SPECIAL REPORT

HEALTHCARE

EXPANDING ACCESS, PROTECTING PATIENTS

A Roadmap for Scope of Practice Reform in South Carolina

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WHAT IS "SCOPE OF PRACTICE"?

At the most fundamental level, **scope of practice** (SOP) in healthcare policy is defined as **"the activities and duties [tasks] that a licensed or certified healthcare professional is permitted to perform, based on their education, training, and experience, as outlined by state laws and regulations."** However, defining SOP boundaries in the real world for each medical professional is not so simple. This report—a broad overview—will consider the impact of SOP on healthcare access and cost, patient outcomes, and safety, while also taking into consideration reforms neighboring states are implementing. Ultimately, this report will create a roadmap to reasonable opportunities for scope of practice and healthcare access reforms in South Carolina.

SOUTH CAROLINA HEALTHCARE LANDSCAPE

South Carolina is struggling with major concerns regarding access to healthcare, especially in rural areas. Many regions in the state face a shortage of primary care physicians (PCPs), limiting residents' ability to receive timely and comprehensive medical care. It could get worse – according to current research, by **2030** South Carolina is projected to be short **3,230** doctors.

The problem is particularly acute in primary care, where the state will need an additional **815** primary care providers by **2030**, to maintain the current PCP to patient ratio. This is due to several factors: the state's growing population, the passage of the Affordable Care Act (Obamacare), and the impending retirement of an estimated **29%** of current PCPs. South Carolina's physician-to-patient ratio is **23** percent worse than the national average. According to America's Health Rankings (2024), South Carolina ranks **37th** among the 50 states in **access to primary care providers**, **40th** in **access to mental health providers**, and **42nd** in **access to dental care providers**. According to the South Carolina Area Health Education Consortium (SC AHEC), the Palmetto State has both a shortage problem (lack of health professionals) and a maldistribution problem (a lack of specific health professionals in all areas).

Furthermore, South Carolina has a large population enrolled in Medicaid and other forms of public health insurance. This population, numbering around **1,310,000**, often experiences more chronic conditions and is burdened with more complex health needs.

There have been a host of studies that suggest that adopting **scope of practice expansion policies in South Carolina could alleviate some of the financial burdens on the healthcare system and ensure that rural populations receive more timely and effective care.** Many South

Carolinians are already struggling to access primary and preventive care, and with increasing demand and trends showing poorer health outcomes and higher rates of chronic disease, it is clear that the state should consider all safe and viable scope of practice expansion solutions.

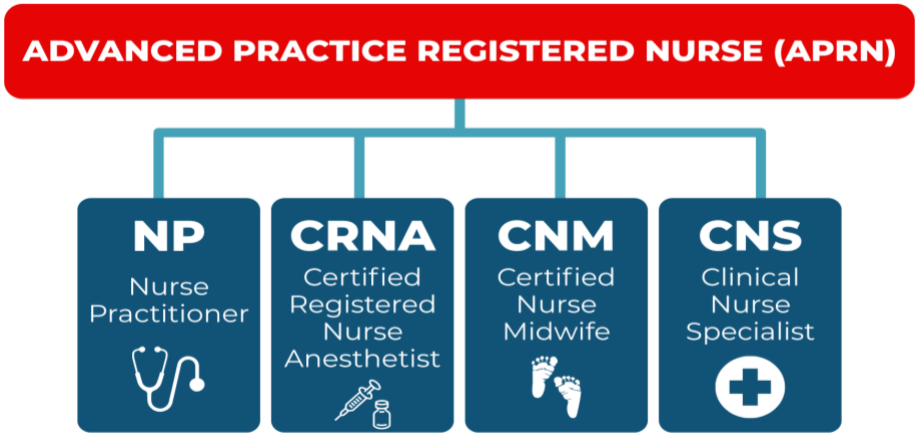
WHAT DOES SOP IN SC CURRENTLY LOOK LIKE?

Opinions differ, but South Carolina's healthcare landscape could generally be characterized as anywhere along the spectrum from “moderately restrictive” or “reduced” to “restrictive” in how its state health statutes set the parameters for scope of practice.

