BUILDING THE RAILS FOR MEDICAID DRUG PRICING ARBITRAGE: A STARTU BLUEPRINT FOR THE GENEROUS MOD

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Abstract

The CMS Innovation Center just dropped something genuinely interesting with GENEROUS Model, a voluntary program that lets pharma manufacturers provid Most Favored Nation pricing to state Medicaid programs through supplemental rebates. This creates a massive coordination problem between manufacturers, st and CMS that screams for a software infrastructure layer. This essay outlines a business plan and technical architecture for a startup that becomes the operatio backbone of GENEROUS, positioning itself as the essential middleware betwee parties while building multiple revenue streams and defensible moats. The opportunity is time-sensitive given the model's January 2026 start date and compressed negotiation timeline.

Key Topics Covered:

- Deep dive into the GENEROUS Model mechanics and market opportunity

- Business model spanning SaaS platforms, consulting services, and data produc

- Technical architecture for international pricing aggregation, rebate calculatio state invoicing systems

- Go-to-market strategy prioritizing manufacturer partnerships and state onboa

- Competitive positioning and defensibility analysis

- Financial projections and funding requirements

- Risk factors and mitigation strategies

The CMS Innovation Center has a funny way of creating multi-hundred-million-market opportunities by accident. The GENEROUS Model, which stands for Generating Cost Reductions for U.S. Medicaid Model in case you were wonderin about that tortured acronym, is one of those rare policy innovations that creates genuine arbitrage opportunities while solving real coordination problems. The b concept is straightforward enough that it fits in a paragraph but complex enoug execution that it demands sophisticated software infrastructure. Pharma manufacturers agree to provide Most Favored Nation pricing to state Medicaid programs based on international reference pricing from G-7 countries plus Den and Switzerland. In exchange, states adopt standardized coverage criteria negoti between CMS and the manufacturers, and everyone theoretically wins through l costs and reduced administrative burden. The model runs from January 2026 thr December 2030, giving participating manufacturers and states a five-year windo figure out if international reference pricing actually works in practice.

Here is why this matters for startups and why someone smart should be building infrastructure right now. The GENEROUS Model creates a three-sided coordina problem between CMS, state Medicaid programs, and pharmaceutical manufact CMS needs to negotiate standardized coverage criteria with each manufacturer, aggregate international pricing data from eight countries, calculate guaranteed r unit prices, and monitor compliance. States need to adopt coverage criteria, invo manufacturers for supplemental rebates, reconcile payments, and ensure their Medicaid managed care organizations comply with model requirements. Manufacturers need to report international pricing data across multiple countri formulations, pay supplemental rebates on top of existing statutory rebates, neg

coverage terms, and maintain compliance with auditing requirements. Nobody currently has the infrastructure to do any of this efficiently.

The gap between what the RFA describes and what actually needs to be built is substantial. CMS mentions engaging contractors for implementation and evalua but does not specify what systems will actually operationalize the model. States a notoriously under-resourced when it comes to pharmacy program administratio most still use decades-old systems for rebate processing. Manufacturers have sophisticated pricing and rebate systems for the existing Medicaid Drug Rebate Program but nothing designed for international reference pricing or the specific GNUP calculation methodology required by GENEROUS. This infrastructure ga represents a clear market opportunity for a well-designed software platform tha becomes the operational backbone of the model.

The Business Opportunity and Market Sizing

Start with the total addressable market which is surprisingly large. There are ro 750 to 800 National Drug Codes that qualify as single source or innovator multi source drugs in the Medicaid Drug Rebate Program at any given time. The avera annual Medicaid spending per branded drug varies wildly but a reasonable estin for high-value drugs that manufacturers might want to include in GENEROUS i around five to twenty million dollars per state per drug. If we assume that twent thirty manufacturers participate in the model covering maybe two hundred to th hundred high-value drug products, and forty states eventually join, you are look total Medicaid drug spending flowing through the model in the range of ten to t billion dollars annually. Even a thin software layer capturing modest fees from multiple parties in this transaction flow generates substantial revenue.

