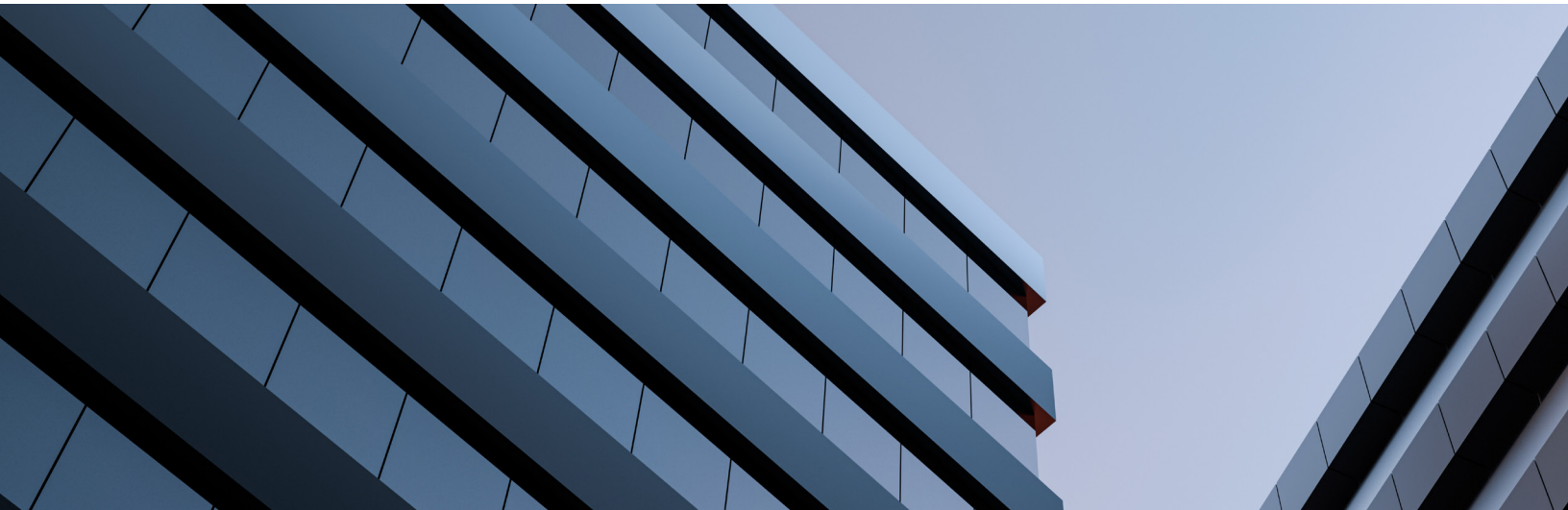
ATI Advisory

WHITEPAPER:

Economic Impact of Medicare Part D Negotiated Drug Prices on Long-Term Care Pharmacy Economics

Produced for the Senior Care Pharmacy Coalition



Executive Summary

In 2022, Congress passed the Inflation Reduction Act (IRA), which authorized the Secretary of Health and Human Services (Secretary) to negotiate prices for certain drugs and biological products under Medicare Parts B and D, with the goal to lower prescription drug costs for Medicare beneficiaries. Acting through the Centers for Medicare and Medicaid Services (CMS), each year the Secretary selects single-source, high-spend brand name drugs without generic or biosimilar competition for negotiation (drugs with over $200 million of Medicare spending), with additional statutory criteria.[1] CMS' negotiated prices (referred to as "Maximum Fair Prices" [MFPs]) take effect in 2026 for 10 Part D drugs selected for price negotiation, followed by an additional 15 Part D drugs in 2027 (Appendix 4).[1,2] This is known as the Medicare Drug Price Negotiation Program (DPNP).

This study aims to understand the effects of the IRA and specifically, the DPNP, on LTC pharmacy economics.

CMS establishes a drug's MFP based on myriad factors and applies the MFP to a drug's ingredient costs. Payment to a pharmacy cannot exceed MFP plus a dispensing fee. In this way, MFP places an upper limit on the base price for beneficiary cost-sharing at the point of sale[3], thereby reducing overall beneficiary spending. Due to these caps, however, long-term care (LTC) pharmacies will be subject to compensation below current pre-IRA reimbursement levels (Appendix 1). Given the potential change in reimbursement, this study aims to understand the effects of the IRA and specifically, the DPNP, on LTC pharmacy economics.

APPROACH AND SUMMARY OF FINDINGS

Supported by the Senior Care Pharmacy Coalition (SCPC), ATI Advisory (ATI) analyzed the financial impact of the IRA DPNP on LTC pharmacies. Analyses leveraged data collected from SCPC-reporting pharmacies and pharmacy services administrative organizations (PSAOs) contracting with LTC pharmacies. ATI performed a *financial impact analysis*, evaluating the effect of negotiated prices under the IRA on Medicare Part D reimbursement and modeling LTC pharmacy revenues and operating margins. ATI also assessed resultant losses (*shortfall analysis*) from the IRA and potential market scenarios to understand additional reimbursement needed by LTC pharmacies to offset the Medicare Part D

1 Fact Sheet: Medicare Drug Price Negotiation Program June 2023

2 Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026

3 Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026. For purposes of the DPNP, CMS defines "point of sale," as the moment a Part D beneficiary receives a prescription drug at the pharmacy, mail-order service, or other dispensing entity, during which price concessions and price reductions are applied. Part D beneficiaries in LTC facilities do not receive prescription drugs directly from LTC pharmacies, but instead from facility staff who are responsible for distributing the drugs to beneficiaries consistent with facility requirements. In addition, while many residents in LTC facilities are dually eligible for Medicare and Medicaid and have minimal or no out-of-pocket costs, premiums and cost sharing can vary depending on the facility type and the payer mix of the resident.

reimbursement losses they uniquely will incur due to the DPNP in 2026 and 2027, under varying assumptions. In all cases, LTC pharmacies are likely to experience declines in revenue and operating margins (see Figure 1).

