April 22, 2016

J. Daniel Gifford, MD, FACP
Chairman, Board of Directors
Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

Humayun J. Chaudhry, D.O., MACP
President and Chief Executive Officer
Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

Dear Dr. Gifford and Dr. Chaudhry,

I write to you in anticipation of the Annual Meeting of the Federation of State Medical Boards. I understand from the pre-meeting materials that, during the course of the meeting, NCCPA intends to conduct a survey of State Board executives and board members regarding NCCPA's proposal to change the Maintenance of Certification requirements for PAs. AAPA is deeply concerned that, without a thorough understanding of the context, lack of evidence, and the serious concern raised by PAs and employers, this "survey" may create bias and inappropriately affect the decision making process regarding Maintenance of Certification for PAs.

As you know, PAs are currently required to complete certain CME requirements every two years and to pass an exam in general medical knowledge every 10 years in order to maintain certification. NCCPA has proposed to modify the exam portion of these requirements to include:

- Two or three take-at-home exams in general medical knowledge during each 10-year recertification cycle; and
- A proctored, closed book exam in one of 9-11 specialty areas at the end of each 10-year recertification cycle.

As President of the American Academy of PAs, which is the representative body of the PA profession, I ask that the FSMB familiarize itself with the concerns about the NCCPA proposal that have been raised by the AAPA Board of Directors, state organizations and specialty organizations of PAs, and many individual PAs. Since February, AAPA has been accumulating and posting information about the proposal issued by NCCPA, as well as letters and other information sent to NCCPA by AAPA and PA organizations

throughout the country. You can access this information with the following link: http://news-center.aapa.org/

Among the most important of the documents you will find on that site is an analysis of the literature cited by NCCPA as the foundation for its proposal. Our blunt assessment is that the literature cited by NCCPA does not support changes it proposes to make in PA Maintenance of Certification requirements. Our review of the literature indicates that many types of CME have a positive effect on provider performance and patient outcomes. There is no literature cited that indicates taking maintenance of certification exams has an effect on provider performance or patient outcomes. A direct link to that analysis can be found here: http://news-center.aapa.org/wp-content/uploads/sites/2/2016/02/Assessment-of-NCCPA-Supporting-Articles-for-Recertification-Exam-Proposal-2.10.16.pdf

Since reviewing the NCCPA literature, the AAPA Board of Directors has had the opportunity to review additional literature, as well as the requirements and trends with regard to Maintenance of Certification for other medical professionals. Unlike any other medical professional – MD, DO, NP, or Pharmacists – a PA who does not pass the recertification exam will lose their license to practice in 20 states and will lose prescribing privileges in three additional states. For PAs, these are truly "high stakes" exams.

Indeed, the trend among MD and DO certification organizations appears to be quite the opposite. Oklahoma, for example, recently enacted S 1148 that adds language applicable to MDs and DOs that each are not required to secure a Maintenance of Certification as a condition of licensure, reimbursement, or employment or admitting privileges at a hospital. The law stipulates that nothing in the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act may be construed as to require a physician to secure a Maintenance of Certification as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital. Likewise, nothing in the Oklahoma Osteopathic Medicine Act may be construed as to require a physician to secure a Maintenance of Certification as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital. A similar law was recently passed in Kentucky, similar proposals have been introduced in Missouri and Michigan, and 19 state medical societies have adopted resolutions supporting the concept.

As a result of our research, the predominance of opinions expressed by PA organizations and individual PAs, and our assessment of the potential ramifications of the proposed changes, the AAPA board last month adopted a statement of principles to guide future policy with regard to PA recertification requirements. These principles, which will be considered by the AAPA House of Delegates at its meeting in May, are:

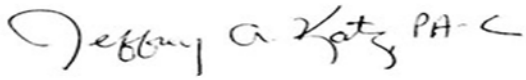
- AAPA supports assessing general medical knowledge for initial certification and licensing of PAs.
- AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.

- AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.
- AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.
- AAPA supports uncoupling maintenance of certification requirements from maintenance of license and prescribing privileges in state laws.
- AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the relationship, if any, between taking the NCCPA recertification test and patient outcomes, safety and satisfaction.

I have attached for your information the rationale behind these principles, which includes additional literature citations that support the premise that recertification exams do not improve patient care or patient safety.

We appreciate your consideration of these issues, which are critical not only to PAs, but to patients throughout the country who will face higher health care costs and decreased access to care if these burdensome new requirements are adopted.