The revenue model has multiple vectors which is always attractive for investor discussions. First, you charge manufacturers a SaaS platform fee for the internat pricing data aggregation and reporting system. These fees could run fifty thousa two hundred thousand per manufacturer annually depending on the number of

products and complexity of their international pricing structures. Second, you cl states a platform fee for the rebate invoicing, reconciliation, and compliance monitoring system. State fees are trickier because of budget constraints and procurement processes but twenty-five thousand to one hundred thousand per s annually is reasonable for a system that helps them capture potentially hundreds millions in supplemental rebates. Third, you charge transaction fees on rebate processing, maybe ten to twenty basis points on the supplemental rebate dollars flowing through your system. If you are processing five billion in supplemental rebates annually, twenty basis points generates ten million in revenue from transaction fees alone.

Beyond the direct platform fees, there are adjacent revenue opportunities that b more valuable over time. You build the authoritative database of international d pricing which has significant value to payers, pharmacy benefit managers, policy researchers, and potentially other government programs. You can productize de- identified pricing analytics and sell them as a subscription service. You own the relationship with state Medicaid programs around pharmacy administration whi creates cross-sell opportunities for other rebate management services or prior authorization workflow tools. You potentially become the preferred implementa partner when CMS wants to expand the model or create similar international reference pricing programs for Medicare Part D or commercial insurance. The i GENEROUS platform is the wedge that opens up a much larger pharmacy pricir infrastructure market.

The Business Model and Core Product Offering

The core product is a cloud-based platform with three distinct user interfaces a backend systems serving CMS, state Medicaid programs, and pharmaceutical manufacturers. Think of it as a three-sided marketplace where each party has different needs but the platform coordinates their interactions around the centr workflow of establishing MFN pricing through supplemental rebates. The manufacturer interface handles international pricing data collection, validation,

reporting. The state interface handles rebate calculation, invoicing, payment trac and reconciliation. The CMS interface handles coverage criteria negotiation, compliance monitoring, and model evaluation support. All three interfaces sit or of a shared data infrastructure that maintains the source of truth for drug produ pricing data, rebate calculations, and transaction history.

For manufacturers, you solve the international pricing aggregation problem whi genuinely complex. Manufacturers need to report average net prices for each dru product at the NDC-9 level for eight different countries, calculated over the pre twelve months, net of all rebates, discounts, and price concessions, then adjuste GDP using purchasing power parity. Most manufacturers do not have this data r available in a standardized format. They sell through different distribution chan in different countries, negotiate different rebates with different payer systems, a use different accounting practices for tracking net prices. Your platform provide standardized data templates, validation rules, currency conversion, GDP adjustr calculations, and audit trails that let manufacturers comply with GENEROUS reporting requirements without building custom systems. You also handle the ongoing rebate payment processing and reconciliation, integrating with their ex accounts payable systems.

For states, you solve the rebate invoicing and tracking problem which is equally messy. States need to calculate supplemental rebate amounts using the formula: Supplemental Rebate equals WAC minus the sum of GNUP plus URA. They nee do this quarterly for every drug product from every participating manufacturer, tracking their actual Medicaid utilization at the NDC-11 level, matching it to th NDC-9 level GNUP values provided by manufacturers, applying the appropriate Rebate Amounts from CMS, and generating invoices. Then they need to track payments, handle disputes, reconcile adjustments, and maintain documentation audits. Most state Medicaid programs still do this with Excel spreadsheets and manual processes for existing supplemental rebate agreements. Your platform automates the entire workflow, integrates with state Medicaid management information systems to pull utilization data, calculates rebate amounts, generate

invoices, tracks payments, and provides dashboards showing rebate collection performance.

