



COMMONWEALTH of VIRGINIA

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TO: The Honorable Mark D. Sickles
Chair, House Committee on Health and Human Services

The Honorable Ghazala F. Hashmi
Chair, Senate Committee on Education and Health

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: October 1, 2025

RE: Study on Physician Assistant Scope of Practice pursuant to HB2489 of the 2025 General Assembly Session

This report is submitted in compliance with HB2489 of the 2025 General Assembly, which required the Department of Health Professions to:

Conduct a study on expansion of the scope of practice for physician assistants in the Commonwealth as a means to increase autonomy in the profession. Such study shall include a review of the education and training requirements for physician assistants in the Commonwealth, as well as a survey of such requirements in the other states and the scope of practice in such states, and an analysis of the costs and benefits to patients of increased autonomy for physician assistants in the Commonwealth. The Department shall submit a report with its findings and recommendations to the Chairs of the House Committee on Health and Human Services and Senate Committee on Education and Health by November 1, 2025.

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 Janet Kelly, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with Chapter 569 (HB2489) of the 2025 Acts of Assembly, which required:

The Department of Health Professions [to] conduct a study on expansion of the scope of practice for physician assistants in the Commonwealth as a means to increase autonomy in the profession. Such study shall include a review of the education and training requirements for physician assistants in the Commonwealth, as well as a survey of such requirements in the other states and the scope of practice in such states, and an analysis of the costs and benefits to patients of increased autonomy for physician assistants in the Commonwealth.

HB2489 requires the Department to submit this report to the Chairs of the House Committee on Health and Human Services and Senate Committee on Education and Health by November 1, 2025.

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I. Executive Summary

Training requirements for physician assistants (“PAs”) are consistent across the United States, including in Virginia. The scope of practice for PAs, however, varies nationally depending on state law. Virginia uses the collaborative practice model, which allows PAs to operate within a team-based model as recommended by the American Academy of Physician Associates (“AAPA”).

As described below, costs to patients may arise related to diagnostic errors in situations with greater PA autonomy, but benefits would likely outweigh any costs to patients related to defensive medicine by a significant amount. Information from states with expanded scopes of practice for PAs regarding costs and benefits of that expanded practice has not been published.

II. Education and training requirements for physician assistants

Education and training requirements for PAs are relatively consistent nationally. Generally, PAs are educated at a master's level and complete 24 – 27 months of academic instruction which includes didactic and clinical training. This education follows hard science prerequisites, generally resulting in a university degree.¹

According to the AAPA, all U.S. states require PAs to graduate from an accredited program and pass the Physician Assistant National Certifying Examination (“PANCE”).² In Virginia, Virginia Code § 54.1-2951.1 and 18VAC85-50-50 require an applicant for licensure to have completed an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (“ARC-PA”).³ Accredited training includes classroom instruction in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics.⁴ Students in accredited programs complete more than 2,000 hours of clinical rotations in medical and surgical disciplines with emphasis on primary care. Rotations may include disciplines such as family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.⁵

To renew a PA license in Virginia, a licensee must maintain certification from the National Commission on Certification of Physician Assistants (“NCCPA”).⁶ While not part of initial education and training to obtain a license as a PA, continued NCCPA certification requires 100 credits of continuing medical education every two years. Additionally, PAs must pass the Physician Assistant National Recertifying Exam (“PANRE”) or the Physician Assistant National Recertifying Exam-Longitudinal Assessment (“PANRE-LA”) by the end of the 10th year of the certifying maintenance cycle.

¹ Some PA programs will allow entry from high school or only partial college credit, but those programs are longer in length, often requiring four to six years of training. See American Academy of Physician Associates at <https://www.aapa.org/career-central/become-a-pa/>.

² The PANCE assesses clinical knowledge, clinical reasoning, and other medical skills and professional behaviors deemed important for entry-level practice as a PA. PANCE consists of five blocks of 60 questions with 60 minutes to complete each block. See National Commission of Physician Assistants website regarding PANCE, available at <https://www.nccpa.net/become-certified/>.