Sincerely,



Jeffrey A. Katz, PA-C, DFAAPA
President and Chair, Board of Directors

cc: State Medical and Osteopathic Boards
PA Licensing Boards

Attachment: AAPA Board Position on PA Recertification Requirements

Principles to Guide PA Maintenance of Certification Requirements
AAPA Board of Directors
March 2016

AAPA supports assessing general medical knowledge for initial certification and licensing of PAs.

AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.

AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.

AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.

AAPA supports uncoupling maintenance of certification requirements from maintenance of license and prescribing privileges in state laws.

AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the relationship, if any, between taking the NCCPA recertification test and patient outcomes, safety and satisfaction.

Background

PAs consistently deliver high-quality and comprehensive medical care across a wide range of clinical settings and specialties and increase patient access to medical care. As a result, demand for PAs has risen by more than 300 percent since 2012, and Forbes, USA Today, and others have ranked the PA profession as the #1 Job in America. With a projected growth of 38 percent between 2012 and 2022, according to the Bureau of Labor Statistics, PAs are poised to have an even greater impact on the nation's health. When PAs are allowed to practice to the full extent of their education and experience, they improve American's access to high-quality care while reducing costs.

As medical providers, PAs are trained at the graduate level in programs modeled after medical school curricula, which include more than 2,000 hours of clinical rotations. They are nationally certified and state-licensed providers who practice medicine—they diagnose, write prescriptions, order and interpret tests, treat patients and assist in surgery. As a profession, PAs are uniquely equipped to play a leading role in the new healthcare paradigm focusing on the quality of outcomes, not simply on the number of medical services provided. PAs practice team-based care, make prevention as important as treatment and help keep healthcare costs down.

The various components of this proposed resolution have been cast as general statements about initial certification and maintenance of certification requirements for PAs. These proposed

policy statements, however, were prompted by the flawed NCCPA proposal to change PA maintenance of certification requirements to include (1) multiple take-at-home tests on general medical knowledge during each recertification cycle, ***and*** (2) a closed-book, proctored specialty exam in one of 10-12 specialty areas during the last two years of each recertification cycle. It is the view of the Board of Directors of AAPA that these proposed requirements -- particularly when added to the CME requirements already in place for PAs -- are unnecessary to ensure safe and effective patient care, will add unnecessary costs to the health care system, and will have negative effects on patient access to care by reducing PA flexibility.

Initial Certification/Licensing. Every PA must pass a national certifying examination to obtain their license to practice medicine. This requirement is consistent with the licensing requirements of other medical professions, and ensures that those entering PA practice have demonstrated that they have the medical knowledge required to practice medicine safely and effectively.

Alternatives to High Stakes Recertification Tests. Currently and as proposed by NCCPA, PAs would be required to take closed-book, proctored exams. These "high stakes" exams put PAs at risk of losing their license to practice in 20 states, their prescribing privileges in 3 additional states, and their ability to seek and attain employment in any of those states. Even in states that do not require NCCPA certification for maintenance of license, employers often require that a PA be certified, so these exams put the livelihood of PAs in virtually every state at risk.

There are numerous evidence-based ways other than exams to ensure that PAs maintain up-to-date competencies and medical knowledge relevant to their scope of practice. Literature[1] cited by NCCPA to support their proposed alternative specifically recommends that "state legislatures empower boards to recognize *a variety of acceptable pathways* [emphasis added] via which licensees can demonstrate their continuing competence." The authors further recommend that "licensing boards need to consider awarding deemed status to qualifying competency evaluation programs at hospitals and other institutions that credential, privilege, and/or employ health care professionals."

A review of the literature cited by NCCPA found no evidence that testing is the best or only way to assess medical knowledge and competencies. In fact, the literature cited by NCCPA specifically contradicts its negative assertions regarding CME. There are two publications cited by NCCPA which review the literature related to the effectiveness of CME strategies designed to change physician performance and health care outcomes. One of the papers[2] found that 70% of the 145 CME interventions reviewed resulted in a positive change in physician performance. It

[1] Swankin, D., LeBuhn, R. A., & Morrison, R. (2006). Implementing continuing competency requirements for health care practitioners. AARP, Public Policy Institute. http://www.nbcrna.com/about-us/Documents/ImplementingCC%20Requirements%20for%20HCP%202006.pdf

