02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

373 BOARD OF LICENSURE IN MEDICINE
Chapter 2

383 BOARD OF OSTEOPATHIC LICENSURE
Chapter 2

JOINT RULE REGARDING PHYSICIAN ASSISTANTS

ADOPTED BY BOARD OF LICENSURE IN MEDICINE NOVEMBER 10, 2020
ADOPTED BY BOARD OF OSTEOPATHIC LICENSURE NOVEMBER 12, 2020

BASIS STATEMENT AND RESPONSE TO COMMENTS

Basis Statement

The Board of Licensure in Medicine and the Board of Osteopathic Licensure (boards) were created by the Legislature with the sole purpose of protecting the public. 10 M.R.S. § 8008 provides:

> **§8008. Purpose of occupational and professional regulatory boards**
> **The sole purpose of an occupational and professional regulatory board is to protect the public health and welfare**. A board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the regulated professions by examining, licensing, regulating and disciplining practitioners of those regulated professions. **Other goals or objectives may not supersede this purpose**.

It is with this purpose in mind that the boards approach the current rule making regarding Chapter 2.

On March 18, 2020 L.D. 1660, a bill entitled "An Act to Improve Access to Physician Assistant Care" was emergently enacted into law in the State of Maine. Prior to its enactment by the full Legislature, L.D. 1660 was reviewed by the Joint Standing Committee on Health Coverage, Insurance and Financial Services (HCIFS), including oral and written testimony in support of and in opposition to the bill. Several individuals and organizations opposed the bill arguing that removing physician delegation and supervision over physician assistants would result in less oversight of physician assistant practice, unnecessary risk to the public, and independent practice by physician assistants who lack post-graduate residency training in a given medical specialty. Individual physician assistants and the Maine Association of Physician Assistants supported the bill arguing that physician assistants are trained medical professionals who should be treated as colleagues and work "in collaboration" with physicians – not under their supervision. In

addition, the HCIFS Committee was presented with testimony regarding the differences between the education and training of physicians (4 years of medical school followed by at least 3 years of residency training in a medical specialty) and physician assistants (2 years of school and no residency training) as well as the administrative paperwork burden placed on physician assistants, physicians, and health care systems regarding physician supervision requirements and written plans of supervision.

The Board of Licensure in Medicine and Board of Osteopathic Licensure (boards) submitted joint written testimony informing the HCIFS Committee that the bill would "represent a significant paradigm shift for the regulation and oversight of physician assistants in Maine," convert physician assistants from "dependent" practitioners to "independent" practitioners, and remove significant physician oversight and accountability. In addition, the boards pointed out to the HCIFS Committee that physician assistants working outside of health care facilities and physician group practices represented the most significant risk to the public as without physician oversight, supervision, and delegation the bill allowed physician assistants to define their own "scope of practice" with the risk that they could choose to perform services that are beyond their education and training. The HCIFS Committee amended the bill to require that certain physician assistants working outside of health care systems or physician group practices have collaborative agreements or practice agreements with scopes of practice approved by the boards. The significant changes of the new law include:

- Elimination of physician supervision and oversight of physician assistants;
- Elimination of the delegation of medical acts by physicians to physician assistants;
- Elimination of the requirement of plans of supervision and replaced them with collaborative agreements and practice agreements;
- Creation of an exception to the need for either a collaborative agreement or practice agreement for physician assistants with 4,000 hours or more of clinical experience who are working within a health care facility or physician group practice;
- Authorizing physician assistants with less than 4,000 hours of clinical experience to work within health care facilities or physician group practices pursuant to a privileging and credentialing document that delineates the scope of practice (in lieu of a collaborative agreement); and
- Authorizing the Boards to approve or deny the scope of practice delineated in a collaborative agreement or practice agreement.

In sum, the new law created the following four categories of physician assistant practice models in Maine:

1. Physician assistants with **less than 4,000 hours** (post-graduate) of documented clinical experience **working in a health care facility or physician group practice** under a system of credentialing and granting of privileges and pursuant to a written scope of practice agreement.

2. Physician assistants with **less than 4,000 hours** (post-graduate) of documented clinical experience working in a private practice setting **other than** a health care facility or

physician group practice under a system of credentialing and granting of privileges pursuant to a written collaborative agreement with a Maine licensed physician.

3. Physician assistants with **more than 4,000 hours** (post-graduate) of documented clinical experience and the principal clinical provider in a practice that does not include a physician partner (own or operate an independent practice) pursuant to a practice agreement with a Maine licensed physician.

4. Physician assistants with **more than 4,000 hours** (post-graduate) of documented clinical experience and practicing in a setting **other than** as the principal clinical provider in a practice that does not include a physician partner (do not own or operate an independent practice) such as a health care facility or physician group practice. **No credentialing and privileging document, no collaborative agreement, and no practice agreement is required** to be maintained or produced to the boards.

Nearly all stakeholders concurred that the vast majority of physician assistants in Maine worked within health care facilities, which operate pursuant to protocols for educating and training them as well as for evaluating and monitoring the quality of medical services rendered by physician assistants. Therefore, decreasing the administrative burdens in these settings, which provide both oversight and a safety net for physician assistants, arguably did not pose a significant risk to the public. In addition, health care facilities are ultimately legally liable and responsible for any medical services rendered by physician assistants employed by them, which should lead to appropriate education, training, and oversight. Finally, health care facilities are mandated by law to report to the boards any adverse employment or privileging decisions regarding physician assistants that are based upon unprofessional conduct or competency issues.

Similarly, nearly all stakeholders agreed that physician assistants who worked alone outside of health care facilities or physician group practices represent the greatest risk to the public due to the lack of oversight and evaluation. Therefore, the Legislature gave the boards the responsibility of reviewing and approving the scopes of practice for these physician assistants who may perform medical services pursuant to a collaborative agreement or practice agreement. As indicated earlier, prior to the enactment of this law that responsibility fell to the physician(s) supervising the physician assistant(s). **As evidence of this intent, the new law specifically provided that both collaborative agreements and practice agreements must include the scope of practice for the physician assistant and specifically provided that both collaborative agreements and practice agreements "shall be submitted to the board for approval" by the physician assistant.**

The new law specifically provides that "scope of practice" for physician assistants "is determined by the practice setting" and that a physician assistant "**may provide any medical service for which the physician assistant has been prepared by education, training and experience and is competent to perform.**" Thus, in evaluating any proposed scope of practice, the legislation requires the boards to consider the physician assistant's education, training and experience, and competency as well as the practice setting. This is to ensure that the public is competently and safely served. For example, the public would not be safely or competently served by a physician assistant with more than 4,000 hours of clinical experience and who has

been practicing for ten (10) years in orthopedics, and who decides to open a private practice in which she is the principal clinical provider without a physician partner providing general family practice services. Because orthopedics is a medical specialty that is significantly different from family practice, allowing a physician assistant to make such a change – without oversight, additional training and/or re-education – may endanger the public.

In addition, to emphasize the HCIFS Committee's (and hence the Legislature's) intent to implement this new model of physician assistant oversight in Maine, the new law included the following language:

> **Construction**. To address the need for affordable, high-quality health care services throughout the State and to expand, in a safe and responsible manner, access to health care providers such as physician assistants, **this section must be liberally construed to authorize physician assistants to provide health care services to the full extent of their education, training and experience in accordance with their scopes of practice as determined by their practice settings**.

With the foregoing Legislative mandate and statutory changes in mind, the boards convened a workgroup to review the draft amendments to the Chapter 2 rule (and accompanying licensing applications and collaborative agreements/practice agreements forms). The work group consisted of the staff and membership of the boards as well as their respective legal counsel:

Members/staff of the BOLIM

- Dr. Louisa Barnhart, M.D., Board member
- Mr. Christopher Ross, P.A., Board Member
- Ms. Lynne Weinstein, Public Board Member
- Timothy E. Terranova, Assistant Executive Director
- Dennis E. Smith, Esq., Executive Director

Members/staff of the Osteopathic Board of Licensure

- Dr. John Brewer, D.O., Board Member
- Ms. Melissa Michaud, P.A., Board Member
- Susan E. Strout, Executive Secretary

Members of the Attorney General's Office

- Assistant Attorney General Michael Miller
- Assistant Attorney General Lisa Wilson

The draft amendments to the rule:

- Add new definitions (e.g. “Health Care Facility,” Health Care Team,” Inactive Status License,” and “Physician Group Practice”) and eliminate old definitions (e.g. “Supervision” and “Written Plan of Supervision”);
- Eliminate registration and supervision requirements;
- Establish criteria for “Inactive Status Licenses;”
- Establish uniform continuing clinical competency requirements;
- Amend the uniform fees;
- Establish criteria for collaborative agreements and practice agreements;
- Amend the uniform notification requirements to include legal change of name; and
- Amend the continuing medical education (CME) requirements, including 3 hours of CME every 2 years regarding opioid prescribing.

The boards published the amendments to the rule for public comment on July 8, 2020. The amendments organized the rule as follows:

SECTION 1. Definitions
SECTION 2. Uniform Qualifications for Licensure
SECTION 3. Uniform Requirements for Renewal/Inactive Status/Reinstatement/Withdrawal of License
SECTION 4. Uniform Continuing Competency Requirements
SECTION 5. Uniform Fees
SECTION 6. Uniform Scope of Practice for Physician Assistants
SECTION 7. Uniform Elements of Written Collaborative and Practice Agreements
SECTION 8. Uniform Notification Requirements for Physician Assistants
SECTION 9. Uniform Citation
SECTION 10. Conduct Subject to Discipline
SECTION 11. Uniform Continuing Medical Education (CME) Requirements and Definitions
SECTION 12. Identification Requirements
SECTION 13. Physician Assistant Advisory Committee

Before delving into the comments, the boards wish to convey their sincere appreciation for the feedback, comments, suggestions and questions regarding the proposed rule amendments. In addition, the boards want to clarify for the commenters and stakeholders that the boards are State agencies created by the Legislature and derive their very existence, membership and authority from the laws enacted by the Legislature. The boards must implement the newly enacted law, and cannot act contrary to law or promulgate a rule or amendments to a rule that conflict with the law. Several of the comments submitted to the boards expressed general opposition to the new law and advocated for continued physician supervision and oversight of physician assistants in the rule amendments. The Legislature has spoken, and the boards are legally bound to enact rules that are both within the law and congruent with the Legislative intent. The boards express their appreciation for the commenters’ and stakeholders’ understanding concerning this issue.

The comment period for the rule as originally proposed closed on August 7, 2020. The boards received 19 written comments from 23 individuals and organizations regarding the proposed rule, which are attached to this Basis Statement and Response to Comments. The boards subsequently reviewed the comments received regarding the proposed rule, and voted to make

several substantive changes to the rule based upon the concerns expressed in the comments, including:

- Adding a definition for "physician."
- Adding a new sub-paragraph D to Section 6, paragraph 8 that identifies acceptable documentation of clinical practice.
- Adding a new paragraph 9 to Section 6 that identifies criteria which the boards will employ in reviewing and evaluating the scope of practice for physician assistants in collaborative agreements or practice agreements.
- Adding a provision in Section 12 that requires physician assistants to verbally identify themselves as physician assistants to patients and to correct patients who refer to them as "doctors."

The proposed rule with the foregoing substantive changes was re-published for public comment on September 30, 2020. The comment period for the re-proposed rule closed on October 30, 2020. The boards received additional comment(s) regarding the re-published rule which are identified below.

Original Comments Following Proposal of the Rule on July 8, 2020

List of Commenters:

1. Sarah Calder, Dir. of Gov't Affairs, *on behalf of* MaineHealth
2. Saul M. Levin, MD, CEO & Med. Dir., *on behalf of* American Psychiatric Association
3. Stuart Glassman, M.D., Chair, *on behalf of* State Advocacy Committee, American Academy of Physical Medicine and Rehabilitation
4. Alan Hull, P.A.
5. Jeffrey Austin, V.P. of Gov't Affairs, *on behalf of* Maine Hospital Association
6. Angela Leclerc, P.A., President, *on behalf of* Me. Assoc. of Physician Assistants (MEAPA)
7. Andrew Nicholson, M.D.
8. Christine Thomas, P.A.
9. Corey Cole, D.O.
10. Maria Paone, M.D.
11. Megan Selvitelli, M.D., President, *on behalf of* Maine Neurological Society
12. Garreth Debiegun, M.D., President, Maine Chapter, *on behalf of* American College of Emergency Physicians (ACEP)
13. Lisa Harvey-McPherson, R.N., V.P. Gov't Relations, *on behalf of* Northern Light Health
14. Dana L. Greene, P.A.
15. Lisa A. Moreno, M.D., President, *on behalf of* American Academy of Emergency Medicine (AAEM)
16. Purvi Parikh, M.D., *on behalf of* Physicians for Patient Protection
17. Alyson Maloy, M.D., *on behalf of* Portland Cognitive and Behavioral Neurology
18. Dan Morin, Dir. Comm. And Gov't Affairs, *on behalf of* Maine Medical Association (MMA), Maine Society of Eye Physicians and Surgeons (MSEPS), Maine Chapter of the

American College of Emergency Physicians (MEACEP), and the Maine Neurological Society (MNS)
19. Amanda Richards, Exec. Dir., *on behalf of* Maine Osteopathic Association
20. Ann Robinson, Esq., *on behalf of* Spectrum Healthcare Partners
21. Robert Grover, M.D.
22. Scott C. Ellis, P.A.
23. Anthony Curro, P.A.