³ ARC-PA is the independent accrediting body for physician assistant training. Accreditation by ARC-PA requires a peer review process that includes documentation and periodic site visit evaluations to substantiate compliance with accreditation standards. ARC-PA reports collaboration with the American Academy of Family Physicians, AAPA, the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the PA Educational Association (“PAEA”), the Society of Emergency Medicine PAs, the Association of PAs in Psychiatry, the Society of PAs in Family Medicine, the Society of PAs in Pediatrics, and the Association of PAs in Obstetrics and Gynecology. ARC-PA only accredits programs within the United States, including United States territories. See <https://www.arc-pa.org/about/>.

⁴ See <https://www.aapa.org/career-central/become-a-pa/>.

⁵ *Id.*

⁶ See 18VAC85-50-56.

III. Scope of practice models for physician assistants

Scope of practice for PAs varies across U.S. jurisdictions. In general, PAs practice with some level of physician or other healthcare provider oversight. Most states require supervision, collaboration, or a combination of supervision and collaboration, with lesser amounts of practice requiring supervision. Virginia uses the collaborative practice model, which allows PAs to operate in a team-based model as recommended by the AAPA.

Supervision models utilize PAs as a dependent practitioner in a patient care setting. These models require close physician or other healthcare provider supervision and may include requirements for co-signatures, chart review, and on-site supervision. Twenty-two states use a supervisory practice model: Arkansas; California; Connecticut; Florida; Georgia; Hawaii; Idaho; Kansas; Kentucky; Louisiana; Massachusetts; Mississippi; Nebraska; Nevada; New Jersey; New York; North Carolina; Ohio, Pennsylvania; South Carolina; Texas; and Washington.

The collaboration model represents a team-based approach to patient care and often allows the PA and healthcare collaborators to determine appropriate oversight, communication, chart review, and consultation levels for the patient care team. Sixteen states and the District of Columbia use a collaborative practice model: Delaware; Illinois; Indiana; Maine; Maryland; Michigan; Minnesota; Missouri; Oklahoma; Oregon; Rhode Island; Tennessee; Vermont; Virginia; West Virginia; and Wisconsin. Some states require that a practice agreement be approved or filed with a state licensing board, while others require the practitioners to maintain a collaborative practice agreement.⁷

Two states use a combination of supervision and collaboration. Colorado requires supervision but permits a PA to collaborate with a physician following completion of more than 5,000 practice hours. Colorado also requires supervision of PAs changing specialty for 3,000 practice hours in the new specialty.⁸ New Mexico requires supervision of PAs but allows a collaborative practice model for PAs in primary care with more than three years of practice.

Eight states have eliminated the legal requirement for a specific relationship between a PA and a physician or other healthcare provider. These states are considered the U.S. jurisdictions that permit the most autonomy for PA practice. Within these eight jurisdictions, the requirements to obtain that level of autonomy vary:

- Utah allows practice without a specific relationship with a physician or other healthcare provider after 10,000 hours of practice.

⁷ Virginia does not require PAs or collaborating healthcare practitioners to file practice agreements with the Board. Va. Code § 54.1-2951.1(D). Legislation in the 2016 General Assembly Session eliminated a previous regulatory requirement that PAs submit practice agreements to the Board for approval.

⁸ Virginia does not license PAs by specialty, but instead provides a general license to practice, consistent with a license to practice medicine. See Va. Code §§ 54.1-2951.1 and 54.1-2951.2; *compare* Va. Code § 54.1-2932.

- Arizona, Iowa, Montana, and New Hampshire allow practice without a specific relationship with a physician or other healthcare provider after 8,000 hours of practice.
- South Dakota allows practice without a specific relationship with a physician or other healthcare provider after 6,000 hours of practice.
- North Dakota allows practice without a specific relationship with a physician or other healthcare provider after 4,000 hours of practice.
- Wyoming does not have a requirement to obtain or maintain a specific relationship with a physician or other healthcare provider.