[2] Davis, D. A., Thomson, M. A., Oxman, A. D., & Haynes, R. B. (1995). Changing physician performance: a systematic review of the effect of continuing medical education strategies. JAMA, 274(9), 700-705.http://www.ncbi.nlm.nih.gov/pubmed/7650822

also found that CME improved over the time period studied (1975-1994). The second paper[3] reviewed studies of CME interventions on physician performance and health care outcomes that were published between 1993 and 1999. Fourteen studies were identified which included 17 interventions that could be characterized as didactic, interactive or mixed. The authors found that 9 of the 14 studies found positive changes in professional practice, and 3 of 4 interventions altered health care outcomes in one or more measures. The authors conclude that their "data show some evidence that interactive CME sessions that enhance participant activity and provide the opportunity practice skills can effect change on professional practice and, on occasion, health care outcomes."

NCCPA has provided no evidence that demonstrates a correlation between PANRE testing and patient outcomes, patient safety, or patient satisfaction. The following articles argue against exam-based recertification methods for clinicians by describing the limitations of written examination for clinical recertification and reviewing data that finds no competency difference between practicing clinicians that take a recertification exam versus those who do not.

(1) In 2001, a publication sponsored by the U.S. Agency for International Development (USAID) as part of USAID's Quality Assurance (QA) Project for health care providers persuasively argues against exam-based recertification by reviewing studies examining students, nurses, physicians, and other clinical providers.[4] After completing the literature review, the publication finds that "assessment methods can be presented on a continuum reflecting the extent to which they approximate actual job performance . . . Written tests are probably furthest from–and the weakest predictor of–actual job performance." In fact, the report concludes that "[p]erformance on [written] tests is inconsistently predictive of performance with patients." On the continuum of assessment methods, the literature review concludes that the strongest predictors of clinician job performance are physical models, job simulation, and job samples.

(2) An article published in the Journal of Continuing Education in the Health Professions finds that standardized testing is especially ineffective when assessing clinical skills for recertification.[5] Noting the deficiencies of standardized testing, the article finds that "[m]ethods successfully used in assessing students and residents do not automatically permit valid inferences to be drawn concerning the competency of practicing physicians." The article goes on to note that although systemic and standardized assessments may be "appropriate for physicians about to enter the supervised environment of postgraduate training, it may not be adequate for measuring

[3] Davis, D., O'Brien, M. A. T., Freemantle, N., Wolf, F. M., Mazmanian, P., & Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes?. JAMA, 282(9), 867-874.http://www.ncbi.nlm.nih.gov/pubmed/10478694

[4] N. Kak, B. Burkhalter, & Merri-Ann Cooper, "Measuring the Competence of Health Care Providers." Operations Research Issue Paper for the U.S. Agency for International Development (USAID) Quality Assurance (QA) Project (July 2001), *available at* https://www.usaidassist.org/sites/assist/files/measuring_the_competence_of_hc_providers_qap_2001.pdf.

[5] Peter V. Scoles, M.D., Richard E. Hawkins, M.D., & Anthony LaDuca, PhD, "Assessment of Clinical Skills in Medical Practice," 23 J. of Cont. Ed. in Health Professions 182 (Apr. 22, 2005), *available at* http://onlinelibrary.wiley.com/doi/10.1002/chp.1340230310/abstract.

clinical skills and abilities of physicians in unsupervised practice . . . assessment methods for evaluation of physicians for initial licensure may not be sufficient for assessment of the performance of practicing physicians."

(3) An article published in the New England Journal of Medicine describes the limitations of written examinations and notes, within a table comparison of commonly used assessment methods that written exams are "not yet proven to transfer to real life situations that require clinical reasoning."[6]

(4) Two studies published in the Journal of the American Medical Association find no difference in the clinical performance of physicians who took a recertification board exam and those who recertified without examination. The first study examined internists providing primary care at 4 VA medical centers and measured patient care quality standards' association with maintenance of certification requirements.[7] The second study examined one group of general internists and measured correlations in care-sensitive hospitalizations with maintenance of certification requirements.[8] Both found no statistically significant difference in patient care quality or in care-sensitive hospitalizations when the cases were handled by internists who had to fulfill a recurrent maintenance of certification requirement versus internists who did not have to fulfill recurrent maintenance of certification requirements.

Cumulatively, these publications hold that recurrent recertification through examination is not an appropriate vehicle for ensuring clinical competency and quality patient care.

