What's Happening to Your Brand-Name Drug Reimbursement (and Your Cash Flow)

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1. What is the MFP program, in plain English?

Starting in 2026, for a small but growing list of **high-cost Medicare drugs**, the government will set a **Maximum Fair Price (MFP)**.

- Medicare wants **patients and plans** to pay closer to this lower MFP, not today's higher prices.
- But you, the pharmacy, still have to **buy the drug, bill the plan, and get paid**.
- The twist is: your **total reimbursement** for these drugs will now come in **multiple pieces**, from **multiple payers**, on **different days**.

The idea is:

You shouldn't be left holding the bag.
Your net reimbursement (plan + manufacturer payment) is *supposed* to at least cover your cost and keep you at or near MFP.

The problem is **timing and complexity**, and that's where your cash flow comes under pressure.

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2. How "multi-part" drug reimbursement works under MFP

For MFP-eligible drugs, your money may come in **up to three stages**:

1. **You buy the drug.**
    - You purchase from your wholesaler just like today.
    - Price is usually based on WAC with your contract discounts and fees.
    - At this point, **cash is going out**.
2. **You bill the Part D plan / PBM.**
    - You submit the claim when you dispense.
    - The PBM pays you whatever its contract says (ingredient + fee).
    - This is **cash in**, but it may **not** be enough to cover your full acquisition cost.
3. **You get a separate payment from the manufacturer.**
    - For MFP drugs, manufacturers are required to **"make the MFP available"** at the pharmacy level.
    - They do this by sending you a **refund / rebate** for each eligible claim to bring your **net** up to the MFP level (at least in theory).
    - This is the **third piece of the puzzle** – and it often arrives **weeks later** than your PBM payment.

So for certain brand-name drugs, your "reimbursement" is no longer **one payment from the PBM**. It's **PBM money now + manufacturer money later**.

3. Two ways manufacturers can handle MFP – and why it matters

Manufacturers get to choose how they "effectuate" the MFP for pharmacies. In practice, you'll see one of two models:

A. Prospective discount (best for you)

In this model, the manufacturer lowers the price **up front**:

- They give discounts/chargebacks to your **wholesaler** or to you directly.
- Your **acquisition cost** is already at or below MFP when you buy the drug.
- You still bill the PBM as usual, but you **don't depend on a later manufacturer refund** to get whole.

This is similar to:

- Traditional chargebacks
- 340B-style pricing
- Some existing brand manufacturer discount programs

Cash-flow impact:

- You pay less up front.
- You get your usual PBM payment.
- No new delay, less risk.
- This is what you'd *like* to see.

B. Retrospective refund (the risky one)

Here, nothing changes at the front end:

- You still **buy at normal wholesale prices**.
- You still **bill the PBM** and get whatever they pay.
- Then, **later**, the manufacturer sends you a **refund** for each MFP-eligible claim.

The refund is meant to cover:

(Your acquisition cost) – (MFP level)
or
WAC – MFP (a standardized amount), depending on the manufacturer plan.

Cash-flow impact:

- You **front the full inventory cost**.
- You **wait** for manufacturer money.
- You carry a **new receivable** from each manufacturer on each MFP claim.
- If payments are slow or mismatched, you're stuck chasing them.

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4. Why your cash flow is at risk

Let's walk through a simple timeline for a retrospective refund:

1. **Day 0–2:**
    - You buy the drug, dispense it, bill the PBM.
    - Cash goes out to the wholesaler; PBM money comes in on the normal cycle (often 7–14 days).

2. **Day 0–7:**
    - The plan sends claim data to Medicare.
    - A CMS contractor validates that the claim is MFP-eligible and sends information to the manufacturer.
3. **Up to Day ~21 (or more):**
    - The manufacturer has a defined window (e.g., up to 14 days after they receive the data) to send you the refund.
    - Realistically, that means you might wait around **three weeks or more** from the date of dispense to see that money.

So now your working capital looks like this:

- Inventory dollars tied up in **high-cost brands**.
- PBM payment that may **not fully cover acquisition cost**.
- A delayed **manufacturer receivable** that you **can't control**.

For an independent pharmacy with thin margins and limited credit:

- A handful of MFP-eligible, high-dollar scripts can create a **serious cash-flow squeeze**.
- If manufacturer payments are late or disputed, your **risk is real**, even though the program is meant to protect you on paper.