Here are the key health professions in play for expansion:

1. **A Nurse Practitioner (NP),** a type **of Advanced Practice Registered Nurse (APRN)** whose training follows a nursing model, operates under a "restricted practice" in South Carolina. This means that, to practice, they require a written practice agreement with a collaborating physician. The agreement outlines the NP's scope of practice, including their prescriptive authority and authorized medical acts. According to the National Council of State Legislatures (NCSL), NPs are not permitted to practice independently without a physician relationship in most Southern and Midwestern states, including South Carolina. APRNs (except CRNAs) obtain their own prescriptive authority licensure from the Board of Nursing and their own federal DEA and state licensure.

   There are **6,696** Advanced Practice Registered Nurses in South Carolina, of which **5,260** are Nurse Practitioners (NP), **1,298** are Certified Registered Nurse Anesthetists (CRNA), **82** are Certified Nurse Midwives (CNM), and **56** are Clinical Nurse Specialists (CNS). This represents **12.9** APRNs per 10,000 residents. **78.6%** of APRNs are NPs, for a ratio of about **10** per 10,000 residents. About **45%** of NPs practice in medical offices or hospitals.



2. A **Physician's Assistant (PA)** or simply **"PA,"** whose training follows a medical model, must have an approved primary supervising physician on file with the South Carolina Board of Medical Examiners before practicing. The supervising physician is responsible for all aspects of the PA's practice, including defining their scope of practice and delegating medical tasks and prescriptive authority.

   There are **1,801** PAs in South Carolina, which represents **3.5** per 10,000 residents. About **83%** of PAs practice in physician offices, hospitals, or freestanding outpatient clinics. **22%** practice in primary care. South Carolina's PA per 100,000 population rate earns the state a ranking of **30th** in the United States, but in percentage growth (2018-2022), South Carolina is ranked **2nd**, behind only Mississippi. North Carolina is ranked **4th** in PAs per 100,000 residents.

   There are **five** PA programs in South Carolina: the. University of South Carolina, North Greenville University, Presbyterian College, Charleston Southern University, and the Medical University of South Carolina (MUSC). Together, these programs graduate about **200-230** students each year. Two additional programs are set to launch pending accreditation— Francis Marion University and a second program at MUSC (hybrid option).

3. **Physicians**, who either hold a **Doctorate of Medicine (MD)** or a **Doctorate of Osteopathic Medicine (DO)**, are the professionals you will call "doctor." For reference, there are **13,531** physicians in South Carolina, for a ratio of **26.1** per 10,000 state residents. About **66**% of doctors practice in private offices or hospitals. Training for physicians is rigorous (see table below), requiring mastery of 56 unique competency areas and 12,000-16,000 clinical hours. Requirements for practice include a doctoral degree, post-graduate residency, and a licensure exam.

The collaborative/supervisory practice model in South Carolina mandates that APRNs/NPs and PAs enter formal agreements that outline the medical services that they may perform and define them as an "agent" of the physician. If an NP or PA loses his or her physician relationship in South Carolina for whatever reason, that NP or PA would not be able to practice until a replacement physician agrees to take them on. This issue seems to be limited to certain professions – in states with independent practice models, APRNs/NPs are more likely than PAs to practice independently.

This begs a few questions: does the desire to address these problems necessarily conflict with the general **principle** that to protect the safety of the

patient, healthcare in South Carolina should be fully or partially physician-led?

Can concerns about training, specifically the ability of NPs and PAs practicing independently to *properly diagnose patients* without physician involvement, be addressed by strengthening current legislation before the General Assembly to require more clinical hours with a physician, more advanced coursework in diagnosis and pharmacology, or restricting independent NPs and PAs to certain types of practice or to serving patients who are not high-risk or acutely ill?

WHAT IS THE SOP ARGUMENT AT HAND?

Over the last several legislative sessions in South Carolina, there have been increasingly substantive conversations in the General Assembly about the expansion of SOP for non-physician healthcare professionals.

Some argue that expanding the scope of practice for non-physician healthcare providers offers a potential solution to the healthcare access crisis driven by the physician shortage by allowing non-physician medical professionals to take on more responsibility in primary care. This would inevitably increase access in regions of the state that need it most. However, others argue that expanding non-physician healthcare will put patients at risk, alleging that APRNs/NPs attempt to function as physicians without the necessary training. The American Association of Nurse Practitioners (AANP) labels the Palmetto State's practice environment as "restricted," but the American Medical Association (AMA) opposes SOP expansion due to concerns about the compromise of physician-directed medicine, patient safety, fragmentation of care, and training disparities between physicians and APRNs/PAs.

