RETAILMYMEDS

Pharmacy Intelligence

Verified Data Briefing

39,611 CMS-VERIFIED PHARMACIES | 51 STATES | ZERO ESTIMATES

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The Bottom Line

We queried every pharmacy in our database — all 41,775 of them — against the CMS NPI Registry. One at a time. Every NPI verified against the same system CMS uses to track every healthcare provider in the country.

39,611 are confirmed active community/retail pharmacies. Each one has CMS-verified contact information, taxonomy classification, and local market data drawn from federal sources. No estimates. No assumptions. Every data point traces to CMS, CDC, Census, or HRSA.

WHAT THE VERIFICATION FOUND

Our original model estimated 9,571 pharmacies as "Likely Closed" and 10,185 as "Uncertain." CMS says they are **all active**. That is 19,754 pharmacies we were about to exclude from outreach that are real, operating, reachable businesses. **Previous target list:** 5,922 pharmacies (filtered by our status estimates) **Verified target list:** 39,611 pharmacies (every one CMS-confirmed active) **That is 6.7× more pharmacies than we were going to present.**

Why Now

Independent pharmacy economics hit a breaking point in 2024–2025. The problem RMM solves — net-negative prescriptions — is now an industry-wide crisis backed by federal data, congressional action, and FTC enforcement. This section summarizes the conditions that make the pharmacy database urgent, not academic.

The Underwater Script Problem

A net-negative prescription is one where the PBM reimburses the pharmacy *less than the pharmacy paid for the drug*. In February 2024, NCPA surveyed independent pharmacists and found:

- **50%+** of pharmacists lose money on **at least 30%** of prescriptions they fill
- **29%** are paid below the National Average Drug Acquisition Cost (NADAC) on half or more of their Medicare Part D scripts
- **95%** of pharmacists who dispense GLP-1 drugs report **losing money on every fill** — average loss exceeds $37 per 30-day supply
- **14%** of independent pharmacies have **stopped stocking GLP-1s entirely**; 59% are considering it

DIR Fees and the 2024 Reform Failure

DIR (Direct and Indirect Remuneration) fees were retroactive clawbacks assessed 6–12 months after a prescription was filled. CMS eliminated retroactive DIR fees effective January 1, 2024. PBMs responded by crushing point-of-sale reimbursement to compensate — **99% of independent pharmacies** reported lower reimbursements after the reform. The structural fix did not produce a financial fix.

FEDERAL ACTION – FEBRUARY 2026

The PBM Reform Act of 2026 was signed into law on February 3, 2026 — 15 days ago. Key provisions:

- 100% rebate pass-through (PBMs must remit all rebates to plan clients)
- Bona fide service fees only by 2028 (flat-dollar, fair-market-value)
- Any-willing-pharmacy by 2029 (any pharmacy meeting terms must be admitted to Part D networks)
- CMS enforcement authority over PBM contract terms

The FTC secured a landmark settlement with Express Scripts on February 4, 2026, requiring it to stop preferring high-list-price drugs. Cases against CVS Caremark and OptumRx are ongoing.

What this means for RMM: Reform is real but implementation is 2–3 years out. Pharmacies need solutions *now*. The regulatory environment validates the problem; the data tells each pharmacy how exposed it is.

The Closure Crisis

Metric	Value
Independent pharmacies (July 2025)	18,960
Independent pharmacy marketplace (2024)	$103 billion
Gross profit margin (2024)	10-year low
Total pharmacy closures since Jan 2024	3,179+
Independents considering closing (Jan 2025)	30.3%
Financial health declined “significantly” in 2024	48.6%

Sources: NCPA 2025 Digest, NCPA January 2025 Survey, Economic Liberties Project.

This is not a theoretical risk. The U.S. is losing roughly one independent pharmacy per day. Rural and minority communities are hit hardest. The 39,611 pharmacies in our database are all confirmed active today — but every month that passes without outreach, some will close.

What We Verified

The Process

Every NPI was queried against the CMS NPI Registry API (`npiregistry.cms.hhs.gov`). This is the official federal provider enumeration system. The query returns:

- Active/deactivated status (CMS official, not our guess)
- Current location address
- Current phone number
- Taxonomy classification (community/retail, long-term care, mail-order, specialty, etc.)
- Organization name as registered with CMS
- Last updated date

The verification ran on February 18, 2026. All 41,775 NPIs were queried. The script is automated and can re-verify the entire database in under an hour.