The technical architecture needs to handle several challenging data problems. F the international pricing data aggregation and validation. You need to ingest pri data from manufacturers in various formats, validate completeness and accuracy apply currency conversions, calculate GDP adjustments using purchasing power parity, compute the second-lowest adjusted country price, and derive the GNUP each drug product. This requires maintaining up-to-date GDP and exchange rat implementing validation rules that catch common errors, and providing clear feedback to manufacturers when data submissions have issues. Second is the ND level matching and mapping problem. Manufacturers report at NDC-9 level but track utilization at NDC-11 level and you need to accurately map between these hierarchies while handling edge cases like package size variations or temporary reassignments. Third is the rebate calculation engine which needs to ingest utili data from fifty-six different state Medicaid programs, each with their own data formats and submission schedules, match utilization to GNUP and URA values, handle quarterly variations in pricing, calculate supplemental rebates, and gener invoices.

The Technical Architecture and Implementation Plan

The platform architecture follows a modern cloud-native design built on AWS o Azure with microservices handling distinct functional domains. The data ingest layer handles file uploads from manufacturers and states, supporting multiple fo including CSV, Excel, EDI, and API integration. You need robust parsing, valida and error handling since incoming data quality will be highly variable, especially the early months. The data storage layer uses a combination of relational databa transactional data and columnar databases for analytical queries. Key entities in drug products, pricing submissions, utilization records, rebate calculations, invo payments, and audit logs. The calculation engine implements the GNUP formul

rebate calculation logic, and reconciliation workflows with full audit trails show how every number was derived.

The manufacturer portal is a web application that guides users through the international pricing submission process with a wizard-style interface that breal down the complex requirements into manageable steps. Step one, select drug pr to include. Step two, upload pricing data for each country with templates pre-populated with previous submissions. Step three, review calculated GNUP value explanations of how they were derived. Step four, submit to CMS with attestatio and supporting documentation. The portal includes a dashboard showing submi status, upcoming deadlines, historical pricing trends, and projected rebate oblig based on state utilization patterns. You also provide API access for manufacture with sophisticated internal systems who want to automate submissions.

The state portal focuses on rebate management workflows with less emphasis on entry since most inputs come from automated feeds. States log in to see which manufacturers have submitted pricing data, review GNUP values for drugs they to include in their Medicaid program, generate rebate invoices based on their ac utilization, track payment status, and handle disputes or adjustments. The porta includes analytics dashboards showing rebate collection performance, savings compared to previous supplemental rebate agreements, utilization trends for MI priced drugs, and compliance monitoring for managed care organization adoptic coverage criteria. States can export data for internal financial systems and gener reports for CMS compliance requirements.

The CMS portal serves model oversight and evaluation functions with read acce all manufacturer and state data along with analytical tools for compliance monit CMS users can see which manufacturers have submitted pricing data on time, w states have executed participation agreements, what coverage criteria have been negotiated for each drug product, and aggregate statistics on rebate collections a savings. The portal supports the model evaluation by providing data exports and for the independent evaluation contractor. It also includes tools for managing th negotiation process between CMS and manufacturers around coverage criteria, tracking negotiation status, and storing finalized agreement terms.

The backend calculation engine is where the real technical complexity lives. The GNUP calculation takes manufacturer-submitted international prices, applies G adjustments using purchasing power parity ratios, identifies the second-lowest adjusted price, and outputs the GNUP value. This seems straightforward until y encounter edge cases like missing price data for certain countries, formulation mismatches between US and international products, currency conversion timing GDP data updates mid-year. Your calculation engine needs business rules for handling each scenario documented clearly with CMS approval. The rebate calculation takes state utilization data at NDC-11 level, maps to NDC-9 level GN retrieves current URA values from CMS, applies the supplemental rebate formu and generates line-item invoices. This runs quarterly for each state-manufacture and needs to handle adjustments for prior quarters when utilization data gets corrected retroactively.

The data integration layer connects to external systems including the CMS Medi Drug Rebate Program system for URA values and drug product master data, stat Medicaid management information systems for utilization data, manufacturer E and accounts payable systems for payment processing, and potentially pharmacy benefit manager systems for managed care utilization. You need flexible integrat patterns supporting batch file transfers, API calls, and manual uploads dependi what each organization can support. The integration layer includes data quality monitoring, error handling, and notification systems that alert relevant parties w data feeds fail or contain anomalies.