To understand the debate, we have broken the competing positions down into their major arguments:

SUPPORT FOR SCOPE OF PRACTICE EXPANSION:

Improved access in underserved areas: The South Carolina Department of Public Health has designated all **46** counties as medically underserved and 41 of 46 counties as health professional shortage areas, highlighting a need for accessible healthcare services. Scope of practice expansion advocates point to studies—like one published in 2016 in Medical Care—that indicate that less restrictive Advanced Practice Registered Nurse (APRN) scope of practice regulations could increase primary care access. According to that research,

with fewer restrictions, **62%** had access to primary care clinicians, compared to **35%** in restricted SOP states.

Lower cost for care: A study from the Mercatus Center at George Mason University found that allowing PAs to prescribe drugs reduced the cost of medical care between **11.8%** to **14.4%**, depending on the specialty. Additional studies indicate that states with Full Practice Authority (FPA) for **APRNs/NPs** experience better accessibility to care in rural areas and lower healthcare costs without a decrease in quality of care. Recent research on opioid prescribing and "avoidable hospitalizations for diabetes and other chronic conditions" indicates that full practice authority increases access and efficiency.

Earnings are not a "zero sum" game. Recent research on the labor market effects of state-level SOP reforms indicates that full practice authority tends to increase earnings for NPs without reducing the earnings of physicians.

OPPOSITION TO SCOPE OF PRACTICE EXPANSION:

Concerns about compromised patient safety: The American Medical Association (AMA) argues that there is a dramatic difference in training rigor between an APRN, a PA, and an MD. The classwork portion of APRN training is often online and is not standardized. There are no competency measures, and shadowing a physician for a year may not result in the ability to correctly *diagnose* an illness or disease—a critical requirement for timely and effective care. Some NPs eventually practice in specialty fields but have no additional specialty certification beyond primary care. A broadening of the Scope of Practice for APRNs in South Carolina (characterized by the AMA as "scope creep") could threaten the safety of patients, placing additional strain on health care systems.

Increased healthcare costs: Also, according to the AMA, independently practicing **APRNs** raise costs by ordering more diagnostic tests and prescribing unnecessary antibiotics and opioids. A study by the Journal of the American College of Radiology found that non-physicians (**NPs** and **PAs** at the time) increased skeletal x-ray utilization per 1,000 for Medicare beneficiaries from 2003-2015 by **441%**. There were also increases in testing for orthopedic surgeons, chiropractors, and podiatrists (by **10.6%** and **14.4%** respectively). As evidence of NPs using more resources, a Mississippi study on the effects of expanding care teams to include more NPs and PAs collaborating with doctors is cited, as well as a Veterans Administration emergency department productivity study published last year (2024).

WHAT DOES EDUCATION FOR DIFFERENT MEDICAL PROFESSIONALS LOOK LIKE?

PROFESSION	UNDERGRADUATE DEGREE REQUIRED?	GRADUATE DEGREE REQUIRED?	FELLOWSHIP/ RESIDENCIES REQUIRED?	AVG. TOTAL CLINICAL HOURS
MD/DO	**YES**	**YES,** MD or DO, 4 years, licensure exam	**YES**, 3-9 years, 1-3 more for subspecialty	**~12,000** to **16,000**
APRN (includes NP, CRNA, CNS, CNM)	**YES**, typically BSN	**YES**, MSN or DNP, 2-4 years; PhD, additional years; National Certification within 2 years of degree completion	**NO**	**~500** to **750+**
PA-C	**YES**, typically. There are some 3+2 dual degree programs where students earn their bachelor's degree along with the PA master's degree.	**YES**, MPAS, 2-3 years; complete approved program, National Certifying Exam	**NO/Optional**	**~2,000**
RN	**NO**, only Associate's required. Typically ADN or BSN.	**NO**	**NO**	**~500** to **700**

A PHYSICIAN OR NO ONE?

