COMMONWEALTH of VIRGINIA

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TO: The Honorable Louise L. Lucas
Chairman, Senate Committee on Education and Health

FROM: Arne W. Owens
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DATE: November 3, 2023

RE: Report Reviewing SB1006 of the 2023 General Assembly Session

This report is submitted by the Department of Health Professions in compliance with the request from the Chairman of the Senate Committee on Education and Health to review SB1006, which was passed by indefinitely during the 2023 General Assembly Session.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable John Littel, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with the request submitted pursuant to Rule 20(o) of the Rules of the Senate, under which rule the Chairman of the Senate Committee on Education and Health directed the Department of Health Professions "to review SB1006, which was passed by indefinitely during the 2023 Session of the General Assembly."

The Department's review of SB1006 and its provisions follows.

Contents

I. Executive Summary

Pursuant to Rule 20(o) of the Rules of the Senate of Virginia, the Senate Committee on Education and Health referred the subject matters contained in Senate Bill 1006 of the 2023 General Assembly to the Department of Health Professions ("DHP") for study. The legislation sought to create an associate physician license and instructed various boards within DHP to collaborate to create regulations for this new practice group. This report includes background on SB1006, a review of the associate physician role and its history throughout the United States, causes of failure to match to a residency, and consideration of the need for associate physicians in Virginia.

SB1006 was passed by indefinitely with a unanimous vote in the Senate Committee on Education and Health during the 2023 General Assembly session. The bill was modeled after similar associate physician language used in other states.

The practitioner category of associate physician was created to address physician shortages by creating a license for medical school graduates who did not get placed into a residency. Every state and territory in the U.S. requires that an applicant complete a residency program prior to licensure as a physician, yet the number of residency spots has not kept pace with increasing medical school enrollments, leaving more graduates without residency spots upon graduation.[1] Currently, there are eight states in the U.S. that provide an associate physician license, with most of these states limiting the amount of time a practitioner may hold the license. In most states, licensure as an associate physician is branded as a transitional license for people to hold and practice medicine until they get into a residency program.

States that have implemented associate physician licensure face unintended consequences that limit any potential effectiveness of the license type. Additionally, Virginia medical school programs do not see a need for associate physician licensure in the Commonwealth. Very few graduates from Virginia medical schools fail to match into a residency program in the first year after graduation. Thus, the schools do not feel state resources would be best spent by creating this pathway.

II. 2023 Legislation

SB1006, filed in the 2023 General Assembly Session, sought to create a two-year associate physician license within the Board of Medicine.[2] The bill required associate physicians to enter into a written practice agreement with a physician licensed by the Board and provided prescriptive authority for associate physicians in accordance with regulations of the Board. The legislation made the license available to applicants who met the following requirements:

[1] The number of residency spots has not increased at pace with the increase in medical school enrollment, leaving thousands of students nationally without a residency match. Primary funding for post-graduate residency positions has remained stagnant since the 1990s, which is a key contributor to this gap.

[2] SB1006, Associate physicians; licensure and practice. In 2022, SB676, identical to this bill, was proposed in the 2022 GA session and was continued into 2023. It was not refiled.

1) 18 years of age or older;
2) Of good moral character;
3) Graduated from an accredited medical school;
4) Successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination ("USMLE") within the two-year period immediately preceding application for licensure or has successfully completed Step 1, Step 2, and Step 3 of the USMLE, regardless of the date of completion of each step; and
5) Had not completed[3] a medical internship or residency program.

This bill required that the Board of Medicine to promulgate regulations to license associate physicians, to include the types of medical tasks that an associate physician may perform, provide requirements for review of services delivered pursuant to practice agreements, and provide requirements for supervision of associate physicians by licensed physicians. The legislation gave associate physicians prescriptive authority for drugs in Schedules II through VI, as addressed in the required written practice agreement. The legislation also required the Board to craft regulations on prescribing for associate physicians in collaboration with the Board of Pharmacy.

SB1006 was passed by indefinitely in the Senate Education and Health committee by unanimous vote.

III. What are Associate Physicians?

Associate physicians – sometimes called assistant physicians - are medical school graduates who may have passed certain parts of the USMLE but do not meet all the requirements of being a licensed physician. Associate physicians are different from physician assistants, who are licensed healthcare practitioners with a specialty physician assistant programs and national certification.[4] Associate physicians, in contrast, are graduates unable to match into a residency program after graduation, whether through the primary match system or through another program. In theory, an associate physician role would allow a person with extensive medical training from an accredited medical program to use their knowledge and skills in practice whereas they would have been ineligible to practice otherwise since they had not completed a residency program. Associate physicians are required to practice under a collaborative practice agreement with a licensed physician, and that practice agreement details any prescribing the associate physician may do.

