Pharmacies as Work Requirement Touchpoints

The Monthly Encounter No One Has Leveraged

Pharmacies see Medicaid patients more frequently than any other healthcare touchpoint, creating opportunities for coverage loss early warning, exemption identification, and navigation access.

Sandra's Story

Sandra Chen has been a pharmacist at a busy CVS location in Columbus, Ohio for eight years. Her store fills prescriptions for forty to fifty Medicaid patients daily, most picking up monthly maintenance medications for diabetes, hypertension, depression, or chronic pain. Sandra knows her regulars. She notices when Mr. Patterson's metformin prescription goes unfilled for the second week. She sees when Maria Gonzalez switches from her brand-name antidepressant to a generic because her copay changed. She recognizes when someone she's seen monthly for years suddenly disappears from her pickup window.

When Sandra runs a prescription through the system, she gets real-time eligibility verification. The screen tells her immediately whether Medicaid will pay, whether the patient has coverage, whether something has changed. She's often the first person in the healthcare system to know when a patient loses coverage. The physician who prescribed the medication won't know until the next appointment, which might be months away. The MCO's care coordinator might not notice until enrollment reports update. But Sandra knows in real time, at the moment the patient stands at her counter expecting their medication.

Starting in December 2026, Sandra will see work requirement coverage losses play out at her pickup window. A patient who's been filling insulin monthly for three years will suddenly show as ineligible. Sandra will watch the confusion, the panic, the desperate calculation of whether they can afford to pay cash for medication they need to survive. She'll see the moment when healthcare policy becomes personal crisis.

No one has asked Sandra to do anything about this. No system connects her real-time eligibility knowledge to navigation resources that might help patients restore coverage. No protocol suggests she mention that the patient might qualify for an exemption based on the very medications they're picking up. No partnership links her pharmacy to community organizations that could assist with work requirement compliance. Sandra has the most frequent touchpoint with Medicaid patients of any healthcare professional, and she has been given no role in helping them navigate work requirements.

The gap between what pharmacies could do and what anyone has asked them to do represents one of the most significant missed opportunities in work requirement implementation.

The Pharmacy Touchpoint Advantage

Pharmacies occupy a unique position in healthcare delivery that makes them potentially valuable partners in work requirement implementation, yet policy discussions rarely consider their role.

Frequency of contact distinguishes pharmacies from other healthcare touchpoints. Patients with chronic conditions fill prescriptions monthly, creating twelve encounters per year compared to the two to four physician visits typical for stable conditions. Someone managing diabetes,

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hypertension, and depression might visit their pharmacy thirty-six times annually while seeing their doctor only six times. The pharmacy encounter happens with predictable regularity, on schedules patients themselves maintain because they need their medications.

Geographic density places pharmacies in communities where other healthcare infrastructure may be sparse. The National Association of Chain Drug Stores reports that 90 percent of Americans live within five miles of a community pharmacy. Rural areas without hospitals, clinics, or community health centers often still have pharmacies. The pharmacy may be the only healthcare presence in small towns where the nearest physician is thirty miles away.

Extended hours make pharmacies accessible when other services are not. Many chain pharmacies operate twelve to fourteen hours daily, with some offering 24-hour service. Evening and weekend hours accommodate working people who cannot access services during traditional business hours. A Medicaid recipient working multiple jobs might be unable to visit a clinic during the day but can pick up prescriptions at 8 PM.

Trust relationships develop between pharmacists and regular patients in ways that formal healthcare encounters often do not facilitate. The pharmacist who fills your prescriptions month after month knows something about your life. They see which medications you take, which ones you skip, which ones you struggle to afford. Patients ask pharmacists questions they might not ask physicians, partly because the encounter feels less intimidating and partly because pharmacists are more accessible. Surveys consistently show pharmacists among the most trusted professionals in America.

These advantages, frequency, density, hours, and trust, make pharmacies potentially powerful touchpoints for work requirement support. The question is whether anyone will leverage them.

Coverage Loss Early Warning

Pharmacies discover coverage problems in real time through point-of-sale eligibility verification. This creates early warning opportunities that no other part of the healthcare system can match.

Real-time eligibility checks occur at the moment of prescription processing. The pharmacy management system queries the payer database and returns coverage status within seconds. When coverage has lapsed, the system reports it immediately. The pharmacist knows before the patient does, often before anyone else in the healthcare system knows.

