Legislation on Unmatched Medical School Graduates

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Background

In 2014, Missouri created the assistant physician designation for medical school graduates who do not match into a residency program.[1] To obtain the designation, a medical school graduate must have passed either Step 1 and Step 2 of the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination of the United States. After only 30 days of clinical training, assistant physicians are allowed to provide primary care services to individuals in rural and underserved areas with limited physician supervision for an indefinite time. For perspective, physicians must additionally pass USMLE Step 3 during their residency before obtaining full licensure.

In Missouri, Collaborative Practice Arrangements, or CPAs, give assistant physicians the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within their scope of practice and is consistent with that individual's skills, training and competence and the skill and training of the collaborating physician.

The Missouri Board of Registration for the Healing Arts began accepting applications for the assistant physician designation on January 31, 2017.[2]

Since the enactment of Missouri's law, several other states have passed similar legislation. Of all the states that have passed such bills, Missouri's law remains the least restrictive and is the only state that does not limit how long an individual may practice as an assistant physician.

State Laws

Arkansas

In 2015, Arkansas passed the Arkansas Graduate Registered Physician Act.[3] It grants a "graduate registered physician" license to those who successfully completed Step 1 and Step 2 of the USMLE or COMLEX-USA or the equivalent of both steps of an Arkansas State Medical Board-approved medical licensing examination within the two-year period immediately preceding application for licensure. These licenses may only be renewed two times, allowing the licensee to be on the license for no more than three years.

Arkansas graduate registered physicians must enter into a "physician-drafted protocol," a delegation agreement signed by both the licensee and supervising physician that expires within six months of the initial license.

Idaho

In 2023, Idaho passed legislation allowing individuals within their first year of medical school graduation to serve as "bridge-year physicians" if they applied but were not accepted into an accredited medical residency training program.[4] The state board of medicine established a one-year, nonrenewable limited license under which the bridge-year physicians may practice medicine within the scope determined by the board and under the supervision of a licensed physician or pursuant to a CPA. The bridge-year physicians qualify as one of a supervising physician's permitted advanced practice professionals and are

subject to requirements that are no less stringent than supervision requirements for physician assistants. Bridge-year physicians also have prescriptive authority as determined by the board.

Utah

Utah also allows unmatched medical school graduates to work as "associate physicians" under the supervision of a collaborating physician.[5] Associate physicians must have graduated from a Liaison Committee on Medical Education-accredited school and completed Steps 1 and 2 of the USMLE or equivalent steps of another board-approved medical licensing exam (completion must be within three years after graduation day and within two years prior to applying for an associate physician license). These individuals may not hold an associate physician's license for more than a total of six years.

Associate physicians must complete a CPA with a Utah physician who agrees to supervise them, and these agreements may include prescribing privileges if certain criteria are met. The Utah law also specifies that while associate physicians may use the title "Dr.," they must still identify themselves as an associate physician.

Kansas

Kansas created a special license for graduates of the University of Kansas School of Medicine who do not match with a residency program that allows them to practice under continuous, direct supervision for a maximum of two years.[6]

Arizona

Arizona's assistant physician law passed in 2021. It created a new assistant physician provider category for medical and osteopathic school graduates who have not completed a residency program.[7] Together, the American Academy of Family Physicians and the Arizona Academy of Family Physicians sent a letter to members of the Arizona Senate Health and Human Services Committee opposing the legislation. Eventually, the bill removed the specific language of an assistant physician licensure category but edited the text to grant a one-year "transitional training permit" to medical school graduates who have not completed residency but have completed Steps 1 and 2 of the USMLE or equivalent exams. Recipients can renew the permit for two additional one-year periods if they still have not been selected for a residency but may not hold a permit for an aggregate period of more than 36 months.

The Arizona Medical Board does not provide or locate a qualifying supervising physician or employment for transitional training permit holders. As of December 2023, only 26 of the 108 permit holders had secured a supervising physician.

Louisiana

Louisiana recently enacted a program that allows unmatched graduates to practice medicine as bridge-year graduate physicians.[8] This certification is valid for one year and may be renewed for no more than two additional one-year periods upon application to the Louisiana State Board of Medical Examiners. Unlike other states with similar programs, applicants in Louisiana must have applied for a residency the first year after medical school graduation. The certification period allows prescriptive authority for legend and certain controlled drugs. It also requires the direct supervision of a board-certified physician.