Response to Comments

Comments and Board Responses:

I. **General Comments Opposing the Law and Rule Amendments**

The boards received a number of general comments in opposition to the new law and the rule amendments eliminating physician oversight and supervision of physician assistants despite the clear intent of the Legislature. In addition, the boards received a number of comments requesting changes to the rule that are beyond the boards' authority or which would contradict the law or conflict with the intent of the law.

1. Saul Levin, M.D. *on behalf of* American Psychiatric Association

   WRITTEN COMMENT: This rule changes the terminology of the relationship between the physician and the physician assistant from "supervision" to "collaborative agreement" and "practice agreement." As a result, this rule authorizes physician assistants to practice far more freely, however it renders a physician no less liable for the actions of a physician assistant. This could be ameliorated by adding language indicating that physicians shall not be held liable in cases where physician assistants are the primary patient contact unless the collaborating physician was willfully negligent.

   - BOARDS' RESPONSE: Comment not accepted. The rule amendment follows the law. The boards do not have the authority to affect the legal liability of physicians collaborating with physician assistants.

2. Stuart Glassman, M.D. *on behalf of* State Advocacy Committee, American Academy of Physical Medicine and Rehabilitation

   WRITTEN COMMENT: AAPM&R writes in opposition to the proposed amendments to remove the physician supervision requirements for physician assistants. Physiatrists work collaboratively with many allied and advanced practice health care providers, who are valued members of the rehabilitation team. However, we believe that physician-led, patient-centered, team-based care is the best approach to providing optimized care for patients. We have great concern that providers who have not gone through the extensive training and medical education that a physician has, would be allowed to practice independently of a physician to provide patient care. Physician assistants, while skilled, knowledgeable, and important to patient care, are not physicians. The role of physician

assistants on the health care team is determined by many factors, including education and training level and individual experience and proficiency. Physician assistants should provide patient care to the extent of their education and training, subject to the oversight of a supervising physician.

There is a significant disparity in the education and training between a physician and physician assistant. Physicians spend over 11 years in medical training in order to ensure they are properly trained and educated to diagnose and treat patients. The skills, knowledge, and abilities of physician assistants and physicians are not equivalent, but instead are complementary. The most effective way to maximize the talents of the complementary skill sets of both professionals is to work as a team to care for patients in the physician-led, team-based approach.

- BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law.

3. Maria Paone, M.D.

WRITTEN COMMENT: I am highly concerned about the language of the new law allowing independent practice for PAs. It will set a dangerous precedent for other states. PAs have only 2 years of graduate education and no residency training. This bill essentially permits them the same rights and privileges as a physician who went to school for 4 years and trained for another 3-7 years after. This bill allows PAs to practice in any specialty of their choice. Even if their 4000 hours are spent in pediatrics, they can get a job in the ICU as an independent practitioner without a single hour of extra training. There should be language in the law mandating another training period before being allowed independent practice in another specialty. The law allows PAs to "collaborate" with physicians and takes out all reference to "supervision" even when they first graduate. This is unsafe. At the very least, their initial post graduate period should be required to be "under direct supervision." How do they expect to learn medicine without guidance? The public should not be experimented on for the satisfaction of their ego and the greed of the corporations who want to hire them in place of physicians. PAs and NPs like to say they want to practice to the "top of their license." In the case of a PA, their license is to practice as a Physician Assistant, not as a Physician. This law enables them to bypass 2 years of school and 3-7 years of training, board specialty exams and recertification and practice to the full extent of a Physician's license. More, actually, because, unlike a physician, they are permitted to switch specialties at will. Either medical school and physician training has value or it doesn't. If a law permitting medical students the same rights as this law does PAs, there would be a public outcry that dangerously undereducated and poorly trained doctors were being licensed. And that would be correct. There should be no shortcuts to the practice of medicine.

- BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law.

4. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Garreth Debiegun, M.D. *on behalf of* Maine Chapter of American College of Emergency Physicians

   WRITTEN COMMENT: We have concerns that the removal of requirements related to supervision potentially compromises patient safety in our practice setting.

   - BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law.

5. Robert Grover, M.D.

   WRITTEN COMMENT: If PAs don't need to be supervised, then surely physicians who had 2 years clinical training in medical or osteopathic school shouldn't need to do a residency to practice either.

   - BOARDS' RESPONSE: Comment not accepted. The law establishes the criteria for licensure of physicians and physician assistants in Maine.

6. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENT: The scope of practice of physicians is determined by completion of a Liaison Committee on Medical Education (LCME)-accredited medical school, followed by highly competitive acceptance into and completion of an Accreditation Council of Graduate Medical Education (ACGME)-approved residency program. This nearly decades-long process to become a physician is most often followed by passing multi-day specialty exams to earn "board-certification." Certification in one's American Board of Medical Subspecialties (ABMS) specialty is determined by a 3 to 7 year-long residency, some with an additional 1 to 3-year long fellowship. This process ensures rigorous standardization of skills and includes multiple overlapping determinants of competence. No similar oversight in PA training exists. The draft appears to show that the BOLIM has opted to forego the need for this rigorous determination of safe scope of practice and opt instead to allow PAs to claim expertise based on practice location or whatever training and education the PA decides is sufficient. Under this system, a PA could legally claim to be a "specialist" in dermatology after working for a few weeks in a dermatology practice, while a physician with many years more training in dermatology is legally barred from such claims. The confusion created by this double standard communicates to patients that the training of a PA "specialist" exceeds that of a physician, and yet this deception is legal on a state level. Likewise, a PA could decide he/she is competent to perform a thoracentesis after watching one in the emergency department. This PA with no formal training in this procedure could decide to perform this procedure on a patient, who has no idea of the lack of training of this clinician and

the associated risk. No true informed-consent is possible, as the risks of the procedure being performed by an untrained individual are additive to the inherent risks of the procedure. Relying on the employer to ensure and/or provide the training and oversight for PAs' scope of practice places the responsibility on to employers, who practice in a business model, not in an altruistic one of educator or supervisor. The BOLIM does not determine scope of practice for physicians through the licensing process because there is already a rigid system in place that determines physician scope of practice. However, since a similar system is not in place for PAs, how is the BOLIM going to protect public safety by ensuring PAs are competent to perform in the scope of practice they self-declare? If there is no answer, perhaps this needs to be carefully established as part of the rule-making process. The speed of the law-making seems to demand more from the medical system than currently exists to determine scope of practice of PAs in a manner commensurate with public safety.

- BOARDS' RESPONSE: Comment not accepted. The law establishes the criteria for licensure of physicians and physician assistants in Maine. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law. Physician assistants must be prepared by education, training and experience to perform a medical service and the rule does not permit physician assistants to provide medical services that they are not competent to perform.

7. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

WRITTEN COMMENT: **Collaboration**
The term collaboration is used when discussing work between nurses and physicians because they belong to different professions. In contrast, physicians and physician assistants both belong to the profession of medicine. Because both physicians and PAs are now being allowed to practice medicine independently, but PAs complete significantly less training than physicians, physicians will continue to be held liable unless they are working in a consultation capacity. When a physician and a PA work together, the physician is either supervising (e.g. the physician shares responsibility for the patient) or the physician is consulting (e.g. not primarily responsible for the patient). When a physician "collaborates" with a PA on a case, the physician will be held liable. Therefore, we propose the term consultation agreement be used instead of collaboration agreements to more clearly define the roles and responsibilities of each party. Simply stating in the amendment that PAs are liable for their own mistakes will not make it so. Changes in language as proposed here, as well as other changes not relevant here (such as holding equal malpractice insurance) will be necessary. In addition to the above discussion of language, we would like to comment on the omission of a consultation agreement (collaborative agreement, as per the draft) requirement for PAs hired by facilities that credential them. We believe this is a dangerous oversight in patient safety

that assumes employers provide physician staff to meaningfully review their work, which is widely known to not occur. Furthermore, it continues to make physicians liable for the work done by PAs at those institutions. We do not see any justifiable reason to exclude inexperienced PAs hired by facilities from the consultation/collaborative agreement proposed by the Board. This is an issue of ensuring ongoing supervision to ensure safety in licensure and we do not believe oversight of that can safely be left to employers whose goal is maximum productivity of employees.

- BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law. The rule amendments cannot define a term to conflict with a definition that already exists in the law ("collaborative agreement") nor can the rule amendments limit the legal liability of physicians providing collaboration or consultation to physician assistants. Finally, the law specifically provides for physician assistants to be able to provide medical services without a collaborative agreement when working in a health care facility or physician group practice pursuant to a credentialing and privileging document that identifies the physician assistant's scope of practice.

8. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENT: **Pay Parity**
   We based our comments on the BOLIM draft, but do want to say that a paragraph in the osteopathic version appears to require pay parity for PAs. We do not see a similar statement in the BOLIM version. Various interests have promoted the false narrative that a generic "health care provider" provides uniform medical services independent of the training of the "provider." This falsity is actualized by an insurance industry coding system that distinguishes the care of other specialties, such as occupational therapists, social workers, audiologists, chiropractors, and nutritionists, but makes no similar distinction between the nature of the service provided by physicians, nurse practitioners, and PAs, other than by a slight *percentage* reduction for nonphysician providers (NPPs). Pay parity laws gloss over the fact that physicians, NPs, and PAs, actually provide different medical services based on their expertise. The only public agencies that truly understand the differences in training and thus can protect the public from a false belief in equivalency are the medical boards. For the osteopathic medical board to promote pay parity is to equate the training and education of PAs with that of physicians. The downstream consequences of this false equivalency in the business-of-medicine model would be devastating to patient safety as lower-cost PAs are hired to provide "the same" medical care as physicians, when in fact the care is not the same. Furthermore, patients lose the right to see a physician when HMOs fill their panels with PAs and insist that rather than see a family practice physician as a PCP, the patient MUST see a PA who works in family practice because they provide "the same" medical service. Our concern with the draft as it stands is that rather than permit a specific type of clinician to work

independently, it functionally gives PAs a license to practice medicine in the same capacity as physicians, without them actually completing the education and training necessary to achieve that level of competence. The practice of medicine would thus be largely performed by people without medical degrees, while the public continues to be lost in confusion about the actual training and oversight of these clinicians, which they understandably assume others (the employers, the BOLIM) are doing.

- BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law. The rule is a joint rule and there are not two versions with one addressing pay parity. Financial reimbursement regarding medical services provided by physician assistants is beyond the scope of the rule and the jurisdiction of the boards.

9. Corey Cole, DO

   WRITTEN COMMENT: I feel that there should be a comment about the PA needing to have malpractice insurance whether it be provided by themselves or their employer.

   - BOARDS' RESPONSE: Comment not accepted. The HCIFS Committee was made aware that no law exists in Maine requiring physicians or physician assistants to obtain medical malpractice insurance. Despite this, the HCIFS Committee and the Legislature declined to make this a requirement in the new law.

II. **General Comments Supporting the Law and Rule Amendments**

1. Jeffrey Austin, VP of Gov't Affairs *on behalf of* Maine Hospital Association

   WRITTEN COMMENT: MHA supports the Chapter 2 Joint Rule Regarding Physician Assistants. MHA participated in the legislative process in connection with the underlying bill. Maine hospitals employ many physician assistants all across the state. A hospital will be considered a "health care facility" under the terms of the rule and will be impacted by the rule. We believe the rule is consistent with the underlying law and addresses the issues in the manner expected by the legislature.

   - BOARDS' RESPONSE: Comment accepted for the reasons stated.

2. Christine Thomas, P.A.

   WRITTEN COMMENT: As a Physician Assistant who has practiced in Maine for 24 years, I would like to support the proposed Joint Rule Regarding Physician Assistants I believe the changes to the current regulations will allow better access to health care for all Mainers by removing limitations. It will also put us on equal footing with other professionals who can work independently despite having less experience.

- BOARDS' RESPONSE: Comment accepted for the reasons stated.

3. Dana L. Green, P.A.

   WRITTEN COMMENT: I would like to thank you for all your professional work during such challenging and uncertain times. I am also thankful for the proposed revisions to the physician assistant medical practice rules of the newly approved Chapter 2. This will provide expansion of physician assistant services in the coming years for Maine's medical communities.