Specialty Recertification Exams. The NCCPA proposal to require every PA to take a specialty exam in order to recertify will put the nation's health system at significant risk. These risks include negative impacts on patient access to care, as well as the cost of health care in the U.S. As generalists, PAs have been able to easily redeploy to fill care gaps in hospitals, health systems, and communities. Although NCCPA claims that it will not reveal which specialty exam a PA has taken, employers cannot be prohibited from asking PAs for that information, nor can NCCPA prevent employers from putting restrictions on PA practice based on liability and litigation concerns. Even though less than 1 percent of PAs hold one, PA job boards already include employment postings limited to PAs who possess a particular CAQ. If all PAs are required to pass a specialty exam, such requirements are likely to proliferate. Like NPs, who are certified only in certain specialty areas, PAs may find it increasingly difficult to fill gaps because their mobility is unnecessarily restricted. This requirement also creates the risk that it will be more difficult for new graduates to enter specialty areas or to change specialties. With decreased PA mobility and flexibility, patient access to qualified providers will be reduced.

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[6] Ronald M. Epstein, M.D., "Assessment in Medical Education." N. Engl. J. Med. (Jan. 25, 2007), *available at* http://www.nejm.org/doi/full/10.1056/nejmra054784.

[7] John Hayes, M.D., et al., "Association Between Physician Time-Unlimited vs Time-Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality," J. of Amer. Med. (Dec. 10, 2014), *available at* http://jama.jamanetwork.com/article.aspx?articleid=2020370.

[8] Bradley M. Gray, PhD, et al., "Association Between Imposition of a Maintenance of Certification Requirement and Ambulatory Care-Sensitive Hospitalizations and Health Care Costs" J. of Amer. Med. (Dec. 10, 2014), *available at* http://jama.jamanetwork.com/article.aspx?articleid=2020369.

We believe that NCCPA has misinterpreted the specialty practice information provided by PAs. While various surveys ask in which specialty area the PA generally practices, this question obscures several important distinctions. First, PAs may practice in multiple specialties and/or focus their practice on a particular subspecialty. These nuances are not captured by survey questions that ask PAs to indicate their "primary" area of practice.

Second, PAs are increasingly practicing in subspecialty areas. A survey of PAs from 1997 to 2006 found that the growth in the number of PAs practicing in subspecialties was significantly outpacing the profession's aggregate growth rate.[9] "Although the number of PAs rose in every specialty examined during the decade 1997-2006 (in part as a result of the doubling of the PA workforce during this period), the growth rate among specialties was uneven . . . subspecialty numbers increased more than those of the total PA workforce." The largest increases was among PAs practicing in internal medicine subspecialties, which grew by two-hundred and sixty-two (262) percent, and surgical subspecialties, which grew by one-hundred and eighty-six (186) percent.

Because of PA subspecialization, a specialty focused and exam based recertification system is impracticable and unduly burdensome on PAs. In its proposal, the NCCPA conceives "approximately 10-12 specialty exam options, including family medicine [and] general surgery." Every practicing PA who wishes to maintain his or her certification will be forced to take one of these specialty exams or the generalist exam. Thus, a PA who practices in and has developed an expertise in one subspecialty of a larger NCCPA-enumerated specialty will have to acquire and become proficient in a broader subject-matter area in order to maintain his or her certification. For example, a PA who focuses exclusively on hip replacement would be tested on all aspects of orthopaedics, if required to take a specialty test in his/her specialty area. Further, PAs who are practicing in specialties or subspecialties that are not represented by the 10-12 specialty exams proposed by NCCPA will continue to be subjected to exams that do not represent their area of clinical practice. Also, any PA who has developed a sub-specialty in an area that encompasses two or more NCCPA-enumerated specialty areas will effectively have to choose which category they want to attempt to fit into for testing purposes and will have to engage in significant preparation to pass an exam that could be largely irrelevant to his or her subspecialized practice. Because of the significant portion of sub-specialized PAs and the growing trend towards sub-specialization, the NCCPA's specialty-based examination will be detrimental to and burdensome for a significant, and growing number of PAs. For those subspecialized PAs, the categorical testing will be predominantly irrelevant to the PAs practice and will thus have no impact on patient safety and ongoing, practical learning. Instead, the large, growing population of subspecialized PAs will have to encumber the costs of testing, the temporal costs of learning irrelevant material, and the stressful emotional and intellectual costs of studying for an exam with no practical benefit.

[9] Perri A. Morgan & Roderick S. Hooker, "Choice of Specialties Among Physician Assistants in the United States," 29 Health Affairs 5 (2010), *available at* http://content.healthaffairs.org/content/29/5/887.full.pdf+html.

