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The PA Licensure Compact: Identification of Significant Factors to Enacting Legislation

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Abstract The PA Licensure Compact (PALC) is an optional agreement between states that aims to increase healthcare services for patients by allowing PA's with a license in a compact member state to practice in any other member state. Currently nineteen states have enacted the PALC. A study was conducted assessing factors that impact a states decision to join the PALC. State population density, number of PA programs, number of medical schools, rural population, rural land area, rural population density, number of PA's in each state, percentage of PA's in each state, PA's that participate in telemedicine, and number of physicians in each state with stratification into neonatal, cardiovascular, critical care, endocrinology, oncology, gastroenterology, and emergency medicine were analyzed in a logistic regression design. The number of PA Programs and PA's in each state, number of physicians practicing in the US, and specialties cardiovascular, gastroenterology, and emergency medicine were found to be statistically significant (P<.05). This study adds to the body of knowledge regarding the PALC and future outcomes as more states pass legislation to join the compact expanding access to healthcare.

Keywords: *logistic regression, telemedicine, physician assistant*

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1. Introduction

An interstate compact is a legally binding agreement between two or more states that embodies a mutual recognition model of interstate practice. It establishes a formal, legal relationship among states to address a common problem. The PA Licensure Compact (PALC) can be described as an interstate occupational licensure compact for physician assistants/associates designed to improve access to healthcare for patients and, in addition, enhance public protection. It is the result of collaboration among the Federation of State Medical Boards (FSMB), the American Academy of Physician Associates (AAPA), the National Commission on Certification of Physician Assistants (NCCPA), and the Council of State Governments (CSG). The PALC received funding from the Health Resources and Services Administration of the US Department of Health and Human Services (H1MRH24097). This accomplishment demonstrates the power of partnerships and support in improving access to healthcare for all [1]. The four entities drafted a model legislation and disseminated it to state medical boards and interested parties in April 2021. Comments and recommendations from stakeholders were incorporated into the final PALC document in November 2022. The first states to enact the PALC were Utah, Delaware, and Wisconsin near the end of 2023. Key points of the legislation include: 1) states joining the compact agree to recognize a valid, unencumbered license issued by another compact member state via a compact privilege, 2) Licensed PA's utilizing the compact can obtain a privilege in each compact member state where they intend to practice, 3) PA's that choose to utilize a compact privilege must adhere to the laws and regulations of the state in which they are practicing, 4) eligibility of the PALC is predicated on having an active license from a compact license state, have graduated from an accredited PA Program, have current NCCPA certification, and are devoid of any felonies or misdemeanor convictions [2]. Adoption of the PALC by states serves to promote workforce development, expands patient access to highly qualified clinicians, reduces application processing time for PA's wanting to practice in another state compared to applying for an individual license for state(s), preserves state sovereignty, increases collaboration among states, engenders clinician mobility during public health emergencies, and accommodates PA's whose spouses are in the military. Moreover, a practicing PA can maintain licensure and avoid licensing-related downtime between employers as long as relevant states are PALC members [1].

There are 19 states that have enacted legislation to join the PALC. They include Arkansas, Colorado, Connecticut, Delaware, Iowa, Kansas, Maine, Minnesota, Montana, Nebraska, North Carolina, Ohio, Oklahoma, Tennessee,

Utah, Virginia, Washington, West Virginia, and Wisconsin (Figure 1). States that are in the process of filing legislation comprise Illinois, Massachusetts, New Jersey, New York, Nevada, Texas, and Oregon. Activation of the PALC is predicated on at least 7 states enacting legislation; this threshold was achieved on April 4, 2024 when the Governor of Virginia signed the bill. A study was done to assess national factors that may have influenced enactment of the PALC. A logistic regression analysis was conducted evaluating 17 variables that relate to a state's rural metrics, number of PA schools and medical schools in the US, number of PA's that are active in telemedicine, number of PA's and MD's across the US, and the number of MD's that practice in select specialties. The heterogenous nature of variables selected will provide insight into the posture of state legislatures decision to join the PALC.