IV. History of Associate Physicians in the U.S.

Associate physicians first appeared as a practice group in Missouri almost a decade ago, and in the years since other states have slowly introduced associate physician licenses. Most states which created associate physician licensure did not do so until 2020 or later, therefore the

[3] This language, included in SB1006, would have allowed individuals who were removed from a residency program by a school to apply and receive licensure as an associate physician. Residents can be removed from residency programs for a variety of reasons, not all of which are communicated to the state entity that licenses residents.
[4] Singer and Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.

most reported on and defined associate physician licensure program belongs to Missouri. Since Missouri started licensing associate physicians, seven other states have adopted legislation creating an associate physician license. The Association of Medical Doctor Assistant Physicians ("AMDAP") advocates for an associate physician license to be available in states, and model language has been provided by multiple entities, including the American Legislative Exchange Council ("ALEC").[5]

A. Introduction of Associate Physicians in Missouri

An associate physician bill first appeared in a state legislature in Missouri in 2014 with the intent of easing doctor shortages in the state. Since 2014, associate physician licenses have appeared in a total of eight states, with most created in 2020 or later.[6] Missouri reports a shortage of primary care providers in nearly every county and requires almost 500 physicians to address those shortages.[7] This includes metropolitan and non-metropolitan areas, with St. Louis being the only metropolitan area in Missouri that has a better ratio of physicians to community need. No community in Missouri reported having enough physicians to match or exceed their community need for healthcare. Efforts to encourage doctors to practice in underserved areas was unsuccessful in the years leading up to the introduction of the associate physician bill, with medical professionals continuingly preferring to practice in urban areas. Lawmakers noticed that thousands of medical school graduates nationally did not place into a residency program each year – 9,155 did not match into a program in 2021 alone through the National Resident Matching Program.[8] While that number decreases as supplemental matching programs work to find residency matches with graduates who did not match through the NRMP, there will still be many graduates who remain unmatched.

The Missouri legislation limited the areas associate physicians could provide care to those designated as rural and underserved, attempting to focus a potential influx of new practitioners to areas historically difficult to staff.[9] The legislation anticipated that associate physicians would see patients, prescribe drugs, and provide treatments as defined in the collaborative practice agreement with a licensed physician. This is similar to the way advanced practice registered nurses and physician assistants practice in Virginia, both of which have distinct master's-level training. The Missouri legislation received opposition, including from the American Medical Association, American Academy of Family Physicians, Accreditation Council for Graduate Medical Education, and the Missouri Nurses Association, who argued the state's nurse practitioners are better suited to address primary care shortages.[10] The Missouri

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[5] AMDAP is a group that advocates for associate physicians around the country. Membership is only available for medical students, associate physicians (and assistant physicians where that title is used), and physicians. Due to the relatively low numbers of associate physicians around the country, it is predicted that this group is made up of only a few hundred people nationwide.

[6] Jeffrey Singer and Spencer Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.

[7] *See* https://www.ruralhealthinfo.org/charts/5?state=MO.

[8] SAP Crystal Reports - (nrmp.org) at 14.

[9] Bram Smith, *Missouri tried to fix its doctor shortage. Now the fix may need fixing,* KCUR; Missouri tried to fix its doctor shortage. Now the fix may need fixing | KCUR - Kansas City news and NPR.

[10] *Id.*

legislation passed in spite of the opposition as there was great hope associate physicians would be able to address primary care needs in the state.

B. Other Jurisdictions

In the last year, Missouri has sought to revise the associate physician bill by adding a cap to the number of years someone can hold an associate physician license, as the current language does not limit the number of years an associate physician license may be held. Missouri licenses expire yearly, and so long as the practitioner renews their license each year, they may continue to practice as an associate physician.[11] Limitation on the duration of an associate physician license is in line with other states that license associate physicians. Most states that license associate physicians (or a similar name) see these roles as a transitionary practitioner role for graduates while they continue to seek residency. Arizona, Louisiana, and Idaho all use the phrase "transitional" or "bridge year" in the role title, indicating a temporary status. Kansas limits their associate physician license exclusively to University of Kansas School of Medicine graduates, helping to keep graduates in state and practicing if they do not match with a residency.[12] Washington exclusively offers the option of associate physician licensure to international medical graduates who have been a state resident for one year and have passed all steps of the USMLE. A practitioner, however, may only hold the license for a maximum of four years.[13] Idaho limits license availability to applicants within the first year after graduation who were not accepted into an accredited medical residency training program.[14] The Idaho license is valid for one year with no possibility for renewal. Although legislation introduced in Utah to license associate physicians sought to limit practice locations for associate physicians to medically underserved areas, the legislation enacted contains no such limitation.[15] Other states have slowly introduced associate physician bills into their state legislatures as they follow the lead of Missouri and other early adopters of the associate physician license. Georgia and New Hampshire are two states that in the last five years have begun to draft and file associate physician legislation, and although there has been no legislation enacted in that time, the possibility of expansion of the associate physician role seems likely.[16]

