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# Understanding the Physician Associate Licensure Compact

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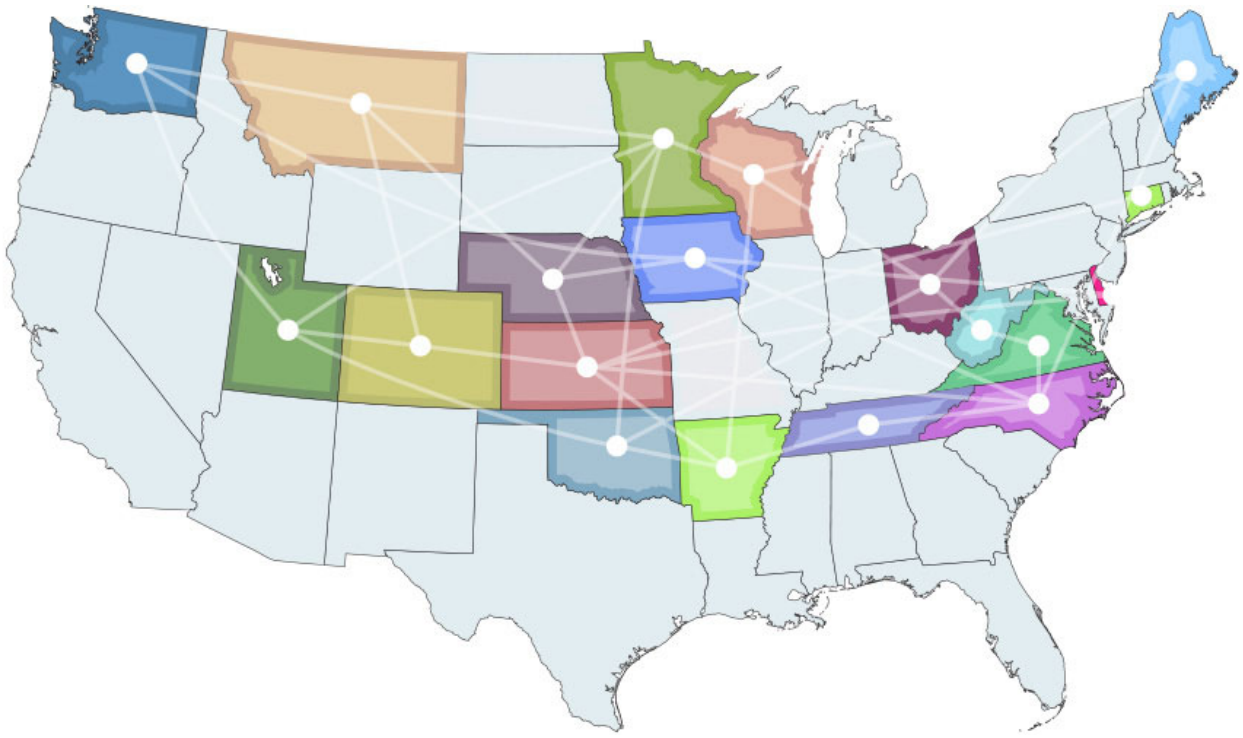

Like so much of what drives state interests, a driving force of their interest in health-related license

portability is rooted in a desire to maintain autonomy from the federal government. While it may be an oversimplification, states have long feared federal overreach in the form of federally issued licenses for certain professions to address delays in licensure and provider shortages. [1] Maintaining this autonomy over health care practitioners allows states to dictate scope of practice, discipline, and, not unimportantly, to set and collect revenue that is generated by the issuance of licenses.

## Compacts Become the Vehicle of Choice for License Portability

In the last 20 to 30 years, the preferred method for states and professions to pursue license portability has been through state licensure compacts. Interstate compacts are legally binding agreements between states that address common issues, such as licensure portability. Compacts are created when states agree upon a uniform set of standards to allow licensed professionals to enter the compact and then the states enact near-identical legislation to commit to join and participate in the compact.