States also vary in prescriptive authority for PAs. Thirty-one states and the District of Columbia allow PAs to prescribe Schedules II – V and all non-controlled substances without exception.⁹ Nineteen states limit prescribing in some way.¹⁰ These limitations include exclusion of certain schedules of drugs (such as Schedule II), limitation on the amount of drugs that may be prescribed (such as limiting to a three-day supply), requiring a physician review of medication prescribed, or limiting prescription options to a formulary.

⁹ These states include: Alabama; Alaska; Arkansas; California; Colorado; Connecticut; Delaware; Hawaii; Idaho; Indiana; Iowa; Kansas; Louisiana; Maine; Maryland; Michigan; Minnesota; Mississippi; Nebraska; Nevada; New Hampshire; New York; North Dakota; Oregon; Rhode Island; Utah; Vermont; Virginia; Washington; Wisconsin; Wyoming; and the District of Columbia.

¹⁰ These states include: Arizona; Florida; Georgia; Illinois; Kentucky; Massachusetts; Missouri; Montana; New Jersey; New Mexico; North Carolina; Ohio; Oklahoma; Pennsylvania; South Carolina; South Dakota; Tennessee; Texas; and West Virginia.

IV. Costs and benefits to patients of increased autonomy of physician assistants in Virginia

A. Costs to patients.

Potential costs to patients for increased autonomy of PAs in Virginia may include an increase in adverse patient outcomes due to less physician-directed care. While several studies have been performed in this area over the last twenty years, patient impact from the expansion of PA autonomy in states without a requirement to maintain a specific relationship with a physician has not yet been studied. Such changes in PA scope of practice occurred within the last six years, beginning in 2019. Studies regarding patient outcomes in states with the most permissive practice models may emerge as more states adopt this model and after more time elapses in which to study patient outcomes.

An article published in 2023 in the *Journal of Medical Regulation* presented findings from a study of medical malpractice payment reports on the National Practitioner Data Bank (“NPDB”) for PAs from 2010 – 2019, comparing malpractice data to state scope of practice requirements. Overall, the study did not find an increased rate of medical malpractice payment reports in states with permissive models of PA care.¹¹ The article posited that if permissive PA practice models presented a threat to patient safety and an increased risk of malpractice,

there should be a greater number of malpractice payments against PAs in states with permissive compared to restrictive PA practice laws and regulations. Reported malpractice payments serve as an approximation of the acts or omissions constituting medical errors or negligence, are highly correlated with adverse patient outcomes, and have been used as a surrogate measure of serious adverse medical events.¹²

The study found, however, that states with more permissive regulatory environments for PA practice were not associated with increases in medical malpractice payment reports for PAs. In contrast, an earlier study which reviewed NPDB practice reports for physicians, PAs, and nurse practitioners from 2005 – 2014 found a higher rate of diagnosis-related malpractice reports for PAs (52.8%) than for physicians (31.9%).¹³ Yet another study noted that the benefits of reliance on PAs would outweigh any costs to patients related to defensive medicine¹⁴ as a result of diagnostic errors.¹⁵

¹¹ S. DePalma, M. DePalma, S. Kolhoff, N. Smith, *Medical Malpractice Payment Reports of Physician Assistants/Associates Related to State Practice Laws and Regulations*, 109 J. OF MED. REG. No. 4 (2023), 27 – 37.

¹² *Id.* at 28.

¹³ D. Brock, J. Nicholson, R. Hooker, *Physician Assistant and Nurse Practitioner Malpractice Trends*, 74 MED. CARE RES. REV. 613-24 (Oct. 2017).

¹⁴ In this situation, defensive medicine refers to additional tests and treatments to avoid litigation or malpractice.

¹⁵ B. Walia, H. Banga, and D. Larsen, *Increased Reliance on Physician Assistants: an Access-Quality Tradeoff?* 10 JOURNAL OF MARKET ACCESS AND HEALTH POLICY (2022) at 3.