   - BOARDS' RESPONSE: Comment accepted for the reasons stated.

4. Scott C. Ellis, P.A.

   WRITTEN COMMENT: With the growing demands for healthcare services in Maine and around the country, the role of the Physician Assistant as a member of the healthcare provider team has never been more necessary. That is why LD1660 has been such an important step forward in Maine to insure that patients, especially in underserved parts of our state with significant physician shortages, have access to quality healthcare. Thank you for all your hard work during this Covid-19 Pandemic to craft these accurate, clear and thoughtful proposed revisions to Chapter 2. The revisions to Chapter 2 Joint Rule Regarding Physician Assistants addresses the growing needs for healthcare providers in Maine by removing the physician supervisory requirements for PAs and establishing collaborative and practice agreements with physicians and other healthcare professionals. Overall, the Rules reflect the intent of LD1660 by eliminating language that implies physician liability for PA care, and allows the PA scope of practice to be determined at the practice level based on the PA's individual education, training, and experience.

   - BOARDS' RESPONSE: Comment accepted for the reasons stated.

III. **Section 1 – Definitions**

1. Saul Levin, M.D. *on behalf of* American Psychiatric Association

   WRITTEN COMMENT: In LD 1660, "physician" is defined as "a person licensed as a physician under this chapter or chapter 48." "This chapter" refers to chapter 36, Osteopathic Physician licensure and chapter 48 is licensure provided by the Board of Licensure in Medicine. The proposed rule has a definition section but does not provide a definition for "physician." To retain the intent of the law, the definition for physician should be echoed in the regulation: "'physician' is a person licensed as a physician under chapter 36 or chapter 48."

   - BOARDS' RESPONSE: Comment accepted for the reason stated. The following definition will be added to Section 1 Definitions: "Physician" means a person licensed as a physician by the Maine Board of Licensure in Medicine or the Maine Board of Osteopathic Licensure. The boards removed the definition of

"physician" previously contained in the rule following the amendment to the definition of "active unrestricted physician license" but will reinsert a definition for that term as stated above.

2. Andrew Nicholson, M.D.

   WRITTEN COMMENT: Maine physician is undefined. This implies a physician licensed and residing in Maine, but it is not defined. Given the movement to telehealth, and the practice of medicine across state lines, I think it is important that "Maine physician" be someone locally available and licensed.

   - BOARDS' RESPONSE: Comment accepted for the reason stated. The following definition will be added to Section 1 Definitions: "Physician" means a person licensed as a physician by the Maine Board of Licensure in Medicine or the Maine Board of Osteopathic Licensure. The boards removed the definition of "physician" previously contained in the rule following the amendment to the definition of "active unrestricted physician license" but will reinsert a definition for that term as stated above.

3. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENT: When a physician and a PA work together, the physician is either supervising (e.g. the physician shares responsibility for the patient) or the physician is consulting (e.g. not primarily responsible for the patient). When a physician "collaborates" with a PA on a case, the physician will be held liable. Therefore, we propose the term consultation agreement be used instead of collaboration agreements to more clearly define the roles and responsibilities of each party.

   - BOARDS' RESPONSE: Comment not accepted. The rule amendments follow the law. The boards do not have the authority to change a law nor to enact rule amendments that conflict with the law or contradict the intent of the law. The rule amendments cannot define a term to conflict with a definition that already exists in the law ("collaborative agreement"). The term "collaborative agreement" in the rule amendments is based upon the definition of that term in the law.

IV. **Section 2 – Uniform Qualifications for Licensure:**

1. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

WRITTEN COMMENT: Point (8) on page 6 of the BOLIM draft under "Uniform Requirements for Full License" requires for licensure that a physician assistant (PA) "demonstrates current clinical competence as required by this law." (This requirement is also found on page 11 under license reinstatement.) Clinical competence is not explicitly defined under the law, per se, but on page 15, under Uniform Scope of Practice for Physician Assistants, PAs are granted the authority to provide "any medical service for which the physician assistant has been prepared by education, training, and experience and is competent to perform. The scope of practice of a physician assistant is determined by the practice setting."

- BOARDS' RESPONSE: Comment accepted. The rule as drafted requires physician assistants who have not rendered medical services within the 24 months prior to application to demonstrate current clinical competency. Section 4 of the amended rule identifies various ways in which an applicant may attempt to demonstrate current clinical competency, which the boards will evaluate based upon the specific facts and circumstances of the applicant.

2. Anthony Curro, P.A.

WRITTEN COMMENT: Can the criteria for demonstrating clinical competency [be] included as part of the proposed Chapter 2 amendments?

- BOARDS' RESPONSE: Comment accepted. The rule as drafted requires physician assistants who have not rendered medical services within the 24 months prior to application to demonstrate current clinical competency. Section 4 of the amended rule identifies various ways in which an applicant may attempt to demonstrate current clinical competency, which the boards will evaluate based upon the specific facts and circumstances of the applicant.

V. **Section 3 – Uniform Requirements for Renewal/Inactive Status/Reinstatement/ Withdrawal of License**

1. Anthony Curro, P.A.

WRITTEN COMMENT: Section 3 indicates the use of an approved form while Item 4 page 10 has "approved by the board" crossed out. The use of an approved form makes sense to me and I suggest Item 4 on page 10 be changed to remove the strikethrough.

- BOARDS' RESPONSE: Comment not accepted. The language was stricken from the amended rule as redundant. "Administratively complete application" defined in Section 1 of the amended rule includes "a uniform application for licensure as developed by the boards."

2. Anthony Curro, P.A.

   WRITTEN COMMENT: Can the criteria for demonstrating continuing clinical competency [be] included as part of the proposed Chapter 2 amendments? The same suggestion applies to item 7.A.(7) on page 16 which addresses demonstrating clinical competency for license reinstatement.

   - BOARDS' RESPONSE: Comment accepted. The rule as drafted requires physician assistants who have not rendered medical services within the 24 months prior to application to demonstrate current clinical competency. Section 4 of the amended rule identifies various ways in which an applicant may attempt to demonstrate current clinical competency, which the boards will evaluate based upon the specific facts and circumstances of the applicant.

VI. **Section 6 - Uniform Scope of Practice for Physician Assistants**

1. Saul Levin, M.D. *on behalf of* American Psychiatric Association

   WRITTEN COMMENT: We are concerned that the proposed rule would authorize a facility or the Board to determine the scope of practice for a physician assistant. This does not correspond with physician scope of practice; for instance, a psychiatrist cannot decide to suddenly become a dermatologist one day and have the facility or Board solely determine the physician's scope of practice. A physician's scope of practice is based on years of training, including Accreditation Council of Graduate Medical Education (ACGME)-approved residency programs and multiple exams proving the physician has the skills needed to be a medical specialist. Similarly, a facility or Board should not unilaterally determine a physician assistant's scope of practice without specific evidence that a physician assistant has completed additional education and training to be certified in that specialty. To address these concerns, we suggest including detailed regulatory language requiring certification in the specialty in which a physician assistant will be practicing **and** defining the specific education and training of each specialty for those physician assistant "specialties" that do not have certification programs.

   - BOARDS' RESPONSE: Comment not accepted. The new law authorizes: (1) the boards to review "collaborative agreements" and "practice agreements" to approve or not approve a physician assistant's scope of practice; and (2) physician assistants with less than 4,000 hours of clinical experience to work within health care facilities or physician group practices pursuant to a written credentialing and privileging plan that identifies the physician assistant's scope of practice. In addition, the new law exempts physician assistants with more than 4,000 hours of clinical experience and who are working within a health care facility or physician group practice to render medical services <u>without</u> a collaborative agreement or a written credentialing and privileging plan that identifies the physician assistant's scope of practice. In crafting the new law, the Legislature intentionally eliminated the legal requirement for physician delegation of medical acts to physician assistants, and shifted the responsibility

for approving the scope of practice for certain physician assistants (depending upon clinical experience and practice setting) to either the boards or the health care facilities/physician group practices employing them. The Legislature was well-aware of the lack of post-graduate training for physician assistants as well as the fact that physician assistants receive additional education and training "on the job" in physician group practices or health care facilities. While it is true that physicians receive post-graduate training in a specific medical specialty, the boards do not license physicians to practice medicine within a particular medical specialty. Physicians are expected to practice medicine within the parameters of their education and training. In addition, a law specifically prohibits the Board of Licensure in Medicine from requiring national board specialty certification for physicians as a condition of licensure or re-licensure (See 32 M.R.S. § 3271(2)). Therefore, the comment suggesting that the boards should require all physician assistants desiring to practice in a specific medical field obtain specialty certification is one that is actually prohibited for physicians. The evaluation of a physician assistant's education and training is appropriate as part of the boards' review of a proposed scope of practice; however, the ways in which physician assistants may be able to demonstrate competency in a specific medical field should – like the current clinical competency requirement and re-entry to practice guidelines – be flexible. Unlike physicians, some physician assistants may work in various practices rendering medical services in a variety of medical specialties. Requiring specialty certifications for physician assistants who have rendered medical services competently for years in several different specialty areas of medicine would be unduly burdensome. On the other hand, requiring physician assistants who have never rendered medical services in a specific medical specialty to demonstrate current competency in that medical specialty is not unduly burdensome and protects the public. Like the current clinical competency requirement, there may be a variety of ways to meet the requirement based upon the specific circumstances of the applicant. For example, physician assistants who obtain additional education and training regarding a new medical specialty while working within a health care facility or physician group practice would be subject to oversight and accountability. In contrast, physician assistants who work outside of such practices (e.g. own their own practice) and contemplate rendering medical services in a novel medical specialty field would likely have to develop and complete a plan for education and training prior to being granted authorization by the boards to render medical services in the novel medical specialty. Such a plan could include specialty certification, education and training under the supervision of a physician or group of physicians who then attest to their competency, or employment for a period of time within a health care facility or physician group practice. Delineating with exclusive specificity all of the ways in which to demonstrate competency runs the risk of unnecessarily limiting the ways in which to so do. Nonetheless, the boards do agree that the rule should include some criteria for the review of a physician assistant's proposed scope of practice in a collaborative or practice agreement, and address that issue in response to other comments below.

2. Corey Cole, D.O.

   WRITTEN COMMENT: Would there be any procedures or scope of practice that they would be restricted from performing such as "major surgery", perimortem c-sections, endovascular procedures, etc.? I realize that there is still a credentialing process as outlined later in the statue but as it written it seems too broad.

   - BOARDS' RESPONSE: Comment accepted. Any physician assistants rendering medical services outside of a health care facility or physician group practice are required to have either a "collaborative agreement" or a "practice agreement" with a scope of practice approved by one of the Boards. This language was specifically inserted into the law – and the rule – due to concerns exactly as those raised by the commenter.

3. Maria Paone, M.D.

   WRITTEN COMMENT: PAs and NPs like to say they want to practice to the "top of their license." In the case of a PA, their license is to practice as a Physician Assistant, not as a Physician. This law enables them to bypass 2 years of school and 3-7 years of training, board specialty exams and recertification and practice to the full extent of a Physician's license. More, actually, because, unlike a physician, they are permitted to switch specialties at will.

   - BOARDS' RESPONSE: Comment accepted. Any physician assistants rendering medical services outside of a health care facility or physician group practice are required to have either a "collaborative agreement" or a "practice agreement" with a scope of practice approved by one of the boards. This language was specifically inserted into the law – and the rule – due to concerns exactly as those raised by the commenter.

4. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENT: [W]e would like to comment on the omission of a consultation agreement (collaborative agreement, as per the draft) requirement for PAs hired by facilities that credential them. We believe this is a dangerous oversight in patient safety that assumes employers provide physician staff to meaningfully review their work, which is widely known to not occur. Furthermore, it continues to make physicians liable for the work done by PAs at those institutions. We do not see any justifiable reason to exclude inexperienced PAs hired by facilities from the consultation/collaborative agreement proposed by the Board. This is an issue of ensuring ongoing supervision to ensure safety in licensure and we do not believe oversight of that can safely be left to employers whose goal is maximum productivity of employees.

- BOARDS' REPONSE: Comment not accepted. As stated previously, the Legislature enacted the law that provided that physician assistants are able to render medical services within a health care facility or physician group practice pursuant to either a collaborative practice agreement or pursuant to "a system of credentialing and granting of privileges and scope of practice agreement." The boards are unable to promulgate a rule that conflicts with or contradicts the law.

