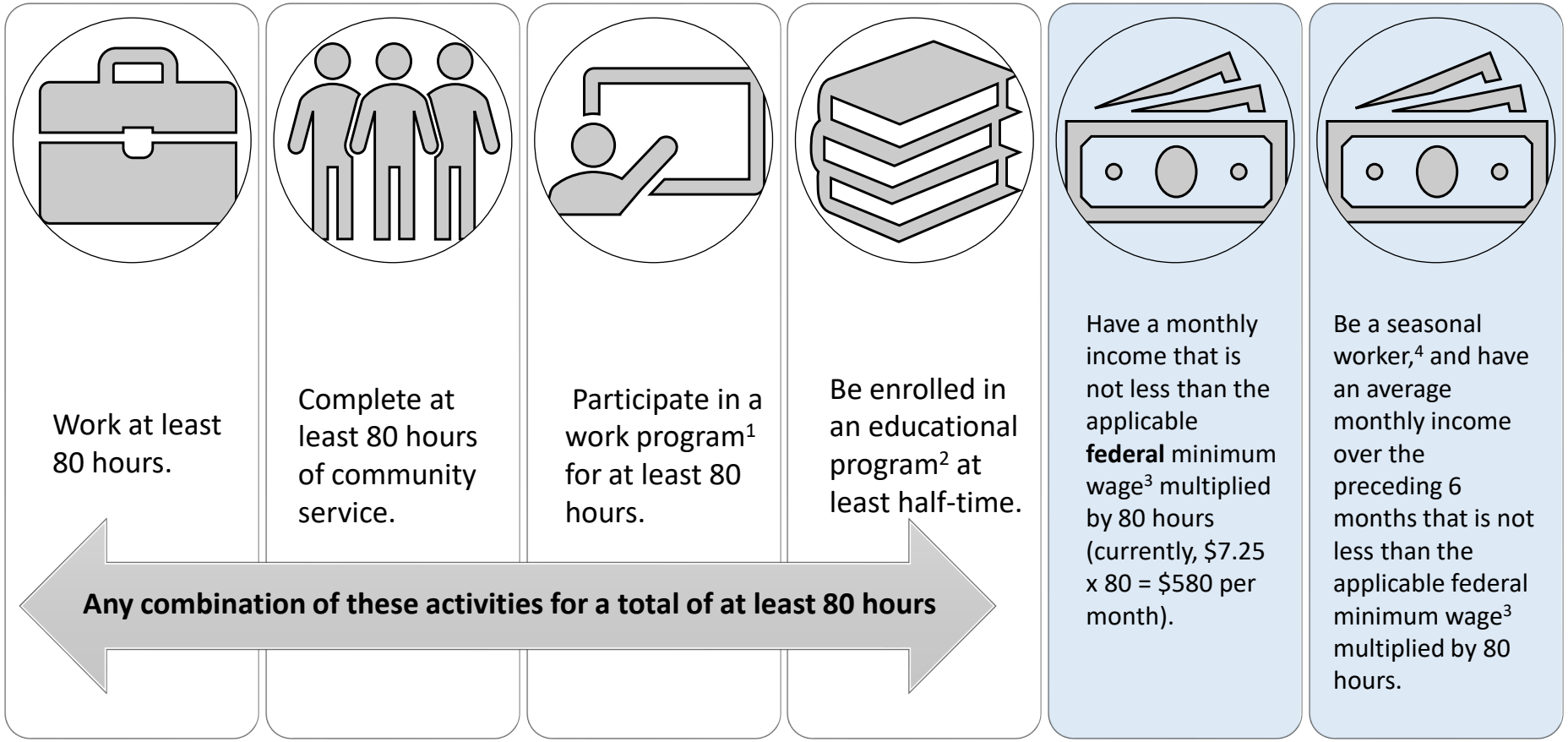
  - Eligible to enroll or enrolled in a section 1115 demonstration that provides minimum essential coverage (MEC), and who are at least 19 and under 65 years of age, not pregnant, not entitled to or enrolled for benefits under Medicare Part A or Part B, and not otherwise eligible to enroll under the state Medicaid plan.

