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As COVID-19 Spreads, Florida Pharmacists' Scope of Practice Expands

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Florida has been contemplating ways to increase patient access to care, especially in light of the COVID-19 pandemic and the anticipated increase in cases. Recognizing the accessibility of pharmacies, Florida is now authorizing certain qualified pharmacists to perform testing, screening, and treatment of nonchronic diseases and specific treatment of certain chronic conditions. On March 11, 2020, the Florida legislature passed CS/HB 389 (the Act). The Act: 1) permits qualified pharmacists to provide specific services to patients with certain chronic conditions under a collaborative pharmacy practice agreement (a "Collaborative Agreement") with a patient's treating physician; and 2) allows pharmacists with supervising physicians pursuant to written agreements to test, screen and treat patients for "minor, nonchronic health conditions."

The Board of Pharmacy (Board) is heeding Governor DeSantis's desire to fast track new rules that will implement the legislature's change. A first draft of the new rules was the subject of discussion at the meeting of the Rules Committee of the Board on June 2, 2020. (Click here to view the afternoon meeting minutes).

Treating Chronic Conditions

In order to provide care to physician's patients suffering from enumerated chronic conditions, a

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pharmacist must, among other things, be certified by the Board, must have completed an initial 20-hour course approved by the Board, and must enter into a Collaborative Agreement, which is submitted to the Board, with a physician authorizing the pharmacist to provide specified patient care to such physician's patients. The initial list of chronic health conditions a Collaborative Agreement may cover includes arthritis, asthma, COPD, Type 2 diabetes, HIV or AIDS, and obesity. However, the Board may adopt additional chronic conditions "in consultation with" the Boards of Medicine and Osteopathic Medicine (together, the "Medical Boards"). Many other states already allow such pharmacist-physician collaboration on "chronic disease management," and pharmacist education modules for chronic disease management are readily available.

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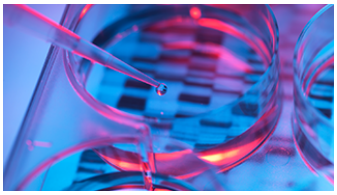

Testing, Screening and Treatment of Nonchronic Conditions

In order to provide testing, screening, and treatment for nonchronic conditions, a pharmacist must, among other things, hold a Board certification in such testing, screening, and treatment that is established by the Board "in consultation with" the Medical Boards. Such services must be performed within the framework of an established written protocol with a supervising physician that must be submitted to the Board. Unlike the list of chronic conditions that requires the Board to act to supplement it, the Act provides a non-exhaustive list of nonchronic conditions that a pharmacist may test for, screen, and treat. The list is intended to include "minor, nonchronic health condition[s that are] typically short-term condition[s that are] generally managed with minimal treatment or self-care." These include influenza, streptococcus, lice, skin conditions such as ringworm and athlete's foot, and minor, uncomplicated infections. Accordingly, it is possible that a pharmacist and supervising physician would independently expand the list.

Even before the passage of the Act, pharmacists had the authority to perform drug therapy management pursuant to an individualized assessment of a patient by a physician, physician assistant, podiatrist, or dentist that specifies conditions under which a pharmacist could order laboratory tests, interpret laboratory values, and execute drug therapy orders. (Click here to view Fla. Rule 64B16-27.830). Curiously, none of the proposed rules involve an expansion of that particular authority. Furthermore, while such services must be performed in a private, distinct, and partitioned area that permits the pharmacist and patient to sit down and discuss the patient's care privately, no such requirement is included in the draft rules from the Board.

The draft rules raise many questions including with respect to logistics for this three-way doctor-pharmacist-patient relationship. From an efficiency standpoint, the doctor might ask all his or her chronic disease management patients to go to the same pharmacy where he or she has Collaborative Agreements with a pharmacist. Would directing patients in that manner constitute limiting a patient's free choice in the selection of their pharmacy? Is the Collaborative Agreement that is between the physician and a licensed pharmacist (without reference to the pharmacy itself) transferable if the pharmacist leaves to work for another pharmacy? Does the patient follow the pharmacist or stay with the pharmacy?

Furthermore, it is unclear how pharmacists and pharmacies can monetize this new authority. What if the patient's health insurance provider network doesn't include the pharmacy selected by the physician? Cash customers could pay for the enhanced care and it may be worthwhile for them to do so in lieu of paying for a physician visit. However, at present, it would be up to the payors to allow the pharmacists to directly submit claims for consultations or the analysis they would undertake to review test results and conduct screenings. CMS

does not allow pharmacists to bill chronic disease management directly, but it may be possible for the physicians to bill these services as “incident to” and reimburse the pharmacists. However, such service arrangements would be subject to potential Stark and anti-kickback review.

A telephonic joint meeting of the Board Rules Committee with representatives of the Board of Medicine and Board of Osteopathic Medicine is scheduled for 9:00 a.m. on June 25, 2020. Perhaps some of these questions will be answered then.