Third, for those PAs who work in two specialties (such as the PA who wrote that s/he practices in emergency medicine and cardiothoracic surgery), being forced to choose one specialty over the other for recertification may unnecessarily limit their practice.

Fourth, many PAs change specialty areas during the course of their career. This flexibility serves not only the PA, but employers and patients as well; it ensures that there are health care providers who can fill gaps and provide care as patient, community and employer needs change. According to the 2015 AAPA National Survey, 11.5% of PAs changed their specialty in 2014, and 48% of PAs have changed their specialty at some point in their career. Importantly, while about 30% of PAs reported that they practice in primary care, 42% of those who practice in specialty areas other than primary care provide basic primary care services to their patients.

A survey published in 2010 also found that PA practice was fluid and mobile among specialty areas.[10] According to the survey:

- Forty-nine (49) percent of active PAs changed the specialty area in which they practiced sometime in their careers;
- Twenty-four (24) percent switched to a different specialty area altogether;
- One-quarter will practice in at least two different specialty areas; and
- At least eleven (11) percent will work in three or more different specialty areas.

Thus, many PAs practice in more than one specialty area during their career. In fact, a PA's unique ability to practice in more than one specialty area and to go where there are clinician shortages for underrepresented and vulnerable populations is especially beneficial. That benefit has been recognized by the government, including by both Congress and the Executive Branch. During the congressional hearing predating the Affordable Care Act, the Committee on Small Business discussed the "Projected Physician Shortage and How Health Care Reforms Can Address the Problem."[11] As a part of the discussion, PAs were discussed as a method of correcting the Physician shortage: "By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities."[12] The Federal Trade Commission (FTC) has also expressed antitrust concerns with occupational rules and regulations that restrict industry competition and mobility, unless necessary to protect against a credible risk of harm.[13] PAs value and utilize the unique career mobility of PA education and training. That mobility allows PAs to practice in a variety of specialty and subspecialty areas with employer-provided training and quality assurance, which in turn benefits the health care system by providing clinicians

[10] Roderick S. Hooker, James F. Cawley & William Leinweber, Career Flexibility of Physician Assistants and the Potential for More Primary Care, 29 Health Affairs 5 (2010), *available at* http://content.healthaffairs.org/content/29/5/880.full.pdf+html.
[11] *Full Committee Hearing on the Projected Physician Shortage and How Health Care Reforms Can Address the Problem Before the H. Comm. on Small Business*, 111th Cong. 34 (2009).
[12] *Id.* at 110.
[13] "FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants." Staff of Bureau of Competition, Federal Trade Commission (Oct. 2015), *available at* https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf.

where there are needs. By allowing for free market fluidity, clinician shortages are addressed, and absent a credible risk, the government recognizes that the PA profession's ability to satisfy market needs has a benefit that regulatory associations should be wary of encumbering.

And, finally, as noted in a recent JAAPA editorial, "PA practice differs in every setting, most of all in specialties. That heterogeneity makes an encompassing evaluation of each specialty difficult and unfair. The very division between specialties and subspecialties invites confusion. Is transplant medicine a surgical specialty, classified by the organ involved, or something else entirely? Layer on top the practice variance influenced by state-specific, facility specific, or collaborating physician-specific paradigms, and credence is borne to the phrase, 'If you've seen one PA in practice, you've seen one PA in practice.'"[14] Recertification tests that require PAs to focus on a single specialty run the risk of making it more difficult for PAs to provide care to patients.

Multiple Exams during the Recertification Cycle. NCCPA's representative at the AAPA Leadership and Advocacy Summit said NCCPA expects the addition of multiple take-home exams and 10-12 new specialty exams to cost as much as $12 million. In addition, NCCPA has not seen the uptake it expected on CAQ exams (with only about 1,000 out of 108,000 PAs earning a CAQ), and NCCPA's revenue from recertification exams is being negatively impacted by the change from a 6-year to a 10-year recertification cycle. While NCCPA has not yet shared its planned fee schedule for the multitude of new tests it plans to require, it is likely that the cost of recertification testing will increase substantially. Further, all PAs will now have to prepare for an in-depth specialty exam, rather than a "refresher" generalist exam, which can be expected to drive up test preparation costs, as well. Not only will these costs affect PAs and their families, but those employers who reimburse or otherwise pay for PA professional development and certification fees, as well. All of these expenses, of course, become part of the expenses that are passed along to patients and their insurance companies, driving up health care costs in America.