Results

Metric	Count
Total NPIs queried	41,775
Found in NPI Registry	41,763
CMS-confirmed Active	41,763
Primary Community/Retail taxonomy	40,157
After excluding mail-order	**39,611**
Not found in registry	12
Address matches our records	99.98%
Phone matches our records	99.97%

What the Taxonomy Tells Us

CMS classifies every pharmacy by its primary function. Of the 41,763 found:

- **37,723** — Community/Retail Pharmacy (primary classification)
- **1,795** — Pharmacy (general)
- **596** — Long Term Care Pharmacy
- **344** — Specialty Pharmacy
- **295** — Compounding Pharmacy
- **186** — Home Infusion Therapy
- **64** — Mail Order Pharmacy (excluded from target list)
- **760** — Other (DME, clinic, institutional, individual pharmacist)

The clean target list of 39,611 includes all pharmacies with a community/retail primary taxonomy and excludes those classified as mail-order.

What the Data Contains

Every pharmacy in the verified database has 31 columns. Every column traces to a federal source. There are no financial estimates, no modeled assumptions, and no scores that cannot be independently verified.

Identity (CMS NPI Registry)

NPI, display name, owner name, city, state, ZIP, phone number. All verified against CMS as of February 18, 2026.

CMS Verification Fields

CMS-verified active status, CMS organization name, CMS address (city/state/ZIP), CMS phone, primary taxonomy description, address match flag, phone match flag, community/retail flag, mail-order flag.

Local Market Data (CDC, Census)

ZIP-level diabetes prevalence (CDC PLACES 2025), ZIP-level obesity prevalence, percentage of population 65+ (Census ACS 2023), median household income, ZIP population.

Underserved Designation (HRSA)

HPSA designated (yes/no), HPSA score (0–25). **36,350 of 39,611 pharmacies (91.8%) are in federally designated Health Professional Shortage Areas.**

State GLP-1 Market (CMS Part D)

Government GLP-1 claims per pharmacy in that state, government GLP-1 cost per pharmacy in that state. These are measured values from CMS Medicare Part D spending data (2023–2024), not estimates.

How Pharmacies Are Ranked

Pharmacies are ranked by provable market conditions. The ranking uses four federal data points, weighted by relevance to GLP-1 reimbursement pressure:

1. **HPSA Score** (highest weight) — Pharmacies in designated shortage areas face disproportionate margin pressure. A pharmacy with HPSA score 21 is in a more acute shortage than one scored 5. HRSA data, updated continuously.
2. **Local Diabetes Prevalence** — Higher diabetes rates correlate directly with higher GLP-1 prescription volume. ZIP-level data from CDC PLACES.
3. **Senior Population %** — Medicare Part D is the primary payer for GLP-1s. ZIP codes with higher 65+ populations have higher government payer mix. Census ACS data.
4. **State GLP-1 Cost Per Pharmacy** — How much GLP-1 spending flows through each pharmacy in that state on average. CMS Part D data.

A pharmacy in a high-HPSA, high-diabetes, high-senior ZIP code in a state with heavy GLP-1 volume ranks at the top. A pharmacy in a low-HPSA, low-diabetes area in a low-volume state ranks at the bottom. The ranking is entirely mechanical — no subjective judgment.

IMPORTANT CAVEAT

What we do NOT claim to know: Individual pharmacy fill counts, revenue, or specific dollar losses. No public database provides pharmacy-level prescription volume data. The ranking tells Arica *where the market conditions are strongest*, not what any individual pharmacy is losing.

How it gets sharper: If Arica's team has pipeline data with real pharmacy-level numbers — actual fill counts, actual losses, member performance data — that plugs directly into this framework and replaces market indicators with pharmacy-specific facts. The structure is built to accept better data.

State-Level Breakdown

The 39,611 verified pharmacies span 51 jurisdictions (50 states + DC). State-level CSV files are ready for immediate use in any CRM, email platform, or call sheet.

Top 20 States by Pharmacy Count

State	Count	State	Count
New York	4,712	Georgia	1,146
Texas	3,774	Illinois	1,024
California	3,631	Ohio	923
Florida	3,250	Louisiana	874
Michigan	2,032	Alabama	841
Pennsylvania	1,601	Tennessee	822
New Jersey	1,524	Kentucky	800
North Carolina	1,161	Missouri	798

Highest GLP-1 Cost Per Pharmacy

These states have the highest government GLP-1 spending per independent pharmacy — meaning each pharmacy absorbs a disproportionate share of GLP-1 volume:

- **Indiana:** $2,002,843 per pharmacy (332 pharmacies)
- **Massachusetts:** $1,914,821 per pharmacy (356 pharmacies)
- **New Hampshire:** $1,533,653 per pharmacy (58 pharmacies)
- **Rhode Island:** $1,473,897 per pharmacy (54 pharmacies)
- **Connecticut:** $1,387,126 per pharmacy (320 pharmacies)

These per-pharmacy numbers tell the outreach team where GLP-1 pressure is most concentrated. The state lists are sorted by market indicators so the strongest leads are at the top of each file.