B. Benefits to patients.

While a potential benefit to patients of greater access to care may be noted, there is no guarantee that increased autonomy of PAs will directly result in the availability of more practitioners in health care deserts. There is some evidence that a model of practice that includes more autonomous PAs may increase coverage in rural areas, though. While not directly comparable, autonomous nurse practitioners are more likely to practice in rural areas compared to non-autonomous nurse practitioners. The DHP Healthcare Workforce Data Center determined, using 2023 licensing data, that autonomous nurse practitioners are more likely to be practicing in rural areas and areas with low numbers of full-time equivalent physicians than non-autonomous nurse practitioners.¹⁶ Increasing health care coverage in areas lacking significant options for medical care requires a multi-pronged approach, of which increasing capacity of mid-level practitioners plays a part.

A likely potential benefit to patients of greater autonomy of PAs is an overall lower cost of healthcare.

Given the large average salary difference between PAs and physicians, it stands to reason that a shift toward PAs would have the direct effect of lowering healthcare costs . . . In fact, several studies find statistical evidence that an increased presence of PAs and nurse practitioners lowers healthcare costs.¹⁷

Various studies have concluded¹⁸ that expansion of scope of practice for PAs does not result in harmful or low-quality care. Several studies have instead indicated less intensive treatment for patients with no noted increase in adverse outcomes.¹⁹ These studies must be viewed alongside those that indicate a higher diagnostic error rate of PAs.²⁰

¹⁶ See Appendix 1.

¹⁷ Walia, *supra* note 15 at 2.

¹⁸ B. McMichael, *Healthcare Licensing and Liability*, 95 INDIANA LAW JOURNAL 821 – 881 (2020) (providing an extensive empirical analysis of all births in the United States from 1998 – 2015, concluding that allowing APRNs and PAs to practice with more autonomy reduced the use of medically intensive procedures); J. Mafi, *et al.*, *US Emergency Care Patterns Among Nurse Practitioners and Physician Assistants Compared with Physicians; a Cross-Sectional Analysis*, 12 BMJ OPEN Iss. 4 (Apr. 2022); P. Morgan, *et al.*, *Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients*, 38 HEALTH AFFAIRS Iss. 6 (June 2019) (finding that use of nurse practitioners and PAs as primary care providers for complex patients with diabetes was associated with less use of acute care services and lower total costs in reviewing 2012-13 data from the Department of Veterans Affairs); D. Johnson, *et al.*, 132 AM. J. MED. Iss. 11 (Nov. 2019) (finding advanced practice providers (nurse practitioners and PAs) did not provide statistically significant differences in quality of care to physicians and can provide high quality care in clinical settings).

¹⁹ McMichael, *supra* note 18; Morgan, *supra* note 18.

²⁰ Walia, *supra* note 15 at 3.

V. Conclusion

In conclusion, training requirements for PAs across the U.S. are consistent with Virginia requirements. The scope of practice for physician assistants varies depending on state law. Virginia uses the collaborative practice model, which allows PAs to operate in a team-based model as recommended by the AAPA.

Costs to patients may arise related to diagnostic errors under more autonomous practice models, but benefits are likely to outweigh any costs related to defensive medicine by a significant amount. Information from states with expanded scopes of practice for PAs regarding costs and benefits of that expanded practice has not been published. Given the limitations of the Department of Health Professions as a licensing and disciplinary agency for healthcare practitioners in the Commonwealth, a more in-depth cost benefit analysis of altering PA scope of practice in Virginia may need to be undertaken by dedicated research bodies, such as the Joint Commission on Health Care.

Appendix 1



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Summary Statistics



Summary Statistics – nurse practitioner

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	Autonomous (n=5,626)	Non-Autonomous (n=2,183)
Mean age	49	44
Female	92%	93%
White	74%	71%
Black	16%	15%
Asian	4%	7%
Hispanic	3%	4%
Other	3%	3%
More than Master's degree	32%	17%
Median hours worked/week	44%	43%
Job satisfaction	93%	94%
Less than 10 years licensed as NP	49%	71%
Median income	\$110,000-\$120,000	\$100,000-\$110,000
Median debt	\$0	\$25,000