5. Lisa Harvey-McPherson, R.N., V.P. Gov't Relations *on behalf of* Northern Light Health

   WRITTEN COMMENT: **Section 6. 8. Criteria for Requiring Collaborative Agreements or Practice Agreements.** The proposed rule refers to agreement requirements for physician assistants with more than or less than 4,000 hours of documented clinical practice. We request that the final rule provide more detail on what qualifies as documented clinical practice. Is the standard as basic as the number of hours generally employed as a physician assistant or it is more complex relating to the number of hours performing clinical tasks as a licensed physician assistant.

   - BOARDS' RESPONSE: Comment accepted for the reasons stated. As indicated in their response to comment 5 below, the Legislature made a clear distinction between physician assistants rendering medical services within a health care facility or physician group practice practices pursuant to "a system of credentialing and granting of privileges and scope of practice agreement" and physician assistants working in private practice who require collaborative agreements or practice agreements. For the former, the health care facilities and physician group practices must determine what "documentation" is acceptable for physician assistants to demonstrate that they have 4,000 hours of clinical experience. These entities, which employ a plethora of health care workers, are in a unique position to oversee and evaluate physician assistant practice and to vet their credentials and qualifications for privileges to render medical services. The boards expect that these entities will perform due diligence in requesting and reviewing documentation from the physician assistants, their former employers, and former colleagues (including any prior supervising physician(s)) regarding their work history and clinical experience. These entities grant written privileges to physician assistants regardless of the number of hours of clinical experience, and therefore provide oversight of physician assistants regardless of the number of hours of clinical experience.

     The boards' review of scope of practice and documentation of 4,000 hours of clinical experience will focus on physician assistants who work in settings other than health care facilities or physician group practices pursuant to "a system of credentialing and granting of privileges and scope of practice agreement." As indicated in their response to comment 5 below, the boards have added a new subsection 9 to add criteria for reviewing physician assistants' scope of practice in certain settings. In addition, in response to the present comment, the boards add the following new paragraph to Section 6(8) entitled "Criteria for Requiring Collaborative Agreements or Practice Agreements":

D. Acceptable documentation of clinical practice includes, but is not limited to the following:

(1) Copies of previous plans of supervision, together with physician reviews;

(2) Copies of any credentialing and privileging scope of practice agreements, together with any employment or practice reviews;

(3) Letter(s) from a physician(s) attesting to the physician assistant's competency to render the medical services proposed;

(4) Attestation of completion of 4,000 hours of clinical practice, together with an employment history;

(5) Verification of active licensure in the State of Maine or another jurisdiction for 24 months or longer.

It should be noted that the documentation of 4,000 hours of clinical practice is a separate and distinct issue from "scope of practice." Physician assistants with more than 4,000 hours of documented clinical practice who render medical services outside of a health care facility or physician group practice still must have their scope of practice delineated in a written "practice agreement" and reviewed and approved by the boards.

6. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society

WRITTEN COMMENT: The terms of Chapter 627 allow a physician assistant to essentially provide medical services independent of meaningful physician oversight if they wish to open a solo practice after 4,000 hours of clinical experience. We would urge the Board to give additional attention to defining "scope of practice" in these rules, particularly what constitutes appropriate education, training, and experience in order to provide a particular medical service. Clearly delineated requirements for detailed and meaningful collaborative agreements and practice agreements that take into consideration practice and clinical settings are essential to promote high quality care and patient safety.

- BOARDS' RESPONSE: Comment accepted for the reasons stated. First, the boards want to once again emphasize that in enacting the law the Legislature was well-aware of the significant changes that would occur in the licensing and regulation of physician assistants. The Legislature – and indeed all of the stakeholders agreed – that the vast majority of physician assistants in Maine worked within health care facilities that have their own processes for educating and training and for evaluating and credentialing medical professionals, including physician assistants. Physician assistants working within health care facilities or physician group practices have the safety net of other medical and nursing colleagues and support staff. Health care facilities have quality control measures

and systems to review medical decision making and treatment and, when necessary, take corrective action. That is why the Legislature enacted the law that allowed physician assistants with less than 4,000 hours of clinical experience and working within health care facilities or physician group practices to render medical services pursuant to either a "collaborative agreement" or "under a system of credentialing and granting of privileges and scope of practice agreement." It is also why the Legislature did not require physician assistants with more than 4,000 hours of clinical experience and working within health care facilities or physician group practices to render medical services pursuant to either of these documents. The Legislature recognized that this would allow physician assistants working in those settings (as well as the hospitals and group practices) the maximum flexibility to move and work within different departments and medical specialties. These settings contain other medical personnel who may review the services rendered by physician assistants, operate pursuant to a system of credentialing and privileging, and are ultimately responsible for all medical services rendered by physician assistants in their employ. In other words, these settings – as the Legislature recognized - provide a safety net for physician assistant practice. Notably, the Legislature did not authorize the boards to review or approve the scopes of practice for physician assistants working within a health care system or physician group practice pursuant to "a system of credentialing and granting of privileges and scope of practice agreement." Thus, the boards will not typically be reviewing or approving these privileging and scope of practice agreements, but may request them when conducting a specific investigation. Therefore, the boards decline to issue specific requirements for delineating the scope of practice of physician assistants working within health care facilities or physician group practices pursuant to "a system of credentialing and granting of privileges and scope of practice agreement."

The boards do, however, agree that the rule should include some minimum criteria for reviewing the proposed scope of practice of physician assistants who render medical services in settings other than health care facilities or physician group practices (e.g. independent practice) pursuant to a "collaborative agreement" or "practice agreement." The Legislature recognized the potential risk to the public posed by physician assistants working outside of a health care facility by authorizing the boards to review and approve the physician assistants' scopes of practice. In formulating these standards, the boards are mindful of the importance of striking a balance between protecting the public and creating unduly burdensome and inflexible criteria. In order to provide transparency to the public and stakeholders regarding the standards for reviewing proposed scopes of practice, the boards add the following new subsection to Section 6, Uniform Scope of Practice for Physician Assistants:

9. **Criteria for Reviewing Scope of Practice for Physician Assistants in Collaborative Agreements or Practice Agreements**

A. In reviewing a proposed scope of practice delineated in a collaborative agreement or a practice agreement, the Board may request any of the following from the physician assistant:

(1) Documentation of at least 24 months of clinical practice within a particular medical specialty during the 48 months immediately preceding the date of the collaborative agreement or practice agreement;

(2) Copies of previous plans of supervision, together with physician reviews;

(3) Copies of any credentialing and privileging scope of practice agreements, together with any employment or practice reviews;

(4) Letter(s) from a physician(s) attesting to the physician assistant's competency to render the medical services proposed;

(5) Completion of Specialty Certificates of Added Qualifications (CAQs) in a medical specialty obtained through the NCCPA or its successor organization;

(6) Preparation of a plan for rendering medical services for a period of time under the supervision of a physician;

(7) Successful completion of an educational and/or training program approved by the Board.

B. Physician assistants who work outside of a health care facility or physician group practice may not render medical services until their scope of practice is reviewed and approved by the Board.

7. Garreth Debiegun, M.D. *on behalf of* Maine Chapter of American College of Emergency Physicians

WRITTEN COMMENT: we would urge the Board to give additional attention to the need to define "scope of practice." Properly defined, an emergency physician is one who has completed residency training and passed rigorous examinations in emergency medicine in order to become a specialist in the field. The requirements for practice in a specialty setting contemplated for independent physician assistants under the proposed rules contain far less rigor and, in fact, would allow for specialty practice largely based on self-reporting related to practice settings but largely independent of actual reportable accomplished training. We believe that this is not in the best interest of patients and that a more rigorous means for determining scope of practice would be appropriate. We advise that the Board in its Rule Making should define what constitutes appropriate education, training and experience in order to provide a particular medical service. Medical training for physicians consists of medical education followed by postgraduate education, generally a minimum of three years or longer. This post graduate training is curriculum

based and training programs are reviewed by the ACGME or the AOA for their ability to provide adequate training to ensure the public that graduates of these programs can provide safe specialty care. Before closing, we should emphasize that we value the training and experience of physician assistants who are an important part of the emergency department environment. None of these comments are intended in any way to denigrate their training and experience. However, it is important that their training and experience be practiced in the context of a health care team that is organized to provide high quality care to our patients. As such, we would suggest that the rules for Chapter 2 should

a. describe the nature of the training that should occur during the 4000 hours of practice in which a physician assistant must have a collaborative agreement. The Rules should include the requirement that any Scope of Practice agreement should be based on evidence of curricula-based training.

b. specify that an additional 4000 hours of training should be necessary if the Physician Assistant elects to practice in a different medical specialty than the one in which the initial training occurred.

- BOARDS' RESPONSE: Comment accepted in part. See the boards' response to comments 4-6.

8. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

WRITTEN COMMENT: The BOLIM does not determine scope of practice for physicians through the licensing process because there is already a rigid system in place that determines physician scope of practice. However, since a similar system is not in place for PAs, how is the BOLIM going to protect public safety by ensuring PAs are competent to perform in the scope of practice they self-declare? If there is no answer, perhaps this needs to be carefully established as part of the rule-making process. The speed of the law-making seems to demand more from the medical system than currently exists to determine scope of practice of PAs in a manner commensurate with public safety. In the absence of an existing system to determine the bounds of PA scope of practice, two options are:

1. to disallow PA claims of specialization based on practice location; see also "Truth in Advertising" below

2. to require consultation with physicians that occurs in person, on-site while practicing, to determine and approve scope of practice. Due to their rigorous standardization of education, physicians *are* in a position to determine safe scope of practice by PAs on a case-by-case basis. This suggestion is different than the on-paper approval provided by BOLIM staff, who are removed from observing

the actual provision of care, that is being proposed in the current draft. Furthermore, this suggestion is *different* from "collaboration" (which suggest equal but complementary expertise between a physician and a PA) or "supervision" (which is not permitted by the statute). The PA would be legally liable for his or her own work, but would be required by the BOLIM to document external validation of safety to function safely within a defined scope of practice. We understand that the BOLIM has attempted to achieve this via collaboration agreements, which we believe does not accomplish one of the stated goals of LD1660 of removing physician liability from PAs' practice. We address this specific issue in greater detail in the section "Collaboration" below.

- BOARDS' RESPONSE: Comment accepted in part. See the boards' response to comments 4-6.

9. Dan Morin, Dir. of Comm. & Gov't Affairs *on behalf of* MMA, MSEPS, MEACEP, MNS
   Amanda Richards, Exec. Dir. *on behalf of* Maine Osteopathic Association
   Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners

   WRITTEN COMMENT: One of our principal criticisms of the legislation was its delegation of overly broad authority to the licensing boards and its failure to specifically enumerate standards for determination of scope of practice and other important parameters for medical services provided by physician assistants. Chapter 627, and these and subsequent regulations, could have far-reaching implications for patient care. Therefore, under any construct of collaborative or practice agreements, we propose the following amendments to the joint rule:

   Amend Section 6 (Uniform Scope of Practice for Physician Assistants), in subsection 1 (General), by establishing a joint subcommittee of physician and physician assistants by the Boards of Licensure in Medicine and Osteopathic Licensure to lead the development of standard agreements and appropriate regulatory oversight. Because physician assistant services until enactment of Chapter 627 were technically medical services under the delegation and supervision of a person licensed to practice medicine, the boards should also develop standard forms and review the appropriateness of certain collaborative and practice agreements in various clinical settings. Such an approach would create a more formal structure and process and promote better communication, coordination, and expectations between the physician and physician assistant communities, and between the two licensing boards. In addition to potentially reviewing individual agreements prior to forwarding them for board review, joint committee members could first establish the proposal of basic standards and criteria that would be applicable to a given type of physician assistant practice setting.

   - BOARDS' RESPONSE: Comment accepted in part. See the boards' response to comments 4-6.

10. Andrew Nicholson, M.D.

    WRITTEN COMMENT: The BOLIM must evaluate and approve each collaboration and practice agreement. I am not sure the Board has the capability to properly evaluate, oversee, update and enforce these agreements. This is critical to the safety of patients. Physicians move, change jobs, and retire. The scope of practice for independently practicing PA's may be on constant flux. It may be much harder to keep an updated collaboration or practice agreement than anticipated by the proposed rule. I am afraid these agreements may just become a "check the box" document that is filed, but never updated or reviewed until after a problem occurs.

    - BOARDS' RESPONSE: Comment accepted in part. See the Boards' response to comments 4-6, 9. The Legislature gave the Boards the responsibility for reviewing physician assistant scope of practice in certain settings. The rule amendment also requires physician assistants to maintain a copy of any collaborative agreement or practice agreement and to notify the Boards in writing within 10 days of any change to a collaborative agreement or practice agreement, thereby triggering review.