Community engagement requirements do not apply to individuals enrolled in an 1115 demonstration if the only coverage available to these individuals is not MEC (e.g., family planning-only services). CMS continues to evaluate which existing state section 1115 demonstration populations fall into the definition of an applicable individual.

Section 1902(xx) of the Act.

Definition of Community Engagement

To meet community engagement requirements in a given month, applicable individuals must do one or more of the following:



Section 1902(xx)(2) of the Act.

1. A work program is defined by section 6(o)(1) of the Food and Nutrition Act of 2008.
2. Including an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) and a program of career and technical education (as defined in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006).
3. Federal minimum wage is defined by section 6 of the Fair Labor Standards Act of 1938, 29 U.S.C. § 206(a)(1)(C).
4. A seasonal worker is described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986.

Exclusions from and Exceptions to Community Engagement Requirements (1/2)

Individuals meeting the definition of a "specified excluded individual" for part or all of a relevant month are not subject to demonstrating community engagement for that month:

- former foster care children defined in §1902(a)(10)(A)(i)(IX);
- certain American Indians and Alaska Natives;[1]
- parents, caretaker relatives, guardians, or family caregivers[2] of a dependent child under the age of 14 or a disabled individual;
- veterans with a total disability rating as defined under 38 U.S.C. §1155;
- individuals who are medically frail or otherwise have special medical needs (as defined by the Secretary);[3]
- individuals who are compliant with Temporary Assistance for Needy Families (TANF) work requirements;[4]
- members of households that receive Supplemental Nutrition Assistance Program (SNAP) benefits and are not exempt from SNAP work requirements;[5]
- participants in certain substance use disorder treatment and rehabilitation programs;[5]
- inmates of a public institution; or
- pregnant women or individuals entitled to postpartum medical assistance.[6]

1. Includes individuals who meet one of the following criteria: (A) is an Indian or an Urban Indian (as defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act), (B) is a California Indian (as described in section 809(a) of such Act), or (C) has otherwise been determined eligible as an Indian for the Indian Health Service under HHS regulations.
2. "Family caregivers" are defined in section 2 of the RAISE Family Caregivers Act, P.L. 115-119.
3. Includes individuals who are blind or disabled (as defined in §1614 in the Act), have a substance use disorder, disabling mental disorder, or physical, intellectual, or developmental disability that impairs the ability of the individuals to perform one or more activities of daily living; or has a serious or complex medical condition.
4. Under section 407 of the Act.
5. As defined in the Food and Nutrition Act of 2008.
6. As defined in section 1902(e)(5) or (16) of the Act.

Exclusions from and Exceptions to Community Engagement Requirements (2/2)

- Applicable individuals are excepted from demonstrating community engagement for a month if, for part or all of that month, they are:
  - under the age of 19;
  - entitled to or enrolled in Medicare Part A or enrolled for benefits under Medicare Part B;
  - described in a mandatory categorically needy eligibility group.[1]
- An additional exception applies to an individual who was an inmate of a public institution at any point during the three-month period ending on the first day of a month in which the individual is otherwise subject to the community engagement requirement.

1. In any of subclauses (I) through (VII) of section 1902(a)(10)(A)(i) of the Act.

Demonstrating and Verifying Community Engagement

At application:

- Applicable individuals must demonstrate community engagement requirements for at least one month preceding the month of application.
- States may elect to require applicable individuals demonstrate compliance for up to three consecutive months immediately preceding the month of application.

At renewal

- Beneficiaries subject to community engagement must demonstrate compliance as part of the state's routine renewal process.
- Such Medicaid beneficiaries must demonstrate community engagement for one or more months (as specified by the state), whether or not consecutive.

