

The Legal Implications of Physician Assistants Providing Telehealth Services Across State Lines

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## Abstract

Audiovisual healthcare, also known as telehealth, has rapidly expanded in the United States, particularly during the COVID-19 pandemic, enabling providers to deliver care remotely and improve access to care for rural and underserved populations. A substantial increase in PAs utilizing telehealth, particularly since 2020, demonstrates that it remains a critical component of clinical use. However, the patchwork structure of the physician assistant scope of practice has inherently increased legal risk, revealing a critical gap between telehealth utilization and legislation. Telehealth is an effective method to increase access to medical care; however, post-COVID reinstatement of pre-public health emergency licensure requirements for PAs brought to light the legal framework encompassing telehealth use by PAs during interstate visits, leaving insufficient policy and legislation addressing interstate telehealth licensing and provider liability. The reinstatement of pre-public health emergency licensure requirements for PAs after the pandemic ended, brought to light the legal framework encompassing telehealth use by PAs during interstate visits. To address this challenge, this thesis proposes healthcare recommendations to include developing a national PA telehealth registry and compact, establishing standardized telehealth competencies and supervision requirements, targeted training linked to certification, credentialing, and continuing education, as well as ongoing monitoring to track effectiveness through the registry and inform policy changes as telehealth and modern medicine evolve. Unified national PA telehealth standards may increase compliance, reduce malpractice exposure, and support telehealth delivery. Future research should evaluate the long-term effectiveness of a national telehealth survey to improve legal outcomes, guide policy reform, and maintain telehealth as an effective component of healthcare.

*Keywords:* telehealth utilization, PA legislative reform, PA compact, telehealth malpractice

## INTRODUCTION

Telehealth is an online form of audiovisual healthcare that provides medical care by a licensed provider from any location through remote telecommunication technology.<sup>1</sup> While telehealth was initially designed to increase access to care in rural and underserved areas of the United States (US),<sup>3</sup> since the COVID-19 pandemic, telehealth across medical specialties and providers, including physician assistants (PAs), has increased exponentially. Telehealth utilization exploded during the COVID-19 pandemic, when in-person provider visits for minor illnesses and injuries were highly discouraged. Prior to 2020, approximately 25% of medical providers utilized telehealth in their workflow, compared to the 79% in 2020.<sup>2</sup> In 2022, over 40% of telehealth providers were PAs or nurse practitioners (NPs).<sup>4</sup> More recently, in 2024, over 74% of physicians with NPs or PAs reported that their practices offered telehealth services.<sup>5</sup> PAs currently utilize telehealth to provide medical advice, review test results, order medications, and make detailed care plans. Currently, no national telehealth regulations are in place to guide PA practices. Telehealth's rapid expansion has outpaced the legal and regulatory frameworks that govern PA practice, creating substantial legal risks when PAs provide care across state lines.

State-by-state variability in licensure, scope-of-practice, and supervisory requirements means a PA may be compliant in their licensed state, yet inadvertently violate another state's law when treating out-of-state patients via telehealth. Regulatory uncertainty is compounded by differing approaches to supervision, inconsistent recognition of PAs under interstate licensure, and variable rules for controlled substance prescribing via telemedicine<sup>5</sup> – all of which carry civil, administrative, and criminal liability. Additionally, these legislative gaps increase malpractice exposure for individual PAs and their collaborating/supervising physicians. Without unified standards, providers and organizations face complex compliance burdens, potential

disciplinary actions from multiple state boards, and legal challenges that could undermine telehealth's benefits for access and continuity of care, especially as PAs increasingly incorporate telehealth into clinical practice. This thesis will explore the legal and regulatory complexities surrounding interstate care that emphasize the need for unified national telehealth regulations, culminating in healthcare recommendations to develop and implement a Physician Assistant Telehealth Compact that will standardize licensing, clarify scope-of-practice, strengthen patient safety, and establish a regulatory framework to expand equitable access to high-quality virtual care nationwide.