11. Scott C. Ellis, P.A.
    Alan Hull, P.A.
    Angela Leclerc, P.A., President *on behalf of* Maine Association of Physician Assistants
    Jeffrey Austin, VP of Gov't Affairs *on behalf of* Maine Hospital Association

    WRITTEN COMMENT: In section 6, UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, subsection 3, "Consultation," the last sentence reads: "Upon request of the Board, a physician assistant shall identify the physician who is currently available ***or was available*** for consultation with the physician assistant." I would ask that "or was available" be modified to read: "or was available within 1 year of the request from the Board." As written, the rule presents an unlimited time frame. The proposed 1 year time frame allows PAs and administrators an appropriate length of time to keep records of available working and on-call physicians in tact.

includes the phrase "or was available for consultation" in the last sentence. This phrase is problematic as there is no addressed time frame as to how far in the past, the physician "available for consultation" will have to be identified. Will these records have to be maintained for 10 days, 10 weeks, 10 months, 10 years, or in perpetuity? Long-term maintenance of these records would be burdensome, and onerous. There should be a definitive timeframe for these records to be maintained.

With our current technology, medical records programs change relatively frequently, and unfortunately, importing all the data from the old system into the new system is expensive, extremely time-consuming, and frequently does not happen. Schedules whether electronic or hard copy, can be misplaced, or inadvertently discarded.

I would ask the physicians on the Boards to see if they can identify who the physician preceptor was on August 7 during the second year of their residency. Could they do so readily? Could they gain access to the records to identify that preceptor? If they were to name the residency director as a default preceptor, could they be assured that that physician would not have been on vacation or out ill that day? To expect a Maine PA to be able to identify the consultant available at five years, 10 years, or 20 years in the past is spurious.

I would respectfully suggest and hope that the phrase "or was available for consultation" can be modified to include a definitive timeframe in the past. One year seems to be reasonable duration of time for the maintenance of those records.

Request for addition of timeframe to identify available physician: MEAPA supports PAs being able to identify which physicians are available for consultation, however, requests that the language be adjusted to include a specific timeframe, and would suggest:

[…] Upon request of the Board, a physician assistant shall identify the physician who is currently available **or was available for consultation** with the physician assistant ***up to one year from the date of care***.[…]

We do agree with the PA Association that the provision in Section 6(3) may present challenges with respect to retrospective requests. A limit of some time seems warranted.

- BOARDS' RESPONSE: Comment not accepted. In response to a complaint received or as part of an investigation, the boards may be required to review the medical services rendered by a physician assistant for any time period that the physician assistant was licensed by a board. While a large percentage of complaints or investigations occur within a relatively short period of time following the provision of services, the boards have the obligation to investigate any complaint received notwithstanding when the medical services were rendered. Therefore, a physician assistant may be requested by the boards to identify the physician(s) that were available to them for consultation in connection with medical services they have rendered during any period in which they have held a license. One way to preserve this information is to document the identity of the consulting physician(s) in the medical record.

12. Anthony Curro, P.A.

WRITTEN COMMENT: Two of my current practice locations have a service, PDRx, which provide a small variety of non-narcotic medications to be prescribed and dispensed

to patients. This can be done for patient convenience when local pharmacies are open as well as when pharmacies are closed. Will this type of service continue to be allowed under the proposed amendment language? In addition the WMHC seasonal clinic at Sunday River has "To go packs" which include narcotics and can be prescribed and provided to patients with orthopedic injuries. Will the proposed amendment allow continuation of that practice?

- BOARDS' RESPONSE: Comment not accepted. The rule follows the law.

13. Anthony Curro, P.A.

WRITTEN COMMENT: While I understand that the PA is responsible for services rendered I would have thought that the legislation and the courts would establish liability rather than in the rules governing PA practice. With a quick electronic search of the version of LD1660 I found on line I did not find language establishing PA liability. Is the proposed language about PA liability part of the final version of LD1660?

With the exception of PA's without a physician partner or who own and/or operate an independent practice PA's practicing under the proposed amendment will have one of the following: a collaborative or practice agreement, a physician partner who is required to be available at all times and who must be named by the PA if requested to do so by the board, or they will be part of a healthcare facility or physician group practice which grants privileges and defines scope of practice. In all of those latter circumstances the delivery of healthcare is a joint responsibility between the PA, physician partner, and their employers.

Unless liability is specified in the final version of LD1660 I request that the language on page 23 section 6 be amended to reflect a joint responsibility between PA, physician partner, and their employer. This suggestion would not apply if the PA were the owner/operator of an independent practice.

- BOARDS' RESPONSE: Comment not accepted. The rule follows the law which specifically provides that physician assistants are legally liable for all medical services they render. This language was specifically included in the new law which eliminated physician delegation and liability for medical acts rendered by physician assistants under their supervision.

14. Dan Morin, Dir. of Comm. & Gov't Affairs *on behalf of* MMA, MSEPS, MEACEP, MNS
Amanda Richards, Exec. Dir. *on behalf of* Maine Osteopathic Association
Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners

WRITTEN COMMENT: We also support the requirement that, "*a physician assistant is legally liable for any medical service rendered by the physician assistant.*"

- BOARDS' REPONSE: Comment accepted. The language of the amended rule is consistent with the law.

15. Scott C. Ellis, P.A.
Alan Hull, P.A.
Angela Leclerc, P.A., President *on behalf of* Maine Association of Physician Assistants

WRITTEN COMMENT: In section 8. Criteria for Requiring Collaborative Agreements or Practice Agreements, B. Practice Agreement, the rule reads: "Physician assistants with more than 4,000 hours of documented clinical practice as determined by the Board and who are the principal clinical provider without a physician partner **or who own and/or operate an independent practice** must have the following in order to render medical services under their Maine license:"… I ask that the phrase "or who own and/or operate an independent practice" be deleted. This phrase is not appropriate as it identifies a business relationship and doesn't pertain to the regulation of the practice of medicine.

The bolded language above references regulation of a structure of business rather than regulation of practice and appears to be inappropriate. It is not in the revised statute. In addition, using the term "independent" is confusing (when thinking of PA practice vs PA business). MEAPA recommends this language be deleted in its entirety, and the revised language read:

> B. **Practice Agreement**. Physician assistants with more than 4,000 hours of documented clinical practice as determined by the Board and who are the principal clinical provider without a physician partner must have the following in order to render medical services under their Maine license:

- BOARDS' RESPONSE: Comment not accepted. The language at issue in the amended rule does not constitute a comment regarding the structure of a business (e.g. sole proprietorship, limited liability corporation, professional service corporation) but rather clarifies and interprets the statutory language.

16. Anthony Curro, P.A.

WRITTEN COMMENT: 8. **Criteria for Requiring Collaborative Agreements or Practice Agreements Sub-Section C Physician Assistants with more than 4000 hours of documented clinical practice**
Comment/Suggestion: My suggestion would be to amend the language to say that "are not required to have, but may enter into, either a collaborative agreement or a practice agreement."
Rationale: Although examples of the collaborative and practice agreements are not included with the proposed amendment the description of the collaborative agreement appears to be similar to current plans of supervision. In my practice I believe a collaborative agreement would provide the safest and most effective care for my patients. As it would be similar to the current POS system it has the advantage of being a known method of delivering patient care.

- BOARDS' RESPONSE: Comment not accepted. Nothing in the law nor rule prevents a physician assistant from entering into a collaborative agreement or a practice agreement with a physician or physicians.

VII. **Section 7 - Uniform Elements of Written Collaborative and Practice Agreements**

1. Sarah Calder, Dir. of Gov't Affairs *on behalf of* MaineHealth

   WRITTEN COMMENT: With a growing health care workforce shortage, we truly appreciate the intent of the proposed amendments to Board Rule Chapter 2 Physician Assistants. We have concerns, however, and proposed suggested revisions, based primarily on the fact that, as drafted, the amendments do not, in some areas, provide the necessary flexibility to implement these changes within a large health care system like MaineHealth. Also, as drafted, the amendments in some instances place the burden on physician assistants to undertake actions that we, as their employer, are better equipped to undertake. The minor revisions we propose below do not take away the intent and/or goals of the proposed amendments, but rather are requested in order to add flexibility to some requirements of collaborative and practice agreements and to enable an employer, in addition to and/or instead of an individual physician assistant, to perform some of the mandated tasks.

   Our requested changes to the proposed rule amendments are as follows:
   Section 7 – Uniform Elements of Written Collaboration and Practice Agreements. Subsection 1. (A): Requested Change: We request the language reflect Public Law, Chapter 627 and state as follows: "the tasks that the physician assistant <u>may be</u> delegating" instead of "<u>will be</u> delegating." This change will still allow for a collaborative agreement and practice agreement to itemize all of the tasks that a physician assistant (PA) may ask a medical assistant (MA) to do (all of which would still be in compliance with the remaining legal obligations and scope of relevant practices), but will not be so restrictive as to require a PA to always ask a MA to do a certain task (via the phrase of commitment "will be"). Flexibility in day-to-day practice is important, including if a PA determines that a particular MA (including a new MA, for example) is unable to do a particular task on a particular day and circumstances under which a PA determines in his/her judgment that it is best, for patient safety, to undertake the task himself/herself. The "will do" language does not afford for that flexibility, and any deviation from the collaborative agreement and/or practice agreement subjects the PA to potential discipline under the current rules as written.

   - BOARDS' RESPONSE: Comment accepted for the reason stated. Section 7(1)(A) will be changed to "may be" to be consistent with the law.

2. Stuart Glassman, M.D. *on behalf of* State Advocacy Committee of the American Academy of Physical Medicine and Rehabilitation (AAPMR)
   Dan Morin, Dir. of Comm. & Gov't Affairs *on behalf of* MMA, MSEPS, MEACEP, MNS

Amanda Richards, Exec. Dir. *on behalf of* Maine Osteopathic Association (MOA)
Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners (Spectrum)

WRITTEN COMMENTS:

(AAPMR) Given the proposed amendment to remove the physician supervision requirements for physician assistants is maintained, a collaborative agreement between the physician and physician assistant must be upheld. Collaborative agreements may allow physician assistants to provide quality patient care to the extent of their education and training, as agreed upon by their health care team to ensure patient safety. A collaborative agreement may also allow the physician to provide more complex patient care and leadership duties suited to their level of expertise. AAPM&R believes that the consultation provision should be enforced to the fullest extent to ensure that physician assistants, based on the patient's condition, the education, competencies and experience of the physician assistant and the standards of care, consult with, collaborate with, or refer the patient to an appropriate physician or other health care professional. Furthermore, we firmly agree that a physician must be accessible to the physician assistant at all times for consultation and that a physician assistant, upon request of the Board, shall identify the physician who is currently available or was available for consultation with the physician assistant.

(MMA, MSEPS, MEACEP, MNS, MOA, Spectrum) We appreciate the opportunity to submit the following comments on the proposed amendments to the proposed joint rule pertaining to the licensure and practice of physician assistants in response to Public Law 2019, Chapter 627. Maine needs physician assistants. They are a vital part of our physician-led health care teams. However, it is critical for the public to understand that physician assistants and physicians are *NOT* essentially interchangeable, and that the two professions *DO NOT* have a body of knowledge and clinical skills that are equivalent. Each member of a physician-led health care team has an important role to play, working together to provide the best outcomes for patients while also driving improvements in patient care. While there is no question about the level of service and professionalism physician assistants bring to a health care team, they are not physicians. Any other characterization underestimates the clinical complexity that often accompanies a medical determination and plan of care.
Nevertheless, the terms of Chapter 627 allow a physician assistant to essentially provide medical services independent of meaningful physician oversight if they wish to open a solo practice after 4,000 hours of clinical experience. While we continue to have strong reservations about aspects of the legislation, we support the provision outlining that, for all physician assistants, in every clinical setting, "*a physician must be accessible to the physician assistant at all times for consultation*," and that upon request of the Board, "*a physician assistant shall identify the physician who is currently available or was available for consultation with the physician assistant*."

- BOARDS' RESPONSE: Comments accepted for the reason stated. The boards agree that consultation is very important to ensure safe rendering of medical

services by physician assistants and that the consulting physician(s) should be available at all times to the physician assistant.

3. Sarah Calder, Dir. of Gov't Affairs *on behalf of* MaineHealth
   Anthony Curro, PA

   WRITTEN COMMENTS:

   (MaineHealth): **Subsection 1 (D)**: Requested change: Allow a PA's employer, and not just a PA, to prepare, maintain and produce/have on file the required collaborative and practice agreements. The current proposed rule places the burden on the PA exclusively to prepare, maintain and keep on file the collaborative or practice agreements, and subjects the PA to penalties/potential discipline if he/she falls short in these regards. Within large and/or organized healthcare systems, which employ PAs and which also place accountabilities on PAs and physicians under credentialing and privileging processes, the burden may be better assumed by the employer to develop/prepare, maintain and produce the collaborative and practice agreements. Also, such employers are able to better track when changes are necessary to such agreements, including if and where changes may be needed due to transitions in employment of consulting/collaborating physicians. MaineHealth's request is to make the following change to the proposed rule under Section 7, Subsection (1)(D): "Physician assistants licensed to practice in accordance with these rules, and/or the employers of such physician assistants, must prepare and have on file in the main administrative office of the practice or practice location a written, dated collaborative or practice agreement …" The requested change does not take away from the intent of the original proposed rule to ensure that required collaborative and practice agreements are prepared, filed and maintained, but rather affords healthcare systems some flexibility in where to place this burden including to ensure that such agreements are prepared, maintained, updated, and filed appropriately.