Figure 1. Summary of Key Study Findings

Financial Impact Analysis	
▼ **57%**	For 2026 alone, reimbursement at IRA negotiated prices would **reduce Part D revenues from negotiated drugs by 57 percent**
▼ **33%**	For 2027 alone, reimbursement negotiated prices would reduce **Part D revenues from negotiated drugs by 33 percent**
▼ **35%**	The average LTC pharmacy in 2027 is **likely to see its operating margin decline by 35 percent due to the financial effects of the IRA DPNP**
Shortfall Analysis	
▼ Up to **$54.09**	Estimated total **shortfalls ranged from a minimum of $42.85 to a maximum of $54.09** per Part D claim for a negotiated drug
▼ Up to **$31.67**	After accounting for manufacturer true-up to negotiated prices (i.e., MFPs), estimated remaining **shortfalls ranged from a minimum of $20.43 to $31.67** per dispensed script for a negotiated Part D claim for a negotiated drug

Issue Background

The Inflation Reduction Act (IRA) of 2022 aims to lower prescription drug costs for Medicare beneficiaries by allowing the Secretary of Health and Human Services (Secretary) to negotiate prices for certain drugs and biological products under Medicare Parts B and D. Through the Medicare Drug Price Negotiation Program (DPNP), the IRA establishes reimbursement, or the maximum amount paid to pharmacies for selected dispensed drugs, for drug ingredient costs for select single-source, high-spend brand name drugs.[1] The reimbursement amount is a price negotiated between the Centers for Medicare and Medicaid Services (CMS) and a drug's manufacturer, and is known as Maximum Fair Price (MFP).[4] Under the DPNP, 10 Part D drugs will be selected for MFP price negotiation starting in 2026, 15 Part D drugs in 2027, another 15 Part D and Part B drugs effective in 2028, and another 20 Part D and Part B drugs every year afterward (Appendix 4).[1]

WAC is the benchmark that determines ingredient cost reimbursement to pharmacies for all branded drugs.

PHARMACY REIMBURSEMENT BASICS

Pharmacy reimbursement is intended to cover a dispensed drug's ingredient cost plus a dispensing fee and is greatly influenced by manufacturers and wholesalers through pharmacy acquisition costs. For ingredient cost reimbursement, pharmacy acquisition costs are:

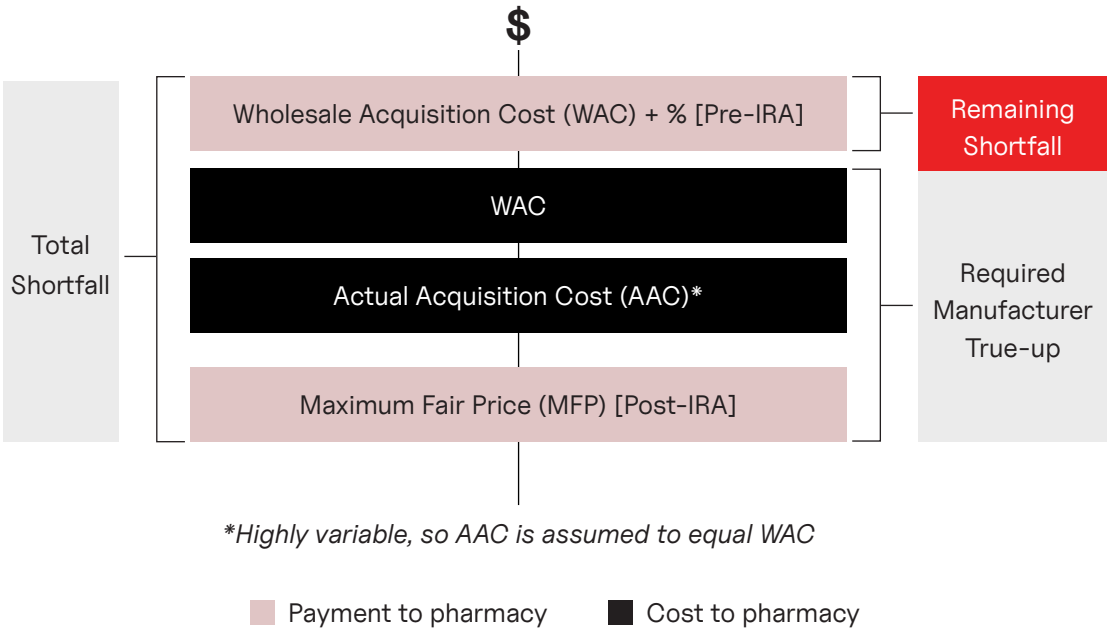
- **The Wholesale Acquisition Cost (WAC)** is the prescription drug list price manufacturers set for wholesalers, absent any discounts (i.e., a manufacturer's initial pricing, or list price).
- **The Actual Acquisition Cost (AAC)** is the net price at which pharmacies purchase a drug and is based on a percentage discount from WAC. Manufacturers and wholesalers determine whether LTC pharmacies acquire drugs at WAC or WAC minus discounts.

Currently, WAC is the benchmark that determines ingredient cost reimbursement to pharmacies for all branded drugs, with pharmacy benefit managers (PBMs) / prescription drug plans (PDPs) paying pharmacies at some percentage over WAC. For branded drugs that will be price negotiated under the IRA, MFP negotiated prices are lower than WAC. When MFP is less than what pharmacies pay for a drug, CMS guidance requires manufacturers to pay the difference between pharmacies' AAC and the negotiated MFP. CMS encourages manufacturers to assume AACs equal WAC, as AACs are highly variable and difficult to calculate, meaning manufacturers pay pharmacies the difference between MFP and WAC (see Figure 2 for the distinct components of reimbursement). LTC pharmacies rely on the difference between AAC and reimbursement, with this difference subsidizing losses on generic drugs and dispensing fees.

4 42 U.S.C. § 1320f.

In contrast, generic drugs are generally reimbursed at some percentage below the average price at which wholesalers sell drugs to physicians, pharmacies, and other purchasers (i.e., the Average Wholesale Price [AWP]). About 90% of dispenses in the LTC pharmacy setting are for generic drugs, and LTC pharmacies generally break even on generic drug dispenses.