De-Couple Recertification and Maintenance of Licensure. In 20 states, PAs must fulfill whatever recertification requirements are set by NCCPA to maintain licensure, and in 3 additional states PAs must do so to maintain certain prescribing privileges. In those states, NCCPA's "high stakes" recertification exam puts every PA's license to practice at risk. Yet NCCPA has not provided any evidence that suggests that requiring PAs to take generalist recertification exams more frequently (in the form of take-home exams) or specialty exams every 10 years will improve patient safety, outcomes or satisfaction.

Further, a high-stakes, exam-based recertification model runs contrary to health care industry practices and trends for similarly situated clinical professionals**.** MDs, NPs, and Pharmacists are not required to take recertification exams in order to retain their license to practice.

[14] Reamer L. Bushardt, PharmD, PA-C, DFAAPA; Harrison Reed, MMSc, PA-C (2016) Unraveling the recertification conundrum. JAAPA, published ahead of print, January 2016. http://news-center.aapa.org/wp-content/uploads/sites/2/2016/02/JAAPA-Unraveling-the-Recertification-Conundrum-Published-Ahead-of-Print.pdf

Recently, physicians have begun advocating against board recertification by examination. In January 2014, the American Board of Internal Medicine (ABIM) attempted to overhaul its recertification approach by requiring regular questionnaires throughout each 10-year period, culminating in a thorough written exam. Physicians vigorously opposed the more onerous exam-based recertification approach. Over 20,000 cardiologists signed a petition calling for the ABIM to revert to its pre-1990 requirements, and many physicians individually expressed their opposition to the new system. One physician remarked, "Medical practice is supposed to be evidence based. There are no data that maintenance-of-certification program makes any difference in what matters: patient outcomes . . . Continuing medical education and lifelong learning make better doctors . . . ."[15] Physicians also staunchly opposed the fiscal costs and associated time commitment of preparing for and sitting for a written recertification examination. In response to the staunch opposition, the ABIM issued a statement in February 2015 saying, "ABIM clearly got it wrong. We launched programs that weren't ready and we didn't deliver a [maintenance-of-certification] program that physicians found meaningful . . . We got it wrong and sincerely apologize. We are sorry."[16] The ABIM went on to reduce certification fees and suspended the intermittent practice assessments and surveys. Although the physician maintenance of certification debate is not yet resolved, the trend against exam-based recertification[17] and the continued absence of evidence that recertification exams correlate with clinical proficiency is significant for all autonomous clinicians, including PAs. Even more significantly for PAs, the ABIM has no authority over a physician's license to practice whereas the NCCPA's proposal would directly affect a PA's license to practice in twenty states.[18]

As the AAPA has noted, both nurse practitioners (NPs) and pharmacists have flexible maintenance of certification systems.[19] NPs who have completed one-thousand (1000) practice hours in the previous five-year recertification cycle just have to meet a broad continuing professional development requirements in order to be recertified. Absent one-thousand (1000) practice hours in the previous five (5) years, an NP has to take an exam in order to renew his or her license along with the same, broad continuing professional development requirements. The professional development requirements can be certified through one-hundred and fifty (150) credits of continuing education along with various combinations of precepting, speaking, research and writing. A pharmacist only has to take between fifteen (15) and thirty (30) continuing education credits depending on the state to be recertified. There is no recertification examination or practice-hours requirement for pharmacists.

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[15] Joshua A. Krisch, "Board Certification and Fees Anger Doctors," NYTimes Blog (Apr. 13, 2015), *available at* http://well.blogs.nytimes.com/2015/04/13/board-certification-and-fees-anger-doctors/?_r=2.
[16] "ABIM Announces Immediate Changes to MOC Program," ABIM.org (Feb. 3, 2015), *available at* http://www.abim.org/news/abim-announces-immediate-changes-to-moc-program.aspx.
[17] *See generally* "Change Board Recertification," *available at* http://www.changeboardrecert.com/.
[18] Twenty states require current NCCPA certification to renew a license (AK, CT, HI, ID, IL, IN, KY, LA, MT, MO, NH, ND, NV, NM, OH, PA, SC, VA, WV, WY). Nevada requires current NCCPA certification for license renewal for PAs licensed by the osteopathic board only. "The Lifecycle of Licensure, Certification, and Maintenance of Certification in Selected Health Professions" AAPA (Feb. 8, 2016), *available at* http://news-center.aapa.org/wp-content/uploads/sites/2/2016/02/The-Lifecycle-of-Licensure_2.7.16n-1.pdf.
[19] *Id.*

PA recertification requirements should be comparable to similarly situated clinical professionals and should adhere to recent trends towards evidenced-based verification of clinical proficiency.

