## Guidelines for State and Territory Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017, 2022)

### Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA believes inclusion of PAs in state and territory law and delegation of authority to regulate their practice to a state and territory agency serves to both protect the public from incompetent performance by unqualified medical providers and to define the role of PAs in the healthcare system.
- AAPA, while recognizing the differences in political and healthcare climates in each state and territory, endorses standardization of PA regulation as a way to enhance appropriate and flexible professional practice.
- When referencing states throughout this paper, the intent is to also be inclusive of U.S. territories and the District of Columbia.

### Introduction

Recognition of PAs as medical providers led to the development of state and territory laws and regulations to govern PA practice. Inclusion of PAs in state and territory law and delegation of authority to regulate their practice to a state and territory regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified medical providers, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states and territories have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate practice by PAs as medical providers while protecting the public's health and safety.

What follows are general guidelines on state and territory governmental control of PA practice. AAPA recognizes that the uniqueness of each state and territory's political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible PA practice nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state and territory practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states and territories as they pursue improvements in state and territory governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult AAPA's model state and territory legislation for PAs.

**Definition of PA**

The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and PA practice should be considered the practice of medicine.

**Qualifications for Licensure**

Qualifications for licensure should include graduation from an accredited PA program and passage of the PA National Certifying Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).

PA programs were originally accredited by the American Medical Association's Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA's Committee on Allied Health Education and Accreditation (CAHEA) In 1976. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, The Accreditation Review Commission on Education for the PA (ARC-PA), which had been part of both the CAHEA and CAAHEP systems, became a freestanding accrediting body and the only national accrediting agency for PA programs.

Because the law must recognize the eligibility for licensure of PAs who graduated from a PA program accredited by the earlier agencies, the law should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies.

The qualifications should specifically include passage of the national certifying examination administered by the NCCPA**.** No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE**.**

The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take its examination. However, between 1973-1986, the exam was open to individuals who had practiced as PAs in primary care for four of the previous five years, as documented by their supervising physician. Nurse practitioners and graduates of unaccredited PA programs were also eligible for the exam. An exceptions clause should be included to allow these individuals to be eligible for licensure.

**Licensure**

When a regulatory board has verified a PA's qualifications, it should issue a license to the applicant. Practice without a license is subject to severe penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers.

Applicants who meet the qualifications for licensure should be issued a license. States and territories should streamline the licensure process and not require unnecessary steps including, but not limited to, employment or identification of a supervising, collaborating, or other specific relationship with a physician(s), jurisprudence exams, or board approval of practice elements as a condition or component of

licensure. A category of inactive licensure should be available for PAs who are not currently in active practice in the state or territory. Regulatory agency staff should be empowered to approve an uncomplicated PA license application without direct board action. If issuance of a full license requires approval or ratification at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

When a PA returns to clinical practice following an extended period of clinical inactivity unrelated to disciplinary action or impairment issues, the board should be authorized to issue a license and allow applicants to practice to the full extent of their education, training and experience. Each PA reentering clinical practice will have unique circumstances; therefore, the board should be authorized to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include unrestricted licensure, requiring continuing medical education, development of a personalized re-entry plan, which may include supervised practice, or temporary authorization to practice for a specified period of time**.** It has not been determined that absence from clinical practice is associated with a decrease in competence, therefore, re-entry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks and/or fingerprinting for PA license applicants. Licensing agencies should have the discretion to grant or deny licensure based on the findings of background checks and information provided by applicants.

**Optimal Team Practice**

Since the inception of the profession, PAs have embraced team-based patient-centered practice and continue to do so. Because both PAs and physicians are trained in the medical model and use similar clinical reasoning, PA and physician collaboration is effective and valued.

Optimal team practice addresses the needs in an evolving medical practice; today's healthcare environment requires flexibility in the composition of teams and the roles of team members to meet the diverse needs of patients. Therefore, the manner in which PAs, physicians and other healthcare providers work together should be determined at the practice level.

Within state and territory laws and regulations, optimal team practice occurs when PAs are not required to have a specific relationship with any other healthcare provider to practice to the full extent of their education, training and experience. PAs will continue to consult, collaborate, or refer, when necessary, as indicated by the patient's condition and the standard of care, and in accordance with the PA's competencies. Alternative requirements diminish team flexibility and therefore limit patient access

to care, without improving patient safety. By removing administrative restrictions, PAs and their teams will have greater flexibility to more effectively care for patients.

Currently, the administrative relationship requirement puts all providers involved at risk of disciplinary action for reasons unrelated to patient care or outcomes. State and territory law should recognize PAs as responsible for the care they provide to their patients.

Optimal team practice is applicable to all PAs, regardless of specialty or experience. Whether a PA is early career, changing specialty or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to ensure that the patient's treatment is consistent with the standard of care.