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5. Other practical risks you should know

Even beyond timing:

1. **Standardized refunds may not match your real cost.**
    - If the manufacturer uses a generic formula like **WAC – MFP**, but your net cost is higher than WAC minus discounts/fees, you **might not be fully made whole.**
2. **PBM payments are not guaranteed to be "MFP + fee."**
    - There is nothing automatic in your PBM contracts that says: "We will always pay at least MFP plus a professional fee."
    - If plans squeeze reimbursement and manufacturers only cover up to MFP, your margin can be thinner than today.
3. **Admin and reconciliation burden.**
    - You'll have **new remittances** (EFT or checks) from manufacturers or the CMS payment hub.
    - Your software and staff will need to **match these payments to specific claims**.
    - Chargebacks, reversals, and adjusted claims will all complicate the ledger.

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6. What independent pharmacies should do about it

You can't stop the program, but you *can* prepare and protect yourself. Here's a practical checklist.

1. Get informed about which drugs are affected

- Identify the **MFP drugs** you dispense or are likely to dispense.
- Flag them in your system (or ask your software vendor to do so) so staff knows:
  "This one is **MFP** → multi-part reimbursement → extra cash-flow attention."

2. Talk to your wholesaler(s)

Ask direct questions:

- "For these MFP drugs, will you be handling any **up-front discounts or chargebacks**, or is this going to be purely **retrospective manufacturer refunds**?"
- "Can you provide a **summary report** of my MFP drug purchases (qty, acquisition cost) each month?"

Goal:
If at all possible, **push toward prospective discounts** on high-cost drugs so you are not forced to finance the gap.

3. Talk to your PSAO and PBM contacts

Key questions:

- "How will our **reimbursement rates** for MFP drugs be set?"
- "Will contracts ensure **at least MFP + reasonable dispensing fee**?"

- "Will you provide **clear remits** showing when a claim is MFP-eligible and what portion was assumed to be covered by manufacturer refund?"

Goal:
Avoid being in a position where:

You're effectively **selling at a loss** and hoping the manufacturer makes you whole later.

4. Prepare your accounting and software

- Work with your **software vendor** to:
    - Tag MFP claims.
    - Record manufacturer refunds as **claim-level payments**, not generic "other income."
    - Generate **aging reports** for "MFP manufacturer receivables."
- Work with your **accountant/bookkeeper** to:
    - Treat MFP refunds as part of **cost of goods/reimbursement**, not forgotten extras.
    - Monitor **days in receivables** specifically for MFP accounts.

Goal:
Make MFP cash-flow visible so you can respond quickly if something is off.

5. Build a small working-capital buffer

As much as possible:

- Talk to your bank or credit union about a **line of credit** sized to your expected MFP exposure.

- Estimate:
    - How many MFP scripts per month?
    - Average acquisition cost per script?
    - How many days until manufacturer money arrives?
- Use that to model, with your accountant, a **worst-case funding gap**.

For example:

- 30 MFP scripts/month × $2,000 cost each = $60,000 of inventory.
- If manufacturer money is consistently **21–30 days behind**, you need to be sure you can carry that without starving the rest of your business.

6. Watch your metrics like a hawk

Once the program starts:

- Track for each MFP drug:
    - **Average cost**
    - **Average PBM payment**
    - **Average manufacturer refund**
    - **Total margin per script**
    - **Average days to full payment** (PBM + manufacturer)

If you see:

- Margins collapsing, or
- Manufacturer payments consistently late or short

→ Raise it with your PSAO, state association, and legislators. These are exactly the kinds of problems the program *claims* it doesn't want to cause.

7. Use your voice

Independent pharmacies are the **canary in the coal mine** for how this will work in the real world.

- Share data (de-identified) with your **state pharmacy association**.
- Support efforts that push for:
  - **Fair PBM reimbursement** on MFP drugs.
  - **Faster manufacturer payments** and **clear reporting**.
  - Options for **prospective discounts** instead of purely retrospective refunds.

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7. Bringing it all together

Here's the essence you can share with your team:

For some high-cost Medicare drugs, we'll now be paid in *pieces*:

- We still pay the wholesaler.
- We still get money from the PBM.
- Then, later, we get a **separate payment from the manufacturer**.

That delay and complexity can hurt our cash flow.
Our job is to **know which drugs are affected**, **track the**

money, and **push for up-front discounts and fair contracts** so we’re not financing the system on our backs.