Need for Rigorous Research. NCCPA's methodology for developing and seeking input on its proposed recertification exam model was significantly flawed. A full range of options should have been offered to the focus groups and survey participants who participated in the initial stages of the NCCPA development process, including the option of basing recertification solely on meeting CME requirements and eliminating the high stakes testing that puts a PA's license at risk every 10 years. The NCCPA "white paper" makes it clear that the focus groups and surveys they conducted in the lead-up to this proposal only permitted respondents to discuss and comment on what a "recertification *exam* process" should look like. Even in the survey sent by NCCPA to obtain feedback from PAs after the new proposal was introduced, NCCPA attempted to bias responses by presenting arguments in favor of the new proposal and then asking questions about it; they did not present any of the potential objections. Similarly, the survey instrument presented the only choices as the current model vs. the NCCPA proposal, and asked about the benefits of each. The survey did not give the respondent the opportunity to answer questions about the negative aspects of either option, nor did it give the respondent the opportunity to consider or offer other alternatives.

Given the numerous flaws in the NCCPA process leading up to its proposal to change the recertification process, along with the absence of rigorous, peer-reviewed research that supports the continued use of high-stakes recertification exams, it is incumbent upon NCCPA or the NCCPA Foundation to either demonstrate that the PANRE exam is associated with improved patient outcomes, patient safety and patient satisfaction, or to eliminate this costly requirement for which there are no proven benefits.

Additionally, individual PAs in the 20 states which tie NCCPA recertification to licensure, or the 3 additional states that tie NCCPA recertification to certain prescribing privileges, risk their ability to practice, thus creating a potentially catastrophic financial impact on them and their families.

The new NCCPA recertification requirements can be also be expected to drive up health care costs, as employers who provide funding to cover PAs' professional development and testing costs pass along those expenses to patients and their insurers.

Related AAPA Policy

HP-3200.2.0 Continuing Education

HP-3200.2.1
AAPA recognizes the concept of continuing professional development (CPD) as a means to maintain competence and ensure the delivery of high quality care. CPD is a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, personal reflection and reassessment.

Continuing medical education consists of clinical and professional educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a PA uses to provide services for patients, the public, and the profession. Continuing medical education is a formal component of CPD. All continuing medical education reported should comply with this definition, regardless of whether it is reported as Category I (pre-approved) or Category II (elective).
[Adopted 1988, reaffirmed 1990, 1993, 1998, 2005, amended 1997, 2009, 2014]

HP-3200.2.2
AAPA reviews and approves for Category 1 CME credit educational activities which serve to develop, maintain, or increase the knowledge, skills and professional performance of a PA. These may include live presentations, enduring material programs, and other educational activities. AAPA stipulates that the following activities meet the requirements for Category 1 CME credit for PAs:

- those approved for Category 1 credit by the American Medical Association (AMA) (i.e. activities sponsored by providers accredited by the Accreditation Council for Continuing Medical Education (ACCME))
- those approved for Category 1-A credit by the American Osteopathic Association (AOA)
- those approved for prescribed credit by the American Academy of Family Physicians (AAFP)
- accredited programs of the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or the Physician Assistant Certification Council of Canada (PACCC)

[Adopted 1979, reaffirmed 1990, 1998, 2003, amended 1985, 1993, 1996, 1997, 2006, 2011]

HP-3200.2.3
AAPA encourages the NCCPA to recognize CME Category 1 credit for continuing education activities that incorporate professional self-assessment and self-improvement activities.
[Adopted 2011]

HP-3200.2.4
AAPA endorses the policies of the Accreditation Council on Continuing Medical Education (ACCME) on commercial support of continuing medical education (CME) and applies those standards to its own review process.
[Adopted 2003, reaffirmed 2008, 2013]

HP-3200.3.7
AAPA recognizes the important role of the PA in the areas of medical specialization, but feels that education in the specialty areas must be concurrent with or after education in general medicine as described in the Accreditation Standards for Physician Assistant Education of the Accreditation Review Commission on Education for the Physician Assistant.
[Adopted 1979, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015]

HP-3200.4.2
AAPA is opposed to specialty certification, the use of specialty examinations and certificates of added qualification that could reduce the profession's versatility and flexibility, drastically altering its value to society.