V. Residency Matching

As mentioned previously, proponents base legislation creating associate physicians on the lack of matching medical school graduates into residency programs. A medical residency program is a period of practical, hands-on training that occurs in a specialized field of medicine upon graduation of a four-year medical school and prior to full licensure as a physician.[17] Medical residents spend time during their first year rotating through medical specialties (obstetrics, cardiology, etc.) or through different areas in one specialty to identify a practice area

[11] 20 CSR 2150-2.210, Assistant Physician Licensure Renewal (Mo. Reg. 2017).
[12] Singer and Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.
[13] The Washington associate physician license is a two year license which may only be renewed once. Rev. Code of Wash. § 18.71.097(6)(e)
[14] Ida. Stat. § 54-1867, Limited License for Bridge Year Physicians.
[15] *Compare* H.B 396, Gen. Sess. (Utah 2017) at lines 182-83 *and* Utah Code § 58-67-302.8.
[16] Information on legislation can be found at https://assistantphysicianassociation.com/news.
[17] *See, e.g.*, https://www.mua.edu/resources/blog/what-is-a-medical-residency-program.

to specialize in for the remainder of their residency and into a career. The length of residencies can vary depending on specialty, with most lasting between two and five years.[18] These are seen as vital educational years for a future medical professional as a residency allows interns to demonstrate practice capability and be supervised by professionals in the field, ensuring patient safety while allowing the student to learn the intricacies of the specialty of medicine they wish to pursue. While every medical licensing board views a residency program as fundamental to training and education of physicians, matching into a residency program is not a guarantee.

Two main programs match medical school graduates with medical residencies. The first is the National Resident Matching Program ("NRMP"), which was created by the Association of American Medical Colleges and the National Student Internship Committee in the 1950s to assign graduating medical school students to accredited residency programs.[19] The Association of American Medical Colleges currently accredits more than 12,000 residencies and fellowship programs in the United States.[20] Students submit lists to the NRMP detailing their preferences and an algorithm is used to match the participants.[21] The NRMP also provides a Supplemental Offer and Acceptance Program ("SOAP") to eligible applicants who did not match with a program. Not all programs with available positions choose to participate in SOAP, and not all unmatched applicants are able to find matches.[22] In any given year, 6.8% of medical school graduates do not match into a residency program nationwide.[23] This number changes when considering certain specialties, with higher percentages of obstetrics and gynecology non-matches than family medicine and pediatrics non-matches, for instance.[24] This includes both domestic and international medical school graduates, who also participate in the NRMP and SOAP matching programs.

Recently, there has been an increase in medical school enrollment as institutions work to address a national lack of physicians. A report by the Association of Medical Colleges published in July 2021 projected that a shortage of 17,800 – 48,000 primary care physicians will exist by 2034, not including other specialties that are needed more by elderly individuals.[25] In the South (including Virginia), medical school enrollment has grown 44%, the greatest growth of any area of the country.[26] Most of this growth has occurred at public universities. As this growth has occurred, medical schools have expressed "moderate" or "major" concerns about incoming students' abilities to find residency positions of their choice after medical school.[27] Residency program increases have not kept pace with the growth in medical school enrollment nationwide, causing an increasing number of medical school graduates to find themselves in the unfortunate position of not matching into a residency to continue their medical training.[28]

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[18] *Id.*
[19] Singer and Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.
[20] *Id.*
[21] National Residency Match Program 2021 Main Residency Match, available at https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf.
[22] *See* https://www.nrmp.org/residency-applicants/soap/.
[23] Singer and Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.
[24] *Id.*
[25] Patrick Boyle, "Medical School Enrollments Grow, but Residency Slots Haven't Kept Pace," AAMCNews, Association of American Medical Colleges.
[26] *Id.*
[27] *Id.*
[28] Singer and Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO Institute.

Residencies receive most of their funding from the federal government through the Medicare program, which is the largest public contributor to graduate medical education ("GME") funding for residencies.[29] For the past two decades, the amount of financial support provided for GME has been capped, effectively freezing support at 1996 levels despite efforts by teaching hospitals, medical schools, physicians, and the Association of American Medical Colleges ("AAMC") to raise the cap to fund more graduate training slots.[30] According to Michael Dill, director of workforce studies for the AAMC, "the federal cap on GME is the main driver of the concern over insufficient residencies." As long as federal funding continues to lag behind and the pace of graduate student enrollment continues to grow, residencies will continue to lack enough positions to effectively train the next generation of physicians.