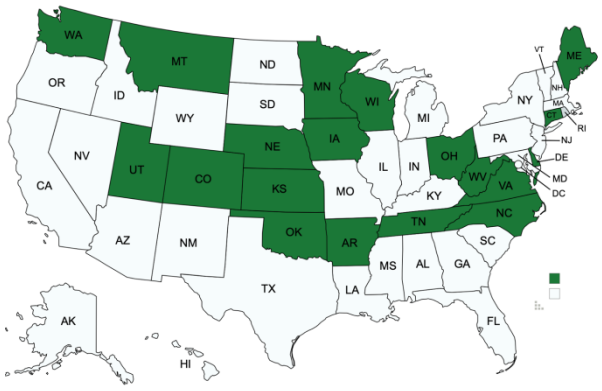

Figure 1. States that have enacted the PALC are depicted in green

2. Methods

Binary logistic regression was employed in this study using state as the unit of analysis. The dependent variable was coded 1 for a state that has enacted the PALC, and coded 0 if they have not enacted legislation. The independent variables were state population density, number of PA programs, number of medical schools, rural population, rural land area, rural population density, number of PA's in each state, percentage of PA's in each state, PA's that participate in telemedicine, and number of physicians in each state with stratification into neonatal, cardiovascular, critical care, endocrinology, oncology, gastroenterology, and emergency medicine. All of the independent variables were continuous or scale variables. Data for state population density was accessed from worldpopulationreview.com for 2025. The number of PA programs by state was accessed from the ARC-PA (Accreditation Review Commission on Education for the PA). The number of medical schools in the US was accessed from the Liaison Committee on Medical Education (LCME). Rural population, rural land area, and rural population density was accessed by worldpopulationreview.com for 2023, 2010, and 2010, respectively. The number of PA's in each state, percent of total PA's in the US, and number PA's that participated in telemedicine was accessed by data provided in the NCCPA Statistical Profile of Board Certified PA's for 2023. Data for active physicians in the US and specialties was accessed by the 2023 US Physician Workforce Data Dashboard AAMC (Association of American Medical Colleges). The binary logistic regression analysis was done using SPSS (v29) employing the Backward Wald method. Goodness of fit model design was assessed using the Hosmer and Lemeshow Test. Statistical significance was defined as P<.05.

3. Results

Variables found to be statistically significant (P<.05) were the number of PA Programs and PA's in the US, number of physicians in the US, number of physicians practicing in cardiovascular, gastroenterology, and emergency medicine. Using the beta coefficient in the logistic regression analysis, the number of PA Programs, PA's, and overall number of physicians practicing in the US represented a direct relationship denoted by a positive Beta coefficient, where the number of physicians practicing in cardiovascular, gastroenterology, and emergency departments represented an inverse relationship denoted by a negative beta coefficient (Table 1). The Hosmer and Lemeshow Test yielded values >.05 indicating a favorable goodness of fit for the regression model employed.

Table 1. SPSS Table of Significant Variables

Variable	Beta Coefficient	P value	Odds Ratio
Number of PA Programs	0.595	0.028	1.8
Number of PA's	0.002	0.03	1.002
Number of MDs	0.003	0.003	1.003
Cardiovascular	-0.046	0.011	0.955
Gastroenterology	-0.065	0.045	0.937
Emergency Med	-0.024	0.006	0.977

4. Discussion

This study found six variables to be statistically significant using binary logistic regression. The number of PA programs, PA's in each state, and number of MD's practicing in the US were direct relationships, and physicians working in cardiovascular, gastroenterology, and emergency medicine were inverse relationships. This can be interpreted as a state is more likely to enact the PALC as the number of PA's and PA programs increase, and the number of MD's increase; and, low numbers of physicians working in cardiovascular, gastroenterology, and emergency medicine may favor a state enacting the PALC. Interestingly, variables related to rural metrics and telemedicine were not found to be statistically significant. Currently there are 318 accredited PA Programs [3]. The range of PA Programs in states that are members of the PALC ranged from 1 (Delaware, Maine, Montana) to 17 (Ohio). The range of PA Programs in states not members of the PALC ranged from 0 (Alaska, Vermont) to 31 (Pennsylvania). The rationale for the significant finding regarding the PA's and PA Programs variable could be that the more PA Programs, the more students that graduate

and go onto practice medicine opting for practicing medicine in more than one state.