   Anthony Curro, PA: D. C. **Maintenance and production of plan of supervision collaborative and practice agreements**
   Comment/Suggestion: My suggestion would be to amend the language to say that: ") Physician assistants licensed to practice in accordance with these rules and their employer must prepare…."
   Rationale: All parties to the agreement should have a stake in the preparation and execution of agreements. Out of a need to become cost efficient there has been significant consolidation in the number of groups delivering healthcare. This has led to fewer independent job opportunities, including for physician assistants, and greater leverage on the part of the employers. Essentially a few large groups now dominate the market for healthcare delivery and employment opportunities. A requirement by the board that both the physician assistant, and their employer, be responsible for the preparation of collaborative and practice agreements will insure that both parties to those agreements have equal standing in, and incentive to prepare, such agreements. For clarity I think it would be reasonable to continue to have the PA responsible to submit the agreement once it is prepared.

- BOARDS' RESPONSE: Comments not accepted. First, while the boards understand the intent of the comments, the boards lack the authority to promulgate rules regarding the employers of physician assistants. The boards' authority extends only to its licensees. Second, as medical professionals it is the personal and professional responsibility of physician assistants to comply with the laws and rules of the boards. Third, there is nothing in the rule amendment that prohibits physician assistants from coordinating with their employer(s) regarding this issue, with the understanding that the physician assistants are ultimately responsible for complying with the rule.

4. Stuart Glassman, M.D. *on behalf of* State Advocacy Committee of the American Academy of Physical Medicine and Rehabilitation
   Lisa Harvey-McPherson, RN, VP of Gov't Relation *on behalf of* Northern Light Health

   WRITTEN COMMENTS:

   (AAPMR) To create a formal structure that would promote standardization of the process for establishing collaborative agreements, we believe that the both licensing boards should develop standard forms and review the appropriateness of collaborative and practice agreements in various clinical settings.

   (Northern Light Health) We ask that the respective boards develop standardized collaborative and practice agreement templates for optional use by physician assistants.

   - BOARDS' RESPONSE: Comments accepted for the reason stated. The boards have developed model collaborative agreements and practice agreement forms for use by physician assistants and their consulting physicians. These model forms are not included in the rule amendments to allow for flexibility in modifying or updating them if necessary.

5. Dan Morin, Dir. of Comm. & Gov't Affairs *on behalf of* MMA, MSEPS, MEACEP, MNS
   Amanda Richards, Exec. Dir. on behalf of Maine Osteopathic Association (MOA)
   Ann Robinson, Esq. on behalf of Spectrum Healthcare Partners (Spectrum)

   WRITTEN COMMENTS: The collaborative agreement and/or practice agreement should contain the following:
   - A requirement that each physician assistant and physician shall jointly review the authorization for collaborative or practice agreements annually,
   - Each authorization for collaborative or practice agreements shall include a cover page containing the date of the annual review by the physician assistant and physician and an acknowledgement and signature of the same,
   - Each authorization for collaborative or practice agreement shall be maintained in either hard copy or electronic format at the physician's and physician assistants' principal place of practice, and

- Medical services performed by a physician assistant under a collaborative or practice agreement must be appropriate to the skills and practice area of the physician as well as the physician assistant's level of competence, as determined by the physician, to ensure that accepted standards of medical practice are followed.

  - BOARDS' RESPONSE: Comments accepted in part for the reason stated. The rule amendments already provide for the physician assistant and collaborating/consulting physician sign a collaborative agreement or practice agreement, and require that physicians providing consultation do so "only within their scope of practice." In addition, the amendments already require the maintenance and production of collaborative agreements and practice agreements by the physician assistants. However, the boards do not agree that there needs to be an annual "joint review" by the physician assistant(s) and collaborating/ consulting physicians and an accompanying cover page with their signatures and the date. Review of a physician assistant's practice is on on-going process involving daily interactions and feedback.

VIII. **Section 8 – Uniform Notification Requirements for Physician Assistants**

1. Sarah Calder, Dir. of Gov't Affairs *on behalf of* MaineHealth

   WRITTEN COMMENT: **Subsections (1) & (2):** Requested changes: First, allow the PA's employer (in addition to and/or instead of the PA) to make the required notifications of any changes to and/or terminations of collaborative or practice agreements, including by submitting revisions and notifications to the Board(s). This request is made in the same spirit as that set forth above under Subsection (1)(D) of Section 7 – specifically, the burden on these matters may better fall to a PA's employer within an organized healthcare system including when the system has its own employment rules and its own credentialing and privileging requirements and processes. The second change is to add some flexibility in the number of days to submit changes to collaborative and practice agreements in writing to the Board(s), due to the immense challenges and work burdens that PAs, physicians and healthcare systems are already facing in delivering and prioritizing patient care. The requested changes are therefore to add the following language in the following areas: Subsection (1) – Change of Collaborative Agreement or Practice Agreement "A physician assistant licensed by the Board and/or the employer for such physician assistant shall notify the board in writing within thirty (30) calendar days of any change to a collaborative agreement or practice agreement to the Board for review and approval." Subsection (2) – Termination of Collaborative or Practice Agreement "A physician assistant licensed by the Board and/or the employer for such physician assistant shall notify the Board in writing within thirty (30) calendar days regarding the termination of any collaborative or practice agreement. Such notification shall include the reason for termination."

   - BOARDS' RESPONSE: Comment not accepted. First, while the boards understand the intent of the comment, the boards lack the authority to promulgate

rules regarding the employers of physician assistants. The boards' authority extends only to its licensees. Second, as medical professionals it is the personal and professional responsibility of physician assistants to comply with the laws and rules of the boards. Third, there is nothing in the rule amendment that prohibits physician assistants from coordinating with their employer(s) regarding this issue, with the understanding that the physician assistants are ultimately responsible for complying with the rule.

2. Sarah Calder, Dir. of Gov't Affairs *on behalf of* MaineHealth

WRITTEN COMMENT: **Subsection 4 – Death/Departure of Collaborating Physician**
MaineHealth's requested changes to Section 8, Subsection 4 have both practical and legal considerations behind it. First – the primary requested change is to eliminate this subsection altogether, as the death or permanent/long term departure of a collaborating physician is already encompassed in a required change to a collaborative agreement under subsection (1) of Section 8. If a physician is no longer able to be a collaborating physician pursuant to death and/or permanent or long term departure, the PA is already required to notify the Board(s) of a change to the relevant collaborative or practice agreements (including for example by changing the agreement to reflect a new collaborative physician) under Section 8, Subsection (1). Moreover, PAs and Hospital systems may learn of death or disability resulting in permanent/long term departures of physicians through conversations, communications or events protected by HIPAA, state privacy laws and/or state or federal employment privacy laws, where further disclosure of such matters by such PAs and/or Hospital systems are legally prohibited. Subsection 4 is therefore not only arguably unnecessary in light of Subsection (1), but also legally complicating.

If Subsection 4 must and is legally able to be retained, then a separate requested change is, again, to enable the PA's employer to undertake the burden of notifying the Board(s) of the death or permanent or long-term departure of a collaborating physician who is a signatory to either a collaborative or practice agreement. Also, we the request that the time limit for making such requested notification be extended to 30 days from the date that the death or disabling condition of the physician became known. MaineHealth therefore requests that Subsection 4 of Section 8 read as follows: "A physician assistant licensed by the Board, <u>and/or the employer for such physician assistant</u>, shall notify the Board in writing <u>within thirty (30) calendar days upon learning of</u> the death or permanent or long term departure of a collaborating physician who is a signatory to either a collaborative agreement or a practice agreement."
The reason behind the requested change(s) are that an employing entity, versus an individual PA, is much more likely (and in the case of MaineHealth, is likely always going to be) knowledgeable about whether and under what specific circumstances a collaborating physician may have a permanent or long term departure from employment. In this regard, typically a long term and/or permanent departure is caused by either a medically disabling condition, and/or termination of employment, which matters are deemed confidential by both federal and state law as well as by employer policy and

practice. Employers are therefore precluded, and/or do not share by policy, this particular kind of information with individual employees, including PAs. It would be unfair to subject a PA to discipline under the new proposed rules for failure to provide information to the Board(s) if the nature of the information is not something that the PA himself/herself would be privy to, whether by law or by operation of employer policy. Further, the request for the extension of time to 30 days from date of notice to notify the Board(s) of the death or permanent/long term departure of a collaborating physician is to enable allowance for the natural period of time that passes in order for an employer to collect underlying information related to health conditions, leaves of absence and/or basis for employment separations as to such physicians (and other employees). For example, as related to permanent and/or long term departures occasioned by medical conditions, the process to obtain documentation of the underlying condition and/or the basis for any alleged period of time needed away from work typically takes numerous weeks, and often more than 10 days. The proposed 10 day notice requirement, therefore, may not be practicably met. MaineHealth would not want its PAs sanctioned or disciplined for events outside of their (as well as the employer's
control).

- BOARDS' RESPONSE: Comment not accepted. First, while the boards understand the intent of the comment, the Boards lack the authority to promulgate rules regarding the employers of physician assistants. The boards' authority extends only to its licensees. Second, as medical professionals it is the personal and professional responsibility of physician assistants to comply with the laws and rules of the boards. Third, there is nothing in the rule amendment that prohibits physician assistants from coordinating with their employer(s) regarding this issue, with the understanding that the physician assistants are ultimately responsible for complying with the rule. Fourth, the boards are health oversight entities under HIPAA. This specific notification requirement does not require the disclosure of protected care information: physician assistants can merely inform the boards that the physician is permanently no longer available without disclosing protected health care information. Fifth, the boards do not agree that 10 days is overly burdensome – especially in the case of physician assistants who own or operate their own practices and render medical services in consultation with a physician. Finally, this notification requirement should affect only a small percentage of physician assistants working within health care facilities. Only those physician assistants with less than 4,000 hours of clinical experience and working within health care systems are required to render medical services pursuant to <u>either</u> a collaborative agreement" <u>or "under a system of credentialing and granting of privileges and scope of practice agreement</u>." In other words, physician assistants working within health care facilities "under a system of credentialing and granting of privileges and scope of practice agreement" are not required to have collaborative agreements – and thus this notification provision does not apply to them. Likewise, physician assistants with more than 4,000 hours of clinical experience and working within health care facilities are not required to have either a collaborative agreement nor a scope of practice agreement – and thus this notification provision does not apply to them. In conclusion, the regulatory impact of this notification provision upon physician

assistants and health care facilities is minimal compared to the importance of the public safety factor for physician assistants working in private practice settings.

IX. **Section 11 – Uniform Continuing Medical Education (CME) Requirements and Definitions**

1. Anthony Curro, PA

   WRITTEN COMMENT: I wanted to clarify CME requirements as they pertain to NCCPA. My Maine license renewal is in November 2020 while my most recent NCCPA certification cycle ended in December 2019 with my submitting at least 100 hours of CME to NCCPA. Will completion of NCCPA CME requirements for a two year cycle ending December 2019 meet the board's requirement for license renewal in November 2020?

   - BOARDS' RESPONSE: Comment not accepted. Rule Section 11(1)(C) provides that proof of current NCCPA certification at the time an application for renewal is submitted satisfies CME requirements.

2. Anthony Curro, PA

   WRITTEN COMMENT: Item 1 under definition of CME Categories includes a list of approved organizations for category 1 CME. In addition NCCPA has used categories of CME which included self-assessment (SA) and Process improvement (PI). Each of those categories was granted more than one hour of CME for each hour spent in the activity; for example self-assessment CME were granted 1.5 hours of CME for each hour of participation. I suggest that we align the list of organizations approved for Category 1 CME, and the value of those activities with current NCCPA requirements. Any future modifications by NCCPA would then be included in the State of Maine requirements and would simplify record keeping for physician assistants.

   - BOARDS' RESPONSE: Comment not accepted. The proposed rule identifies any number of organizations that provide qualifying Category 1 CME opportunities for physician assistants.

