MARKET BRIEF

MFP Crisis Response Brief

RETAILMYMEDS

Medicare Maximum Fair Price | Cash Flow Impact | Independent Pharmacy

PREPARED FOR **Arica Collins, PharmD** February 2026 | *v1.0 — Market Brief* PREPARED BY **Matthew Scott**

Executive Summary

On January 1, 2026, the Medicare Drug Price Negotiation Program began enforcing Maximum Fair Prices (MFPs) on the first 10 negotiated drugs. While framed as a win for consumers, the program has created an immediate *cash flow crisis* for independent pharmacies. Pharmacies must now dispense these medications at the negotiated MFP — often **60% below** wholesale acquisition cost — and then wait for manufacturer refunds that arrive **21–30+ days** later.[1] Three Axis Advisors, in partnership with NCPA, estimates this creates a **$722.55 per-transaction shortfall** and a **$10,838/week** cash flow gap per pharmacy, based on 15 MFP-impacted transactions per week.[2] Annualized, the program eliminates **$40,000–$46,000** in margin per pharmacy on these drugs alone.[2]is not a one-time event. Cycle 2 adds 15 more drugs (effective January 2027), including Ozempic, Wegovy, and Trelegy Ellipta.[3] Cycle 3 — announced January 27, 2026 — selects another 15 drugs for 2028 implementation, including the first Part B medications.[4] The financial pressure compounds with each cycle. Meanwhile, the PBM Reform Act signed February 3, 2026 mandates 100% rebate pass-through and PBM compensation delinking — but key provisions do not take effect until **2028–2029**.[5] Pharmacies cannot wait.addresses this timing gap directly. By routing unprofitable prescriptions — including MFP-impacted drugs — to mail-order fulfillment while the local pharmacy retains the patient relationship, the platform eliminates the cash flow bleed at its source. At **$275/month** with **30–45 day ROI**, it is the operational bridge independent pharmacies need while the regulatory landscape catches up to the crisis.

The MFP Cash Flow Crisis

What Is the Maximum Fair Price?

The Medicare Drug Price Negotiation Program, established by the Inflation Reduction Act of 2022, authorizes CMS to negotiate prices for high-spend Medicare drugs. The resulting Maximum Fair Prices (MFPs) represent the ceiling that pharmacies can charge Medicare Part D beneficiaries for selected medications.[6] For the first cycle, MFPs reflect discounts of **38% to 79%** off 2023 list prices, with Januvia seeing the deepest cut (79%) and Imbruvica the shallowest (38%).[6]

The Delayed Refund Mechanism

Here is the problem: pharmacies purchase these drugs from wholesalers at or near Wholesale Acquisition Cost (WAC). They then dispense them at the MFP — which is approximately **60% below WAC**.[2] To close this gap, CMS requires manufacturers to refund pharmacies the difference between acquisition cost and the MFP. But refunds are not immediate. The manufacturer has **14 days** after receiving finalized claim data to issue payment.[7] CMS has proposed shortening the plan submission window from 30 days to 7 days for selected drugs, yielding a best-case **21-day** refund cycle.[7] In practice, pharmacies report waits of 30 days or more.[1]Medicare Transaction Facilitator (MTF) — a CMS-developed system with Data Module and Payment Module components — was designed to streamline this process.[7] But even with the MTF fully operational, the structural timing gap persists: pharmacies must front the cost of every MFP prescription and float the difference

until the manufacturer refund arrives. At **15 transactions per week**, that is **$10,838** in weekly working capital tied up in the refund pipeline.[2]