## **BACKGROUND**

### **The History of Telehealth**

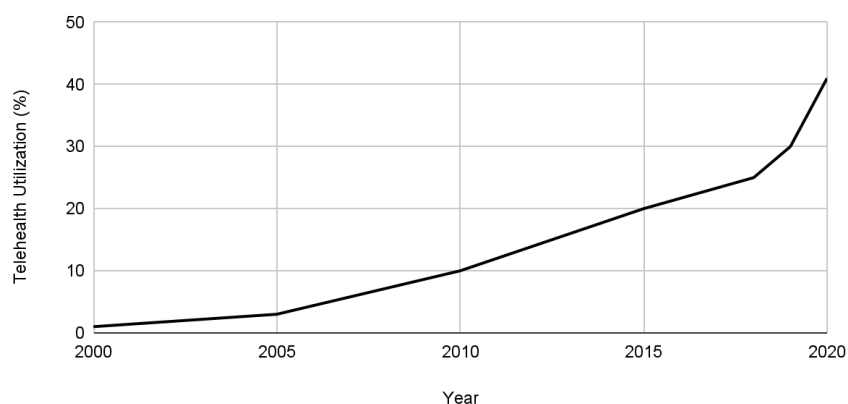
Telehealth use dates back to the late 1800s, when an article in *The Lancet* described the newly invented telephone for communicating medical information across the United States.<sup>3</sup> In 1925, the first documented transmission of medical information through radio helped to diagnose a severely ill patient, which demonstrated the usefulness of telehealth and paved the way for modern technology to extend access to healthcare.<sup>4</sup> By the 1950s, technology had advanced to enable closed-circuit television connections between the Nebraska Psychiatric Institute and Norfolk State Hospital, allowing audio and visual observations of psychiatric patients and changing how telehealth was used in mental health services.<sup>4</sup> By 1964, the development of 2-way videoconferencing linked the 2 hospitals over 100 miles apart, providing the first interactive consultations between clinicians and patients.<sup>4</sup> The success of this connection garnered national attention and highlighted the potential for expanding access to medical treatment across all specialties.

**Invention of the internet.** By the 1990s, telehealth technology had skyrocketed with the invention of the internet. Through the internet, providers could initiate internet-based consultations via electronic health records (EHR), modernizing how telehealth is used today. In 1996, the Health Insurance Portability and Accountability Act (HIPAA)<sup>5</sup> effectively established the essential standards for audiovisual telehealth by creating the foundational federal Privacy and Security Rules<sup>6</sup> that set national standards for protected health information (PHI), including when the information is created, transmitted, and stored electronically. The Standards apply regardless of whether care is provided in person or remotely. HIPAA ensured that telehealth providers and technologies safeguard patient information and data against unauthorized use and breaches, which established essential legal and technical benchmarks that guide telehealth practice.<sup>5-7</sup>

**COVID-19 pandemic.** Since the invention of telehealth, its use has waxed and waned throughout the years, until the COVID-19 pandemic, which prompted a significant shift in the delivery of healthcare nationwide. Amid a global lockdown, medical practices scrambled to continue patient care safely and effectively. Early in 2020, emergency licensure waivers under the Coronavirus Preparedness and Response Supplemental Appropriations Act<sup>8</sup> allowed providers with out-of-state licenses or temporary emergency permits to deliver healthcare across state lines, easing traditional state licensure requirements that normally restricted practice to the patient's location.<sup>8</sup> The Center for Medicare and Medicaid (CMS)<sup>9</sup> temporarily removed its geographic and originating site restrictions, which permitted telehealth services from patients' homes and expanded coverage and reimbursement for telehealth services previously limited to rural or facility-based patients.<sup>9</sup> The Health and Human Services (HHS) for Civil Rights issued the Notice of Enforcement Discretion,<sup>10</sup> which allowed healthcare providers to use

non-public-facing communication platforms (such as Zoom, Teams, and FaceTime) for telehealth without penalty for HIPAA noncompliance, prompting rapid adoption of remote care.<sup>7</sup> CMS also waived requirements for existing in-person relationships between providers and patients before establishing telehealth care, allowing new patients to be seen entirely through telehealth.<sup>9-11</sup> On May 11, 2023, the COVID-19 public health emergency (PHE) ended.<sup>12</sup> The end of this PHE brought an end to almost all of the previously relaxed telehealth laws, including licensure waivers and the Notice of Enforcement Discretion.<sup>13</sup> From 2000-2020, telehealth increased 40%, as shown in Figure A. At the end of the PHE, almost 64 million Medicare patients alone were at risk of losing access to care.<sup>11</sup>

Figure A. Growth in Telehealth Utilization and Healthcare Access in the United States 2000 - 2020



*Values represent literature-synthesized estimates derived from peer-reviewed studies and national surveys; early period data reflect limited pilot use, while post-2020 values are informed by large-scale utilization analyses.<sup>15-21</sup>*