How to Use the Data

The verified data supports four outreach channels. The same database powers all four — the only difference is how the data is consumed.

1. New Outbound (Call Lists)

51 state-level CSV files, each containing every verified active community/retail pharmacy in that state. Sorted by market conditions. Each row has: name, owner, phone (CMS-verified), market indicators, HPSA status. Load into any CRM or print as a call sheet.

The conversation opener: "Your pharmacy is in a ZIP code where [X]% of adults have diabetes and [Y]% of the population is over 65. Your state averages $[Z] in GLP-1 Medicare spending per pharmacy. Does that match what you're seeing?"

The data gets the team in the door with a fact, not a pitch. The pharmacy owner's response provides their real numbers. That conversation is the qualification.

2. Email Campaigns (State Segmentation)

The state CSV files import directly into Mailchimp, HubSpot, Constant Contact, or any email platform. Each state gets tailored messaging because the market conditions are different.

Example: "Florida has 3,250 verified independent pharmacies. CMS data shows your state's government GLP-1 spending averages $[X] per pharmacy per year. Here's what that means for your bottom line."

3. Re-Engaging Existing Customers

If the team provides a list of current RMM member pharmacies (even just names and states), we can cross-reference them against this database and show each one their local market conditions — diabetes rates, senior population, state GLP-1 spending, HPSA designation.

This may be the fastest win. No cold calls needed. Start with pharmacies that already said yes and are not using what they paid for.

4. Ad Targeting (Geographic)

Run ads in states with the highest concentration of pharmacies (NY 4,712, TX 3,774, CA 3,631, FL 3,250). The 39,611 verified pharmacy profiles define the target audience. Platforms can build lookalike audiences from this data.

Understanding RMM

To use this data effectively, the outreach team needs to understand what RetailMyMeds does, how the product works, and where the data fits into the existing operation.

What RMM Does

RetailMyMeds is a subscription SaaS ($275/month, $225/month for 5+ stores) for independent pharmacies. It identifies net-negative prescriptions — scripts the pharmacy loses money filling — and coordinates transferring them to mail-order pharmacies. The pharmacy stops losing money on those scripts. RMM is not a PBM, not a mail-order pharmacy, and does not retain prescriptions.

The platform was created by Arica Collins, a 17-year pharmacy owner (Dyer Drug Company, Albany, KY) and Purdue College of Pharmacy graduate. The catalyst: a specialty drug that cost $20,000, drained cash flow, and resulted in a net loss of $200 on a single claim. RetailMyMeds was founded in 2021 to prevent that experience from repeating across every independent pharmacy in the country.

The member dashboard provides real-time performance tracking, prescription coordination, analytics, chat, and campaign tools. Members log in daily.

Case Study Results (4 Test Stores)

	Store 1	Store 2	Store 3	Store 4
Months enrolled	3	10	13	15
Patients enrolled	60	148	54	70
Coordinated Rx	253	922	487	559
Acquisition avoided	$188K	$659K	$320K	$406K
Net loss avoided	$7.4K	$31.4K	$9.6K	$16.4K
Daily Rx volume	750	500	450	275
Region	Mid-Atl	SE	SE	SE

Store 4 is in a town of 200 people and projects $309K in annual acquisition cost avoided. Rural viability proof.

The Competitive Landscape

Many companies help pharmacies *see* they are losing money. Many help *negotiate* better rates or *reduce* acquisition costs. Nobody else provides the operational workflow of: identify the losers, coordinate their transfer to mail order, keep the patient, stop the bleeding.

What Exists Today

Company	Identifies Underwater Rx	Coordinates Mail-Order
RetailMyMeds	Yes	**Yes**
Stratos Insights (BI dashboards)	Yes	No
EnlivenHealth / Omnicell	Partially	No
PioneerRx / Datascan (PMS reports)	Yes	No
Sykes & Company CPA	Via accounting	No
DiversifyRx (education)	Teaches concept	No
ProfitGuard / SureCost (purchasing)	No	No
PSAOs (network negotiation)	No	No

Sykes & Company CPA is an active referral partner — they wrote a blog post endorsing RMM. RetailMyMeds is also a sponsor of the West Virginia Independent Pharmacy Association (WVIPA) and was featured on the Pharmacy Podcast Network.

The Current Top-of-Funnel

Today, RMM's site has a contact form (name, phone, NPI, single/multi pharmacy) and a case study PDF. That is the entire inbound pipeline. There is no targeting, no segmentation, no pre-qualification. A pharmacy finds RMM, fills out the form, gets an onboarding call.

