



Policy Document

ASCP and NCPA's Recommendations to Manufacturers to Effectuate Medicare's Maximum Fair Price (MFP) for Pharmacies with Material Cash Flow Concerns

The pharmacist members of the American Society of Consultant Pharmacists (ASCP)¹ and the National Community Pharmacists Association (NCPA)² are committed to providing the highest quality pharmacy care to our patients, including Medicare beneficiaries. To that end, we provide the following policy recommendations to manufacturers of the first 10 selected drugs covered under Medicare Part D to effectuate maximum fair price (MFP) for pharmacies with material cash flow concerns.

In CMS' recent [Draft Guidance on the Medicare Drug Price Negotiation Program](#), CMS stated that the following types of pharmacies can self-identify when they enroll in the Medicare Transaction Facilitator Data Module (MTD-DM) as having cash flow concerns:

For example, CMS expects dispensing entities of the types that have raised material concerns about cashflow related to the effectuation of MFP—**such as sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, long-term care pharmacies, 340B covered entities with in-house pharmacies, and Indian Health Service, Tribal, and Urban Indian (I/T/U) pharmacies**—may self-identify through this process. [ASCP, NCPA emphasis]

ASCP and NCPA represent “sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, [and] long-term care pharmacies.” These pharmacies

¹ASCP is the only international professional society devoted to optimal medication management and improved health outcomes for older adults. ASCP represents 5,000 pharmacists and 1,800 long term care pharmacy members that manage medications and improve the quality of life of older adult and medically complex patients and others living in various settings, including sub-acute and long-term care facilities (LTCF), skilled nursing facilities (SNFs), assisted living communities, psychiatric hospitals, hospice programs, correctional facilities, home and community-based care.

²NCPA represents America's community pharmacists, including 18,900 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members employ 205,000 individuals and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers.

serve a disproportionate number of Medicare patients, and therefore would be more significantly impacted by the Medicare Drug Price Negotiation Program (MDPNP).

MDPNP ADDS FINANCIAL STRESS TO PHARMACY PROVIDERS, IMPACTING PATIENT CARE

ASCP and NCPA stress to manufacturers that financial challenges to pharmacies' acquisition and inventory carrying costs for selected drugs under the MDPNP will be only exacerbated as the program is implemented in future years. That is because up to 15 additional drugs will be covered under the program in 2027 as well as 2028 and beyond.

A recent analysis by NCPA reveals that the MDPNP, as currently structured, imposes severe financial strains on pharmacies. The analysis found that pharmacies will experience payment delays of at least seven additional days for negotiated drugs, surpassing current Medicare Part D prompt pay requirements, which require payment within 14 days of adjudication. Additionally, pharmacies under the MDPNP face significant cash flow shortfalls, with independent pharmacies potentially losing nearly \$11,000 in weekly cash flow (i.e., the average pharmacy would need an additional \$11,000 on its credit limit), and an average annual revenue loss of roughly \$43,000, equivalent to approximately 5 percent of an average independent pharmacy's gross profit (or alternatively, a certified pharmacy technician's annual wages), which significantly impacts pharmacies financial viability.

Furthermore, in a recent NCPA survey of independent pharmacy owners/managers, over 93 percent of respondents said they have already decided to not stock the first 10 selected drugs covered under Part D in the MDPNP or are considering not stocking them, as they cannot afford to stock these drugs at a guaranteed loss.

Additionally, the MDPNP will have a disproportionate effect on long-term care pharmacies with more than half predicting challenges dispensing critical medication. A study of long-term care pharmacies found that:

- 60 percent would be forced to close pharmacy locations,
- 91 percent would be forced to lay off pharmacy staff,
- 85 percent would be forced to limit essential services,
- 82 percent would be forced to shift costs to LTC customers, and
- 56 percent would be challenged to dispense certain medications.³

These financial disruptions are occurring at a time when pharmacies, especially community pharmacies, are already closing at an alarming rate, with over 7,000 closures in less than a decade. The consequences of these closures will be devastating for patients—especially seniors in rural communities—who depend on local pharmacies for their essential medications and healthcare services.

¹ See [New SCPC Member Survey Shows More than Half of America's LTC Pharmacies May Close Locations Without Congressional Action](#). Senior Care Pharmacy Coalition. March 12, 2025.

Additionally, Avalere released a [study](#) showing the impact of the MDPNP on independent pharmacies and beneficiaries alike. The study found that 34 percent of prescriptions (or 74 million prescriptions) slated for the MDPNP for 2026 or 2027 are currently filled at an independent or franchise pharmacy. Avalere defined franchise pharmacies as “independently owned pharmacies that operate under a franchisor’s branding and business model within a specific region.” The report found that 30 percent of Medicare Part D beneficiaries (or 12 million beneficiaries) received at least one of these prescriptions at an independent or franchise pharmacy. The study concluded that it is vital to understand impacts on dispensers and beneficiaries as manufacturers plan to submit effectuation plans under the MDPNP by September 2025.