### Telehealth and Increased Access to Healthcare

Telehealth dramatically expanded the availability of remote clinical services and helped overcome traditional barriers, such as geography, transportation, and physical mobility challenges.<sup>22</sup> Currently, about 20% of the US population lives in rural areas, while only 9% of primary care providers and 10% of specialists practice in this region.<sup>23</sup> Telehealth expansion has

been linked to increased access to care in underserved rural areas, reducing travel burdens and wait times, and improving continuity of care.<sup>23</sup> Telehealth services have also increased substance use disorder treatment in underserved areas, with an average of 45 visits per month in 2019 to nearly 11,000 visits per month in 2023.<sup>16</sup> With persistent access disparities in rural and underserved areas, telehealth represents a crucial tool for PAs to reach patients who might otherwise go without care. Telehealth has remained at higher levels than pre-pandemic levels due to enabling patients, including those with chronic conditions and frequent care needs,<sup>24</sup> to continue receiving care when in-person visits are limited. By lowering logistical barriers and expanding the options for delivering care, telehealth has helped many patients maintain access to primary, specialty, and behavioral healthcare services.<sup>22</sup>

### **The Physician Assistant Licensure Compact**

Due to varying state laws, the PA Compact Commission was created in 2019 to draft new legislation to streamline PA licensing across state lines resulting in the PA Licensure Compact.<sup>25</sup> The PA Compact Commission released its statutes for adoption in November 2022 to state legislatures. The new legislation outlines a “compact privilege,” which allows PAs licensed in a compact state to have a reciprocal license in other compact states, granting licensed PAs the ability to practice medicine in all compact states, regardless of where their license originates.<sup>25</sup> Enacting this compact ensures that PAs are covered under their license in the compact states; however, the legislation does not include specific guidelines for telehealth practice. Currently, 21 states have adopted this compact, with the aim of all 50 states and the District of Columbia adopting it.<sup>25</sup> The compact will streamline the licensing process and move PAs 1 step closer to a universal scope of practice. Telehealth legislation, however, remains to be drafted to cover PAs from further litigation, including multistate telehealth law violations.<sup>25</sup> As of 2025, all 50 states,

the District of Columbia, Puerto Rico, and the US Virgin Islands have amended their individual statutes to include telehealth-specific definitions; however, individual states require specific documentation records to ensure compliance with telehealth laws.<sup>26</sup> All states require the PA (and other providers) to be fully licensed in the state the patient is located in at the time of the visit, and the patient must be physically located in that state at the time of the visit, whether in person or via telehealth<sup>26</sup>, this means that visits cannot occur when the patient or provider is outside of their respective states. Providers may deliver telehealth services across state lines; however, they must hold licensure in each state where care is provided.<sup>26</sup>

## **DISCUSSION**

The practice of medicine by PAs is regulated at the state level in the US; state law governs this practice as occurring where the patient is located.<sup>26</sup> Individual states broadly outline the PA scope of practice, and then hiring companies and supervising physicians to create a more tailored scope<sup>26</sup> This patchwork structure allows scopes of practice to differ among specialties and supervising/collaborating physicians. What is legal for a PA in 1 state may not be legal in another; therefore, PAs in the same specialty can have different scope-of-practice agreements.<sup>26</sup> Prior to the COVID-19 pandemic in 2020, only about 10% of PAs across the US reported telemedicine use in their practice, with most of those PAs practicing in psychiatry.<sup>7, 27</sup> In 2020, more than 67% of practicing PAs reported using telemedicine, with numbers increasing in the years since the pandemic.<sup>7, 27</sup> In 2024, almost 90% of practicing PAs reported using telehealth services at least weekly.<sup>26</sup> This rapid shift increased PAs utilizing audiovisual telehealth for medical advice, reviewing test results, ordering medications, and making detailed care plans.<sup>27</sup> Since the pandemic, telehealth has been a useful tool for PAs to facilitate increased access to care and reduce barriers that lead to low attendance rates at in-office visits.<sup>28</sup>