In an ideal world, every patient would see a **physician** for every health concern. But South Carolina, much like many other parts of America, is grappling with a severe provider shortage. Over **80%** of South Carolina counties have at least one federally-designated Health Professional Shortage Area (**HPSA**). This means that, in many of these communities, there is not a single full-time practicing physician. For patients in these areas, the choice is not between seeing a physician or a nurse practitioner—it is between seeing a nurse practitioner and seeing no one.

Despite having fewer clinical hours than **Physicians**, **Nurse Practitioners (NPs)** and **Physician Assistants (PAs),** along with other medical professionals, are trained to deliver quality, evidence-based care *within their scope*. Their education emphasizes patient-centered care, chronic disease management, and preventive services, all of which are critically needed in South Carolina, where chronic illness and maternal health outcomes continue to rank poorly.

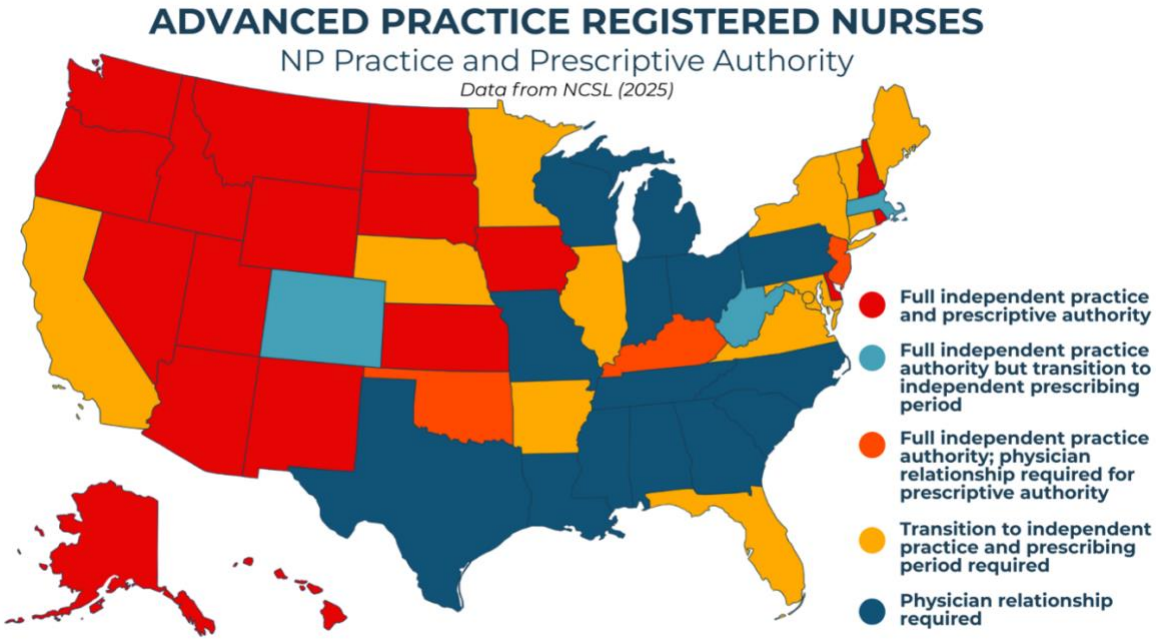
It is a simple fact that physicians undergo the most extensive training, and nurse practitioners should not replace doctors. The questions at hand with this scope of practice argument are:

- *What level of care is safe and effective for the type of services being provided?*
- *What level of physician supervision or collaboration should be required for a non-physician?*

For routine primary care, checkups, chronic disease management, mental health support, and wellness visits, multiple peer-reviewed studies have shown that NPs and PAs deliver care that is comparable in quality to physicians. This is especially true when the NP has many years of experience with a physician and graduate-level training in family or internal medicine.

THE SOUTH CAROLINA CONTEXT

ADVANCED PRACTICE REGISTERED NURSES



Act 234 (S.345, 2018) amended South Carolina law by defining *collaborative* practice agreements for APRNs, a notable shift away from pure "supervision" and "approved written protocols." The requirement of "near proximity" and the 45-mile limit were also removed. The reform defined parameters for APRN prescription of drugs and devices, the use of telemedicine, and medical acts that they could perform. This includes providing non-controlled prescription drugs at an entity that provides free medical care, certifying that a student is unable to attend school, referring a patient to physical therapy for treatment, pronouncing death and signing death certificates, issuing an order for a patient to receive appropriate services from a licensed hospice, and certifying that an individual is handicapped for purposes of the individual's application for a parking placard.