This real-time knowledge could trigger intervention if systems were designed to enable it. Imagine a protocol where coverage denial generates an alert, prompting the pharmacist to mention that the patient's coverage appears to have lapsed and providing a phone number for Medicaid enrollment assistance. The patient learns about the problem while standing in the pharmacy rather than weeks later when a bill arrives or months later when they need care and discover they're uninsured.

Pattern recognition at the pharmacy level could identify problems before complete coverage loss. When a patient who consistently fills prescriptions monthly suddenly misses a fill, something has changed. Perhaps they lost coverage. Perhaps they're struggling with costs. Perhaps their condition worsened and they're hospitalized. The missed fill is a signal that warrants attention. Pharmacies with robust systems could flag irregular patterns for follow-up.

Pharmacist intervention opportunities exist at the coverage loss moment. A patient learning at the pharmacy counter that their coverage has lapsed is standing in front of a healthcare professional who could provide information, suggest resources, or facilitate connections to assistance. The

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pharmacy has computers, phones, and staff. A patient could potentially complete a Medicaid reinstatement call from the pharmacy rather than leaving without medication and trying to figure things out alone.

Connecting coverage problems to navigation support requires infrastructure that mostly doesn't exist. Pharmacies would need contact information for local navigation resources, protocols for when and how to offer assistance, and ideally warm handoff capabilities to connect patients directly with help. Building this infrastructure takes investment, but the potential return in prevented coverage loss and maintained medication adherence is substantial.

The operational model could work several ways. A minimal intervention might simply train pharmacy staff to say "Your coverage shows as inactive. Here's a number you can call for help getting it restored" and hand over a card with navigation resources. A moderate intervention might include a pharmacy staff member offering to call the navigation line with the patient right then, facilitating immediate connection rather than leaving the patient to follow up independently. A robust intervention might station a navigator at high-volume pharmacies during peak hours, available to assist patients who encounter coverage problems at the pickup window.

Each level requires different investment and generates different results. The minimal intervention costs almost nothing but depends on patients following through independently. The moderate intervention requires staff time but increases the likelihood of connection. The robust intervention requires personnel investment but catches patients at the moment of crisis when intervention is most effective. States and MCOs must decide what level of pharmacy-based intervention justifies the required investment.

Exemption Trigger Identification

The medications patients fill at pharmacies often indicate conditions that would qualify for work requirement exemptions. This creates opportunities for pharmacies to identify patients who should be exempt but may not know it.

Medication profiles indicating exemption-qualifying conditions are visible to pharmacists through prescription records. Someone filling clozapine is being treated for serious mental illness. Someone filling chemotherapy medications is undergoing cancer treatment. Someone picking up dialysis-related medications has end-stage renal disease. Someone on medication-assisted treatment for opioid use disorder is actively engaged in SUD treatment. Each of these medication profiles suggests a condition that likely qualifies for work requirement exemption under most state frameworks.

Cancer treatment medications provide particularly clear exemption signals. Oral chemotherapy agents, antiemetics for chemotherapy-induced nausea, and supportive care medications for cancer treatment side effects all indicate someone undergoing active cancer treatment. These patients almost certainly qualify for medical exemption but may not know that exemptions exist or how to obtain them.

Psychiatric medications can indicate serious mental illness qualifying for exemption. Antipsychotic medications, mood stabilizers, and certain antidepressant combinations suggest conditions that may impair work capacity. The pharmacist cannot diagnose mental illness, but they can recognize medication profiles consistent with conditions that warrant exemption consideration.

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Chronic disease management medications indicate ongoing conditions that might qualify for exemption depending on severity. Insulin regimens, multiple cardiac medications, immunosuppressants, and complex pain management protocols all suggest significant medical burden. Not everyone on these medications qualifies for exemption, but the medications flag people who should at least be screened for exemption eligibility.

Medication-assisted treatment for opioid use disorder provides another clear exemption signal. Patients filling buprenorphine, methadone through pharmacy programs, or naltrexone are actively engaged in SUD treatment, a category most states exempt from work requirements. These patients may not realize that their treatment engagement qualifies them for exemption, and the pharmacy encounter provides an opportunity to inform them.

The practical challenge is translating medication knowledge into exemption referrals without practicing medicine. ***A pharmacist cannot diagnose conditions or determine exemption eligibility.*** They can recognize that a medication profile is consistent with potentially exempting conditions and suggest the patient discuss exemption eligibility with their prescriber or with navigation services. The pharmacy serves as a screening and referral point rather than a determination point.