The post-pandemic era brought changes to numerous healthcare professional legislations. Nurse practitioners welcomed the adoption of new legislation that granted full practice authority in some states, such as Delaware, Massachusetts, and Arkansas.<sup>29</sup> Once the PHE ended, PAs, however, lost the temporary suspension of supervising physicians and scope-of-practice agreements,<sup>11</sup> the leniency in PA supervision, and out-of-state practice flexibilities.<sup>17</sup> The PA profession experienced an abrupt reversion from pandemic-era practice interstate flexibilities to pre-pandemic regulatory standards, effectively reversing recent advancements,<sup>7,17</sup> such as returning to HIPAA-compliant documentation practices and compliance with multistate licensure laws. The HHS rescinded the ability of PAs to use non-public-facing communication platforms for telehealth,<sup>10-11</sup> and CMS also rescinded the ability to use telehealth for new patient visits,<sup>9,11</sup> forcing patients to return to inpatient visits for their initial evaluations. Following the expiration of the PHE, regulatory changes created potential legal exposure for PAs related to interstate practice violations.<sup>7</sup> The post-pandemic era witnessed a clamor among hospital administrations to amend their scope of practice policies for PAs to allow for continued access to the newly utilized technology.<sup>3, 13</sup> Because patients were accustomed to telehealth, medical institutions could not end telehealth practice without also causing a reversion to pre-pandemic attendance levels of healthcare visits.<sup>3,15</sup>

### **The Legal Framework of Telehealth Use in the Physician Assistant Profession**

**Telehealth requirements post COVID-19.** Clinical documentation for telehealth must meet the same standard of care as in-person visits. The patient record needs to comprehensively reflect clinical decision-making, history, exam, assessment, and plan to support safe care, quality measurement, and reimbursement.<sup>30</sup> In addition to in-person requirements, telehealth documentation must include patient-informed consent, type of telehealth visit (ie, visual, audio,

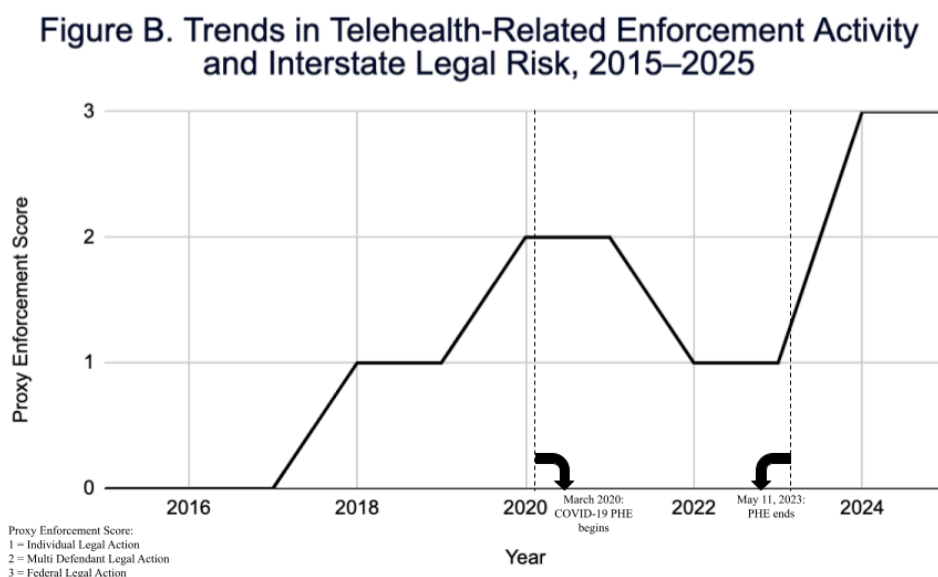
or both), patient and provider location at the time of the visit, names and roles of all participants, and visit start and end times.<sup>30</sup> These extra pieces help to ensure legal and HIPAA compliance, reimbursement integrity, and continuity of care.<sup>30</sup>

**Interstate telehealth penalties.** Providing telehealth services as a PA carries inherent legal risks. Beyond the standard liabilities associated with in-person care, telehealth introduces the potential for interstate legal claims. Practicing medicine in a state without a license is illegal and defined as unlicensed practice of medicine.<sup>25</sup> Legal recourse for unauthorized medical practice can include penalties ranging from misdemeanor to felony criminal charges.<sup>31-33</sup> Unauthorized practice is also a basis for administrative action at the institution level and licensure disciplinary action at the state level, which can include suspension of license, revocation, and fines.<sup>31-33</sup> For example, providing telehealth services to a patient in New Jersey with an out-of-state license can result in up to 5 years in prison and fines with a minimum of \$10,000.<sup>32</sup>