Security and compliance are critical given the sensitive pricing data and PHI inv The platform needs HIPAA compliance for handling Medicaid beneficiary data e though you are primarily dealing with aggregate utilization rather than individu records. You need strong authentication and authorization controls with role-ba access ensuring manufacturers only see their own data, states only see their own and CMS has appropriate oversight access. Audit logging tracks every data acces calculation with immutable records for compliance verification. Data encryption covers data at rest and in transit. The platform architecture supports disaster re

with regular backups and the ability to reconstruct calculations from source dat needed.

Go-to-Market Strategy and Customer Acquisition

The go-to-market strategy needs to solve a chicken-and-egg problem where manufacturers will not invest in your platform unless states are participating an states will not pay for your platform unless manufacturers are offering attractive pricing. The solution is to initially offer free or heavily discounted access to earl adopters on both sides, absorbing the cost of building the infrastructure in exch for reference customers and feedback that makes the product better. You target to ten manufacturers in the first cohort, ideally ones with broad portfolios of hig value specialty drugs where MFN pricing represents significant potential saving states. You offer them free platform access through the first year in exchange for being reference customers and providing product feedback. You simultaneously target ten to fifteen states, focusing on larger states with significant Medicaid pharmacy spending and more sophisticated program administration, offering th the same deal.

The sales approach for manufacturers emphasizes three value propositions beyo core platform functionality. First, reduced administrative burden compared to negotiating supplemental rebate agreements separately with fifty-six state Medic programs. Second, more predictable pricing and market access through standard coverage criteria negotiated once with CMS rather than managed separately by e state. Third, potential competitive advantage if they are early movers in offering pricing, gaining preferred access to Medicaid formularies before competitors joi model. The sales process involves educating manufacturer executives on the GENEROUS Model mechanics since this is brand new, demonstrating the platfo and providing analysis of potential financial impact based on their current Medi rebate obligations and international pricing.

The sales approach for states emphasizes the supplemental rebate revenue opportunity and administrative efficiency gains. Many states struggle to negotia meaningful supplemental rebates with manufacturers of high-cost specialty dru because they lack leverage and negotiating expertise. GENEROUS gives them ac to MFN pricing negotiated by CMS with standardized terms, potentially generat tens or hundreds of millions in additional rebate revenue. Your platform makes operationally feasible to participate in the model without hiring additional staff building custom systems. You provide ROI analysis showing projected rebate collections based on their Medicaid utilization patterns and manufacturers curr participating, making the value proposition concrete rather than abstract.

The initial customer acquisition targets are manufacturers with broad specialty portfolios in therapeutic categories where Medicaid utilization is significant. Oncology, immunology, rare disease, and diabetes drugs are obvious targets. Companies like AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & John Merck, Novartis, Pfizer, Regeneron, and Sanofi all have products where GENER participation makes strategic sense. On the state side, you target larger states lik California, New York, Texas, Florida, Pennsylvania, Ohio, Illinois, Michigan, an North Carolina where Medicaid pharmacy spending is substantial enough to jus the operational investment. You also target states with more progressive Medica programs that tend to be early adopters of innovation like Massachusetts, Rhode Island, Oregon, and Washington.

The procurement process for states is its own challenge requiring specialized expertise. State Medicaid programs typically require competitive procurement processes for software systems even when the contract values are relatively small need to understand state procurement rules, respond to RFPs when they are issu and potentially get on existing contract vehicles or cooperative purchasing agree that streamline procurement. An alternative approach is positioning your platfo a CMS-endorsed implementation solution or even working through the CMS contractor supporting model implementation, essentially becoming a subcontrac rather than selling directly to states. This is slower and gives you less control bu reduces the sales complexity.