Between (Re)determinations

- States may elect to verify compliance in between determinations or redeterminations of eligibility for beneficiaries.

States must first attempt to use reliable information available to the state, including from the individual case record or information obtained through reliable data sources, to establish whether an individual met the community engagement requirement or was not required to do so.

Sections 1902(xx)(1)(A) of the Act.

Procedures in the Case of Non-Compliance

- If a state cannot establish that someone met the community engagement requirements or was not required to do so, it must provide notice of noncompliance and allow the applicant or beneficiary 30 calendar days from the date such notice is received to demonstrate compliance or show that the requirement does not apply to them.
    - The notice of noncompliance must include information on how to demonstrate compliance or show that the requirement does not apply, and how to reapply for medical assistance if the individual's application is denied or if the beneficiary is disenrolled.
- A state must continue to provide medical assistance to an enrolled beneficiary during the 30-day period.
- If no satisfactory showing of compliance with or inapplicability is made, the state must determine whether the individual has any other basis for eligibility for Medicaid or another insurance affordability program.
- The state must then provide written notice and fair hearing rights[1] and, if there is no other basis for Medicaid eligibility, deny the application or terminate eligibility by the end of the month following the 30-day period.

Section 1902(xx)(5) of the Act.

1. In accordance with 42 C.F.R. part 431 subpart E (including advance notice in the case of an eligibility termination or other adverse action).

Resources on Section 71119

CMS is committed to supporting states in this effort and anticipates that ongoing partnership and engagement with states and other stakeholders will inform areas of need for additional guidance, including rulemaking by June 2026.

- Community Engagement Overview CIB
- Community Engagement Overview Deck
- CMS is available to answer questions and provide technical assistance to states; requests can be directed to MedicaidWorks@cms.hhs.gov.

Presentation on CMMI DQ Atlas Briefs State Call

CMMI TAF Analytic Research Briefs for the DQ Atlas

12/9/2025

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Introduction

CMMI TAF Analytic Research Briefs

- The Center for Medicaid and CHIP Services (CMCS), in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), has published two comprehensive Transformed-Medicaid Statistical Information System (T-MSIS) Analytic File (TAF) research briefs on the DQ Atlas platform. These briefs, developed between 2023-2025, address critical aspects of Medicaid data analysis and expenditure measurement:
    1. Using T-MSIS and TAF to Measure State Expenditures and Expenditures to Providers - A methodology brief providing guidance on measuring Medicaid expenditures using administrative data
    2. State-Level Variations in Medicaid Fee-for-Service Use and Spending Patterns in TAF - An analytic brief examining state-level differences in Medicaid fee-for-service utilization and spending
- The briefs are available on the DQ Atlas Analytic Briefs landing page (Date published: 10-22-25) at https://www.medicaid.gov/dq-atlas/landing/briefs.

DQ Atlas

- The DQ Atlas serves as CMS's primary platform for disseminating Medicaid data quality information and analytic resources to states, researchers, and stakeholders. .
- The briefs address critical knowledge gaps in Medicaid data analysis, particularly around expenditure measurement methodologies and state-level variation analysis.
  - They provide technical specifications for handling data quality considerations, best practices for implementing inclusion and exclusion criteria for different beneficiary populations, and guidance on analyzing fee-for-service utilization patterns across participating states.

Using T-MSIS and the TAF to Measure State Expenditures and Expenditures to Providers Brief

Overview of using TAF to measure

- This research brief describes methods and key considerations for using TAF to measure Medicaid and CHIP expenditures on beneficiary care, defined at the state level or as the sum of provider payments. The methods can help researchers using TAF data for expenditure analyses determine:
    1. Which scope of benefits to include in the analysis,
    2. Which services to examine,
    3. How to account for variations in service delivery across states, and
    4. How to handle provider payments that cannot be assigned to individual beneficiaries.