**Malpractice liability.** Unauthorized practice of medicine also increases medical malpractice exposure risk.<sup>32</sup> The patient's jurisdiction standard of care applies to unauthorized practice of medicine, and the provider can be held liable under that state's malpractice regime.<sup>33</sup> In addition, violating one state's laws for unauthorized practice of medicine can lead to disciplinary action and malpractice liability in the provider's originating state as well.<sup>33</sup> Providers who are unlicensed in the patient's state may not be covered under their malpractice insurance, leading to costly claims.<sup>33</sup>

**Federal legal action.** Federal penalties apply when services are submitted that were not legally provided, and providers may face penalties under the False Claims Act.<sup>34</sup> Civil actions can also arise when patients are harmed due to negligent care across state lines.<sup>35</sup> Patients may

sue in their home state for negligence and medical malpractice, seeking damages for injury and substandard care.<sup>31-33</sup> In *Hageseth v. Superior Court*,<sup>36</sup> an out-of-state practice prosecution case, a Colorado-licensed psychiatrist was criminally prosecuted for practicing medicine without a license in California after prescribing medication through telehealth when the patient subsequently committed suicide. Dr. Hageseth was sentenced to 9 months in prison.<sup>36</sup> Figure B represents the sharp increase in interstate legal risks related to telehealth practice, further demonstrating the inherent risks providers are taking when practicing telehealth.



*Interstate legal risk and enforcement activity related to telehealth remained minimal prior to COVID-19, increased during the PHE, and escalated following the reinstatement of pre-pandemic regulatory frameworks.*<sup>16, 33, 37-44</sup>

Although telehealth has expanded access to care and become widely integrated into PA practice, the current PA licensure system creates significant legal and regulatory barriers for interstate telehealth delivery. This disconnect between telehealth utilization and regulatory infrastructure highlights the need for a standardized Physician Assistant Telehealth Compact.

## **HEALTHCARE RECOMMENDATIONS**

PAs must navigate evolving regulations at the state, institutional, and supervisory levels, creating a complex legal landscape. As a result, many PAs may be unaware of the full extent of their authorized scope of practice. Importantly, responsibility for compliance with state telehealth laws rests with the PA, not the supervising or collaborating physician. Although a supervisory or collaborative agreement may permit telehealth services, such authorization does not confer legal authority to practice across state lines.<sup>25</sup> The reinstatement of key public health emergency telehealth policies, specifically the Coronavirus Preparedness and Response Supplemental Appropriations Act<sup>8</sup> and CMS<sup>9</sup> temporary suspension of geographic and originating site restrictions, combined with the nationwide adoption of the Physician Assistant Compact, would provide a foundation for advancing the legal and regulatory landscape governing PAs who utilize telehealth. If unaddressed, inconsistent PA telehealth scope-of-practice across states will continue to create legal uncertainty, limit patient access to timely care in underserved areas, and may increase malpractice and regulatory risk for employers and payers, undermining safe, scalable telehealth practice.

### **Adoption of a Telehealth Compact**

With the adoption of the PA Licensure Compact, developing and implementing a telehealth compact is a practical next step to outline minimum practice standards. Member states of the PA licensure compact could review and adopt a similar telehealth compact to establish a harmonized core scope of practice for PAs. The implementation process could follow the current PA licensure compact with a telehealth focus.<sup>45</sup> The process could convene the American Academy of Physician Associates (AAPA), the National Commission on Certification of Physician Assistants (NCCPA), state medical/PA boards, and legislators, to draft model compact

language. This compact could then be introduced across willing US regions/states, with the goal of adoption, following the precedent of the PA licensure compact. Adoption would allow PAs who are licensed in compact states to provide in-person and telehealth services in reciprocal states. Eligibility to provide telehealth services would require licensure under the telehealth compact and can then be linked to national certification for PAs through the NCCPA, allowing for criminal background checks prior to certification in telehealth services and defining continuing education requirements to maintain telehealth services.

### **Establishing Core Telehealth Scope and Competency**

While a PA telehealth compact is being drafted, the AAPA, the Accreditation Review Commission on Education for the Physician Assistant, Inc (ARC-PA), and the NCCPA could outline and publish a consensus of the core telehealth scope and competency set, similar to the Six Key Elements, to aid in PAs practicing at the top of their licenses. In 2008, the AAPA published the Six Key Elements of a Modern PA Practice Act, a landmark legislation that outlined modern PA practice, which was quickly adopted by all 50 states within 8 years.<sup>46</sup> This legislation allowed PAs to practice to the full extent of their training and helped to offload administrative burden. To implement a core telehealth scope, a panel of experts, clinicians, regulators, malpractice carriers, and patient advocates should be convened to design and address a telehealth scope outline, publish guidance for documentation and implementation in practices, and integrate the process into PA programs and legislation across the US. Guidance for documentation would mirror current guidelines, including telehealth mode, consent, location, time, clinical content, and billing modifiers.