VI. Associate Physicians in Virginia

In Virginia, medical schools do not see the same problems that occur nationwide. Dr. Lee Learman, Dean of the Virginia Tech Carilion School of Medicine, recognizes that in the Commonwealth, some students do not match into a residency program upon graduation from medical school. "At Virginia Tech," he reported, "we had very few such graduates over the past 10 years [who did not match into a residency program]." However, "most will eventually match into the specialty they desire or another specialty, particularly if they are motivated to practice where they are needed." Other schools echoed that sentiment at a roundtable hosted by the Medical Society of Virginia this summer, with Dr. Art Saavedra, Dean of the VCU School of Medicine, stating that 100% of VCU's graduates match into a residency position after both the NRMP and SOAP programs are completed each year. Further, Dr. Learman said that, for medical school graduates who do not match into a residency program and want to practice as associate physicians, "without post-doctoral specialty training it would be difficult to define and measure the medical knowledge and patient care competencies of associate physicians that would allow health systems (and the public) to rely on these physicians to address work force needs." The time and resources that it would take to create "new licensure requirements and high-reliability assessments of their knowledge and skills could be put to better use expanding graduate medical education positions in the Commonwealth, so more of them can match here and complete their training in Virginia." Dr. Saavedra reported that new medical school graduates require a great deal of supervision, which may be difficult to accomplish in private practice.

Regarding residency shortages, Dr. Saavedra notes that there will always be more applicants than residency positions in Virginia as well as nationwide, as international applicants who want to participate in residency domestically must use the same program pathways as US students. Additionally, some specialties have more shortages of residency positions than others, making a fix that much harder. While increasing the payment per resident amount for each residency position would help, it would not address the maldistribution of physicians that is present in Virginia, particularly in rural Virginia. Dr. Saavedra points to the need to enhance and

[29] Patrick Boyle, "Medical School Enrollments Grow, but Residency Slots Haven't Kept Pace," AAMCNews, Association of American Medical Colleges.
[30] *Id.*

better pay for telehealth, rural residency tracks, and creation of more incentives for individuals to practice in underserved areas.

VII. Effectiveness of Licensure and Unintended Consequences

Missouri, the first state to introduce associate physicians, now faces unintended consequences related to the decision to license associate physicians. Associate physicians are unable to bill Medicare for services they render, a primary source of income for doctors who see rural and underserved patients. This has led to some practices in Missouri to have no associate physicians on staff, even in locations that were very supportive of the concept of associate physicians.[31] While Missouri has not issued disciplinary orders to associate physicians at a higher rate than other practitioner types, a state representative who has sought to expand associate physician responsibilities in the state and create a transition-to-physician element of the associate physician license was indicted on charges of selling fake stem-cell treatments, illegally prescribing drugs, and fraudulently receiving covid relief funds as an associate physician.[32] Efforts are underway in Missouri to: (1) restrict the number of years a license is valid and how many renewals a licensee can obtain; and (2) allow practitioners who hold an associate physician license for a certain number of years to transition to a full physician license. As of writing, neither initiative has been addressed by the Missouri legislature, but the disparity of opinions surrounding associate physicians in Missouri highlights the complexity and polarizing nature of the license type.

If the General Assembly enacted legislation licensing associate physicians, the Board of Medicine would need to promulgate extensive regulations to effectively regulate the new license type and ensure patient safety in the Commonwealth. Associate physicians would become the 23rd practitioner category within the Board of Medicine. This would create a fiscal impact, as adding another practitioner category to regulate may require an increase in staff, which would in turn raise licensing fees for practitioners of the Board of Medicine.[33] Costs related to associate physician licensure include licensing staff to verify credentials and issue licenses, discipline staff to manage disciplinary complaints and proceedings, and other Board staff to address the day-to-day operations of the Board. Typically, smaller practitioner groups require higher fees since fewer people supply funds used to regulate the profession. Therefore, associate physicians may require significant licensure and renewal fees. These potential costs should be considered along with legislation to license associate physicians. Additionally, inability of associate physicians to bill Medicare would render these practitioners to a sideline role, especially considering most rural patients would not or could not pay out of pocket for medical expenses. Therefore, although addressing the healthcare needs of rural communities is often cited as a primary benefit of the licensure of associate physicians, licensure would be unlikely to have the desired effect where healthcare is needed most.

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[31] Bram Smith, *Missouri tried to fix its doctor shortage. Now the fix may need fixing,* KCUR; Missouri tried to fix its doctor shortage. Now the fix may need fixing | KCUR - Kansas City news and NPR.

[32] *Id.*

[33] DHP, as a special fund agency, receives operating funds solely from licensing and renewal fees. Va. Code § 54.1-2400(5).