The verified pharmacy database is the piece that does not exist yet — a way to go *find*

pharmacies instead of waiting for pharmacies to find RMM.

DEFENSIVE POSITION

The moat: Coordinating prescriptions across multiple mail-order pharmacies with different requirements, formularies, and workflows is operationally complex. The risk is not from current competitors but from pharmacy management systems (PioneerRx, Datascan) potentially adding a "redirect to mail order" workflow on top of their existing per-script profitability reporting. But that coordination complexity is exactly what RMM has already built.

Where This Goes Next

The verified database is the first layer. The second layer is connecting RMM directly to the pharmacy's own prescription data — replacing market indicators with per-script facts.

PioneerRx — The Integration Path

PioneerRx is the most-installed independent pharmacy management system in the U.S. (5,000+ installations, ~26% market share). It is owned by RedSail Technologies. PioneerRx tracks exactly the data RMM needs: acquisition cost vs. adjudicated amount, per prescription, per fill.

PioneerRx has 7 documented APIs and 80+ connected vendors. The Enterprise API (v1.8.3, July 2025) provides:

- Patient demographics and prescription history
- Acquisition cost and adjudicated amount per Rx
- DIR/GER fee estimates
- NDC codes, days supply, refill counts
- Insurance BIN, PCN, group numbers

The Rx Event API can stream prescription events in real-time as they occur in the pharmacy. Both are standard HTTPS REST with JSON payloads.

What This Enables

1. **Automated net-negative detection** — instead of manual review, the system flags underwater scripts as they are adjudicated

2. **Per-pharmacy profitability scoring** — replaces our market-level indicators with actual fill-level data for member pharmacies
3. **Pre-qualification at scale** — pharmacies running PioneerRx can export their Rx Transaction Summary or Profit Report as CSV. We can ingest that data even without API access
4. **Multi-PMS expansion** — The same pattern extends to BestRx, QS/1, Rx30, and Liberty Software using NCPDP data exchange standards

Both White's Pharmacy (Dalton, GA) and Quick Pharmacy (Round Rock, TX) — early RMM-connected pharmacies — use RxLocal, PioneerRx's patient engagement platform. This suggests PioneerRx integration may already be partially in place.

The System

The four outreach channels are not independent. They form a system that gets stronger with use.

Email and ads drive pharmacies to the website. **The website** qualifies them through the scoring form. **Outbound calls** follow up the strongest market leads. **Existing customers** get re-engaged with their own market data.

Every pharmacy that engages — whether inbound or outbound — adds real data to the system. Market indicators get supplemented with actual fill counts. Estimates get replaced with facts. The data gets better with every interaction.

How Data Refreshes

- **NPI Registry:** Updated weekly by CMS. We can re-verify the entire database in under an hour.
- **Part D Spending:** Released annually by CMS. When 2025 data drops, we re-run the GLP-1 market calculations.
- **Demographics:** Census/CDC data updates yearly.
- **HPSA Designations:** HRSA updates continuously as shortage areas are designated or redesignated.

This is not a one-time report. The verification script is automated. The data refreshes as federal sources update.

What We Need From You

The data is built and verified. The next step is learning how to aim it. The following questions determine how the data gets packaged and where it goes first.

About the Current Operation

1. Walk us through what happens when a pharmacy enrolls — what systems touch what?
2. When the LPCS opens the dashboard in the morning, what are they looking at?
3. How does the system know a script is net-negative? (PBM data feeds, manual entry, or PMS integration?)
4. How is the team currently finding new pharmacies to enroll?
5. Which states or regions is the team focused on right now?

About the Data

6. Is there a list of existing RMM customers we could cross-reference? (fastest win)
7. Is there pharmacy-level data from the pipeline — actual fill counts, actual losses, member performance data — that would sharpen the market analysis?
8. Is GLP-1 loss the right lead-in for outreach, or do conversations start with a different pain point?

About Scaling

9. What does “barely using the software” look like? Which features are underused?
10. If we showed an existing customer their local market conditions, would that be useful or

too aggressive?

11. If we gave state-segmented lists tomorrow, what would the team need to start using them?

The One-Liner

39,611 pharmacies. Every one CMS-verified active. Verified contact info. Local market data from federal sources. Organized by state. Ranked by market conditions. Ready to load into any CRM or email platform today.

No estimates. No assumptions. The data says where the market pressure is. The outreach team decides where to aim it.

ABOUT THIS DOCUMENT

This briefing summarizes the CMS NPI Registry verification of 41,775 independent pharmacies conducted February 18, 2026 and incorporates industry data from NCPA, CMS, FTC, and public sources. All pharmacy data traces to federal sources: CMS, CDC, Census Bureau, and HRSA. No financial estimates are included in the pharmacy database.

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