Figure 2. Visualization of the Various Pharmacy Reimbursement Components for Negotiated Drugs



The analysis detailed in this paper aims to quantify the economic impact of IRA/DPNP on LTC pharmacies, in the context of current reimbursement methods and rates, and potential approaches PBMs, PDPs, Manufacturers, and Wholesalers may take in response to the new law. Specifically, ATI estimates the effects of reimbursement at MFP relative to current reimbursement rates and AACs for drugs selected for Medicare negotiation.

Study Findings

ATI Advisory performed a 2-part analysis to quantify economic impacts of the IRA DPNP on LTC pharmacies. This included a financial impact analysis, quantifying revenue and costs associated with DPNP. This also included the shortfall analysis, quantifying the likely per script financial shortfall LTC pharmacies would need to offset the Medicare Part D reimbursement losses LTC pharmacies will incur in 2026 and 2027 due to the DPNP.

FINANCIAL IMPACT ANALYSIS

ATI collected data from pharmacy services administrative organizations (PSAOs) for drugs with negotiated prices going into effect in 2026 and 2027. These PSAOs represent a total of 2,481 LTC pharmacies, which include both closed-door, institutional LTC pharmacies, and LTC pharmacies with mixed services. Drugs negotiated in 2026 and 2027 included 71 and 66 unique National Drug Code 11s (NDC-11s), respectively.

PSAO-submitted data showed that drugs with MFPs going into effect in 2026 accounted for $2.77 billion in revenue to LTC pharmacies, of which 71.9 percent was attributable to Part D drugs on average. Drugs with MFPs going into effect in 2027 accounted for less revenue overall at $1.52 billion (see Figure 3).

Figure 3. Study PSAOs Negotiated Drug-associated Revenue

	2026 drugs	2027 drugs
Unique NDC-11s reported for negotiated drugs	71	66
Total revenue from negotiated drugs, by payer		
All Payers	$2.77B	$1.52B
Part D only	$2.27B	$1.25B

Most LTC pharmacy revenue comes from ingredient cost reimbursement rather than dispensing fees. For SCPC reporting pharmacies, 91 percent of total reporting pharmacy revenue for all dispensed drugs was from ingredient costs and the remaining nine percent was attributable to dispensing fees. This proportional revenue makes pharmacies sensitive to price ceilings like the MFP.

In addition to revenue sensitivity to price ceilings created through MFP, negotiated MFP drugs comprise a high proportion of revenue among pharmacies in this study. The first cohort of drugs with MFPs going into effect in 2026 accounted for one quarter (25.7 percent) of all revenues from all LTC pharmacies in the study, while the second cohort of drugs with MFPs going into effect in 2027 represents 6.7 percent of pharmacy revenue.

Assuming dispensing volume remains constant, reimbursement at MFP would reduce the LTC pharmacy Part D revenue from 2026 selected drugs by 57% and 2027 selected drugs by 33%. By 2027, product-level margin (i.e., the difference between ingredient costs and ingredient cost reimbursement, independent of volume) under Part D could decline by 21 percent. Out of all drugs, revenue attributable to Part D drugs could decline by 13 percent by 2027, and product-level margin from Part D would decrease by 10 percent. Across all payers and drugs, the reduction in Part D reimbursement for negotiated drugs translates to a reduction of 7 percent in product-level margin by 2027 (see Figure 4).

Figure 4. DPNP Financial Effects on Study LTC Pharmacies

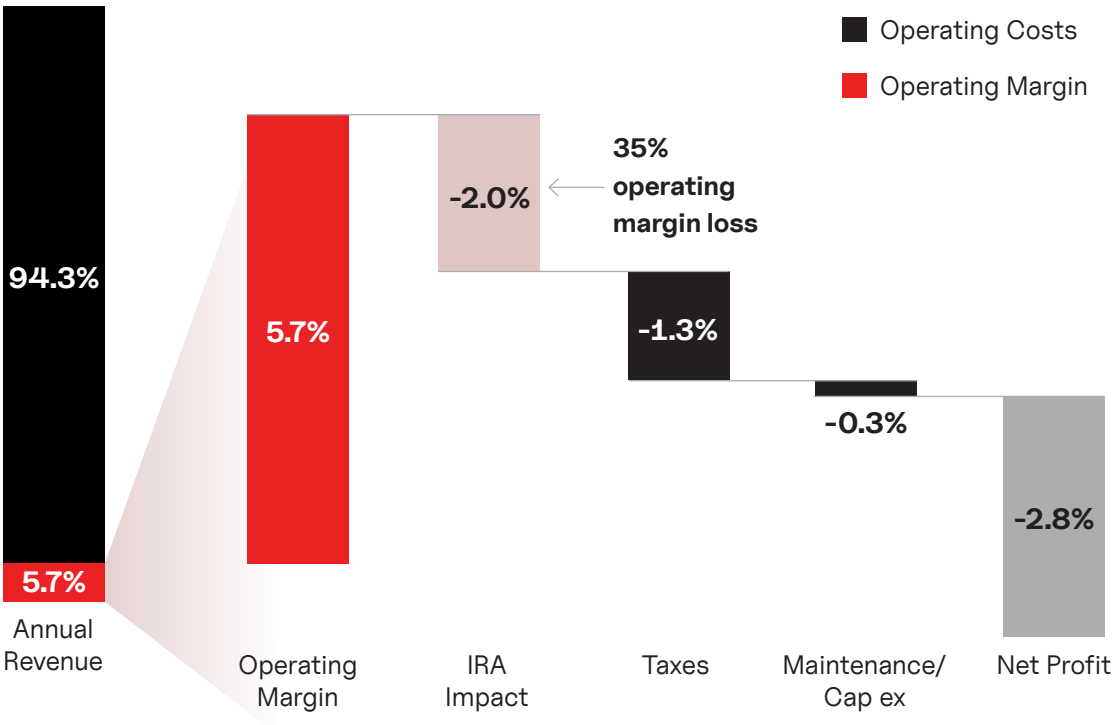
Financial Measure		2026 Drugs	2027 Drugs	2026 & 2027 Drugs
Effect of negotiation on reporting pharmacies' average annual Part D financials from negotiated drugs				
AAC	*Pre-IRA*	$38.6m	$13.9m	$52.5m
	Post-IRA	$15.4m	$9.2m	$24.6m
*Reimbursement**	*Pre-IRA*	$42.7m	$15.3m	$57.9m
	Post-IRA	$18.5m (-57%)	$10.3m (-33%)	$28.8m (-50%)
Product-Level Margin	*Pre-IRA*	$4.1m	$1.3m	$5.4m
	Post-IRA	$3.1m	$1.1m	$4.2m
Effect of negotiation on reporting pharmacies' average annual Part D financials from all drugs				
AAC	*Pre-IRA*	$207.5m	$207.5m	$207.5m
	Post-IRA	$184.3m	$202.8m	$179.6m
*Reimbursement**	*Pre-IRA*	$219.4m	$219.4m	$219.4m
	Post-IRA	$195.3m (-11%)	$214.4m (-2%)	$190.3m (-13%)
Product-Level Margin	*Pre-IRA*	$11.9m	$11.9m	$11.9m
	Post-IRA	$11.0m	$11.6m	$10.7m
Effect on reporting pharmacies' average annual total revenue from all drugs				