Partnership strategy is critical given the short timeline and need to establish credibility quickly. You want partnerships with existing players in the Medicaid rebate administration space including companies like Conduent, HP Enterprise Services, or specialized Medicaid fiscal agents. These companies have existing relationships with state Medicaid programs and could resell your platform as pa their service offerings. You want partnerships with pharmacy benefit managers a Medicaid managed care organizations since they need to implement the coverag criteria and could benefit from having a standardized platform that coordinates state fee-for-service programs. You want partnerships with health IT consulting like Deloitte, Accenture, or Booz Allen Hamilton that help states with Medicaid program implementation and could recommend your platform as the technical solution for GENEROUS participation.

Competitive Landscape and Defensibili

The competitive landscape is surprisingly open because GENEROUS is brand ne and requires specialized capabilities that existing vendors do not necessarily hav The Medicaid rebate administration market is dominated by state fiscal agents a the states themselves using in-house systems. These systems are built around the existing MDRP statutory rebate calculations and do not handle the international pricing data aggregation or GNUP calculations required by GENEROUS. Fiscal agents could build GENEROUS capabilities but they move slowly and have limit product development resources. This gives a nimble startup a meaningful windo establish the category before incumbents respond.

Potential competitors include enterprise software vendors that sell to state governments like Tyler Technologies or NIC that could build GENEROUS modu for their existing Medicaid systems. The challenge for them is that GENEROUS requires domain expertise in pharmaceutical pricing, international data aggrega and rebate calculation logic that generalist government software vendors typical lack. Another potential competitor category is pharmacy pricing analytics compa like 46brooklyn Research or 3 Axis Advisors that have deep pricing expertise an relationships with states but are primarily consulting firms rather than software

vendors. They could build a platform but would need to develop software capabi and scale beyond their consulting model.

The most significant competitive threat is CMS building the system itself or the primary implementation contractor providing a basic platform that meets minin requirements. If CMS provides a free basic system, you need differentiation thro superior user experience, analytics capabilities, integration with other systems, a additional services that make the model easier to operationalize. The good news that government-built systems tend to be clunky and limited to core requiremen leaving room for commercial vendors to provide better solutions that customers willing to pay for. You see this pattern repeatedly in healthcare IT where govern systems establish the baseline but commercial vendors build the products peopl actually want to use.

Defensibility comes from several sources beyond just being first to market. Netv effects kick in once you have critical mass of manufacturers and states on the pla because it becomes the natural coordination point for GENEROUS transactions. advantages accumulate as you process more rebate transactions and build the mo comprehensive database of international drug pricing and Medicaid rebate patte Integration advantages compound as you connect to more state Medicaid system manufacturer ERP systems, making it harder for competitors to displace you wit rebuilding all those integrations. Regulatory advantages emerge if you work clos with CMS on model implementation and your platform becomes the de facto sta or even required implementation approach.

The intellectual property is primarily in the algorithms, data models, and domai expertise rather than patentable inventions. You can potentially patent specific methods for calculating GNUP adjustments or handling NDC mapping edge cas the core value is in execution rather than novel technology. Trade secret protecti around your pricing database and calculation logic provides some defensibility b does not prevent competition. The real moat is operational excellence and trust, becoming the reliable infrastructure that manufacturers and states depend on fo complex and high-stakes process where errors or downtime have significant fina consequences.

Financial Projections and Funding Requirements

The financial model starts with some reasonable assumptions about model adopt and pricing. Assume twenty manufacturers participate in year one, thirty-five in two, and fifty by year three, plateauing around fifty to sixty manufacturers throu model's conclusion. Assume fifteen states participate in year one, thirty in year t and forty-five by year three, eventually reaching most states by year four. Manufacturer SaaS fees average one hundred thousand per year, state SaaS fees average fifty thousand per year, and transaction fees average fifteen basis points supplemental rebate dollars flowing through the platform.