The other variable that yielded a direct relationship was the number of practicing physicians in the US across all specialties. The range for the number of physicians in member states ranged from 2947 (Montana) to 36757 (Ohio). The range for non-member states is 2152 (Alaska) to 118491 (California). Of the 7 specialties selected for inclusion, only cardiology, gastroenterology, and emergency medicine were found to be statistically significant and each exhibited an inverse relationship. The range for MD's in cardiology among member states was 48 (Montana) to 841 (Ohio); the range for non-member states was 25 (Wyoming) to 2324 (California). The range for MD's in gastroenterology in member states was 32 (Montana) to 576 (Ohio); non-member states ranged from 12 (Wyoming) to 1857 (California); for emergency medicine the ranges were 155 (Delaware) to 2011 (Ohio), and 93 (North Dakota) to 6155 (California), respectively. Diminishing numbers of physician's in the cardiovascular, gastroenterology, and emergency medicine departments compared to all departments and specialties invite a conversation surrounding the need for PA's in these areas engendering support for the PALC. In support of this assertion, in the sphere of emergency medicine, a study was done assessing attrition of physicians in the ER from 2013 to 2019. Percent attrition increased for males from 3.3 to 7.4, and for females 2.8 to 8.2, respectively [4]. A total of 25,839 males and 10,954 women were included in the study. They also noted female gender was significantly associated with attrition at 12 years younger than their male counterpart. In regard to the cardiovascular variable, with heart disease as the number one cause of death in the US, nearly half of all US counties lack a practicing cardiologist which translates to a 31 percent higher risk of heart disease and related complications in these areas. Moreover, sixty percent of cardiologists are older than 55 years [5]. These statistics tip the pendulum in favor of the PALC expanding access of medical care.

Architects of the PALC had a plethora of compact agreements to reference in crafting their document. The Nurse Licensure Compact [6] was established in 1999 by the National Council of State Board of Nursing allowing nurses to work in other states. Other health related compacts include the Interstate Medical Licensure Compact [7], Physical Therapy Compact [8], Psychology Interjurisdictional Compact [9], Emergency Medical Services Compact [10], Audiology & Speech-language Pathology Interstate Compact [11], Dentist and Dental Hygienist Compact [12], Occupational Therapy Licensure Compact [13], Social Work Licensure Compact [14], and Dietitian Licensure Compact [15] to name a few. All of these compacts share a common thread that healthcare licensure portability is a salient issue for healthcare professionals traversing state lines. In addition, a provision for telehealth services allows for flexibility and greater access to healthcare services particularly in rural areas; this was especially evident during the COVID-19 pandemic when many patients were told early on not to come to their doctor's office to curtail the spread of the virus; predictably, telemedicine activities continued to rise after the pandemic exceeding pre-pandemic levels [16,17]. The percentage of PA's that practice telemedicine in member states was 34 (Connecticut) to 53.4 (Utah); in non-members it was 32 (New York) to 62 (Alaska). Lack of statistical significance for this variable may be the result of the normalization of telemedicine from the pandemic across all states. Rural parameters analyzed in this study such as rural population, rural land area, and rural population density also did not yield statistical significance. There are no other studies that included these parameters in a regression design to offer a comparison of findings.

A poll was conducted in 2024, assessing the percentage of PA's that favored the PALC. The sample consisted of 454 PA's from Barton Associates (Peabody, Mass). Ninety-nine percent of respondents agreed that the PALC should be implemented. The majority of PAs surveyed articulated they would be more likely to consider working in a different state if there was a compact; in addition, they stated the compact would increase patient access to high-quality healthcare; moreover, 99.5% of respondents agreed that every state should implement the PALC [18].