What started as a slow trickle in the 1990s with the initial Nurse Licensure Compact (NLC), interstate licensure compacts have exploded in the last five to ten years. Most professions that have a licensure compact or are in the process of pursuing one are health care professions. Currently, there are 17 professional licensure compacts that are either activated or are working to achieve the minimum number of states necessary to activate. [2] Many of these compacts have seen wide adoption; for example, the NLC has 43 participating jurisdictions [3] and the Interstate Medical Licensure Compact (IMLC) has more than 40 jurisdictions with at least partial adoption or participation (more than 35 are full participants). [4]

Despite this expansion, not all states have joined these compacts for a number of reasons. State legislators and regulators in particular frequently cite concerns about patient safety, threats to state sovereignty, scope of practice changes for licensees, costs, and potential lost revenue. States also may be skeptical about the actual potential of compacts to ease health care workforce shortage.

## Compacts Generally: Commonly Recognized Benefits and Support

Compacts have many goals, both for the professions that pursue them, and the states that adopt them. For health care professionals, licensure compacts enhance providers' ability to practice across state lines; standardize and streamline the licensure process; and offer a swifter path to interstate telemedicine practice. For states, compacts may help increase access to providers, particularly in rural and underserved areas, and promote competition within their health care markets, potentially improving the quality of care. Compacts achieve these benefits by establishing uniform standards to multi-state practice while simultaneously upholding a state's practice act and initial licensure process. Additionally, licensure compacts, like the physician associate/physician assistant (PA) compact, allow each state to set a fee for a compact privilege. Each member state has a seat at the table to develop rules, bylaws, and other administrative functions of the compact. Rules written by the compact commission only apply to the specific compact procedures implementing the interstate

extension of member state authority across state lines without taking over individual state regulatory authority. Licensure compacts also create an interstate data system that is specifically designed to improve information sharing among compact member states, including investigative and disciplinary information, which can advance patient safety.

## Physician Associate Licensure Compact—The Long and Winding Road

The history of the PA licensure compact dates to early discussions regarding the physician licensure compact. In 2013, the Federation of State Medical Boards (FSMB) began working on what would eventually become the IMLC, the licensure compact for physicians. From the beginning, the PA profession strongly advocated for PA inclusion within the physician compact. However, it was thought that setting up one compact for two distinct professions would not be possible for a variety of reasons, including, but certainly not limited to, licensure requirements and the fact that while there is some overlap, not all states license PAs and physicians through the same regulatory entity.

Not discouraged, the American Academy of Physician Associates (AAPA) continued to follow the development and eventual launch of the IMLC and stayed engaged with FSMB on other projects related to license portability behind the scenes. In early 2019, with the IMLC up and running, FSMB approached AAPA and the sole certifying organization for the profession, the National Commission on Certification of Physician Assistants (NCCPA), to write letters of support for a Health Resources and Services Administration (HRSA) grant that FSMB was applying for that would include supporting license portability for PAs. The Licensure Portability Grant Program is only eligible to state professional licensing boards, including but not limited to, organizations that are in consortia with or associations of state licensing boards. In August of 2019, FSMB was awarded the grant. [5] Work began in earnest and AAPA, FSMB, and NCCPA, together with the guidance and expertise of The Council of State Governments' National Center for Interstate Compacts (CSG), developed a compact that was activated in April 2024 when Virginia became the seventh state to enact the model compact legislation. [6] To date, 19 states have joined the PA Licensure Compact. [7]

## Current Status of Efforts

The first step that is required for states that wish to join the compact (and become "compact member states") is the enactment of the model compact legislation. AAPA has been working closely with state PA chapters to advocate for the PA Compact. As of this writing, 19 states (Arkansas, Colorado, Connecticut, Delaware, Iowa, Kansas, Maine, Minnesota, Montana, Nebraska, North Carolina, Ohio, Oklahoma, Tennessee, Utah, Washington, West Virginia, Wisconsin, and Virginia) have enacted compact legislation thereby joining the PA Compact, and legislation is being considered in four states, with more expected for introduction when the 2026 legislative session begins.

The PA licensure compact required seven states to enact the model legislation for it to become activated. Upon activation, the PA Compact Commission, a joint government agency and national administrative body, was formed to begin to operationalize the compact. The PA Compact

Commission is an instrumentality of the compact states acting jointly and not an instrumentality of any one state. The PA Commission creates and administers the compact's rules, policies, and procedures. Each state that joins the compact must have one delegate, who is either a current PA, physician, or public member of a licensing board or PA council/committee or an administrator of a licensing board.