Practice settings – nurse practitioner

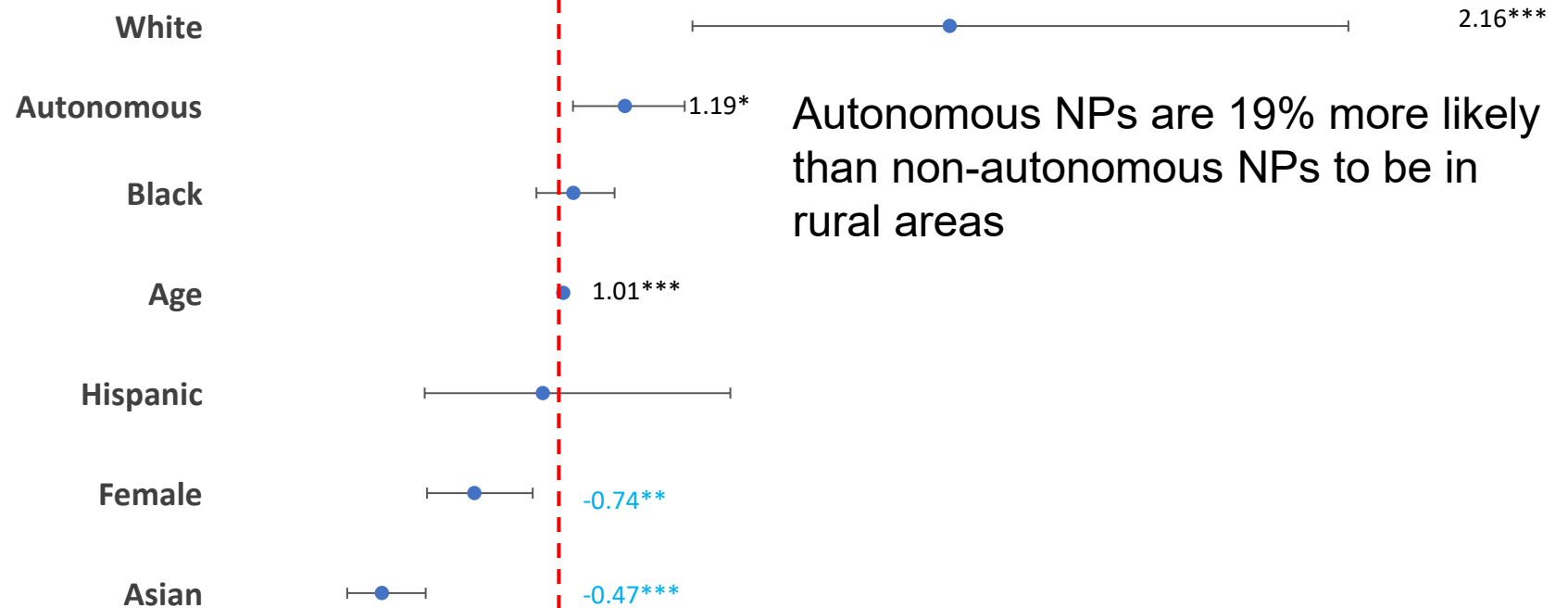
	Autonomous	Non-autonomous
Physician Office	7%	9%
Private practice, solo	4%	2%
Private practice, group	8%	6%
Clinic, Primary Care or Non-Specialty (e.g. FQHC, Retail or Free Clinic)	25%	23%
Hospital, Inpatient Department	9%	15%
Hospital, Outpatient Department	5%	6%
Hospital, Emergency Department	1%	3%
Mental Health, or Substance Abuse, Outpatient Center	9%	4%
Rural	15%	12%
In county/city with <1 physician FTE/1,000 Population	11%	8%
Primary care specialty	76%	78%