Year one revenue comes mostly from early adopter manufacturers and states at discounted rates or free access. You might generate three hundred thousand in S revenue and two hundred thousand in transaction fees from early rebate process totaling five hundred thousand. Year two revenue grows substantially as you con early adopters to paid subscriptions and add new customers. Manufacturer SaaS of two million, state SaaS fees of one million, and transaction fees of two million generate five million in total revenue. Year three hits inflection as the model rea critical mass. Manufacturer SaaS fees of four million, state SaaS fees of two milli and transaction fees of six million generate twelve million in total revenue. Year and five continue growth to fifteen million and eighteen million respectively as remaining states join and transaction volumes increase.

Cost structure front-loads investment in product development and customer acquisition. Year one requires two million in seed funding covering engineering of six to eight people, product and design resources, cloud infrastructure, initial to-market including sales and partnerships, and operational overhead. Year two requires additional four million in Series A funding for scaling the engineering t to fifteen people, expanding sales and customer success, building out data opera and compliance, and funding working capital for transaction processing. Year th requires another six million in Series B funding for continued scaling, geographi

expansion if the model extends beyond Medicaid, M&A opportunities, and build adjacent products.

Cumulative cash burn through year three totals approximately eight million bef the company reaches cash flow breakeven in year four. The five-year cumulative revenue totals around fifty million with EBITDA margins improving from negati eighty percent in year one to positive thirty percent by year five. This assumes disciplined spending, successful customer acquisition, and reasonable pricing p The model is sensitive to transaction volumes which depend on how many high- drugs manufacturers include and how many states actually implement MFN pric rather than just signing participation agreements. You need robust scenario ana around different adoption curves and transaction volumes.

The funding strategy starts with a seed round of one to two million from healthc focused angel investors or early-stage VCs with domain expertise in health polic Medicaid, or pharmaceutical pricing. Ideal lead investors include firms like Andreessen Horowitz bio fund, Lux Capital, Town Hall Ventures, Transformatic Capital, or groups that have invested in government technology or healthcare infrastructure. You need investors who understand long sales cycles, appreciate government contracting dynamics, and have relationships that can help with cus acquisition. The seed round closes before the RFA submission deadline in Marc to fund initial product development and early customer acquisition.

Series A of three to five million follows twelve to eighteen months later once you ten to fifteen customers across manufacturers and states, proven platform functionality, and clear evidence that the model is gaining traction. Series A inve want to see product-market fit, repeatable sales motion, and path to profitability Series B of six to ten million comes at the twenty-four to thirty-six month mark fund scaling to majority market coverage and potential geographic or product expansion. By Series B you should have forty-plus customers, fifteen to twenty m in ARR, and clear market leadership in GENEROUS infrastructure.

Alternative funding paths include bootstrapping through consulting revenue, he states and manufacturers implement GENEROUS participation without the full

platform, then using that revenue to fund platform development. This is slower reduces dilution and forces customer-driven product development. Another alternative is partnering with an existing health IT company or fiscal agent that provides funding and go-to-market access in exchange for equity or revenue sha This accelerates customer acquisition but reduces independence and may limit u if the partnership terms are unfavorable.

Risk Factors and Mitigation Strategies

Model adoption risk is the elephant in the room. What if manufacturers decide n participate because MFN pricing is too expensive or operationally complex? Wh states decide not to participate because the coverage criteria restrictions outwei rebate revenue benefits? The model is voluntary for everyone which means your business depends on sufficient participation to justify the platform investment. Mitigation starts with deep customer discovery before building anything, validat that the value propositions resonate with target customers. You need champions CMS who believe in the model and actively promote participation. You need ear wins with large manufacturers and states that create momentum and social proo others to join.

Technical execution risk is significant given the complexity of the calculations a data integrations required. Errors in GNUP calculations or rebate invoicing crea financial exposure and loss of customer trust. Data integration failures prevent t platform from functioning. Security breaches expose sensitive pricing informati create regulatory liability. Mitigation requires strong engineering leadership wit experience in healthcare data systems, robust testing and quality assurance, clea documentation of calculation logic with regulatory approval, phased rollout that validates functionality with small volumes before scaling, and comprehensive monitoring and incident response capabilities.