Alabama
Alabama's 2023 Physician Workforce Act provides for limited, supervised practice for unmatched, accredited medical school graduates, referring to them as "bridge-year graduate physicians."[9]

The Alabama Board of Medical Examiners has not yet developed its rules for the act. Once the rules are final, ALBME will issue a permit to qualified applicants to practice under the on-site supervision of an Alabama-licensed physician. The permit will be valid for one year and is renewable upon application and payment of a renewal fee for no more than an additional one-year period.

A bridge-year graduate physician holding a permit may prescribe, dispense or administer legend drugs based on a formulary approved by the supervising physician and the board.

After the bridge year, the supervising physician must submit a report to the board highlighting the scope and breadth of the practice, instruction and training and a statement indicating whether the bridge-year graduate physician is recommended for a residency position upon reapplication.

Tennessee
A 2023 Tennessee law allows medical school graduates without a residency position to practice primary care under a supervising physician for two years.[10] After the two-year cap, the individual can no longer practice medicine without entering residency.

AAFP Guidelines

The term "associate physician" will be used throughout the remainder of this document to refer to individuals granted practice authority before matching into residency. The term encapsulates the myriad of titles in states, including assistant physician, bridge-year graduate physician, bridge-year physician, graduate registered physician, etc.

The AAFP *does not support* awarding a full license without residency training with our following related policies:

- Education, Physician Retraining
- Family Medicine, Specialist in
- Guidelines on the Supervision of Non-Physician Clinicians (NPCs)
- Health Care Professionals, Family Physician Training With

However, we recognize that state legislatures are searching for ways to reduce the primary care physician workforce shortage, and the above-mentioned state policies are their solutions. To guide AAFP chapters who work with lawmakers on legislation to grant practice privileges to unmatched medical school graduates, the AAFP evaluated the recent state laws and identified certain provisions that may help establish appropriate guardrails. The AAFP recommends the following key provisions to be included in future legislation on this topic:

- Legislation must provide a limited scope of practice for a limited time.
- Individuals shall only practice under the **supervision** (*not collaboration*) of a licensed physician approved by the state medical licensing board. The level of supervisory oversight required shall, at minimum, include on-site physician supervision.

- Patients must be informed they are seeing an associate physician and have the right to request face-to-face time with the supervising physician.

Other important provisions for chapters to advocate for include:

Applicants

- Legislation must include both allopathic and osteopathic graduates.
- Applicants must have successfully completed Steps 1 and 2 of the USMLE or COMLEX-USA or the equivalent of both steps of a board-approved medical licensing examination within the two-year period immediately preceding application for licensure as an associate physician, but not more than two years after graduation from a medical school, an allopathic medical college or an osteopathic medical college.
- Applicants must not have licensure, certification or registration under current discipline, revocation, suspension or probation for cause resulting from the applicant's medical practice.

Associate Physician Acceptance

- Associate physicians must establish a supervising physician agreement within six months of acceptance.
- Associate physicians must participate in at least 50 hours of continuing medical education programs approved by the board during each of their temporary license periods.
- Associate physicians must notify the board of any acceptance to an accredited internship or residency program.

Guidelines for Employing Entities of Associate Physicians

- Employing entities must provide to the associate physician, in collaboration with the supervising, qualified physician, ongoing clinical training related to the services that the supervising, qualified physician may delegate to the associate physician.
- Employing entities must be responsible, along with the supervising, qualified physician, for all aspects of the performance of an associate physician.
- Employing entities must ensure the health care tasks performed by the associate physician are within the associate physician's scope of medical training, experience and competence and have been properly delegated and supervised by a supervising, qualified physician.
- Employing entities must ensure that during the associate physician's first six months of full-time practice, all clinical encounters performed by the associate physician are under the direct supervision of a supervising, qualified physician. Subsequent encounters performed by the associate physician after the initial six-month period must require that a supervising, qualified physician be immediately available for direct supervision.
- Employing entities must ensure that all physician supervision is documented.
- Employing entities must ensure that the associate physician is clearly identified as a medical graduate in training in all clinical or other patient encounters.
- Employing entities must define the employment or contractual relationship with the associate physician, including the terms of compensation and benefits, billing and reimbursement and general and professional liability coverage.
- Employing entities must establish and document a process for evaluating the associate physician's performance that includes a review by the supervising, qualified physician of all medical records related to the clinical encounters the associate physician performs.