Financial Measure		2026 Drugs	2027 Drugs	2026 & 2027 Drugs
AAC	*Pre-IRA*	$295.8m	$295.8m	$295.8m
	Post-IRA	$272.6m	$291.1m	$267.9m
*Reimbursement**	*Pre-IRA*	$312.8m	$312.8m	$312.8m
	Post-IRA	$288.6m (-8%)	$307.8m (-2%)	$283.6m (-9%)
Product-Level Margin	*Pre-IRA*	$16.9m	$16.9m	$16.8m
	Post-IRA	$16.0m	$16.7m	$15.8m

**Reimbursement is inclusive of both ingredient cost reimbursement and dispensing fee*

Extrapolated to the average reporting SCPC LTC pharmacy, reimbursement at MFP is estimated to reduce operating margin by 35 percent for pharmacies captured in the data, from 5.7 percent to 3.7 percent in 2027 (see Figure 5).

Figure 5. Operating Margin Loss of Reporting LTC Pharmacies for 2026 and 2027 Combined



Notes:

1. Operating margin = EBITDA (Earnings Before Interest and Taxes) used as a proxy for cash flow from operations
2. Proforma for average SCPC member pharmacies (n=13)
3. Does not include inhalers 2025 impact – TBD
4. Based on 2024 data for 2026 and 2027 MFP drugs
5. Does not include any increase in costs for LTC pharmacy
6. 2027 is estimated as a factor of 2026

SHORTFALL ANALYSIS FINDINGS

The second part of this study focused on potential financial shortfalls of the DPNP on LTC pharmacy reimbursement under varying assumptions about wholesaler discounts, manufacturer discounts, and Part D reimbursement. ATI compared pre- and post-IRA reimbursement levels for negotiated drugs, modeling both the incremental and aggregate financial impacts per dispensed script.

Under the DPNP, average total LTC pharmacy financial shortfall (i.e., the gross impact) varies from $42.85 to $54.09 per negotiated Part D drug script, depending on manufacturer, wholesaler, and PBM/PDP actions and is referred to herein as "scenarios." In the baseline scenario, ATI assumes wholesaler and manufacturer discounts continue and PBMs / PDPs fully reimburse LTC pharmacies at MFP. This results in the minimum amount that average LTC pharmacies would need to break even after the DPNP's impact on revenue is $42.85 per dispensed negotiated drugs under Part D. The minimum additional amount needed to hold LTC pharmacies harmless from DPNP may be reduced by manufacturer true-up which is defined as the shortfall between WAC and MFP, at $22.42 per negotiated Part D drug script, on average. In the worst-case scenario modeled for this study, LTC pharmacies would lose wholesaler and manufacturer discounts and PBMs/PDPs would reduce LTC pharmacy reimbursement, which increases LTC pharmacy financial shortfalls by an additional $31.67 per script (for a total $54.09 per negotiated drug script) (see Figure 6).

Figure 6. Summary of Shortfall Analysis Findings Among LTC Pharmacies

Scenario	**Description of Scenario**	**Estimated Total Shortfall** (per dispensed negotiated drug under Part D)	**Estimated True-Up of Applied Scenario*** (per dispensed negotiated drug under Part D)	**Estimated Remaining Shortfall After Applied Scenario** (per dispensed negotiated drug under Part D)
Baseline Scenario ("business as usual")	Manufacturer and wholesaler discounts are continued & pharmacy benefit managers (PBMs) / PDPs fully reimburse at MFP	$42.85	$22.42 (shortfall between WAC and MFP)	$20.43
Loss of manufacturer discounts	Wholesaler discounts are continued & PBMs / PDPs fully reimburse at MFP	$42.85	$26.51	$16.34

Scenario	**Description of Scenario**	**Estimated Total Shortfall** (per dispensed negotiated drug under Part D)	**Estimated True-Up of Applied Scenario*** (per dispensed negotiated drug under Part D)	**Estimated Remaining Shortfall After Applied Scenario** (per dispensed negotiated drug under Part D)
Loss of wholesaler discounts	Manufacturer discounts are continued & PBMs / PDPs fully reimburse at MFP	$42.85	$38.76	$4.09
Continued discounts and lower reimbursements from PBMs / PDPs	Both manufacturer and wholesaler discounts are continued & PBMs / PDPs reimburse 5% below MFP	$54.09	$33.65	$20.43
No discounts and lower reimbursements from PBMs / PDPs	Both manufacturer and wholesaler discounts are discontinued & PBMs / PDPs reimburse 5% below MFP	$54.09	$54.09	--

**Estimated true-up amounts beyond the baseline scenario are cumulative*

Conclusion

Assuming dispensing volumes remain similar to current trends, this study demonstrates that LTC pharmacies could face meaningful revenue and operating margin reductions beginning in 2026. This is potentially disproportionate to other pharmacy types because drugs subject to MFP represent a substantial share of LTC pharmacy revenues ($2.77 billion in total for 2026 MFP drugs and $1.52 billion for 2027 MFP drugs), and because the majority of LTC pharmacy revenue (91 percent) is tied to ingredient costs, for which reimbursement will be capped through the DPNP.