**PA Practice Payment, Ownership, and Employment**

In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital, health system, or large practice. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of physicians.

To allow for flexibility and creativity in tailoring healthcare systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to PAs. The healthcare team relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence their ethical obligations to patients. State and territory law provisions should authorize the regulatory authority to discipline a PA or other healthcare provider who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

**Disasters, Emergency Field Response and Volunteering**

PAs should be allowed to provide medical care in disaster and emergency situations without requiring a specific relationship with a physician or other healthcare provider. This may require the state or territory to adopt language that permits PAs to respond to emerging public health threats, sudden emergencies, or other events necessitating emergency medical care, regardless of setting, provided the care is within the PA's education, training, and experience.

This exemption should extend to PAs who are licensed in states or territories other than where the care is provided or who are federal employees. PAs should be granted "Good Samaritan" immunity to the same extent that it is available to other health professionals under the laws of the state or territory in which the care is rendered.

PAs who are volunteering without compensation or remuneration should be permitted to provide medical care as indicated by the patient's condition and the standard of care, and in accordance

with the PA's education, training, and experience. State and territory law should not require a specific relationship between a PA, physician, or any other healthcare provider for a PA to volunteer.

**Scope of Practice**

State and territory law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any legal medical service that is within the PA's education, training and experience, and be determined at the practice level.

Medical services provided by PAs may include but are not limited to ordering, performing and interpreting diagnostic studies, ordering and performing therapeutic procedures, formulating diagnoses, providing patient education on health promotion and disease prevention, providing treatment and prescribing medical orders for treatment. This includes the ordering, prescribing, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics.

Additional training, certificates of added qualifications (CAQs), education or testing should not be required as a prerequisite to PA prescriptive authority.

PAs who are prescribers of controlled medications should register with the United States Drug Enforcement Administration and relevant state or territory agencies.

Dispensing is also appropriate for PAs. The purpose of dispensing is not to replace pharmacy services, but rather to increase patient ability to receive needed medication when access to pharmacy services is limited. Pharmaceutical samples should be available to PAs just as they are to physicians for the management of clinical problems.

State and territory laws, regulations, and policies should allow PAs to sign any forms that require a physician signature.

**Title and Practice Protection**

The ability to utilize the title of "PA," "physician associate" (or its predecessor "physician assistant") or "asociado médico" when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state or territory as a PA. The title may also be utilized by those who are exempted from state or territory licensure but who are credentialed as a PA by a federal employer and by those who meet all of the qualifications for licensure in the state or territory but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless credentialed as a PA by a federal employer. The state or territory should have the clear authority to impose penalties on individuals who violate these provisions.

**Regulatory Agencies**

Each state and territory must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state and territory agencies can be charged with this task, the

preferable regulatory structure is a separate PA licensing board responsible for the licensure, discipline, and regulation of PAs and comprised of a majority of PAs, with other members who are knowledgeable about PA education, board certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of healthcare settings — primary care, specialty care, institutional and rural based practices.

If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs and physicians who practice with PAs be full voting members of the board.

Any state or territory regulatory agency charged with PA licensure should be sensitive to the manner in which it makes information available to the public. Consumers should be able to obtain information on health professionals from the licensing agency, but the agency must assure that information released does not create a risk of targeted harassment for the PA licensee or their family.

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state and territory regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public's right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high- risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public.

Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

**Discipline**

AAPA endorses the authority of designated state and territory regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state or territory law. Disciplinary actions may include, but are not limited to, suspension or revocation of a license or approval to practice. In general, the basic offenses are similar for all health professions and the language used to specify violations and disciplinary measures to be used for PAs should be similar to that used for other licensed healthcare professionals in the state or territory. The law should authorize the regulatory agency to impose a wide range of disciplinary actions so that the board is not motivated to ignore a relatively minor infraction due to inadequate disciplinary choices. Programs and special provisions for treatment and rehabilitation of impaired PAs should be similar to those available for physicians. AAPA

also endorses the sharing of information among state or territory regulatory agencies regarding the disposition of adjudicated actions against PAs.

**Inclusion of PAs in Relevant Statutes and Regulations**

In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws and regulations that specifically enumerate physicians and nurse practitioners, including provisions that grant patient-provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of injuries, such as wounds from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize those appropriately trained PAs to use them.

For all programs, states and territories should include PAs in the definition of primary care provider when the PA is practicing in the medical specialties that define a physician as a primary care provider.

It is in the best interest of patients, payers and providers that PA-provided services are measured and attributed to PAs; therefore, state and territory law should ensure that PAs who render services to patients be identified as the rendering provider through the claims process and be eligible to be reimbursed directly by public and private insurance.