The PA Compact Commission met for the first time September 24-25, 2024, during which it elected members of the executive committee and adopted bylaws and rulemaking protocols. Its executive, finance, and rules committees have been meeting monthly to work on the details of implementation. It typically takes 18-24 months from the initial meeting of the commission for a compact to be operational upon activation.

The current expectation is that PAs may receive privileges to practice in early 2027. Throughout the next year, the PA Commission will continue to meet to hire an Executive Director and Secretariat to run the Commission's operations and create a shared database for verification of licensing and disciplinary information.

## Features of the PA Licensure Compact

The operationalization of occupational licensure compacts is usually achieved by one of two approaches: expedited licensure or mutual recognition. The PA licensure compact is a mutual recognition model. Compact member states agree to mutually recognize a valid, unencumbered license from other compact member states via a compact privilege. A compact privilege is equivalent to a license and is the authorization for a PA to practice in another compact member state. Licensed PAs utilizing the compact can obtain a privilege to practice in each compact member state where they want to practice, adhering to each state's practice laws while maintaining their primary residence in their home state.

The mutual recognition model of licensure compacts is utilized by other professions, such as physical therapy, occupational therapy, audiology and speech language pathology, social work, and teaching. This model differs from the IMLC for physicians, which utilizes an expedited licensure model. The primary difference between these types of licensure compact models is in how they handle license recognition. With the mutual recognition model, the practitioner's qualifying license is accepted across all compact states, with an applicant applying and receiving their privilege to practice through the IMLC Commission. The IMLC expedited licensure model allows eligible physicians to complete a single application within the Compact and receive separate licenses from each state in which they intend to practice. This expedited licensure model requires individuals to apply for a license in each state in which they wish to practice; however, the application process is streamlined through the centralized data and standardized requirements.

The PA Compact also differs slightly from the NLC. The NLC also uses a mutual recognition model; however, nurses receive a multistate license that is issued by their primary state of residence, whereas with the PA Compact, the license is issued by the PA Compact Commission. During initial stakeholder meetings, it was quickly decided that a mutual recognition model was preferable to the expedited licensure model. Not only is the mutual recognition model less cumbersome for the

licensee, but states were more familiar with it because of the various other professions that were working on similar compacts at the time.

The PA Compact is optional for PAs and can be used in addition to the "traditional" licensure route. Here are a few examples of how the PA Compact can work for a PA. In these examples, states A and B are compact members; however, state C has not joined the compact:

- A PA is licensed in state A but is not interested in practicing in other states through the compact, even though they hold a license in another compact member state. This PA can continue to seek a license in the states in which they wish to practice through the traditional method.
- A PA is licensed in state A and wishes to provide telehealth services in state B. The PA can use their qualifying license of state A to apply for a privilege to practice in state B. The PA must abide by all laws and regulations of states A and B when providing services in those states.
- A PA lives in state C, is licensed in state A, and now also wishes to provide services in state B. The PA may use their qualifying license in state A to apply for a privilege to practice in state B, and may maintain their license through the traditional licensure process in state C.
- A PA is licensed in state C and wishes to practice in state B. The PA cannot access the compact for licensure in state B because state C is not a member of the compact. The state in which they are licensed, the qualifying state, must be a member. They may, however, receive a license in state B through the traditional method, and utilize that license in a qualifying state to access the compact and apply for privileges to practice in other compact member states, while still holding their license in state C.

The PA Compact has requirements for both states to join and for individuals who wish to participate. As a condition of joining the PA compact, states must meet certain initial licensure and public protection requirements, as well as requirements to participate after they join. States must license PAs, utilize passage of a recognized national exam such as the NCCPA's Physician Assistant National Certifying Examination (PANCE), and grant the compact privilege to a holder of a qualifying license in another state participating in the compact. States must also fully implement a criminal background check, have a mechanism in place for receiving and investigating complaints against licensees and license applicants, and notify the PA Compact Commission of any adverse actions against or significant investigation information of a licensee or license applicant. Lastly, states must participate in the PA Compact Commission, the intergovernmental agency responsible for the administration of the compact and comply with its rules.