Reimbursement at MFP is projected to reduce Part D product-level reimbursement by more than half in 2026 and by one-third in 2027. Even with acquisition costs falling to MFP, LTC pharmacies would still experience Part D revenue decline by 13 percent across selected drugs by 2027, with product-level margins decreasing by 10 percent. Across all payers, the declines equate to a 9 percent reduction in total revenue and a 7 percent reduction in product-level margins by 2027. LTC pharmacy operating margin would be reduced by 35 percent for pharmacies included in this study.

In addition, LTC pharmacies will experience financial shortfalls per negotiated Part D drug script depending on reimbursement dynamics. For the average prescription for a negotiated drug, LTC pharmacies will experience a loss between $42.85 and $54.09. This range represents the amount needed to hold LTC pharmacies harmless from reduced revenue from negotiated drugs under Medicare Part D and the DPNP. While there are manufacturer true-ups to MFP, shortfalls will likely remain for LTC pharmacies, depending on reimbursement dynamics.

About This Work

ATI engaged with SCPC to describe the financial impacts of lower drug prices on LTC pharmacy revenues. The objective of this study was to quantify the impacts of DPNP on Part D revenues for LTC pharmacies and to quantify the remaining shortfalls per negotiated drug script under Part D, in order to offset the Medicare Part D reimbursement reductions that LTC pharmacies will uniquely incur due to the DPNP in 2026 and 2027.

ABOUT SCPC

SCPC is a national organization based in Washington, D.C representing long-term care pharmacies. The advocacy organization represents the interests of its 325 members to ensure LTC pharmacies can serve their patients with high-quality, affordable care safely.

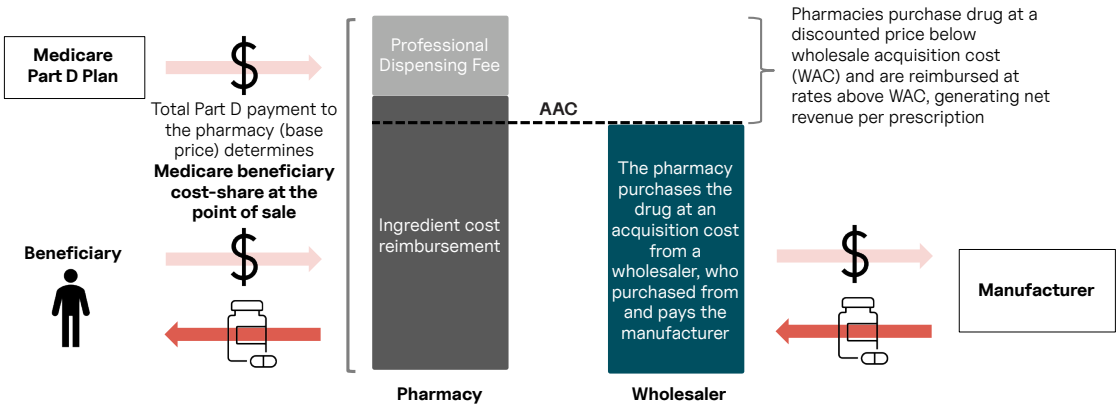
ABOUT ATI ADVISORY

ATI Advisory is a healthcare research and advisory services firm dedicated to system reform that improves health outcomes and makes care better for everyone. ATI guides public and private leaders in solving the most complex problems in healthcare through objective research, deep expertise, and bringing ideas to action. For more information, visit atiadvisory.com.

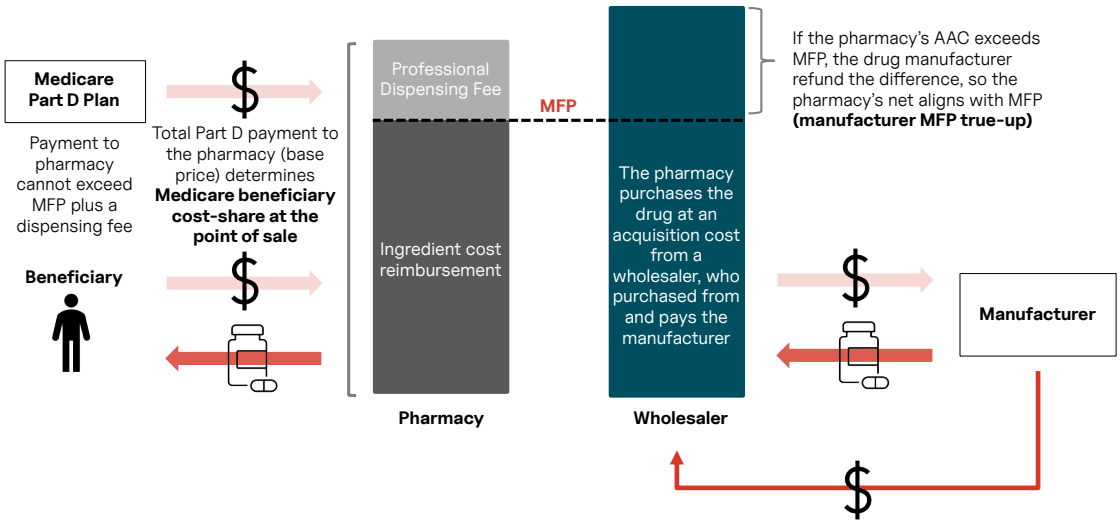
Appendix 1. Visualizations of Pharmacy Reimbursement

These visualizations summarize the pre- and post-IRA processes of pharmacy payment and costs.

Pre-IRA Pharmacy Reimbursement



Post-IRA Pharmacy Reimbursement



Appendix 2. Study Data Sources and Methods

ATI's analysis was based on the development of a financial model of overall LTC pharmacy economics based on SCPC reporting pharmacy and PSAO data, evaluating pharmacy-level and drug-level data by payer and negotiation status. PSAO data was used to analyze the proportional impact of the DPNP on revenues and acquisition costs and subsequently was applied to reporting pharmacies' financial data.

Across all payers for SCPC reporting pharmacies, ATI analyzed revenues (i.e., reimbursement for ingredient cost and dispensing), gross profits, and costs at the company level. For price-negotiated drugs only, ATI also evaluated product-level margin. For all SCPC reporting pharmacies that shared data, ATI determined the annualized operating margin loss resulting from the IRA, reported in both unweighted and weighted averages by number of individuals each pharmacy serves.