While pharmacies across the board are concerned about the impacts and implementation of the MDPNP, the new negotiation program also requires the establishment of a new direct financial relationship that previously did not exist between pharmacies and manufacturers to make these refunds. As such, ASCP and NCPA believe it is necessary to establish clear expectations of pharmacies’ views on this new relationship. This new transactional relationship could allow for better transparency between pharmacies and manufacturers with respect to non-Medicare Part D claims, such as 340B, Medicare Part A for skilled nursing homes, and others.

RECOMMENDATIONS

Therefore, we submit the following recommendations that manufacturers should:

- Pay the pharmacy the SDRA refund amount as WAC minus MFP for selected drugs;
- Pay pharmacies within 14 days of the Part D plan adjudicating the claim;
- Prefund MFP refund payments based on historic claims data from the pharmacy;
- To allow for consistency in the process, effectuate the Standard Default Refund Amount (SDRA) payment via the Medicare Transaction Facilitator Payment Module (MTF-PM);
- Work with pharmacies prior to the submission to CMS of manufacturers’ MFP effectuation plans, due Sept. 1, 2025, as pharmacies need to understand manufacturer payment terms to make decisions on PBM/plan contracts for 2026;
- Consider various factors that would qualify a pharmacy as having MFP-related material cashflow concerns as stipulated below.
- In addition to any dispensing fees paid to pharmacies by the Part D plans, establish a reasonable “professional fee” **and** “administrative fee” for pharmacies dispensing selected drugs;
- Refrain from making amendments to their effectuation plans until the start of a new calendar year, and only submit plan changes to CMS through the annualized process on Sept. 1 for the forthcoming year, unless necessary to facilitate effective pharmacy operations and/or implementation;
- Provide a 45-day notice to pharmacies before conducting an audit;
- Include dispute resolution provisions as stipulated below.

Please see below for greater clarification regarding these recommendations.

Manufacturers should adopt SDRA as WAC minus MFP

ASCP and NCPA urge manufacturers to adopt the Standard Default Refund Amount (SDRA) as WAC minus , as the “the claim-level data elements that the Primary Manufacturer will receive from the MTF-DM will include the SDRA that will reflect the difference between the WAC per unit and the MFP per unit of the selected drug on the date of service, then multiplied by the quantity dispensed, as described in section 40.4.1 of [CMS’] final guidance.”⁴ We urge that manufacturers use WAC to calculate the MFP refund amount for pharmacies with material cashflow concerns; as an equation: $WAC - \text{negotiated MFP} = \text{MFP refund}$.

However, the voluntary nature of the use of WAC as the SDRA is concerning for dispensers, considering that pharmacies need to be reasonably compensated for these MFP drugs. We recommend that manufacturers use WAC as the standardized metric, and that the WAC price should reflect the date of claim adjudication, not the date the refund was processed. We advise manufacturers to provide the MFP using the SDRA and that dispensers have sufficient protections for reasonable and fair reimbursement.

Timely frequency of transmission of claim-level payment data to the MTF-DM, and payment within 14 days of adjudicating the claim

As it stands now, pharmacies will be waiting a minimum of 21 days, and likely longer, for the manufacturer refund payments. A timeframe of at least 21 days is unsustainable, as pharmacies need to pay their wholesalers between every seven and 14 days (with some even paying daily). If pharmacies do not pay in a timely fashion, they lose significant dollars in prompt pay discounts, which in turn significantly impacts pharmacies’ operating margins. Manufacturers should therefore pay pharmacies swiftly, defined as within 14 days of the Part D plan adjudicating the claim. Additionally, to facilitate timely payment, we recommend daily transfers of data to the manufacturer from the MTF-DM.

Manufacturers should prefund MFP refund payments to pharmacies

We propose that manufacturers should use CMS’ proposed “Option 2” in its recent [Draft Guidance on the Medicare Drug Price Negotiation Program](#), specifically that “Primary Manufacturers ... establish prefunded MFP refund payment accounts directly with dispensing entities.” Manufacturers should pay a prefund to dispensing entities or their PSAOs, with material cashflow concerns at least a month in advance. To calculate that refund, pharmacies

⁴ See [Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027](#). CMS 2 Oct 2024; See also: “The claim-level data elements that the Primary Manufacturer will receive from the MTF DM will include the SDRA that will reflect the difference between the WAC per unit and the MFP per unit of the selected drug on the date of service, then multiplied by the quantity dispensed, as described in section 40.4.1 of this draft guidance.” [Draft Guidance on the Medicare Drug Price Negotiation Program](#). CMS 12 May 2025.

should proactively work with manufacturers so that pharmacies can share data allowing them to calculate total claims for each NDC number they have per month, and prefund the dispensers beginning a month prior to Jan. 1, 2026. For any over-amount that is prefunded, pharmacies should receive a credit towards future prefunds, and manufacturers should pay pharmacies quickly for any under-amount that is prefunded.

Manufacturers need to use the MTF-PM

Manufacturers can voluntarily effectuate the MFP via the Medicare Transaction Facilitator Payment Module (MTF-PM) or another method of the manufacturer's choosing. This variability creates greater uncertainty and administrative burden on independent and long-term care pharmacies. The use of the MTF-PM will benefit manufacturers and pharmacies while decreasing variability and uncertainty among effectuation plans. We are aware that effectuation plans are due to CMS by Sept. 1, but we encourage manufacturers to **publicly** identify their intention to use the MTF-PM as early as possible.