Logistic Regression Results



Odds Ratio of APNPs Being in a Rural Area



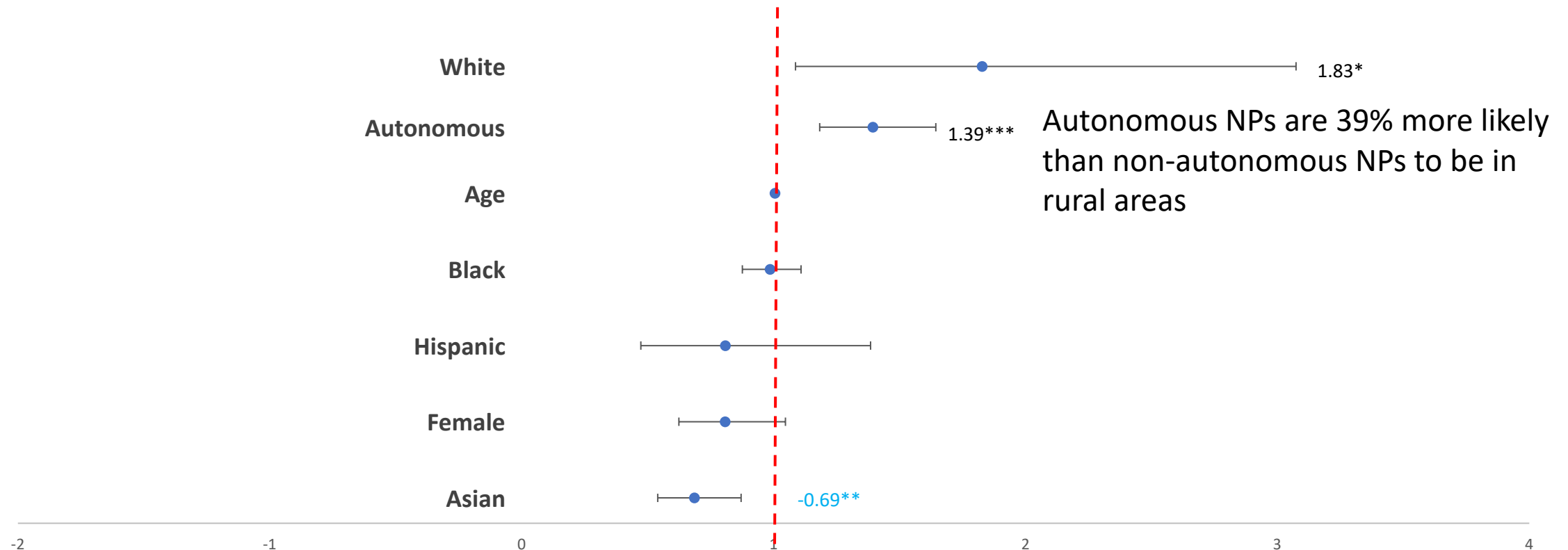
Chi-square (DF, p): 159.58 (7, 0.001); Nagelkerke R Square: 0.03



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Odds Ratio of APNPs Being in a Low Physician FTE Area



Chi-square (DF, p): 65.36 (7, 0.001); Nagelkerke R Square: 0.02



Limitations and Conclusion



As suggested in the literature and as hypothesized in this study, autonomous APNPs in Virginia were more likely to be practicing in rural areas



Autonomous APNPs also appear to be filling the gaps where there were few physicians available



Limitations and Conclusion



About 10% of APNPs reported multiple specialties and autonomous designation does not always equate practice



Findings support literature on importance of APNPs for rural areas and areas with low physician access; conclusions are made within limitations of the survey and data used