An individual wishing to obtain a compact privilege must first meet license, certification, and education qualifications such as holding an unrestricted license issued by a participating compact state to provide medical services as a PA, graduation from an accredited PA program, and current NCCPA certification. Not every state requires current and maintenance of NCCPA certification; this is a higher bar of entry for the licensure compact. PAs must also have no felony or misdemeanor convictions; have never had a controlled substance license or permit suspended or revoked; have no limitation or restriction on any state license or compact privilege; and have no permit or registration suspended or revoked by a state or by the U.S. Drug Enforcement Administration. Lastly, PAs must notify the PA Compact Commission of their intent to seek a compact privilege in a remote state (a

state participating in the PA Compact, where a licensee is seeking to exercise the compact privilege), meet any jurisprudence requirements of the remote state, and report to the Commission any adverse action taken by a non-member state within 30 days after the action is taken.

## Benefits of the PA Compact for PAs, Regulators, and Health Systems

There are many benefits for PAs who wish to utilize the licensure compact. First, it reduces the time and effort needed to receive authorization for licensure. In addition, privileges to practice renew at the same time as a PA's qualifying state license, which makes it easy to keep track of renewal periods. Lastly, a PA is only required to meet continuing medical education (CME) requirements for the state in which they have their qualifying license, not in every state in which they hold a privilege. The PA Compact will charge a nominal compact fee, determined by the PA Compact Commission, and states can set fees for the privilege to practice for their state. While utilizing the licensure compact will likely not be more than receiving a license from each state, there may not be significant cost savings; however, a PA may save some money as they will not have to complete CME in every state.

The compact also has benefits for regulators since it facilitates the exchange of licensure and disciplinary information, which improves cooperation across states in regulating the profession and ensuring public safety. States still retain control of scope of practice and the initial licensure process, while also being able to set a fee for privileges to practice and renewals of those privileges.

The PA Compact—by extension—may also be advantageous for hospitals and health systems, including by simplifying access to a wider pool of qualified PAs for rapid deployment in emergencies; reducing administrative burdens and improving efficiency; enhancing patient continuity, particularly in areas where patients are likely to seek care across state lines; and facilitating telehealth access and delivery.

## How the PA Compact Addresses Concerns and Misconceptions About Interstate Licensure

Despite the benefits considered above, apprehensions around and misconceptions about interstate occupational licensure compacts are commonplace. Much of the apprehension results from misconceptions, and similar to other newer policy ideas, many states prefer to take a wait and see approach. While the PA Compact does allow states to retain their initial licensure requirements and requires those seeking a compact privilege in their state to meet specific requirements (e.g., jurisprudence exam), states are still hesitant to give up some control over their licensing process. States also worry about potential revenue loss from practitioners who will be utilizing the compact as opposed to obtaining a separate license to practice in their states despite having the ability to set a fee for a compact privilege to make up for the anticipated loss. There is also concern that implementing the necessary technology and administrative changes to join the compact will be costly to states—especially to connect to the compact database. Some states also express apprehension that joining a compact could lead to an influx of out-of-state practitioners, potentially

impacting the job market of those based in the state.

While licensure compacts can exist alongside other approaches (e.g. reciprocity and endorsement), states that have already taken steps to improve licensure portability may prefer to see how these changes improve licensure portability before introducing the licensure compact, or they may see these as preferable, given the other concerns outlined above.

## Patient Safety

It is well understood that in the United States, the licensing, regulation, and oversight of professions are accomplished by the states. [8] Each jurisdiction adopts rules by which individuals within a profession must comply, including the qualifications, responsibilities, and ethical obligations licensees must meet. Today, all states, the District of Columbia, and all U.S. territories have passed laws to authorize and regulate the practice of medicine by PAs.