Compounding with DIR Fee Compression

The MFP cash flow gap does not exist in isolation. The 2024 CMS rule moved Direct and Indirect Remuneration (DIR) fees to point-of-sale, which was intended to improve transparency. In practice, it compressed upfront reimbursement from **AWP minus 4–11%** (2023) to **AWP minus 18–26%** (2024).[8] Express Scripts' publicly available contracts show rates as low as **AWP minus 26.3%**.[8] Pharmacies absorbed the 2023 retroactive DIR clawbacks simultaneously with the 2024 point-of-sale assessments — a "double whammy" that compressed cash flow from both directions.[8]add MFP on top. Independent pharmacies are being squeezed by three forces at once: lower upfront reimbursement (DIR reform), delayed manufacturer refunds (MFP), and the ongoing PBM practice of reimbursing below acquisition cost on a significant share of prescriptions. NCPA survey data shows **40.8%** of independent pharmacists are paid below what they pay to buy the drug on more than 40% of their Medicare Part D scripts.[9]

Three Cycles of Negotiation

Cycle 1 — Active January 2026

Drugs included:

- Eliquis (apixaban) — $231 MFP vs. $521 list (56% discount)
- Jardiance (empagliflozin) — $197 MFP vs. $573 list (66% discount)
- Xarelto (rivaroxaban) — $197 MFP vs. $517 list (62% discount)
- Januvia (sitagliptin) — $113 MFP vs. $527 list (79% discount)
- Farxiga (dapagliflozin) — $178 MFP vs. $556 list (68% discount)
- Entresto (sacubitril/valsartan) — $295 MFP vs. $628 list (53% discount)
- Enbrel (etanercept) — $2,355 MFP vs. $7,106 list (67% discount)
- Imbruvica (ibrutinib) — $9,319 MFP vs. $14,934 list (38% discount)
- Stelara (ustekinumab) — $4,695 MFP vs. $13,836 list (66% discount)
- Fiasp/NovoLog (insulin aspart) — $119 MFP vs. $495 list (76% discount)

> CASH FLOW IMPACT
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> **$722.55** per-transaction shortfall. At 15 transactions/week: **$10,838/week** or **$563,589/year** in working capital tied up in the manufacturer refund pipeline. Estimated annual margin loss: **$40,279–$46,476** per pharmacy.[2]

> TIMELINE
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> MFPs effective January 1, 2026. Three of the ten drugs will lose MFP status in 2027 due to biosimilar/generic entry.[6]

Cycle 2 — MFPs Effective January 2027

Drugs included:

- Ozempic (semaglutide) — diabetes/cardiovascular
- Wegovy (semaglutide) — weight management
- Rybelsus (semaglutide) — diabetes
- Trelegy Ellipta — COPD/asthma
- Janumet (sitagliptin/metformin) — diabetes

- Austedo (deutetrabenazine) — Huntington's disease
- Ibrance (palbociclib) — breast cancer
- Pomalyst (pomalidomide) — multiple myeloma
- Xtandi (enzalutamide) — prostate cancer
- Calquence (acalabrutinib) — leukemia
- Xifaxan (rifaximin) — IBS
- Plus 4 additional medications

> CASH FLOW IMPACT
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> Negotiated discounts range from **38% to 85%** off list prices. Ozempic/Wegovy/Rybelsus negotiated to **$274/month** from ~$1,000/month (71% discount).[3] Total Medicare spending on these 15 drugs: **$40.7 billion** (Nov 2023–Oct 2024), covering **5.3 million** beneficiaries.[3] The inclusion of GLP-1 medications — already the single largest source of below-cost fills for independents — will dramatically amplify the cash flow problem.

> TIMELINE
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> Drugs selected January 2025. Negotiated prices announced November 2025. MFPs take effect January 1, 2027.[3]

Cycle 3 — Negotiations in 2026, MFPs Effective 2028

Drugs included:

- Trulicity (dulaglutide) — diabetes
- Rexulti (brexpiprazole) — depression/Alzheimer's agitation
- Botox/Botox Cosmetic (onabotulinumtoxinA)
- Cosentyx (secukinumab) — psoriasis/arthritis
- Entyvio (vedolizumab) — Crohn's/UC
- Biktarvy (bictegravir/emtricitabine/TAF) — HIV
- Erleada (apalutamide) — prostate cancer
- Kisqali (ribociclib) — breast cancer
- Lenvima (lenvatinib) — thyroid/liver cancer
- Orencia (abatacept) — rheumatoid arthritis
- Verzenio (abemaciclib) — breast cancer
- Xeljanz/Xeljanz XR (tofacitinib) — RA/UC

- Xolair (omalizumab) — asthma/allergies
- Cimzia (certolizumab pegol) — Crohn's/RA
- Anoro Ellipta (umeclidinium/vilanterol) — COPD

CASH FLOW IMPACT

First cycle to include **Part B drugs** alongside Part D, expanding the financial exposure beyond retail dispensing. CMS also selected Tradjenta (linagliptin) for the program's first renegotiation.[4] The compounding effect of three active cycles will strain working capital for any pharmacy dispensing Medicare medications.