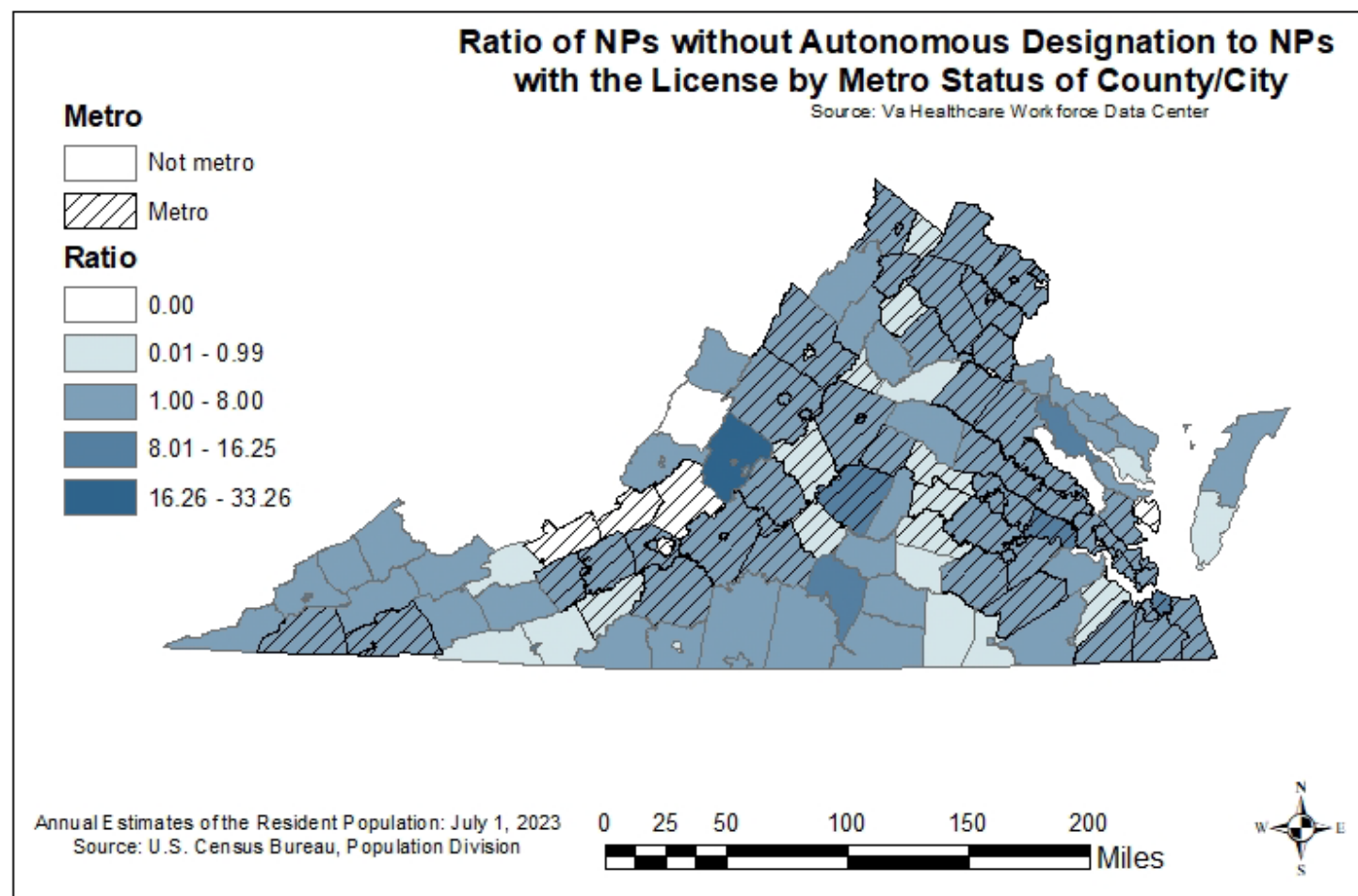


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In 2024, there were 5,626 NPs who did not have autonomous designations in Virginia; they provided 7,024 FTEs. There were another 2,183 NPs with autonomous designation who provided 2,716 FTEs in the state.

This map shows the distribution of the ratio of the FTEs provided by NPs without an autonomous designation to those with the designation. Lighter blue (<1) indicates more NPs with autonomous designation than those without. Even though there are fewer NPs with the designation, in non-metro areas (without hatch), they were more likely to report higher FTEs than those without the designation.