X. **Section 12 – Identification Requirements**

1. Saul Levin, M.D. *on behalf of* the American Psychiatric Association

   WRITTEN COMMENT: In 2013 and 2015, Governor LePage signed health care practitioner transparency legislation into law (24 M.R.S.A. § 2988), requiring a health care practitioner to disclose the license under which the health care practitioner is practicing. We recommend including similar language in this rule requiring physician assistants to identify the license under which they practice. We also strongly advise that physician assistants be required to say aloud that they are physician assistants, especially during the pandemic when telehealth patients will not be able to see practitioners' name

badges. Patients should be provided this information in a clear manner so that they can make informed decisions about their medical care.

- BOARDS' RESPONSE: Comment accepted for the reason stated. See the boards' response to comment 3 below.

2. Megan Selvitelli, M.D. *on behalf of* Maine Neurological Society
Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
Purvi Parikh, M.D. *on behalf of* Physicians for Patient Protection
Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENT: **Truth in Advertising**
   As discussed above, the draft proposal as written allows PAs to define their own scope of practice. This option not only lacks safeguards for patient safety, but also allows misleading self-promotion on specialization. The AMA performed a longitudinal Truth in Advertising survey that found that 61% of patients thought that PAs with a doctorate of medicine science were physicians (https://www.ama-assn.org/sites/amaassn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf). We believe as regulators of both physician and PA practice, the BOLIM is in a unique position and indeed obligated to clear up the confusion and thereby empower them to make autonomous, educated decisions about healthcare purchasing. In the Truth in Advertising campaign stated above, 91% of respondents said that a physician's years of medical education and training are vital to optimal patient care. PAs should not be allowed to claim to be a "dermatology specialist" simply because they work in a dermatology office, which implies to patients that they have more experience in dermatology than the patient's primary care physician. Additionally, a PA with a medical science doctorate who passed the National Commission on Certification of Physician Assistants (NCCPA) certification program should not be allowed to claim she is a "board-certified family medicine doctor." These claims are misleading and dangerous. We propose that the rule-making process include truth in advertising language that includes, but is not limited to, requirements for disclosure of licensure title to every patient, as well as require PAs to explicitly correct patients who refer to them as "doctor."

   - BOARDS' RESPONSE: Comment accepted for the reason stated. See the boards' response to comment 3 below.

3. Dan Morin, Dir. of Comm. & Gov't Affairs *on behalf of* MMA, MSEPS, MEACEP, MNS
Amanda Richards, Exec. Dir. *on behalf of* Maine Osteopathic Association
Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners

   WRITTEN COMMENT: We also respectfully request amending Section [12] of the joint rule under Identification Requirements to include: • Physician assistants licensed under these rules shall keep their license available for inspection at the location where they render medical services and shall, when rendering medical services, wear a name tag identifying themselves as a physician assistant. Physician assistants shall also verbally

identify themselves as a physician assistant to each new patient. Despite the enactment of Public Law 2019, Chapter 627, state law still clearly defines physicians as engaging in the "practice of medicine or surgery", while describing physician assistants as rendering "medical services." Studies have increasingly shown patients are confused about the qualifications of different health care professionals. Many non-physicians earn advanced degrees, and some degree programs now confer the title "doctor." As a result, patients often mistakenly believe they are meeting with physicians (medical doctors or doctors of osteopathic medicine) when they are not. As non-physicians increasingly seek to expand their scope of practice, there should come the added responsibility of visually, and verbally, disclosing their education, qualifications, and training. The latter also is necessary for the visually impaired. Maine can leverage the knowledge and skills of physician assistants, and the increased availability of convenient settings for care delivery, to meaningfully expand access to services, while maintaining a clear focus on patient safety and quality in care coordination and integration. Developing clear parameters and uniform expectations for allowing physician assistants to practice at the highest level of their knowledge and clinical training, while recognizing the important role physicians play in a physician-led care team, is the right path to take.

- BOARDS' RESPONSE: Comment accepted for the reasons stated. This section of the proposed amended rule will be changed to read as follows:

SECTION 12. IDENTIFICATION REQUIREMENTS

Physician assistants licensed under this rule shall:

1. Keep their licenses available for inspection at the location where they render medical services;

2. When rendering medical services, wear a name tag identifying themselves as physician assistants; and

3. Verbally identify themselves as physician assistants whenever greeting patients during initial patient encounters and whenever patients incorrectly refer to them as "doctors."

Response to Additional Comments Following Re-Proposal of the Rule on September 30, 2020

Before delving into the comments, the boards wish to again convey their sincere appreciation for the feedback, comments, suggestions and questions regarding the proposed rule amendments. In addition to the specific comments identified below, the boards received and reviewed information from the Federal Trade Commission (FTC) for the boards to consider as they undertake the current rule making regarding Chapter 2. The boards intent in promulgating the new rule and the criteria for reviewing physician assistant scope of practice is to protect the public by ensuring that the scope of practice is consistent with the education, training and experience of the physician assistant as required by the new law.

Once again, the boards want to clarify for the commenters and stakeholders that the boards are State agencies created by the Legislature and derive their very existence, membership and authority from the laws enacted by the Legislature. The boards must implement the newly enacted law, and cannot act contrary to law or promulgate a rule or amendments to a rule that conflict with the law. The Legislature has spoken, and the boards are legally bound to enact rules that are both within the law and congruent with the Legislative intent. The boards express their appreciation for the commenters' and stakeholders' understanding concerning this issue as well as the new paradigm for physician assistant licensure and regulation in Maine as enacted by the Legislature.

In addition, the boards reminds all stakeholders that their sole purpose is to protect the public and that the current rule making regarding Chapter 2 is being undertaken with that mandate in mind, and that the re-proposed rule was open for comments regarding the new language identified in the re-proposed rule – and not regarding the entire language of the proposed rule.

List of Commenters:

1. Pamela Barter-Chessman, P.A.
2. Angela Coton, P.A.
3. David Duchin, P.A.
4. Amy Hoffman, P.A. licensed in Maryland
5. Jed Jankowski, P.A.
6. Tillie Fowler, J.D. *on behalf of* the American Academy of Physician Assistants (AAPA)
7. Scott Ellis, P.A.
8. Angela Leclerc, P.A. *on behalf of* Maine Association of Physician Assistants
9. Gretchen Morrow, P.A.
10. Scott Ellis, P.A.
11. Kristi Kalajian, P.A.
12. Ryan Trosper, P.A.
13. Lisa Allen, P.A.
14. Erwin Morse, P.A.
15. Alan Hull, P.A.
16. Dan Morin *on behalf of* The Maine Medical Association
17. Amanda Richards *on behalf of* The Maine Osteopathic Association
18. Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners
19. Andrew Dionne, M.D.
20. Rebekah Bernard *on behalf of* Physicians for Patient Protection
21. Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
22. Matthew Davis, M.D. *on behalf of* Maine Association of Psychiatric Physicians
23. Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology
24. Erin Muthig, P.A.
25. Cynthia Davies, P.A.
26. Charles Dingman, Esq. *on behalf of* Maine Primary Care Association

Comments and Board Responses:

I. **Section 1 – DEFINITIONS, paragraph 11 "Health Care Facility"**

1. Charles F. Dingman, Esq. *on behalf of* Maine Primary Care Association

WRITTEN COMMENT: The definition of "health care facility" should be amended to include community health centers that are not licensed by the State of Maine such as federally qualified health centers that have a system of credentialing and granting of privileges to perform health care services. The current definition appears to have unintentionally omitted these types of facilities that employ physician assistants.

- BOARDS' RESPONSE: Comment accepted for the reason stated. The language of paragraph 11 shall be changed to read as follows:

"Health care facility" means a facility, institution or entity licensed pursuant to State law or certified by the United States Department of Health and Human Services, Health Resources and Services Administration that offers health care to persons in this State, including hospitals, any clinics or offices affiliated with hospitals and any community health center, each of which has a system of credentialing and granting of privileges to perform health care services and that follows a written professional competence review process.

II. **Section 6 – UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, paragraph 8.C.**

1. Allan Hull, P.A.
Jed Jankowski, P.A.
Angela Leclerc, P.A. *on behalf of* Maine Association of Physician Assistants
Tillie Fowler, J.D. *on behalf of* the American Academy of Physician Assistants (AAPA)

WRITTEN COMMENT: The commenters state that this subsection does not appear to be consistent with the law and may be confusing. One commenter suggests removing the reference to "practice agreements" as it is unnecessary. The other commenter suggests clarifying this subsection to include physician assistants with more than 4,000 hours of documented clinical experience and who work within a physician-owned practice or physician group practice that lack a credentialing system.

- BOARDS' RESPONSE: Comments accepted. The boards agree that this subsection omitted a category of physician assistants and make the following non-substantive clarification to the subsection:

C. Physician assistants with more than 4,000 hours of documented clinical practice as determined by the Board and are employed with a health care facility or with a practice that includes a physician partner – regardless of whether or not the facility or practice have a system of credentialing and granting of privileges - are not required to have either a collaborative agreement or a practice agreement.

III. **Section 6 – UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, "9. Criteria for Requiring Collaborative Agreements or Practice Agreements."**

1. Dan Morin *on behalf of* The Maine Medical Association
   Amanda Richards *on behalf of* The Maine Osteopathic Association
   Ann Robinson, Esq. *on behalf of* Spectrum Healthcare Partners

   WRITTEN COMMENTS: "We appreciate the boards' willingness to better establish basic standards and criteria under a new paragraph to Section 6(8) entitled 'Criteria for Requiring Collaborative Agreements or Practice Agreements.'"

   - BOARDS' RESPONSE: Comments accepted for the reasons stated.

IV. **Section 6 – UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, "8.D Acceptable documentation of clinical practice includes, but is not limited to the following:"**

1. Alan Hull, P.A.

   WRITTEN COMMENTS: The commenter suggests this subsection "provides some welcome guidance" regarding the types of acceptable documentation but nonetheless also states "the wording suggests an overly complex, burdensome, and lengthy process." The commenter also suggests that the wording of the subsection is "unclear if ALL of the 'acceptable documentation'… is required." The commenter also suggests some minor changes to the language.

   - BOARDS' RESPONSE: Comments not accepted.

     First, the language of the proposed rule, including this subsection, is both brief and clear. The language of this proposed subsection states:

     D. Acceptable documentation of clinical practice <u>includes, but is not limited to the following</u>:

        (1) Copies of previous plans of supervision, together with physician reviews;

        (2) Copies of any credentialing and privileging scope of practice agreements, together with any employment or practice reviews;

        (3) Letter(s) from a physician(s) attesting to the physician assistant's competency to render the medical services proposed;

        (4) Attestation of completion of 4,000 hours of clinical practice, together with an employment history;

        (5) Verification of active licensure in the State of Maine or another jurisdiction for 24 months or longer.

Second, this specific subsection was added in response to comments requesting guidance from the boards regarding the types of documentation that would be accepted to demonstrate 4,000 hours of clinical practice. It is not intended to be nor is it "overly complex, burdensome, and lengthy." The language of this subsection actually provides transparency, guidance and flexibility to the boards, physician assistants, and the public regarding the types of documentation not specifically identified in the subsection; hence the language "includes, but is not limited to the following." The types of documentation required may actually differ upon the specific circumstances of the physician assistant. By identifying what type of documentation is acceptable, the boards are also streamlining the process – not lengthening it.

Third, the language as proposed is sufficiently clear and concise, while also allowing physician assistants to submit - and the boards to consider – other types of documentation not specified within the language of the subsection.

V. **Section 6 – UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, "9. Criteria for Reviewing Scope of Practice for Physician Assistants in Collaborative Agreements or Practice Agreements", Subparagraph A.**

1. Pamela Barter-Chessman, P.A.
   Angela Coton, P.A.
   David Duchin, P.A.
   Scott Ellis, P.A.
   Amy Hoffman, P.A.
   Jed Jankowski, P.A.
   Angela Leclerc, P.A. *on behalf of* Maine Association of Physician Assistants
   Gretchen Morrow, P.A.
   Kristi Kalajian, P.A.
   Ryan Trosper, P.A.
   Lisa Allen, P.A.
   Erwin Morse, P.A.
   Alan Hull, P.A.
   Tillie Fowler, J.D. *on behalf of* the American Academy of Physician Assistants (AAPA)
   Edward D. Burbach *on behalf of* AAPA
   Rebekah Bernard *on behalf of* Physicians for Patient Protection
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Matthew Davis, M.D. *on behalf of* Maine Association of Psychiatric Physicians
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology
   Cynthia Davies, P.A.
   Gretchen Morrow, P.A.
   Erin Muthig, P.A.