There is a paucity of papers in the literature covering the PALC given it is still in its infancy. This study represents the first paper analyzing 17 factors toward the enactment of the PALC. Limitations of the study involved lack of data in the state of Alaska for the Neonatal specialty, lack of data in Alaska and North Dakota for the Endocrinology specialty, and lack of data in Wyoming for Neonatal, Endocrinology, and Critical Care.

5. Conclusion

This study identified factors that were found to be statistically significant toward states enacting the PALC. The number of PA Programs, practicing PA's and physicians were found to be statistically significant factors, as were physicians practicing in cardiovascular, gastroenterology, and emergency medicine. The PALC aims to increase the ability for PA's to travel to a new state to provide essential healthcare services to patients in need, inclusive of telemedicine provisions. To date, 19 states have enacted the PALC. It will be informative to track outcomes and metrics at regular intervals of the PALC as well as hear from PA's on their experiences.

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Appendix: Raw Data

State	PALC	PDen	PAPGM	MED	RP	RLA	RPD	#PA	%PA	#MD	TM	NN	CV	CC	EN	ON	GE	EM
AL	No	103	4	2	42	95.6	40.4	1312	0.7	11387	33.5	68	275	173	74	196	194	460
AK	No	1	0	0	35	100	0.4	690	0.4	2152	62	*	26	18	*	20	13	161
AZ	No	68	5	2	11.5	98.1	5.8	3947	2.2	18942	47.1	81	399	294	121	306	312	1045
AR	Yes	60	2	2	43.9	97.9	25.1	685	0.4	6842	42.4	50	152	81	45	104	97	310
CA	No	255	20	13	5.8	94.7	12.7	14023	7.9	118491	54.3	770	2324	1757	992	1998	1857	6155
CO	Yes	58	4	1	14.4	98.5	6.8	4860	2.7	17896	51	101	286	303	114	240	246	1176
CT	Yes	766	6	3	13.8	62.3	142	3198	1.8	13728	34	88	395	232	176	285	292	574
DE	Yes	548	1	0	17.9	79.1	97.3	523	0.3	3049	38.9	31	65	38	21	42	48	155
FL	No	445	16	8	9.1	86.2	35.9	11821	6.6	62202	39.4	390	1681	1026	531	1121	1221	3238
GA	No	196	7	4	26.6	91.7	45.8	5087	2.9	26315	37.3	161	632	430	212	403	444	1322
HI	No	226	1	1	14	93.9	18.2	502	0.3	4592	58.2	25	67	57	21	43	54	302
ID	No	25	1	0	30.8	99.4	5.6	1548	0.9	3723	49.1	27	74	32	14	36	60	258
IL	No	230	9	8	13.2	92.9	28.6	4738	2.7	38252	43.7	329	917	654	383	704	673	1985
IN	No	195	8	1	28.9	93	53.7	2392	1.3	16406	32.5	120	386	266	147	265	237	851
IA	Yes	58	5	1	37.3	98.3	20	1455	0.9	7280	44.2	50	161	123	49	109	93	271
KS	Yes	37	2	1	28.2	98.8	9.1	1409	0.8	7073	42.7	37	161	115	49	110	91	301
KY	No	117	4	2	41.6	96.4	47.4	1899	1.1	10945	41.4	83	258	190	68	189	194	583
LA	No	107	4	3	29.1	95.4	29.5	1678	0.9	13036	37.8	87	309	211	110	199	226	728
ME	Yes	46	1	0	61.5	98.8	26.7	1098	0.6	4581	40.9	13	114	64	30	66	59	301
MD	No	650	5	3	14.7	79.4	96	3769	2.1	24517	37.8	141	549	471	315	604	431	999
MA	No	924	9	4	8.9	61.7	109	4867	2.7	33530	40.9	208	899	687	487	906	618	1382
MI	No	180	10	6	27.1	93.6	47.5	6983	3.9	30888	43.8	146	631	516	258	507	429	2033
MN	Yes	73	5	2	28.9	97.9	18.2	3818	2.1	18476	50.7	89	449	352	177	387	316	865
MS	No	63	2	1	54.4	97.6	32.8	424	0.2	5990	37.4	46	132	80	57	92	107	347
MO	No	91	5	4	30.8	97	26.6	1739	1	19228	39.1	170	443	450	190	308	318	889