- Employing entities shall notify the department of health services on a form prescribed by the department or on an equivalent form from the entity before employing or contracting with an associate physician of all the following:
  - Types and extent of medical training the employing entities plan to provide to the associate physician
  - Names of the supervising, qualified physicians who will supervise the associate physician and the types of health care tasks that may be delegated to the permittee by the supervising, qualified physicians
  - Employing entities shall post on their public website and submit to their state's department of health services an annual report that includes the:
    - Number of associate physicians and supervising, qualified physicians employed by or contracted with the entity.
    - Length of time each associate physician and supervising, qualified physician have been employed by or contracted with the entity.
    - Number of hours of medical education provided to each associate physician.
    - Number of hours of clinical care provided by each associate physician.
    - Number of associate physicians who obtained a match with an accredited internship or residency program.

Supervising, Qualified Physicians

- Supervising, qualified physicians shall notify the state medical board in writing of the agreement to serve as a supervising, qualified physician before supervising an associate physician. The notification shall include the name of the associate physician and the name and location of the eligible entities where the supervision will occur.
- Supervising, qualified physicians are responsible for all aspects of an associate physician's performance, whether or not the supervising, qualified physician employs the associate physician.
- Supervising, qualified physicians are responsible for ensuring that the health care tasks performed by the associate physician are within the associate physician's scope of medical training and experience, appropriate to the associate physician's level of competence and properly delegated by the supervising, qualified physician. Additionally, the health care tasks performed by the associate physician must not exceed the supervising, qualified physician's training, experience and competence.
- Supervising, qualified physicians shall notify the state board of medicine, the employing entity and the associate physician in writing if the associate physician exceeds the scope of the delegated health care tasks to allow the board to investigate.
- Supervising, qualified physicians and associate physicians may designate backup physicians who agree to supervise the associate physician during the absence of the supervising, qualified physician.

Prescribing Authority

- Prescribing authority may be delegated by a supervising, qualified physician to an associate physician to include prescribing, ordering and administering Schedules III-V controlled substances, all legal drugs and all nonscheduled prescription medications and medical devices.
- Prescribing authority for all prescriptions and orders issued by an associate physician shall also identify their supervising, qualified physician.

- Associate physicians' level of prescribing authority shall not exceed the level of the supervising, qualified physician.
- Associate physicians who prescribe controlled substances shall register with the United States Drug Enforcement Administration as part of the U.S. DEA's Mid-Level Practitioner Registry.

Post-permit Protocol

- At the end of the permit period, the supervising, qualified physician shall submit a report to the state medical board indicating the scope and breadth of the practice of the associate physician and the instruction and training provided to the permit holder. The supervising, qualified physician's report shall contain a statement as to whether or not the associate physician would be recommended for a residency position upon reapplication.
- A permit issued in accordance with this law shall not confer any future right to licensure to practice medicine.

ALEC Model

In 2021, the American Legislative Exchange Council finalized its Associate Physician Act, model legislation allowing medical graduates who have not yet completed a residency to provide primary care services to underserved areas in collaboration with a licensed physician.[11]

The AAFP analyzed the ALEC model and cautions chapters working with legislatures *not* to use all the language in this model. For example, we recommend replacing "collaborate" with "supervise" and modifying the model's language for the sections listed below with AAFP recommendations in the corresponding bullet points.

Note: The ALEC model section language has been slightly modified for style and ease of understanding. We kept the model's language in this section of "collaborating physician," but we prefer the more thorough term of "supervising, qualified physician."

Section 1. E. An associate physician shall clearly identify themself as an associate physician. An associate physician may use the terms "doctor," "Dr.," or "doc," but they may not practice or attempt to practice without a CPA, as described in Section 2 of the ALEC model, except as otherwise provided in this section and in an emergency situation.

- **AAFP recommendation:** *While the terms are accurate, we recommend identifying associate physicians as "doctors under supervision."*

Section 1. H. Each health insurance carrier or health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued or renewed shall reimburse an associate physician for diagnosing, consulting or treating an insured or enrollee on the same basis that the health carrier or health benefit plan covers the service when it is delivered by another comparable mid-level health care provider, including a physician assistant.