Manufacturers should consider the following factors in determining material cashflow concerns

As stated above, ASCP and NCPA represent "sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, [and] long-term care pharmacies." ASCP and NCPA ask manufacturers to ensure pharmacies would qualify for having material cashflow concerns if they have one or more of the following characteristics:

- High percentage of total revenue from prescription sales;
- High percentage of total prescription revenue from Medicare Part D;
- High percentage of total prescription revenue from Medicaid;
- High percentage of total prescription revenue from MFP drugs; or
- If the pharmacy is serving a Medically Underserved Area.

Manufacturers should provide early access to cashflow mitigation mechanisms

Given the nature of the pharmaceutical supply chain and the need for many pharmacies to stock medications for immediate dispensing, we believe manufacturers should initiate their material cashflow mitigation plans sooner than Sept. 1, and ideally upon pharmacy enrollment in the MTF, of the year before the negotiated MFP takes effect, as many products that will be dispensed at the MFP beginning in January will be purchased by pharmacies in the fourth quarter of the preceding year; that is, October-December 2025. This policy would ensure an adequate stock of a manufacturer's product for immediate dispensing.

Manufacturers need to establish a reasonable “professional fee” and “administrative fee,” and pay them through the MTF-PM

The current models that ensure access to needed medications for individuals covered by Medicare Part D have been dependent on revenue from dispensing branded medications, especially for long-term care pharmacies (LTCPs).

We recommend that manufacturers, as part of the effectuation plans, provide a **professional fee** as part of the MFP refund provided to the pharmacy types highlighted above. We believe this professional fee should be a percentage of the MFP refund, instead of a flat fee for each dispensed prescription. In cases of very expensive medications with a large difference between WAC and MFP, it would be reasonable for the manufacturer to cap this handling fee at a specific dollar amount or restrict it to the set number of dispensed prescriptions (i.e., the first 100 prescriptions for the product per month). The professional fee would assist in making pharmacies whole from any additional concessions incurred by the pharmacies from third parties such as PBMs and wholesalers.

The professional fee would help cover the pharmacy’s operating costs for licensed staff to ensure that the proper drug is dispensed as well as clinical recommendations to prescribers regarding medication therapy management and therapeutic interchange. A percentage fee could be negotiated based on volume as well as access improvement. In the draft guidance, CMS states that “CMS expects and encourages interested parties to work together as necessary to develop mechanisms to assure timely effectuation of MFP refund payments consistent with statute, CMS’ guidance, and all other applicable laws, regulations, and guidance, including without limitation the Anti-Kickback Statute.” ASCP and NCPA stress that any such professional fee should be compliant with all applicable laws, including but not limited to the Anti-Kickback Statute and Stark Laws.

Additionally, standing up reconciliation procedures and interoperability with data and payment systems has been left to pharmacy to carry. Manufacturers should pay pharmacies an **administrative fee** to cover pharmacy time involved in administering the program and reconciliation of payments through the MTFs. This fee should be a flat rate per prescription and could be adjusted and incentivized for use of the MTF-PM.

Amendments to effectuation plans

While CMS allows 90-days for updates for effectuation plans to be in place, we strongly encourage manufacturers to refrain from making amendments to their effectuation plans until the start of a new calendar year. Changes to the effectuation plans should be submitted through the annualized process of submitting plans to CMS on Sept. 1 for the forthcoming year, unless the amendments are necessary to facilitate effective pharmacy operations and/or patient access.

Auditing of transactions

We believe it is fair and reasonable that manufacturers may audit transactions. We believe manufacturers should provide a 45-day notice to pharmacies before conducting an audit and that all audits be closed promptly, within four weeks of initiation. Additionally, we believe manufacturers should limit the audit to MFP-eligible claims filled within the last six months. Further, we believe audits should be limited to two per calendar year. As the contracts are two-party contracts between manufacturers and pharmacies, audits should not involve third parties contracted with the pharmacy, such as PBMs, in part to prevent anticompetitive practices. Finally, any concerns identified during the audit should trigger a pre-identified dispute resolution process between the manufacturer and pharmacy.

Dispute resolution

As disputes will arise, we recommend that both parties submit any disputes using the specific X12 835 claim number. To facilitate continued pharmacy operation and access to medications by patients, we recommend that manufacturers do not interrupt payments to pharmacies during a dispute and that all claims be paid promptly. The credit/debt ledger exists as a mechanism for manufacturers to recoup any overpayments or incorrect payments. To ensure disputes are rapidly addressed, we believe manufacturers and pharmacies should agree to binding arbitration if they are unable or unwilling to resolve the dispute within 60 days on the initial complaint. Finally, we recommend that both parties identify a singular point of contact for all disputes.

Conclusion

In sum, ASCP and NCPA greatly appreciate manufacturers taking our members' concerns related to material cashflow concerns into account when creating their effectuation plans.