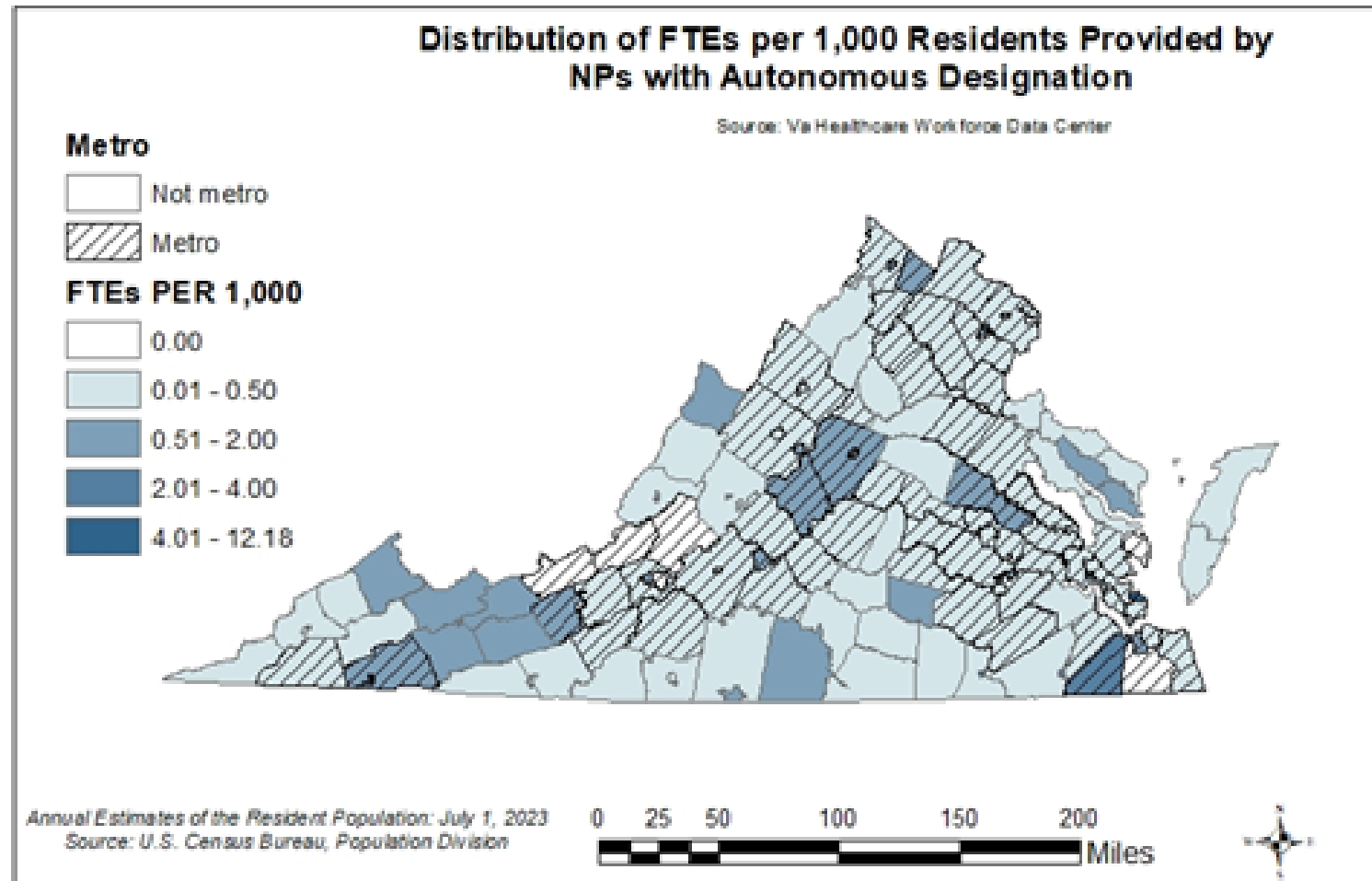




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This map shows the distribution of NPs with autonomous designation in Virginia. Counties with higher concentration of FTEs per capita provided by these NPs (in darker blue) were more likely to be non-metro areas.





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In 2023, when the most recent PA workforce survey occurred, there were 5,174 PAs in VA workforce and they provided 4,478 FTEs.

Counties with higher concentration of physician assistants per capita (in darker blue) were more likely to be metro areas.