TIMELINE

Drugs announced January 27, 2026. Manufacturers must decide on participation by February 28, 2026. Negotiations occur throughout 2026. MFPs take effect January 1, 2028.[4]

Financial Impact

Three Axis Advisors / NCPA Analysis

The January 2025 study by Three Axis Advisors, commissioned by NCPA, provides the most rigorous quantification of the MFP cash flow impact on independent pharmacies:[2]

- **Per-transaction shortfall**: **$722.55** — the difference between pharmacy acquisition cost and the MFP, which must be floated until the manufacturer refund arrives.
- **Weekly impact**: **$10,838.25** per pharmacy, based on 15 MFP-impacted transactions per week.
- **Profitability loss**: **$59.58** per MFP-impacted claim in eliminated margin.
- **Annual margin loss**: **$40,279–$46,476** per pharmacy from the elimination of margins previously yielded on MFP medications.
- **Industry-wide float**: The average community pharmacy must carry over **$27,000/month** in MFP refund receivables, adding up to more than **$500 million/month** across the industry.[1]

DIR Fee Compression

The MFP shortfall sits on top of a reimbursement environment already in crisis. Since the 2024 CMS DIR reform:[8]

- Medicare Part D reimbursement dropped from **AWP minus 4–11%** (2023) to **AWP minus 18–26%** (2024).
- Express Scripts contracts show rates as low as **AWP minus 26.3%**.
- DIR fee assessments grew from less than 0.5% of total prescription sales (2015) to **3.7%** (2023) — a sevenfold increase.[8]
- Approximately **1,800 retail pharmacies closed** between December 2020 and November 2023.[8]

NCPA Survey Data

The January 2025 NCPA member survey quantifies the scale of the crisis:[9]

- **96.5%** of independent pharmacists say PBM and plan reimbursement threatens their viability.
- **80.3%** report declining financial health in 2024 (48.6% say “significantly”).
- **30.3%** are considering closing in 2025.
- **40.8%** are paid below acquisition cost on 40%+ of Medicare Part D scripts.
- One-third of independent pharmacies indicated they would not carry drugs in the MFP program.[10]

PBM Reform — Progress and Gaps

On February 3, 2026, President Trump signed the Consolidated Appropriations Act of 2026 (HR 7148), which includes the most significant federal PBM reform in the program's history.[5] The Senate passed it 71–29 on January 30. Key provisions:

- **100% rebate pass-through**: PBMs must remit all rebates, fees, alternative discounts, and other remuneration within 90 days quarterly. Upstream contracts require pass-through within 45 days.[11]
- **PBM compensation delinking**: PBMs acting on behalf of Part D sponsors may receive compensation only in the form of bona fide service fees (BFSFs) — flat-dollar amounts for services genuinely performed at fair market value. No compensation may vary based on drug price, rebates, formulary decisions, or referral volume.[11]
- **Semiannual reporting**: PBMs must provide detailed reports on net drug spending, rebates, spread pricing arrangements, PBM-affiliated pharmacy dispensing, and benefit designs that steer patients to affiliated pharmacies.[5]
- **"Reasonable and relevant" contract standards**: CMS must define and enforce what constitutes reasonable and relevant PBM contract terms for pharmacies by April 2028, with an appeals process for pharmacies to challenge unfair terms.[11]
- **Any-willing-pharmacy**: Beginning 2029, Part D sponsors must allow any pharmacy meeting standard terms to participate.[11]
- **Enforcement**: CMS receives **$188 million** for implementation. Civil monetary penalties for non-compliance. Anti-retaliation protections for pharmacies reporting violations.[11]

The critical gap: Part D remuneration restrictions begin in **2028**. Any-willing-pharmacy standards take effect in **2029**. CMS finalizes contract standards by **April 2028**. The MFP cash flow crisis is happening *now* — January 2026. Pharmacies face a **two-to-three year gap** between the onset of the MFP problem and the arrival of meaningful PBM reform. This is the window where operational solutions matter most.