Additionally, ATI conducted a shortfall analysis to understand the financial outcomes in various reimbursement scenarios, estimating the additional remaining shortfall from the DPNP. Reimbursement scenarios varied by the level of manufacturer / wholesaler discount and/or PBMs / PDPs reimbursement.

DATA

ATI requested data from five SCPC pharmacies and PSAOs servicing with LTC pharmacies to analyze the effects of the DPNP, based on the first and second cohorts of drugs subject to IRA negotiation. SCPC reporting pharmacies provided company-level financial information such as total drug revenues, while PSAOs provided drug-level details about acquisition costs and reimbursement by payer status. All requested data represent the financial information for a full calendar year (January 1, 2024–December 31, 2024).

Data from SCPC Reporting Pharmacies

Pharmacy-level revenue, cost of goods sold, and reimbursement for DPNP selected drugs in Calendar Year (CY) 2024 under Part D and all payers were reported by SCPC pharmacies operating LTC pharmacies using a standardized reporting form (see Appendix 3).

At the company level, ATI collected the following from SCPC pharmacies:

- Total number of individual brick-and-mortar pharmacies represented by the member
- Total acquisition cost for all drugs

- Total volume of packages acquired for all drugs
- Total revenue (i.e., total reimbursement from ingredient costs, dispensing fees, and other sources of income, such as fixed fee contracts)
- Percentage of total revenue that comes from Part D
- Percentage of total revenue from the first cohort of selected drugs for price negotiation in 2026
- Percentage of total revenue from the second cohort of selected drugs for price negotiation in 2027

Data from PSAOs

The PSAOs that service LTC pharmacies provided NDC-11-level data summarizing WAC, AAC, reimbursement, and dispensing volume for selected drugs in CY 2024 under Part D and all payers (Appendix 3).

- Average acquisition cost for each NDC-11 drug
- Total units of drugs dispensed for each NDC-11 drug
- Total reimbursement of all products (broken down by ingredient costs and dispensing fees) by all payers and Part D, collected separately, for each NDC-11 drug

ATI obtained information about selected drugs, negotiated prices, and associated NDCs for 2026 and 2027 drugs from the official CMS website.[5]

METHODS

To estimate the financial effects of DPNP on LTC pharmacies, ATI estimated how revenues, operating income, and operating margins would change if reimbursement for selected drugs under Part D were changed to MFP. The model assumes dispensing volumes for negotiated drugs remain constant for simplicity, though market shifts could occur. This analysis also assumed that AACs for selected drugs were set at MFP.

MFP Prices

For 2026 drugs, calculations of MFPs for negotiated drugs relied on finalized MFPs released by CMS in August 2024.[1] For 2027 drugs, ATI estimated MFPs for drugs without public or finalized MFPs, based on the lower of the statutory discount or the estimated rebates by therapeutic areas published by the Government Accountability Office (GAO).[3,4]

Financial Impact Analysis Methodology

SCPC reporting pharmacies submitted annual financial data, including total revenue broken out by ingredient costs, dispensing fees, and other sources of income (such as fixed fee contracts). Pharmacies also reported the share of their total revenue attributable to drugs

5 Selected Drugs and Negotiated Prices | CMS

subject to negotiation under the DPNP in 2026 and 2027, as well as the proportion of revenue derived from Part D overall.

ATI estimated and applied MFPs to determine the percentage reduction in Part D revenue attributable to 2026 and 2027 drugs from the data PSAOs submitted. This estimated loss was then applied proportionally to each SCPC reporting pharmacy's financial profile to assess the projected financial impact of the DPNP on LTC pharmacies.

Similarly, ATI applied the proportional changes in total acquisition costs calculated from PSAO data to SCPC reporting pharmacy data. This was used to calculate the impact on operating margin, which is reported as the difference in product-level margin (i.e., the difference between total acquisition costs and reimbursement) before and after the DPNP, as a percentage of total operating margin.

Shortfall Analysis Methodology

The analysis assumed that selected negotiated drugs would be acquired and reimbursed at their respective MFPs, as determined by the DPNP or estimated by ATI. ATI modeled five different scenarios, ranging from "business as usual" (baseline) to discontinued discounts in addition to reduced reimbursement by PBMs/ plans. Reimbursement scenarios varied by whether discounts provided by manufacturers and/or wholesalers continued and whether PBMs or PDPs fully reimburse at MFP. The different scenarios reflect the differential impacts of the DPNP on pharmacy reimbursement of negotiated drugs, based on potential trajectories.

The five scenarios modeled were the cases where:

1) All manufacturer and/or wholesaler discounts continue, and PBMs/ plans fully reimburse pharmacies at MFP (baseline scenario)
2) No manufacturer discounts are provided, but wholesaler discounts continue
3) No wholesaler discounts are provided, but manufacturer discounts continue
4) PBMs/ plans reimburse 5 percent below MFP and all manufacturers and/or wholesaler discounts are continued
5) PBMs/ plans reimburse 5 percent below MFP and all manufacturers and/or wholesaler discounts are discontinued

In the baseline scenario (Scenario 1), ATI assumes that both manufacturer and wholesaler discounts remain in effect and that pharmacies are fully reimbursed at 100 percent of the MFP. This scenario incorporates a "manufacturer true-up," defined as the assumed reimbursement by manufacturers for the difference between WAC and MFP, as reported by PSAOs. The remaining amounts that are needed to hold pharmacies harmless are referred to as "remaining shortfall," as described previously. This scenario serves as the baseline estimate of manufacturer support under the DPNP.

ATI calculated the remaining financial shortfall by subtracting the estimated manufacturer true-up from the gross financial impact of DPNP. The resulting amount is the lost contribution of wholesaler and manufacturer discounts to product-level margin. Based on feedback from SCPC reporting pharmacies, ATI assumes a 4:1 ratio of wholesaler to manufacturer discounts.

ATI modeled different scenarios, each with varied assumptions about manufacturer and wholesaler responses to MFP. These scenarios are analyzed at the NDC level and then aggregated to LTC pharmacy averages weighted by each NDC's volume. Additional scenarios include a sensitivity analysis in which PBMs/ plans reimburse at 5 percent below the MFP.