State-Level Variations in Medicaid Fee-for-Service Use and Spending Patterns in TAF Brief

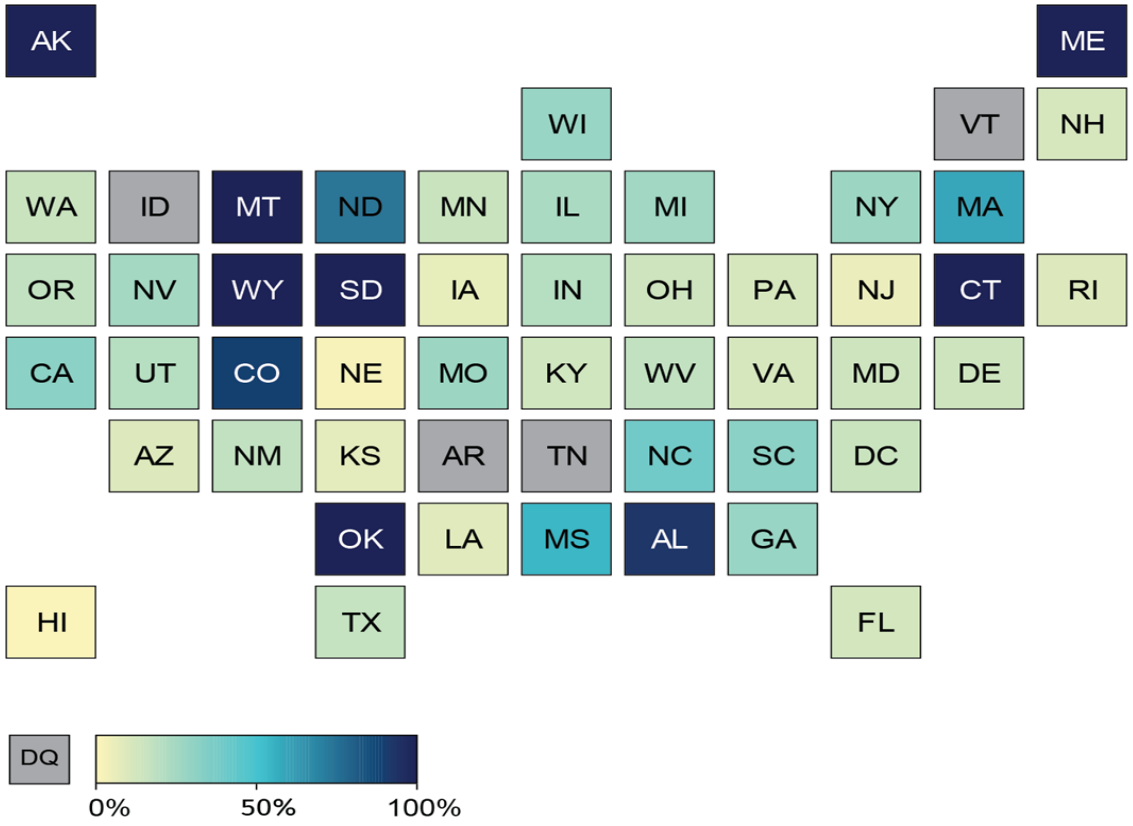
Overview of State Level Variations

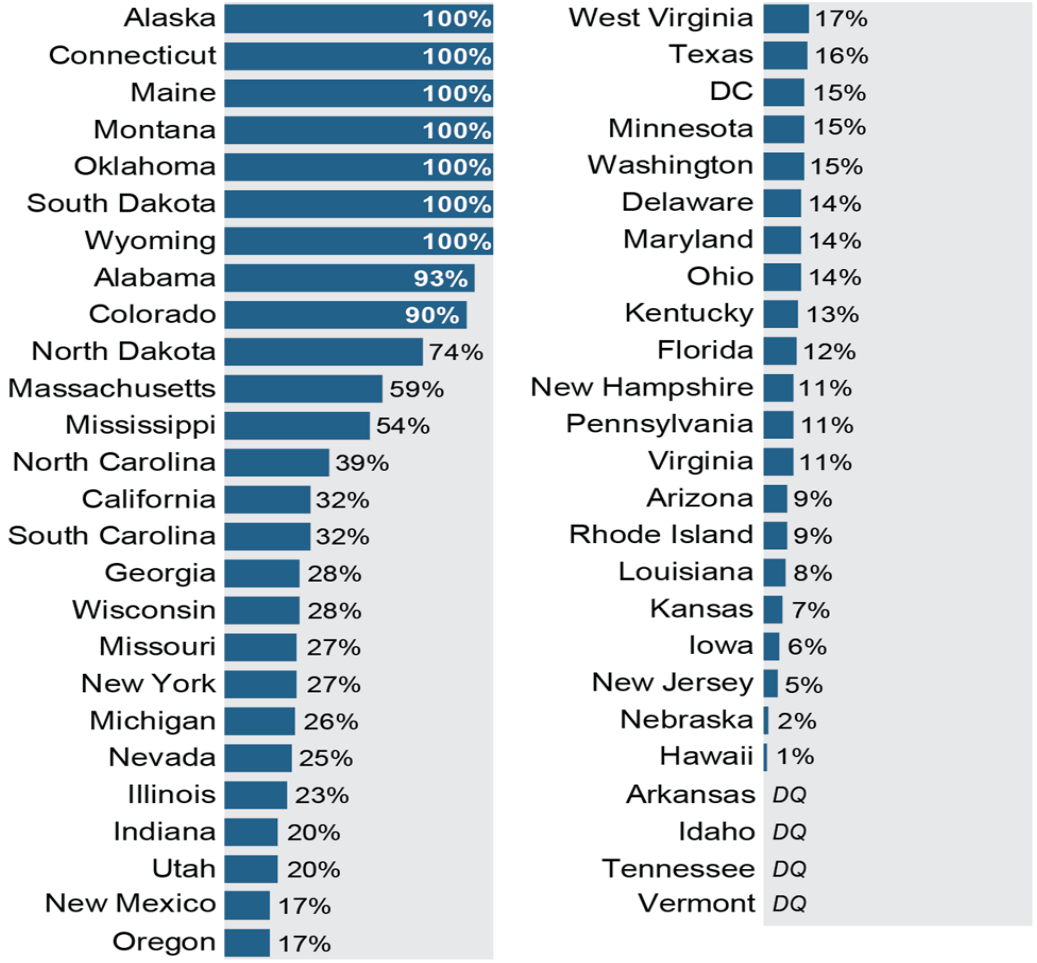
- This research brief presents a TAF-based analysis of the extent of fee-for-service (FFS) delivery and payment systems among state Medicaid programs from 2017 to 2022.
- The brief also explores FFS patterns by beneficiary dual eligibility status and among the top 10 service categories with the highest expenditures in 2022.
- The brief aims to help researchers using TAF data understand the variation in FFS use across state programs and key considerations for using TAF eligibility, claims, or expenditure data to measure FFS trends among Medicaid and CHIP beneficiaries.
  - Uses 2 methods: 1) **Eligibility-based approach** to classify and measure FFS use and 2) **Spending per beneficiary** to analyze mean FFS at the state level

Key Findings

- Variation found in Medicaid FFS Use by State
- Tracking FFS Use overtime
  - Fluctuations found, evolving state policies, changes in managed care penetration, or shifts in healthcare provider participation.
- Variation found in Medicaid FFS Use by Dual-Eligibility Status
  - Dual eligible beneficiaries are generally more likely to be covered under FFS compared to non-dual eligible beneficiaries across most states.
- Role of FFS in Medicaid payment systems
  - Considerable variation in mean Medicaid FFS spending across states.

Key Findings Example - Variation in Medicaid FFS Use by State





Questions?

Questions