How RetailMyMeds Addresses the MFP Gap

RetailMyMeds was built by an independent pharmacist — Arica Collins, PharmD, owner of Dyer Drug Co. in Albany, Kentucky — to solve exactly this type of cash flow crisis. The platform addresses the MFP timing gap through three mechanisms:**1. Prescription routing intelligence.** RetailMyMeds identifies prescriptions where the pharmacy loses money — including MFP-impacted drugs where the acquisition-to-reimbursement gap creates an immediate cash drain. These prescriptions are routed to mail-order fulfillment, eliminating the need for the pharmacy to front $722.55 per transaction and wait 21–30+ days for the manufacturer refund.[12]**2. Patient relationship preservation.** The pharmacy coordinates the entire mail-order process for the patient through the RetailMyMeds dashboard. The patient's trusted pharmacist remains their point of contact. Prescriptions are shipped to the patient or back to the referring pharmacy. The patient never has to choose between pharmacies.[12]**3. Cash flow protection at scale.** The dashboard manages multiple patients, multiple prescriptions, multiple refill dates, and multiple mail-order pharmacies from a single interface. Individualized performance trackers show savings in real time. The platform is designed to be managed by a pharmacy technician — not requiring pharmacist time.[12]

Operational Details

- **Price**: **$275/month**
- **ROI**: Typically **30–45 days**
- **Independence**: Not affiliated with a PBM or mail-order pharmacy. Does not retain PHI.[12]
- **Validation**: WVIPA sponsor. Featured on TWIRx (Pharmacy Podcast Network), Bottom Line Pharmacy Podcast (Sykes & Company), and Cardinal Health podcast.
- **Documented results**: Pharmacies report reducing medication orders by tens of thousands of dollars per month.[13]

MFP-impacted prescription routed through RetailMyMeds is one fewer transaction where the pharmacy must float $722.55. For a pharmacy dispensing 15 MFP transactions per week, even routing *half* recovers over **$5,400/week** in working capital.

ACTION ITEMS FOR PHARMACISTS

1. **Audit your MFP exposure now.** Identify which of the 10 Cycle 1 drugs you dispense to Medicare Part D patients. Calculate your weekly transaction count and multiply by $722.55 to quantify your specific cash flow gap. Factor in your wholesaler payment terms (typically biweekly) against the 21–30+ day manufacturer refund timeline.
2. **Evaluate prescription routing immediately.** For every MFP-impacted prescription, determine whether routing to mail-order fulfillment eliminates the cash drain while preserving the patient relationship. RetailMyMeds provides this capability at $275/month with 30–45 day ROI. Contact `retailmymeds.com` to schedule a demo.
3. **Prepare for Cycle 2 (January 2027).** The addition of Ozempic, Wegovy, and Rybelsus — already the most cash-flow-destructive drug category for independents — will dramatically amplify MFP exposure. Pharmacies that build routing infrastructure now will be positioned to absorb the Cycle 2 shock. Those that wait will face the same crisis at larger scale.
4. **Do not wait for PBM reform.** The Consolidated Appropriations Act is real progress, but key provisions do not take effect until 2028–2029. The MFP cash flow crisis is *today*. Operational solutions — not legislative solutions — are what keep your doors open for the next two years.

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ABOUT THIS DOCUMENT

This market brief was prepared using publicly available data from CMS, NCPA, Three Axis Advisors, and federal policy documents. It is intended as a resource for independent pharmacy owners evaluating the impact of the Medicare Maximum Fair Price program on their operations.

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