The board or agency responsible for regulating the PA profession varies from state to state. PAs practice medicine, so when the profession started, PA regulation was almost always delegated only to a medical/multidisciplinary "healing arts" board. Such sole regulatory authority of PAs continues present-day, except in nine states that have established separate state PA boards. [9] No matter what the designated board for PA regulation may be, ensuring patient safety is a paramount responsibility it shares with other health care regulators throughout the country. It is therefore not surprising for officials to have questions about how interstate licensure compacts governing health care providers aim to maintain or improve public health and safety; a failure to have satisfactory safeguards in place can thwart a compact's enactment. For example, the power to prevent a reduction in competency standards and review a licensee's criminal history were cited as the rationale by some Oregon officials for their inability to support the NLC and the United States Emergency Medical Services Compacts. [10]

To counter these competency and safety concerns, the PA Compact imposes requirements on individual licensees and the state. As noted above, individuals must possess and maintain current NCCPA certification—a higher standard of entry. Again, for states, participation in the PA Compact is contingent on full implementation of a criminal background check requirement and the establishment, maintenance, and utilization of a coordinated data and reporting system (Data System) containing licensure, adverse action, and investigative information on all licensed PAs in participating states. If any participating state takes adverse action, it must notify the administrator of the Data System. The administrator is responsible for subsequently notifying other participating states of adverse actions taken by a participating state. As a result, the PA Compact creates a licensure Data System designed to improve information sharing between compact member states, including disciplinary information.

## State Sovereignty

A misconception about interstate compacts is that they have the potential to invade state sovereignty, thereby invalidating state laws. On the contrary, one of the benefits of interstate compacts is their ability to permit states to preserve sovereignty in matters customarily reserved for

the states with regional or national implications. The PA Compact has no impact on a state's laws and regulations except as defined within the compact—there is no invalidation, preemption, or appropriation of state regulatory authority. In short, states cannot specify the laws and regulations a PA must follow in a remote state. Thus, the compact works to respect the PA laws and regulations of each individual state. States maintain their regulation of the PA profession, including, but not limited to matters pertaining to:

- Collaboration/supervision requirements
- Prescriptive authority
- Ratios
- Title change

PA Compact privilege holders must always abide by the laws and regulations of the state in which they are practicing at the time they deliver patient care. This extends to providing telehealth services. PAs using the compact privilege may render telehealth services in accordance with the law and regulations of the state in which the patient is located.

As it pertains to disciplinary action and investigations, pursuant to the PA Compact, states can:

- Investigate compact privilege holders for action taken in their state; states do not lose the right to enforce compliance with state laws and regulations and can take action, as long as the action is taken in their state
- Act on a license or privilege issued by their state
- Participate in joint investigations with other compact member states if they are also included

States cannot:

- Act on a license or privilege issued by another member state
- Deny a privilege or investigate a PA for lawful action/lawful facet of scope of practice in another state

## Scope of Practice

"Scope of practice" refers to the services a health care professional may provide and includes two subcategories: professional scope of practice and legal scope of practice. The former encompasses services that members are educated, trained, and competent to provide. The latter refers to state laws and regulations that define the services and procedures an occupation may or may not provide by law. States are not uniform in their laws regarding PA practice. Nevertheless, all 50 states, the District of Columbia, and all U.S. territories authorize PAs to be licensed to practice medicine as members of the health care team with physicians, prescribe non-controlled and/or controlled medications, [11] and engage in a wide range of medical diagnostic and treatment services. Each PA's scope of practice is determined by the PA's education and experience, state law, employer and facility policies, and the needs of the patients.

Often coupled with matters pertaining to state sovereignty, another point of contention concerns the assumption that all compacts are an attempt to expand a profession's scope of practice. For

example, some groups who oppose the PA Compact view it as a system through which PAs will be permitted to attain independent practice or prescriptive authority that does not currently exist, akin to efforts to enact a multistate licensing compact for advanced practice registered nurses. [12] However, pursuant to the PA Compact, PAs must follow the laws and regulations of the state in which the care will be provided, including those provisions governing the prescribing of medications. The PA Compact cannot be used as a mechanism to change PA scope of practice, grant independent practice to PAs, or confer/remove limitations on prescriptive authority.