Regulatory and policy risk includes CMS changing model rules mid-stream, stat challenging the legality of the participation agreements, manufacturers disputin rebate calculations, or the model being cancelled entirely if evaluation results ar

unfavorable. The RFA explicitly states that CMS retains the right to modify mod policies or cancel it entirely. Mitigation involves staying close to CMS throughou implementation, participating in industry working groups and policy discussion building flexibility into the platform to accommodate rule changes, maintaining strong compliance and audit capabilities, and diversifying the business model be GENEROUS if possible.

Competitive risk from government-provided free infrastructure or incumbent ve building competing solutions threatens your pricing power and market position CMS provides a basic free platform that meets minimum needs, customers may n pay for your premium solution. If established fiscal agents build GENEROUS capabilities, they have existing customer relationships and can bundle it with oth services. Mitigation requires differentiation through superior user experience an capabilities that justify premium pricing, speed to market before competitors ca respond, strong customer relationships and lock-in through integrations, and potentially partnering with incumbents rather than competing against them.

Financial sustainability risk emerges if transaction volumes are lower than proje or if pricing pressure reduces your revenue per customer. The model could succe lowering drug costs for Medicaid while still processing lower total rebate dollar expected if fewer high-value drugs are included or if manufacturers provide mor aggressive baseline pricing that reduces the supplemental rebate amounts. Mitig includes conservative financial projections, diversified revenue streams beyond j transaction fees, focus on profitability and cash flow generation rather than grov all costs, and building adjacent products that serve the same customers with additional revenue opportunities.

The dependency on a single government program is unavoidable but creates existential risk if GENEROUS fails or is not renewed after the initial five-year te period. This forces you to think about the business as a bridgehead into a larger pharmacy pricing infrastructure market rather than just a GENEROUS implementation tool. The platform capabilities around international pricing dat rebate calculation, and multi-party coordination have applications beyond this specific model including potential Medicare Part D reference pricing programs,

commercial insurance international benchmarking, state pharmaceutical purcha collaboratives, or pharmacy benefit manager rebate administration.

Strategic Options and Long-Term Visio

The long-term vision extends beyond just being GENEROUS infrastructure to becoming the operating system for value-based pharmaceutical pricing across multiple payer types and geographies. GENEROUS validates the concept of softv enabled coordination for complex multi-party pricing agreements and internatic reference pricing. The same platform capabilities apply to other contexts includi Medicare Part D if CMS implements international reference pricing for that prc state pharmaceutical purchasing consortia like NASHP that negotiate supplemer rebates collectively, employer health plans that want to benchmark drug prices against international markets, or even international expansion helping other cou implement reference pricing against US or European markets.

Adjacent product opportunities emerge from the customer relationships and dat assets you build. State Medicaid programs need better tools for prior authorizati management, utilization review, clinical decision support around formulary deci and fraud and abuse detection in pharmacy claims. Your platform could expand these areas leveraging your existing state relationships and pharmacy domain expertise. Manufacturers need better market access intelligence, competitive pri analytics, and payer relationship management tools. You could build products se their commercial teams with data and insights from your rebate processing operations.

Strategic acquirers might include established health IT vendors looking to add pharmacy pricing capabilities, pharmacy benefit managers wanting better tools f rebate administration, or even payers building direct sourcing and pricing capabilities. Companies like Optum, CVS Health, Express Scripts, McKesson, or Change Healthcare could all see strategic value in acquiring your platform and customer relationships. The acquisition timing depends on market maturity but

comes in the three to five-year window once you have proven the model and achi significant market penetration.

The exit scenarios include acquisition by strategic buyer at four to six times reve based on healthcare software comparables, remaining independent and building profitable software business serving government healthcare markets, or potentia going public if you successfully expand beyond GENEROUS into a broader phar pricing platform with sufficient scale. The most likely path is strategic acquisiti given the concentrated customer base and natural strategic acquirers with distribution advantages and complementary products.