### **Standardizing Telehealth Supervision and Training**

In addition to outlining a standardized scope and competency framework for telehealth, the NCCPA and AAPA could mandate a standardized telehealth supervision and

scope-of-practice agreement between the collaborating/supervising physician and PA. This mandate could detail remote supervision modalities and escalation pathways for adverse events and telehealth visits that need to be converted to in-person visits. The NCCPA and AAPA could collaborate to develop standardized template agreements to be used and filed together with the license and telehealth compact. Professional development courses to standardize telehealth can be created that provide continuing education credits and are mandated for PAs, to reduce legal ambiguity and potential malpractice exposure, requiring PAs to earn a specific number of CME credits per renewal cycle through the NCCPA for telehealth certification. The adoption of incentive-based training programs, such as linking completion to malpractice insurance premium discounts, may promote greater participation in telehealth education. Standardized training would include documentation review to limit malpractice exposure and liability, proper telehealth etiquette to increase HIPAA compliance, and education on commonly treated conditions in which telehealth is used, including updates to the standard of care for these conditions. Increased engagement in standardized training can help reduce legal and documentation-related liability by ensuring PAs remain current with evolving telehealth laws, regulatory requirements, and best practices.

### **Addressing Future Improvements**

It is also important to consider quality improvement and support for telehealth research. To address this, national telehealth surveys for PAs should be distributed through NCCPA during licensure renewal every 2 years to collect data on telehealth encounters. The NCCPA could track telehealth specific data, including number of telehealth visits conducted per month, common conditions treated through telehealth, diagnoses that were initially tried as a telehealth visit, but had to be converted to in person due to complexity, number of cross-state telehealth encounters

performed, legal issues or repercussions relating to telehealth, and provider rate of emergency department visits after a condition was initially evaluated as a telehealth visit through these surveys. This data could be used to inform policy and practice changes to help reduce legal ambiguity. Implementation of a national PA telehealth survey represents a critical step toward advancing telehealth practice by providing objective, longitudinal data to guide long-term changes for scopes of practice and competency sets, clarify areas of legal ambiguity, and strengthen telehealth laws. Systematic tracking would enable regulators and professional organizations to detect trends in adverse events that expose PAs to malpractice, enabling the development of targeted education, standardized practice guidelines, and evidence-based policy reforms. In addition, survey data could help malpractice carriers and licensing boards establish clearer expectations for safe telehealth practice, thereby reducing liability uncertainty.<sup>47,48</sup> From a patient safety perspective, ongoing surveillance of clinical outcomes and follow-up care would help evaluate the effectiveness of telehealth services, verifying that remote care meets established standards of care.<sup>47,48</sup> Collectively, these efforts would strengthen licensure compliance, support the creation of uniform telehealth regulations, improve quality assurance processes, and promote safer, more effective telehealth services. Future research studies, such as meta-analyses and systematic reviews are needed to assess the overall safety, compliance, and effectiveness of telehealth.

## **CONCLUSION**

Telehealth has revolutionized healthcare delivery across the United States by expanding access to care. The rapid expansion during the COVID-19 pandemic revealed significant gaps in the legal framework controlling physician assistant practice. Because PA practice is regulated at the state level, current legislation has created a fragmented system in which PAs face substantial

legal and malpractice risk when utilizing telehealth. The reinstatement of pre-pandemic licensure and supervision requirements reversed temporary gains in telehealth flexibility, which further highlights the disconnect between the outdated legislative structures and modern healthcare delivery. To address these challenges, several healthcare recommendations are presented, including the development and adoption of a national telehealth compact for PAs modeling the PA Licensure Compact to harmonize interstate practice requirements; the establishment of a standardized telehealth scope-of-practice competencies, supervision agreements, and continuing education expectations; and the creation of a national telehealth survey to monitor outcomes, safety, and regulatory compliance. Together, these measures may reduce legal ambiguity, support safe use of telehealth, and continue to increase access to medical care. Further meta-analyses and systematic reviews are needed to evaluate overall safety, compliance, and effectiveness of telehealth. Addressing these legislative barriers through a coordinated national compact represents a critical step towards ensuring that telehealth remains at the forefront of accessible healthcare, while also protecting physician assistants from legal recourse.

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