MT	Yes	8	1	0	47.1	99.8	3	949	0.5	2947	47.6	14	48	39	16	41	32	210
NE	Yes	26	4	2	28.1	99.3	6.4	1542	0.9	4994	43.8	25	112	100	46	84	78	182
NV	No	30	2	3	6.2	99.3	1.4	1287	0.7	6921	46	41	132	90	61	86	95	438
NH	No	158	2	1	42.4	92.8	62.9	1117	0.6	4522	43.4	15	112	102	32	89	85	281
NJ	No	1308	6	4	6.3	60.3	106	4664	2.6	28299	34.1	201	930	435	341	569	624	1183
NM	No	18	1	1	24.7	99.3	3.9	966	0.5	5432	49.8	35	94	81	40	81	78	371
NY	No	424	29	15	12.9	91.3	54.6	16168	9.1	78362	32	531	2304	1457	906	1801	1625	3360
NC	Yes	231	12	4	33.3	90.5	73.5	9115	5.1	29042	43.1	192	677	480	252	599	519	1557
ND	No	12	1	1	39.3	99.7	3.9	408	0.2	1921	50	18	24	28	*	29	25	93
OH	Yes	292	17	6	24	89.2	69.9	5264	3	36757	36.4	279	841	732	292	630	576	2011
OK	Yes	60	5	1	35.8	98.1	18.8	2019	1.1	8456	40.3	62	176	104	52	120	123	433
OR	No	45	3	1	19.7	98.9	7.7	2521	1.4	13420	57	62	212	220	94	226	183	851
PA	No	294	31	7	23.6	89.5	67.7	11471	6.4	43739	41.7	348	1234	849	417	929	855	2098
RI	No	1084	2	1	9.7	61.3	154	618	0.3	4103	42.6	25	108	80	36	89	81	244
SC	No	185	5	3	31.8	92.1	56.3	2730	1.5	12918	39.2	70	276	190	92	192	209	888
SD	No	12	1	1	42.3	99.7	4.7	723	0.4	2288	44.4	22	38	29	16	33	32	103
TN	Yes	177	12	5	34.7	93	55.6	3202	1.8	18414	38.8	138	447	340	136	337	311	818
TX	No	122	14	13	17	96.7	15.2	11687	6.6	70589	47.7	579	1435	1088	603	1287	1195	3829
UT	Yes	43	4	1	10.8	98.9	3.2	2211	1.2	7812	53.4	67	125	120	44	123	117	516
VT	No	70	0	1	66.1	98.3	42.2	478	0.3	2523	45.6	13	43	49	19	46	26	147
VA	Yes	225	9	4	24.9	93.3	53.3	4812	2.7	23917	39.6	155	507	392	238	376	394	1292
WA	Yes	121	2	2	16.6	96.4	16.7	4160	2.3	22772	49.1	92	359	343	161	438	376	1238
WV	Yes	74	5	2	55.2	97.3	40.6	1150	0.6	5090	43.4	20	110	80	55	72	70	240
WI	Yes	111	5	2	33.6	96.5	32.5	3673	2.1	16759	43.9	103	323	256	132	291	248	921
WY	No	6	0	0	37.4	99.8	2	310	0.2	1265	51.7	*	25	*	*	15	12	94

PDen = population density, PAPGM = PA programs, MED = medical schools, RP = rural population, RLA = rural land area, RPD = rural population density, #PA = number of practicing PA's in each state, %PA = percent of PA's in each state out of total practicing across the US, #MD = number of medical doctors in each state, TM = number of PA's that participate in telemedicine, NN = number of MD's that practice in a neonatology department, CV = number of MD's that practicing in cardiovascular department, CC = number of MD's that practice in critical care department, EN = number of MD's that practice in endocrinology department, ON = number of MD's that practice in oncology department, GE = number of MD's that practice in gastroenterology department, EM = number of MD's that practice in emergency department.