Every effort must be made to prevent regulators, employers, third-party payers, and others, including PAs from misusing specialty certification, the use of specialty examinations and certificates of added qualification.
See: *Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification* (Policy Paper 16*)*
[Adopted 2002, reaffirmed 2007, amended 2012]

HP-3200.4.4
AAPA believes that NCCPA must limit its role to that of a certifying body and focus its resources on improving the certification process. AAPA further believes that disciplinary actions by NCCPA must be restricted to matters dealing with the examination, such as falsifications of applications for certification or cheating on an examination, not serving as the arbiter of morals for PAs. Allegations or evidence of criminal behavior, moral turpitude, or unprofessional behavior received by the commission should be returned to the sender with the suggestion that it be sent to appropriate state regulatory agencies, the Federation of State Medical Boards, and/or the National Practitioner Data Bank.
[Adopted 1990, reaffirmed 1995, 2000, 2005, 2010, 2015]

HP-3400.2.0 Utilization

HP-3400.2.1
AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. More specifically, PA employment and supervision are separate issues. The regulatory requirements of PA supervision should be unrelated to any aspect of employment.
[Adopted 1996, amended 1997, reaffirmed 2001, 2007, 2012]

HP-3400.2.2
AAPA shall promote optimal utilization of PAs. This includes providing information on credentialing, cost-effectiveness, scope of practice, reimbursement, and other relevant data.
[Adopted 1996, amended 2006, reaffirmed 2001, 2012]

HP-3500.00 Profession – Regulation/Certification

HP-3500.1.0 General

HP-3500.1.1
AAPA believes the integrity of PA credentials should be assured through a credentialing process.

Credentialing is a process for validating the background and assessing the qualifications of health care professionals to provide health care services in a variety of patient care settings. Privileges granted to PAs should be consistent with state laws and regulations and hospital bylaws.
[Adopted 1999, amended 2009, reaffirmed 2004, 2014]

HP-3500.1.2
AAPA recognizes that many federal PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by their federal agencies or by Congress. These federal requirements include graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs [CAAHEP]), and/or passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) and continual maintenance of national certification when required by the federal agency. Therefore, the Academy believes that federal PAs should not be required to have a state license to obtain full practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team. In states where federal and state requirements do not conflict; federal PAs may hold state licenses. Any federal PA may opt to hold a state license.
[Adopted 1996, reaffirmed 2008, amended 2001, 2003, 2013]

HP-3500.2.0 Certification

HP-3500.2.1
AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) certification exam as the only entrance standard for PAs.
[Adopted 1982, reaffirmed 1990, 1995, 2000, 2005, 2007, 2012]

HP-3500.2.2
AAPA opposes examinations given by any organization other than the NCCPA for the purpose of establishing entrance-level standards for individuals not eligible for the National Commission on Certification of Physician Assistants examination.
[Adopted 1982, reaffirmed 1990, 1995, 2000, 2010, amended 2005, 2015]

HP-3500.2.3
AAPA believes that the NCCPA certificate should be time-limited and that maintenance of a current valid certificate requires that PAs pass the Physician Assistant National Recertifying Exam (PANRE) within four attempts if initiated within the final two years of the recertification cycle**.**
[Adopted 1999, reaffirmed 2009, amended 2004, 2014]

HP-3700.4.0 Continued Competence

HP-3700.4.1
AAPA recognizes life-long learning provides opportunities to improve competence, supports preparedness for certification/licensure and increases the vitality and efficiency of a practice by providing learning opportunities which are intended to improve performance in practice as measured ultimately by patient outcomes.

AAPA believes it is the ethical responsibility of the practicing PA to maintain a level of competence sufficient to practice medicine safely and effectively. A component of that commitment is demonstrated by participating in continuing educational activities which are scientifically valid, evidence-based, commercially unbiased, and based on principles of effective adult learning.
[Adopted 1987, reaffirmed 1992, 1997, 2002, 2006, amended 1996, 2003, 2011]

HP-3700.4.2
Professional Competence (Policy Paper 10)
[Adopted 1996, amended 2005, 2010, 2015]

HP-3700.4.3
Competencies for the PA Profession (Policy Paper 28)
[Adopted 2005, reaffirmed 2010, amended 2013]