All remaining shortfall estimates are volume-weighted by total volume of dispensed Part D drugs and calculated per Part D negotiated drug script to assess the level of financial support needed to offset reimbursement shortfalls. Note that 2027 drug prices were not adjusted for inflation, as the net effect on estimates was found to be minimal.

STUDY LIMITATIONS

Study Design

ATI's analyses of LTC pharmacies do not establish causality and do not test for statistical significance on the financial impact of LTC pharmacies' revenue; thus, findings are descriptive. The estimated MFP for 2027 drugs also may be higher than expected, as finalized negotiated prices are set to be released by November 30, 2025. The analysis is limited to the financial impact of DPNP on Part D revenues only. ATI does not assume any spillover effect of the program on other non-Medicare payers.

Confounders

One significant limitation of the analysis is that ATI did not adjust or account for other factors that could contribute to changes in LTC pharmacy economics nor market changes in WAC in anticipation of the DPNP. The analysis assumes that the pharmacy reimbursement had not already shown signs of decline for reasons unrelated to DPNP.

Sample Selection

Data used in the analysis is limited to a non-random sample of five SCPC reporting pharmacies and PSAOs focused on LTC, which limits the external validity of the analysis and may not be generalizable to all LTC pharmacies not represented by SCPC. These SCPC reporting pharmacies who shared their data represent large groups of pharmacies with an average of 15 brick-and-mortar pharmacies per SCPC reporting pharmacy. There may also be selection bias, as reporting pharmacies who belong to SCPC (an advocacy organization) may have different financial risks than other LTC pharmacies/PSAOs without SCPC membership.

Study Assumptions

Actual pharmacy acquisition costs are reported by PSAOs and their represented pharmacies, when available from the wholesaler. Another caveat shared with ATI is that some PSAO data on AACs may not be current, as pharmacies related to this PSAO do not routinely update this confidential and proprietary data on total costs. To estimate AACs for this single PSAO, ATI applied the average AAC of the other PSAOs.

In addition, ATI did not model the effects of declining volume of negotiated drugs. Because many of the drugs selected for negotiation have close therapeutic equivalents, it is possible that Part D plans may begin to prefer those that offer better discounts than negotiated drugs. For example, Breo Ellipta (an inhaler) will be negotiated beginning in 2027, but there are close therapeutic equivalents such as Trelegy Ellipta and Advair that can be used as substitutes. Lastly, shifts in dispensing volume would affect results aggregating across products, including the financial impact analysis and aggregate shortfall analysis.

Appendix 3: Reporting Forms

SCPC LTC PHARMACY REPORTING FORM

Pharmacy-level revenue, cost of goods, and reimbursement for DPNP selected drugs under Part D, were reported by SCPC pharmacies operating LTC pharmacies using a standardized reporting form at the pharmacy level:

Please provide data from January 1, 2024 to December 31, 2024

Company name:								
No. of pharmacies:								
% revenue by facility type:		NH, SNF, ICF		ALF		GH		Other
% revenue by payer type:		Medicare Part D						
COGS *(for all payers and drugs)*								
Total acquisition cost:								
Total packages acquired:								
Total revenue *(for all payers, drugs, and activities)*								
Total reimbursement for drugs dispensed:								
Ingredient costs:								
Dispensing fees:								
Other income: *(if applicable)*		*E.g., fixed fee contracts*						
Total scripts:								
Total days supplied:								
% reimbursement for CMS10:		*Exposure to selected drugs in Part D by revenue, inclusive of dispensing fees (e.g., 15% of total revenue is attributed to CMS10 drugs)*						
% reimbursement for CMS15:		*Exposure to selected drugs in Part D by revenue, inclusive of dispensing fees (e.g., 15% of total revenue is attributed to CMS15 drugs)*						

SCPC PSAO REPORTING FORM

SCPC members operating PSAOs that service LTC pharmacies provided NDC-11 level data summarizing AAC, reimbursement, and dispensing volume for selected drugs under Part D:

Please provide data from January 1, 2024 to December 31, 2024

Number of LTCPs represented:	
Total $ reimbursed, all payers all NDCs:	
Total $ reimbursed, Part D all NDCs:	

		Acquisition			
		All Payers			
Brand Name	NDC-11	Unit	Avg WAC / Unit ($)	Avg GPO or WAC acquisition / Unit ($)	Avg pharmacy acquisition cost / Unit ($)
Example	*12345-6789-01*	*1 tab*	*$500*	*$475*	*$475*
AUSTEDO	68546-0170-60				
AUSTEDO	68546-0171-60				
AUSTEDO	68546-0172-60				
AUSTEDO XR	68546-0470-56				
AUSTEDO XR	68546-0471-56				
AUSTEDO XR	68546-0472-56				
AUSTEDO XR	68546-0473-56				
AUSTEDO XR	68546-0474-56				
AUSTEDO XR	68546-0475-56				
AUSTEDO XR	68546-0476-56				
AUSTEDO XR	68546-0479-56				
BREO ELLIPTA	00173-0859-10				
BREO ELLIPTA	00173-0859-14				

SCPC PSAO REPORTING FORM (CONTINUED)

Please provide data from January 1, 2024 to December 31, 2024

Number of LTCPs represented:	
Total $ reimbursed, all payers all NDCs:	
Total $ reimbursed, Part D all NDCs:	

		Reimbursement									
		All Payers					Part D ONLY				
Brand Name	NDC-11	Total reimbursed amount ($)	Total ingredient cost ($)	Total dispensing fees ($)	Total number of scripts reimbursed	Total days supply	Total reimbursed amount ($)	Total ingredient cost ($)	Total dispensing fees ($)	Total number of scripts reimbursed	Total days supply
Example	*12345-6789-01*	*$500,000*	*$400,000*	*$100,000*	*5,000*	*70,000*	*$300,000*	*$240,000*	*$60,000*	*3,000*	*42,000*
AUSTEDO	68546-0170-60										
AUSTEDO	68546-0171-60										
AUSTEDO	68546-0172-60										
AUSTEDO XR	68546-0470-56										
AUSTEDO XR	68546-0471-56										
AUSTEDO XR	68546-0472-56										
AUSTEDO XR	68546-0473-56										
AUSTEDO XR	68546-0474-56										
AUSTEDO XR	68546-0475-56										
AUSTEDO XR	68546-0476-56										
AUSTEDO XR	68546-0479-56										
BREO ELLIPTA	00173-0859-10										
BREO ELLIPTA	00173-0859-14										

Appendix 4. Negotiated Drug Lists

Each year, CMS selects single-source, high-spend drugs for negotiation (over $200 million of Medicare spending) without generic or biosimilar competition, with additional statutory criteria. Negotiated prices (i.e., "Maximum Fair Prices" [MFPs]) will take effect in 2026 for ten Part D drugs selected for price negotiation, followed by an additional fifteen Part D drugs in 2027. Published MFPs for 2026 and estimated MFPs for 2027 are listed here, with the calculated discounts.