Referral pathways to exemption documentation could flow from pharmacy identification. When a pharmacist recognizes that a patient's medication profile suggests exemption eligibility, they could provide information about exemption categories, offer contact information for providers who could document exemptions, or facilitate connections to navigation services that could assist with exemption applications. The pharmacy becomes a screening point that identifies people who should seek exemptions they might not otherwise know about.

Privacy considerations and patient consent must govern any pharmacy role in exemption identification. ***Patients must consent to their medication information being used for purposes beyond filling prescriptions.*** Some patients will prefer to maintain separation between their pharmacy and their Medicaid status. Any pharmacy-based exemption identification must be voluntary, consent-based, and protective of patient privacy.

Navigation Access Point

Beyond early warning and exemption identification, pharmacies could serve as navigation access points where patients receive information and connect to assistance with work requirement compliance.

Pharmacy as information distribution hub leverages the foot traffic pharmacies already generate. ***Patients visiting monthly for prescriptions could receive work requirement information alongside their medications.*** Printed materials explaining requirements, exemption categories, and compliance pathways could be distributed at pickup. Posters in pharmacy waiting areas could advertise navigation resources. The pharmacy becomes a channel for reaching Medicaid recipients with information they need.

Medication therapy management encounters create extended pharmacist-patient interactions that could incorporate work requirement support. MTM services, covered by Medicare and some Medicaid programs, involve comprehensive medication reviews, adherence support, and coordination with prescribers. These encounters typically last fifteen to thirty minutes, providing time for discussion that brief pickup window interactions cannot

accommodate. MTM visits could include work requirement counseling for patients whose medications indicate Medicaid coverage.

Partnership with CBOs and MCOs could position pharmacies as navigation access points. A community organization providing work requirement navigation could establish a presence at local pharmacies, staffing tables during high-traffic hours or providing materials for pharmacy distribution. MCOs could contract with pharmacy chains to provide member outreach at the point of prescription fills. These partnerships would require investment but could reach patients who don't engage with other outreach channels.

The pharmacy staff already present represent potential navigation capacity. Pharmacy technicians, who handle much of the prescription processing workflow, could be trained to provide basic work requirement information and referrals. They see patients at the pickup window and have brief interactions that could include asking whether patients need help with Medicaid paperwork. Even thirty seconds of informed assistance at each pickup could significantly increase patient awareness of requirements and resources.

Technology integration could enhance pharmacy-based navigation without requiring extensive staff time. Prescription bag stuffers could include work requirement information targeted to Medicaid patients. Automated phone systems could add work requirement reminders to prescription ready notifications. Mobile apps used for prescription management could display compliance status and provide links to navigation resources. These technology-enabled approaches reach patients without consuming staff time during busy pharmacy operations.

The 340B drug pricing program creates particular opportunities for safety-net pharmacy engagement. Hospitals and clinics qualifying for 340B pricing often operate outpatient pharmacies serving high proportions of Medicaid patients. These pharmacies have institutional connections to navigation services, care coordination programs, and social work resources. Integrating work requirement support into 340B pharmacy operations leverages existing safety-net infrastructure.

Pharmacy Business Model Considerations

Leveraging pharmacies as work requirement touchpoints requires understanding the business constraints under which pharmacies operate and designing interventions that fit within those constraints.

Time pressure and workflow constraints define pharmacy operations. ***Retail pharmacies face constant tension between patient volume and available pharmacist time.*** Filling prescriptions accurately, counseling patients on new medications, managing drug interactions, and handling insurance problems already consume available time. Adding work requirement responsibilities to pharmacist workflows competes with existing obligations. Any pharmacy-based intervention must be designed to minimize time burden on already-stretched staff.

Reimbursement for expanded services determines whether pharmacies can afford to participate. Pharmacies operate on thin margins and cannot absorb significant unreimbursed labor costs. If work requirement navigation takes fifteen minutes of pharmacist time per patient, someone must pay for that time. ***State Medicaid programs could create billing codes for navigation services.*** MCOs could compensate network pharmacies for member outreach. Without reimbursement, pharmacy participation will be minimal regardless of good intentions.

Chain versus independent pharmacy capacity affects what interventions are feasible. Large chains like CVS, Walgreens, and Walmart operate thousands of locations with centralized systems,

standardized workflows, and corporate decision-making. Implementing systemwide work requirement support requires corporate buy-in but could then scale rapidly. Independent pharmacies have more flexibility to innovate but lack resources for sophisticated interventions and cannot scale individually. Different approaches may be needed for different pharmacy types.