   WRITTEN COMMENTS: The commenters expressed concern with the new proposed section, "9. Criteria for Reviewing Scope of Practice for Physician Assistants in Collaborative Agreements or Practice Agreements." Some commenters assert that the law distinguishes between collaborative agreements and practice agreements, and that the

criteria for evaluating the scope of practice for physician assistants with collaborative agreements may not be the same as that for physician assistants with practice agreements. Some commenters assert that the boards are attempting to combine collaborative agreements and practice agreements when the Legislature created two different agreements. Some commenters believe that the criteria for evaluating the scope of practice for physician assistants under each type of agreement should not be combined as each scenario requires unique regulation and may cause confusion. Therefore, some commenters believe that the rule should set out separate criteria for each type of agreement. Some commenters believe the proposed wording may possibly be a result of misunderstanding of these two very different agreements and one commenter asserts it would be detrimental to Maine's most vulnerable underserved population for which healthcare is often limited. Some commenters believe that the language of the new subsection should be changed from "may request" to "shall be required" to create more uniformity in scope of practice determinations. Finally, some commenters believe that this section should be eliminated in its entirety.

- BOARDS' RESPONSE: Comments not accepted.

  First, the boards fully understand the distinction between the two agreements – which is based upon the practice setting and whether a physician assistant has achieved 4,000 hours of documented clinical experience. While the majority of "new" or "recent" physician assistant graduates may fall within those that may require a collaborative agreement, there may be many physician assistants who are not new or recent graduates and who still have not achieved 4,000 hours of clinical practice. For one example, a physician assistant could graduate from an approved PA program, yet fail to pass the national certification examination – resulting in a delay in clinical practice until the passage of the examination. For another example, a physician assistant may graduate from an approved PA program but not enter clinical practice for several years for any number of reasons (e.g. health reasons, additional education, different field of employment, raising a family) or have an interruption in their clinical practice. Therefore, the criteria regarding "Documentation of at least 24 months of clinical practice within a particular medical specialty during the 48 months immediately preceding the date of the collaborative agreement" *may* be relevant for the boards to consider – depending upon the specific circumstances of the physician assistant. The operative point is that the boards will be able to request the relevant information to specific circumstances of the individual physician assistant. To be clear, the boards are not requiring all of these types of criteria for "new" or "recent" graduates of approved physician assistant programs; therefore, they will not be barriers to employment or practice.

  Second, the boards are not "combining" collaborative agreements and practice agreements. The title of the new section should inform everyone that the purpose of the section is to establish criteria for reviewing a physician assistant's scope of practice – whether that scope of practice is set out in a collaborative agreement or a practice agreement.

Third, the proposed rule aligns with the law and establishes criteria that the boards *may* use in evaluating a physician assistant's scope of practice under either type of agreement. As indicated earlier, the law shifted the responsibility for determining the scope of practice of physician assistants working outside of a health care facility or physician group practice (where there is oversight and accountability) to the boards. Before the enactment of the law, that responsibility fell to physicians who supervised physician assistants. The law specifically authorizes the boards to review the scopes of practice for physician assistants working pursuant to either a collaborative agreement or a practice agreement. By including this language in the law, the legislature recognized the risk posed to the public by physician assistants who may attempt to render medical services in specialty areas outside of their training and experience. For example, a physician assistant who has rendered clinical medical services for 10 years in orthopedics may not be qualified to safely treat patients as the principal clinical provider in a practice rendering family medicine services – at least not without additional education, training, and oversight.

Fourth, as the boards are required to review the scope of practice of physician assistants who work pursuant to either a collaborative agreement or a practice agreement, there is no rational basis for having a separate and distinct set of criteria for each. The boards added the "criteria" in response to comments received during the initial publication of the rule so that physician assistants and the public would know what information that the boards *may* consider in deciding whether or not to approve a proposed scope of practice of a physician assistant who works pursuant to either a collaborative agreement or a practice agreement. Identifying the criteria in the rule provides for transparency and avoids allegations that the decisions made by the boards regarding scope of practice are arbitrary or capricious. The rule does not require the boards to apply each and every criteria listed – only those that are relevant to the particular circumstances of the physician assistant and the particular agreement. The criteria are not confusing, do not impact access to care, and are specifically designed to ensure access to "safe" care. Finally, the language "may request" is sufficient for the boards to obtain information needed to conduct scope of practice reviews. Requiring ALL of the types of information to be provided every time the boards are reviewing scope of practice does not necessarily result in uniformity and deprives the boards of flexibility in making such determinations based upon the individual circumstances of the physician assistant.

2. Edward D. Burbach *on behalf of* AAPA

WRITTEN COMMENT: This new section imposes "more stringent requirements regarding collaborative agreements and practice agreements."

- BOARDS' RESPONSE: Comment not accepted. The law shifted the responsibility for determining the scope of practice of physician assistants working outside of a health care facility or physician group practice (where there is oversight and accountability) to the boards. Before the enactment of the law,

that responsibility fell to physicians who supervised physician assistants. The law specifically authorizes the boards to review the scopes of practice for physician assistants working pursuant to either a collaborative agreement or a practice agreement. The law specifically states that the scope of practice of a physician assistant must be delineated in each type of agreement and that each agreement must be submitted to the boards "for approval."

By including this language, the legislature recognized the risk posed to the public by physician assistants who may attempt to render medical services in specialty areas outside of their training and experience. For example, a physician assistant who has rendered clinical medical services for 10 years in orthopedics may not be qualified to safely treat patients in a family medicine setting – at least not without additional education, training, and oversight.

The proposed rule aligns with the law and establishes criteria that the boards *may* use in evaluating a physician assistant's scope of practice under either type of agreement when submitted to the boards for approval. The boards added the "criteria" in response to comments so that physician assistants and the public would know what information that the boards *may* consider in deciding whether or not to approve a proposed scope of practice of a physician assistant who works pursuant to either a collaborative agreement or a practice agreement. Identifying the criteria in the rule does not impose stringent requirements, provides for transparency and avoids allegations that the decisions made by the boards regarding scope of practice are arbitrary or capricious. The rule does not require the boards to apply each and every criteria listed – only those that are relevant to the particular circumstances of the physician assistant and the particular agreement.

VI. **Section 6 – UNIFORM SCOPE OF PRACTICE FOR PHYSICIAN ASSISTANTS, "9. Criteria for Reviewing Scope of Practice for Physician Assistants in Collaborative Agreements or Practice Agreements", Subparagraph B.**

1. Alan Hull, P.A.

   WRITTEN COMMENT: "The way this is written, a single unclear or controversial item on a proposed Scope of Practice, could delay approval of the Collaborative Agreement for a considerable amount of time. This section could cause hardship for an underserved community and/or the practice and PA if the process is delayed. Please consider modifying this sentence to provide for a partial approval of a Scope of Practice until such time as the items of debate could be addressed."

   - BOARDS' RESPONSE: Comments not accepted. The rule aligns with the law, which requires physician assistants to submit Collaborative Agreements or Practice Agreements to the boards for review and approval. The boards already have the authority to approve or not approve any proposed agreement submitted to them for review. It is only logical that the boards can already do what the

commenter suggests – namely approve a modified agreement. Finally, even underserved communities deserve to have the credentials of its medical professionals – of whatever background – thoroughly vetted to ensure that safe and competent care is provided. The boards understand the health care challenges facing all Mainers, and will employ due diligence in implementing this rule.

VII. **Section 12 – Identification Requirements**

1. Pamela Barter-Chessman, P.A.
   Scott Ellis, P.A.
   Amy Hoffman, P.A.
   Jed Jankowski, P.A.
   Andrew Dionne, M.D.
   Angela Leclerc, P.A. *on behalf of* Maine Association of Physician Assistants
   Lisa Allen, P.A.
   Cynthia Davies, P.A.
   David Duchin, P.A.
   Alan Hull, P.A.
   Kristi Kalajian, P.A.
   Gretchen Morrow, P.A.
   Erin Muthig, P.A.
   Ryan Trosper, P.A.

   WRITTEN COMMENTS: The commenters expressed concern over a new requirement in Section 12 that licensed physician assistants: "Verbally identify themselves as physician assistants whenever greeting patients during initial patient encounters and whenever patients incorrectly refer to them as 'doctors.'" The commenters assert that this is "demeaning" and "onerous and detracts from patient centered care." The commenters believe that this requirement is "excessive and unnecessary," "difficult and detracts from patient care," and that physician assistants should "correct and move on." The commenters state that physician assistants are professionals, that no other Maine health care providers have such a requirement and that "repeatedly correcting a patient would lead to further harm and confusion… [and] undermine patient care." In addition, one commenter was concerned about the requirement of a name tag identifying him as a physician assistant, and one commenter noted that some physician assistants have "PhD or doctorates in a different field."

   - BOARDS' RESPONSE: Comments not accepted. The intent of this requirement is to ensure that the public is informed about the actual credentials of the individuals who are providing their care. The boards understand that some patients may care more or less about credentials than others and/or that some patients may lack the ability to understand or appreciate the differences in credentials of health care providers due to medical issues (e.g. neurocognitive or psychological issues). Therefore, the boards do not expect that physician assistants will correct patients each and every time during a single patient encounter. However, the boards expect that physician assistants will employ

judgment and tact during patient clinical encounters during which this issue may arise – and as one commenter stated, “correct and move on.” The rule already included a requirement for physician assistants to wear a name tag identifying themselves as physician assistants. Such a requirement is also mandated by Maine law: 24 M.R.S. § 2988(3).[1] http://legislature.maine.gov/statutes/24/title24sec2988.html. The requirement that physician assistants verbally introduce themselves to new patients as physician assistants is not onerous, is informative, and does not negatively impact patient care. Similarly, the requirement that physician assistants “correct” patients who refer to them as “doctors” is not onerous and will not negatively impact patient care. Finally, Maine law prohibits a physician assistant with a doctorate and who is actively engaged in rendering medical services from referring to herself as “doctor.” See 32 M.R.S. § 3270.[2] http://legislature.maine.gov/statutes/32/title32sec3270.html.

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[1] **3. Identification.** A health care practitioner shall comply with the following identification requirements.

A. [PL 2015, c. 35, §1 (RP).]

B. A health care practitioner seeing patients on a face-to-face basis shall wear a name badge or some other form of identification that clearly discloses:

(1) The health care practitioner's first name or first and last name, except that if the health care practitioner is a physician, the name badge or identification must disclose the physician's first and last name; and

(2) The type of license, registration or certification the health care practitioner holds, including the common term for the health care practitioner's profession.

[2] **§3270. Licensure required**

Unless licensed by the board, an individual may not practice medicine or surgery or a branch of medicine or surgery or claim to be legally licensed to practice medicine or surgery or a branch of medicine or surgery within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes of this State. An individual licensed under chapter 36 may prefix the title "Doctor" or the letters "Dr." to that individual's name, as provided in section 2581, or a chiropractor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Chiropractor," or a dentist duly licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name or a naturopathic doctor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Naturopathy" or the words "Naturopathic Medicine" or an optometrist duly licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Optometrist" or a podiatrist licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Podiatrist" or "Chiropodist."

Whoever, not being duly licensed by the board, practices medicine or surgery or a branch of medicine or surgery, or purports to practice medicine or surgery or a branch of medicine or surgery in a way cited in this section, or who uses the title "Doctor" or the letters "Dr." or the letters "M.D." in connection with that individual's name, contrary to this section, commits a Class E crime. Nothing contained in this section prevents an individual who has received the doctor's degree from a reputable college or university, other than the degree of "Doctor of Medicine" from prefixing the letters "Dr." to that individual's name, if that individual is not engaged, and does not engage, in the practice of medicine or surgery or the treatment of a disease or human ailment. Nothing contained in this section prevents an individual who has received the degree "Doctor of Medicine" from a reputable college or university but who is not engaged in the practice of medicine or surgery or the treatment of a disease or human ailment, from prefixing the letters "Dr." or appending the letters "M.D." to that individual's name, as long as that individual's license to practice has never been revoked by the board.

VIII. **Request for New Section entitled "Protection for Physicians who Decline to Participate"**

1. Rebekah Bernard *on behalf of* Physicians for Patient Protection
   Lisa Moreno, M.D. *on behalf of* American Academy of Emergency Medicine
   Matthew Davis, M.D. *on behalf of* Maine Association of Psychiatric Physicians
   Alyson Maloy, M.D. *on behalf of* Portland Cognitive and Behavioral Neurology

   WRITTEN COMMENTS: The commenters urge the boards to include a provision in the rule to protect physicians from retaliation in employment, medical staff status, and credentialing when they do not want to enter into collaborative agreements, practice agreements, or the correlate of these agreements presented by their health care system or physician group practices. The commenters further urge the boards to protect physicians who "disagree with the contractual rules by a health care system or physician group that require physicians to enter into such formal agreements with PAs."

   - BOARDS' RESPONSE: Comments not accepted. This request is beyond the rule making authority of the boards and is outside of the scope of the re-proposed changes to the rule.

Nothing in this chapter may be construed as to affect or prevent the practice of the religious tenets of a church in the ministration to the sick or suffering by mental or spiritual means.