2026 Drugs	Actual Discount (MFPs Published)
Eliquis	-28% to -56%
Enbrel	-28% to -67%
Entresto	-53%
Farxiga	-68%
Fiasp	-69% to -76%
Imbruvica	-28% to -37%
Januvia	-79%
Jardiance	-66%
Novolog	-32% to -76%
Stelara	-40% to -66%
Xarelto	-2% to -62%

2027 Drugs	Estimated Discount (MFPs Not Yet Published)
Austedo	-28%
Breo Ellipta	-28%
Calquence	-28%
Ibrance	-28%
Janumet	-40%
Linzess	-28%
Ofev	-28%
Otezla	-28%
Ozempic	-32%
Pomalyst	-28%
Rybelsus	-32%
Tradjenta	-32%
Trelegy Ellipta	-28%
Vraylar	-28%
Wegovy	-32%
Xifaxan	-40%
Xtandi	-28%

Appendix 5. Glossary

Actual Acquisition Cost (AAC) – the net cost the pharmacy pays, including discounts, rebates, chargebacks, and other price adjustments; does not include the pharmacy's dispensing fees.

Average Wholesale Price (AWP) – the average price at which wholesalers sell drugs to physicians, pharmacies, and other purchasers.

Confounder – a third, external variable that is related to both the independent variable and the outcome, creating a misleading relationship between them.

Dispensing entity – organization responsible for providing prescribed medications to patients.

Dispensing fee – a fee paid to a pharmacist for dispensing a medication, paid in addition to reimbursement for the ingredient cost of the drug.

Drug Price Negotiation Program (DPNP) – government-mandated initiative allowing Medicare to directly negotiate a maximum fair price with pharmaceutical manufacturers for high expenditure, single source drugs without generic or biosimilar competition.

Inflation Reduction Act (IRA) – law signed in 2022 including several provisions to lower prescription drug costs for people with Medicare and reduce drug spending by the federal government.

Ingredient cost – the cost to the pharmacy to acquire the drug from the manufacturer or wholesaler.

Long-term care (LTC) – any service, care, or item (including an assistive device), including a disease prevention and health promotion service, an in-home service, and a case management service— (A) intended to assist individuals in coping with, and to the extent practicable compensate for, a functional impairment in carrying out activities of daily living; (B) furnished at home, in a community care setting (including a small community care setting as defined in subsection (g)(1), and a large community care setting as defined in subsection (h)(1), of section 1929 of the Social Security Act (42 U.S.C. 1396t)), or in a long-term care facility; and (C) not furnished to prevent, diagnose, treat, or cure a medical disease or condition.

Manufacturer – any entity engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly.

Manufacturer discount – a reduced price on a drug offered directly by the manufacturer through negotiated contracts with purchasers.

Maximum Fair Price (MFP) – ceiling price CMS negotiates with drug manufacturers for certain Medicare Part D drugs under the IRA.

National Drug Code (NDC) – unique identifying prescription drug product number that is listed with the Food and Drug Administration identifying the product's manufacturer, product, and package size and type.

Operating margin – Profitability ratio after deducting all operating expenses, but before paying interest, taxes, depreciation, amortization or reinvesting in capital repair and replacement, and expansion.

Part D drug – a drug, vaccine, or supply that may be dispensed only upon a prescription and is paid under the Medicare prescription drug benefit.

Pharmacy benefit manager (PBM) – third-party administrators contracted by health plans, prescription drug plans, large employers, unions, and government entities to manage prescription drug benefits programs.

Prescription drug plan (PDP) – a standalone plan from a private insurer that provides prescription drug coverage to those with Original Medicare (Parts A + B)

Product-level margin – profit calculated at the individual drug level, inclusive of both ingredient cost reimbursement and dispensing fee.

Pharmacy reimbursement – reimbursement to the pharmacy of the total amount to fill a prescription, composed of the drug ingredient cost and the dispensing fee. Current payment for drug ingredient cost is WAC plus a percentage, while post-IRA, payment will be at MFP.

Pharmacy services administrative organization (PSAO) – an organization that represents independent pharmacies and provides pooled negotiating power.

Remaining shortfall – remaining product margin shortfall after accounting for the manufacturer true up payment and assumptions

Revenue – income generated by a pharmacy, from reimbursement or other sources.

Therapeutic equivalents – drug or treatment from a different manufacturer that offers similar clinical benefit or addresses the same medical condition as a primary or reference drug.

True-up – the difference in acquisition costs and negotiated prices manufacturers are required to retrospectively reimburse pharmacies for, in the case that acquisition costs are higher than negotiated prices.

Wholesale Acquisition Cost (WAC) – prescription drug list price manufacturers set for wholesalers, absent any discounts or rebates (i.e., a manufacturer's initial pricing)

Wholesaler – intermediary company that purchases large quantities of medications from pharmaceutical manufacturers and distributes them to pharmacies and health care providers.

Wholesaler discount – a reduced price on a drug offered directly by the wholesaler through negotiated contracts with purchasers.

ATI Advisory

About ATI Advisory

ATI Advisory is a healthcare research and advisory services firm dedicated to system reform that improves health outcomes and makes care better for everyone. ATI guides public and private leaders in solving the most complex problems in healthcare through objective research, deep expertise, and bringing ideas to action. For more information, visit atiadvisory.com.