Pharmacist ***scope of practice*** varies by state and affects what pharmacists can do. Some states have expanded pharmacist authority to include prescribing certain medications, administering vaccines, and providing other clinical services. Other states maintain more limited scopes. ***Work requirement support activities must fit within whatever scope of practice applies in each state.*** Providing information and referrals likely fits any scope; providing clinical documentation for exemptions may or may not depending on state law.

The business case for pharmacy participation must be articulated clearly. ***Pharmacies benefit when patients maintain coverage because covered patients fill prescriptions that generate revenue.*** Patients who lose Medicaid coverage often stop filling prescriptions entirely, eliminating revenue that would otherwise continue. Helping patients maintain coverage, whether through work requirement compliance or exemption documentation, preserves the pharmacy's customer base. This self-interest could motivate participation if the operational model is feasible.

The Untapped Resource

Sandra Chen will continue seeing Medicaid patients at her Columbus pharmacy. She will continue running eligibility checks that reveal coverage status in real time. She will continue recognizing when longtime patients suddenly lose coverage. She will continue filling prescriptions for medications that indicate exemption-qualifying conditions.

And unless something changes, she will continue doing all of this without being connected to any system that could help her patients navigate work requirements. The pharmacist with the most frequent Medicaid patient contact in her community, with real-time eligibility information, with medication knowledge suggesting exemption eligibility, will stand behind her counter watching coverage losses she could potentially help prevent.

The gap between pharmacy capacity and pharmacy utilization in work requirement implementation reflects a broader pattern: policy designed without considering where patients actually are. Work requirement navigation resources concentrate in government offices, community organizations, and healthcare facilities. Pharmacies, where Medicaid patients appear monthly with predictable regularity, remain outside the navigation infrastructure.

States building work requirement implementation systems have an opportunity to leverage pharmacy touchpoints. Real-time eligibility alerts could trigger navigation referrals. Medication profiles could flag exemption candidates. MTM encounters could incorporate work requirement counseling. Pharmacy waiting areas could distribute information. Partnerships could position CBOs and MCO representatives in pharmacy settings.

None of this will happen automatically. Pharmacies are businesses operating under economic constraints. Pharmacists are professionals with full workloads. Building pharmacy-based work requirement support requires intentional design, adequate reimbursement, and integration with broader navigation infrastructure. But the potential is substantial. Millions of Medicaid recipients visit pharmacies monthly. Those visits could become touchpoints for work requirement support if anyone decides to leverage them.

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References

1. National Association of Chain Drug Stores. "Community Pharmacy: Access and Quality Care." NACDS.org, 2024.
2. Gallup. "Honesty/Ethics in Professions: Pharmacists Among Most Trusted." Gallup.com, 2024.
3. American Pharmacists Association. "Medication Therapy Management Services." Pharmacist.com, 2024.
4. Centers for Medicare and Medicaid Services. "Medicaid Pharmacy Benefits and Reimbursement." CMS.gov, 2024.
5. National Community Pharmacists Association. "Independent Pharmacy Economics and Demographics." NCPA.org, 2024.
6. Kaiser Family Foundation. "Medicaid Prescription Drug Coverage." KFF.org, 2024.
7. IQVIA Institute. "Medicine Use and Spending in the U.S." IQVIA.com, 2024.
8. Health Resources and Services Administration. "Pharmacy Workforce Projections." HRSA.gov, 2024.
9. Journal of the American Pharmacists Association. "Community Pharmacy Services and Patient Outcomes." JAPhA, 2024.
10. Pharmacy Times. "Pharmacist Roles in Chronic Disease Management." PharmacyTimes.com, 2024.
11. National Association of Boards of Pharmacy. "State Pharmacy Practice Acts: Scope of Practice Survey." NABP.org, 2024.
12. American Society of Health-System Pharmacists. "Pharmacist Prescriptive Authority by State." ASHP.org, 2024.
13. Drug Channels Institute. "The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers." DrugChannels.net, 2024.
14. Rural Health Information Hub. "Rural Pharmacy Services and Access." RuralHealthInfo.org, 2024.
15. Medicaid and CHIP Payment and Access Commission. "Pharmacy Benefit Management in Medicaid." MACPAC.gov, 2024.

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