- **AAFP recommendation:** *We recommend omitting this language. Instead, billing should be done by the supervising, qualified physician to reflect the amount of service the supervising, qualified physician provided. Our recommendation is similar to residency billing and should resolve any insurance coverage issues.*

Section 2. B. (5) b. The manner of collaboration between the collaborating physician and associate physician shall include how the collaborating physician and associate physician maintain geographic proximity (except that the CPA may allow for geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics as defined in 42 United States Code Section 1395x). As long as the CPA includes alternative coverage as required by subdivision (c) of this paragraph (i.e., provide for alternative coverage during absence, incapacity or infirmity or an emergency), the geographic proximity exception applies only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 United States Code Section 1395i-4 or provider-based rural health clinics if the main location of the hospital sponsor is more than 50 miles from the clinic. The collaborating physician shall maintain documentation related to this requirement and present it to the board on request.

- **AAFP recommendation:** *We recommend omitting this language as it threatens health equity. In addition, the associate physician must always have their supervising, qualified physician on-site.*

Section 2. B. (9). A description of the time and manner of the collaborating physician's review of the associate physician's delivery of health care services, including the provision that every 14 days, the associate physician must submit a minimum of 10% of the charts documenting the associate physician's delivery of health care services to the collaborating physician for review by the collaborating physician or any other physician designated in the CPA.

- **AAFP recommendation:** *We recommend omitting this language as patient charts should be reviewed by the associate physician **and** supervising, qualified physician each day. Our recommendation applies the same level of supervision the CMS requires for incoming residents.*

Section 2. B. (10). A requirement that the collaborating physician, or any other physician designated in the CPA, review every 14 days a minimum of 20% of the charts in which the associate physician prescribes controlled substances.

- **AAFP recommendation:** *We recommend omitting this language as every patient should be reviewed by the associate physician **and** supervising, qualified physician each day. Our recommendation applies the same level of supervision the CMS requires for incoming residents.*

Section 2. G. A collaborating physician may not enter into a CPA with more than six full-time equivalent associate physicians, full-time equivalent physician assistants or any combination thereof.

- **AAFP recommendation:** *We recommend replacing six full-time equivalent associate physicians with two. This fits the reality of education for entering residents, and CMS only offers up to four equivalent providers.*

Section 2. H. The collaborating physician shall determine and document the completion of at least a one-month period during which the associate physician practices in a setting where the collaborating physician is continuously present before allowing the associate physician to practice when the collaborating physician is not continuously present. Board rules may not require the collaborating physician to review more than 10% of the associate physician's patient charts or records during that one-month period.

- **AAFP recommendation:** *We recommend omitting this language as we propose an associate physician must **always** have on-site their supervising, qualified physician (or an equally licensed physician in the supervising, qualified physician's absence).*

Section 10. M. An associate physician granted controlled substances prescriptive authority as provided in the ALEC model may prescribe any controlled substance listed in Schedule III, IV or V and may have restricted authority in Schedule II when delegated the authority to prescribe controlled substances in a CPA. Prescriptions for Schedule II medications prescribed by an associate physician with a certificate of controlled substances prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the board. The collaborating physician may limit a specific scheduled drug or scheduled drug category that the associate physician is allowed to prescribe. Any limits shall be listed in the CPA. Associate physicians may not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II hydrocodone prescriptions are limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a 30-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician. Associate physicians authorized to prescribe controlled substances under this section shall register with the U.S. DEA and include the U.S. DEA registration number on prescriptions for controlled substances. The collaborating physician shall determine and document the completion of at least 120 hours in a four-month period by the associate physician during which the associate physician practices with the collaborating physician on-site before prescribing controlled substances when the collaborating physician is not on-site.

- **AAFP recommendation:** *We recommend omitting this language and instead applying standards for entering residents. Associate physicians should have no independent controlled substance prescribing authority without direct supervision. At most, associate physicians should only be allowed to prescribe Schedule III medications with supervision.*

Contact

Chapters working on legislation about licensing unmatched medical school graduates are welcome to contact the following AAFP staff for assistance:

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- Karen Mitchell, M.D., Vice President of Student and Resident Initiatives, kmitchell@aafp.org

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