Why This Works and Why Now

The fundamental insight is that GENEROUS creates a genuine market opportur through government policy rather than technology innovation. The barriers to e are lower than typical healthcare IT infrastructure plays because you do not nee integration or healthcare system deployment capabilities. The customer concent is manageable with around fifty to sixty potential manufacturer customers and fi state Medicaid programs. The sales cycle is compressed by the model timeline fo decisions in 2026. The value proposition is clear and financially quantifiable thr rebate revenue for states and administrative burden reduction for manufacturer

The timing is critical because the model launches in January 2026 with manufac RFAs due March 31, 2026, and state participation agreements due August 31, 20 Nobody has existing infrastructure ready. CMS is still figuring out implementati details. This creates a narrow window where a well-executed startup can establis category before larger competitors respond or government builds its own solutio months from now is too late to start because customers will have made implementation decisions and committed to other approaches.

The team requirements are specific and not easily assembled. You need pharmaceutical pricing domain expertise, Medicaid program knowledge, enterp SaaS product experience, government sales capabilities, and technical leadership health data platform experience. This combination is rare and suggests that the

founding team should include people with Medicaid program administration backgrounds, pharmaceutical industry experience, and successful health IT start experience. The investors you pitch need to understand long government sales cy and appreciate the strategic value of infrastructure positions rather than just use facing applications.

The market entry playbook is to move fast during the RFA response period, sign early adopter manufacturers and states as reference customers, using their requirements and feedback to guide product development, launching a minimall viable platform by summer 2026 that handles core GNUP calculation and rebate invoicing, scaling functionality and customers through 2027 as the model gains traction, and expanding into adjacent products and markets by 2028 once you ha established the initial beachhead. Speed and execution matter more than perfect products because the window is time-bound and first-mover advantages are substantial.

This is the rare health policy innovation that translates into a clear software opportunity with defined customers, quantifiable value propositions, reasonable technical scope, and manageable competitive dynamics. Someone is going to bui infrastructure. The question is whether it is a nimble startup that becomes a meaningful standalone business and potential acquisition target, or an incumbe contractor that delivers the minimum required functionality and captures mode value. For the right team at the right time, this could be a genuinely exciting opportunity at the intersection of government policy, pharmaceutical pricing, an healthcare software infrastructure.

If you are interested in joining my generalist healthcare angel syndicate, reach o treyrawles@gmail.com or send me a DM. We don't take a carry and defer annual for six months so investors can decide if they see value before joining officially. Accredited investors only.

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Eric Leventhal Nov 21

This is really interesting. When I worked on gaining more rebate revenue - includi supplemental rebates - at a state Medicaid agency, I found the vendor tools in thi to be extremely lacking. When we dug into details, we found we'd been mising ou many millions in rebates - which the vendor tools had obfuscated.

That said, there's many outstanding questions about the GENEROUS model:

-Will manufacturers participate at scale, or just make a token gesture by including minor drugs? From their POV, it only makes sense to participate 1) if the GENERO rebates are likely to be modest and 2) if they can be the preferred drug in a given

-Will states participate? They have the reverse incentive from pharma. States sho participate if they can get higher rebates than what they're already obtaining via supplemental rebates.

-Can CMS negotiate better deals than the existing pooled purchasing consortiums SSDC? In this new model, CMS is basically offering to do for states what these cor were already doing - negotiating supplemental rebates from pharm in exchange f preferred formulary placement.

I'm curious if anyone has done a back-of-the-envelope estimation about whether t proposed MFN rebate is likely to be lower than the avg. supplemental rebates stat already getting (~5% of WAC, I believe). That might provide good insight on whet GENEROUS will really take off, and in what form...

Regardless, I still think there's opportunity to improve upon the existing vendor to the Medicaid drug rebate space. State procurement is hard to navigate, but there

billions of dollars at stake there....

Feel free to DM if anyone is curious to connect on this topic.

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