### Costs/Potential Lost Revenue

Compacts require funding for development, administration, and maintenance. States must be thoughtful in how they will achieve these goals. While some compacts, like the PA Compact, have initially benefited from seed funding through grants from HRSA, those monies are not provided in perpetuity. Developmental costs can vary depending on a myriad of factors. For example, since each compact is unique in how it addresses different professions and issues associated with them, some may warrant more complex and expensive developmental considerations than others. Costs may also differ due to the extent of stakeholder involvement during the compact's initial developmental phase when they examine issues, current policy, best practices, alternate structures, and establish recommendations for a compact's content prior to and post-drafting for incorporation into the final product. Lastly, the level of onsite education and technical assistance each state desires to provide fluctuates. While costs for developing the compact are not usually passed on to states, there is concern from states around the cost to connect to the Data System to share information, implementing criminal background checks, and any expenses associated with sending a delegate to in-person compact commission meetings. With regards to the Data System, the compact commission will likely look at the systems states already have in place to ensure it is not overly cumbersome or costly to the state. States also will have a bit of time to ensure they are doing criminal background checks for those wishing to join the compact, and those costs are often passed on to applicants. Lastly, most compact commission meetings will be virtual, and in-person engagements may be supplemented by the HRSA grant and the compact budget.

States also are concerned that by joining a compact, they will lose revenue from both licensing and application fees. To address this concern, while there is no fee for states to join the PA Compact, the Compact Commission has the authority to generate revenues through the establishment of fees, including through a compact privilege fee, paid by applicants. Participating states may also assess fees to PAs applying for a compact privilege (including renewals).

## Looking Ahead: The Future Is Bright

The future is bright for licensure compacts, including the PA Compact. As stated, there are 17 professions with available occupational licensure compacts, with two more in development. Over 350 pieces of legislation to enact licensure compacts have been passed by the states since 2016. [13] The PA Compact Commission continues to meet, with the database expected to be up and running by the end of the year and the hope that PAs will be able to apply for privileges to practice through the compact by early 2027.

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1 Ateev Mehrotra, M.D., Alok Nimgaonkar, B.A., & Barak Richman, J.D., Ph.D., *Telemedicine and Medical Licensure – Potential Paths for Reform,* 384 N. ENGL. J. MED. 687, 688 (Feb. 25, 2021).

2 Council of State Governments: National Center for Interstate Compacts, Occupational Licensure Compacts, https://compacts.csg.org/compacts/ (last visited Dec. 17, 2024).

3 National Council of State Boards of Nursing, Nurse Licensure Compact: Participating Jurisdictions, https://www.nursecompact.com/ (last visited Aug. 26, 2025).

4 Interstate Medical Licensure Compact Commission, U.S. State Participation in the Compact, https://imlcc.com/ (last visited Aug. 26, 2025).

5 Federation of State Medical Boards, News Release: Federal Grant Awarded to Expand Interstate Medical Licensure Compact; Support License Portability for PAs (Aug. 27, 2019), https://www.fsmb.org/advocacy/news-releases/federal-grant-awarded-to-expand-interstate-medical-licensure-compact/.

6 American Academy of Physician Associates, PA Profession Secures Passage of Licensure Compact Legislation in Seven States (Apr. 5, 2024), https://www.aapa.org/news-central/2024/04/pa-profession-secures-passage-of-licensure-compact-legislation-in-seven-states/. (last visited Dec. 17, 2024).

7 PA Compact, PA Licensure Compact: License Portability for Physician Assistants, https://www.pacompact.org/.

8 See U.S. Const. amend. X.

9 Arizona, California, Iowa, Massachusetts, Michigan, Rhode Island, Tennessee, Texas, and Wisconsin have separate PA boards.

10 Lucas Manfield, Doctors and Nurses Can't Cross State Lines to Work in Oregon. Why Not?, Willamette Week, Oct. 2, 2024, https://www.wweek.com/news/2024/10/02/doctors-and-nurses-cant-cross-state-lines-to-work-in-oregon-why-not.

11 All states, the District of Columbia, and all U.S. territories except Puerto Rico authorize prescribing by PAs. All states, the District of Columbia, and all U.S. territories except American Samoa and Puerto Rico allow PAs to prescribe some or all of Schedule II-V controlled substances.

12 Mackenzie Bean, Physician Nursing Groups Oppose APRN Compact, Becker's Hosp. Rev., June 28, 2024, https://www.beckershospitalreview.com/workforce/medical-groups-oppose-aprn-compact.html.

13 Nat'l Ctr. for Interstate Compacts, Occupational Licensure Compacts, https://compacts.csg.org/compacts/.

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