In 2019, with Act 87 (H.3821) the legislature granted APRNs the ability to certify the manner and cause of death, execute Do Not Resuscitate orders, and order Schedule II narcotics in long-term care facilities. In 2021, with Act 55 (S.503), the General Assembly permitted APRNs to issue orders for home health services.

For the 2025-26 session, under the proposed S.45, Advanced Practice Registered Nurses (APRNs)—Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNS)—would have varying degrees of independent authority if certain requirements are met. These requirements include **2,000** hours of clinical practice experience after initial licensure, malpractice insurance, and approval from the State Board of Medical Examiners (BME). Not all APRNs practicing in the state would necessarily apply for full practice authority, and many APRNs would continue to operate as they do now under practice agreements with oversight by physicians. The intention is that APRNs would be limited to the scope of what they are trained to do.

In the Southeastern states neighboring South Carolina—North Carolina, Georgia, Tennessee, and Florida—only Florida has taken a significant step in transition to independent practice; the rest require a physician relationship for APRNs to practice. Another issue reported by APRNs and PAs is that although physicians are compensated for overseeing them, there is a lack of regular communication or formal review of records with their physicians.

What Other States Are Doing on APRNs

Passage of **Florida** statute § 464.0123 (2020) allows certain **APRNs**—including Certified Nurse Midwives (**CNMs**) and Nurse Practitioners (**NPs**) to register for autonomous practice if they hold an active, unencumbered license, have

completed at least **3,000** clinical practice hours under physician supervision within the past five years, have not been subject to disciplinary action in the past five years, have completed advanced courses in diagnosis and pharmacology, and possess liability insurance or letter of credit. **CRNAs** are not eligible for autonomous practice or prescriptive authority in Florida or in any other Southern state.

A 2018 study published in *Nursing Outlook* projected an increase in **APRN** supply in Florida by **11%**, less pressure on physician supply, and a reduction of shortages of primary care physicians, OB-GYNs, and anesthesiologists, and cost savings of **$50** to **$493** per Florida resident.

Georgia (2024) took an incremental approach to expanding **APRN/NP** and **PA** scopes of practice, similar to South Carolina. **APRNs** and **PAs** in Georgia now also have the authority to sign death certificates, if authorized in their supervision agreements (HB 1046). Georgia has also increased the number of **APRNs** and **PAs** a physician may supervise from **four** to **eight** and increased prescriptive authority (HB 557). After 2018, South Carolina allowed APRNs to sign death certificates and has allowed for the prescription of Schedule II controlled substances for a certain number of days under certain limitations. According to NCSL, APRNs are recognized as primary care providers in South Carolina but not in Georgia. Physicians may supervise/collaborate with up to **six** APRNs, PAs, or a combination of each in South Carolina.

Other reforms that gained traction in 2025 were:

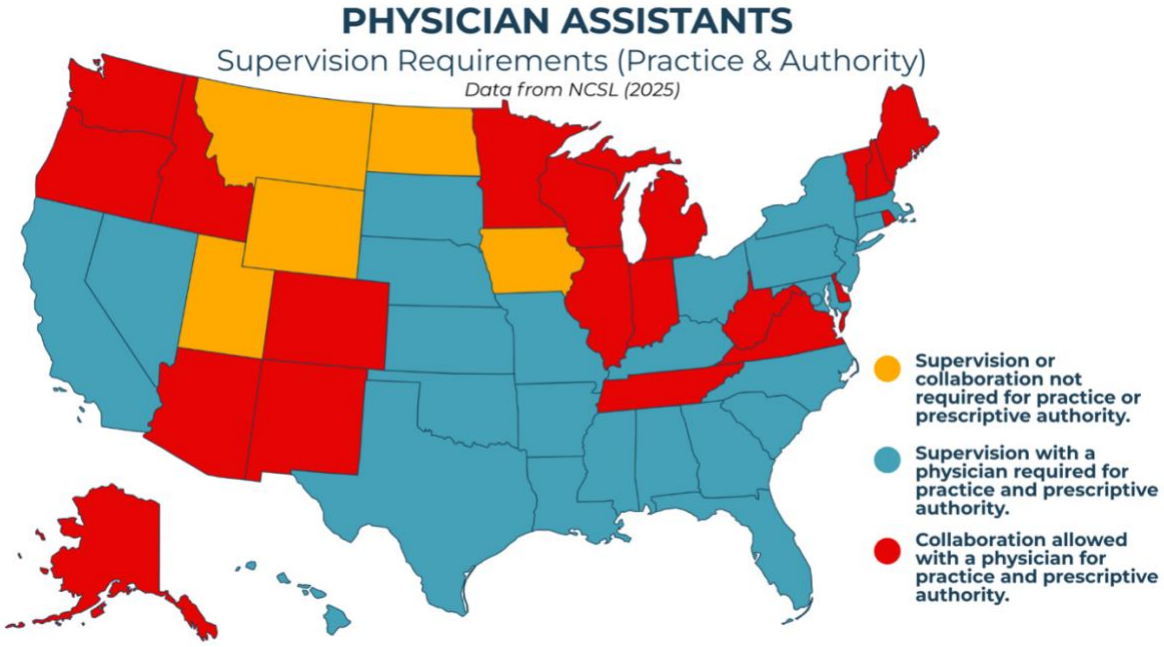
- **Oklahoma** (HB 2298) granted nurse practitioners (NP), nurse midwives (CNM), and clinical nurse specialists (CNS) the ability to prescribe some medications without physician supervision after **6,240** hours of supervision with a physician of the specialty in which they are practicing. Governor Kevin Stitt said the bill was “a step too far” as this authority extended beyond primary care.

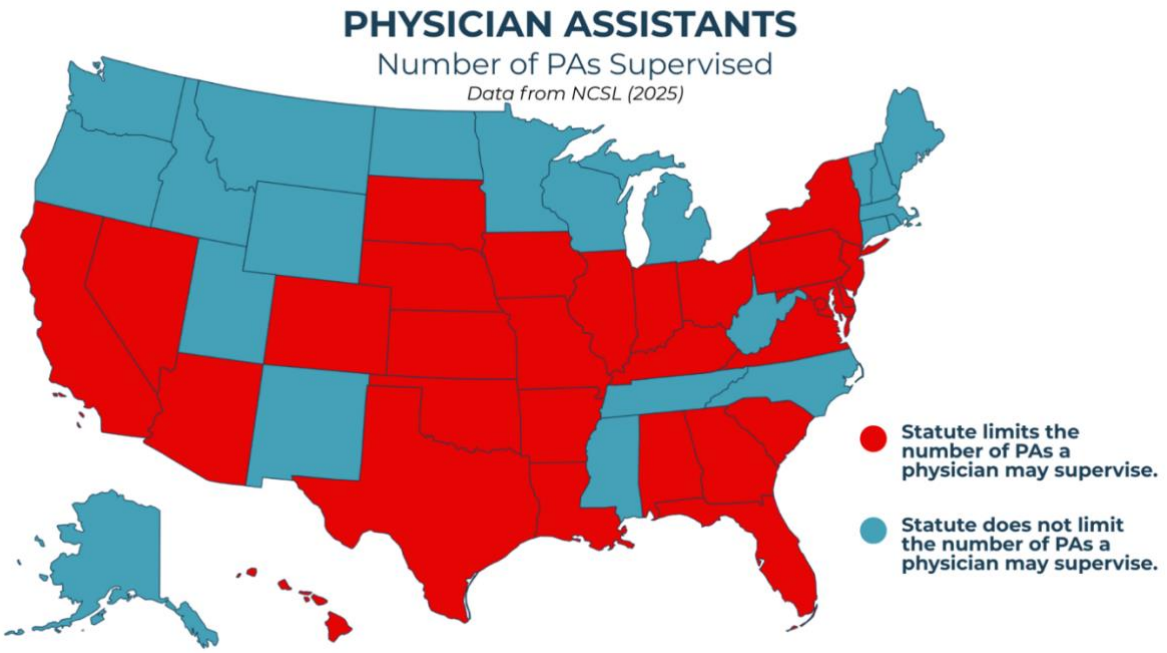
- **Arkansas** passed a much narrower bill (HB 1167) granting nurse practitioners (NP) and physician assistants (PA) signatory authority for orthotics, prosthetics, and diabetic shoe inserts to prevent diabetic foot ulcers.

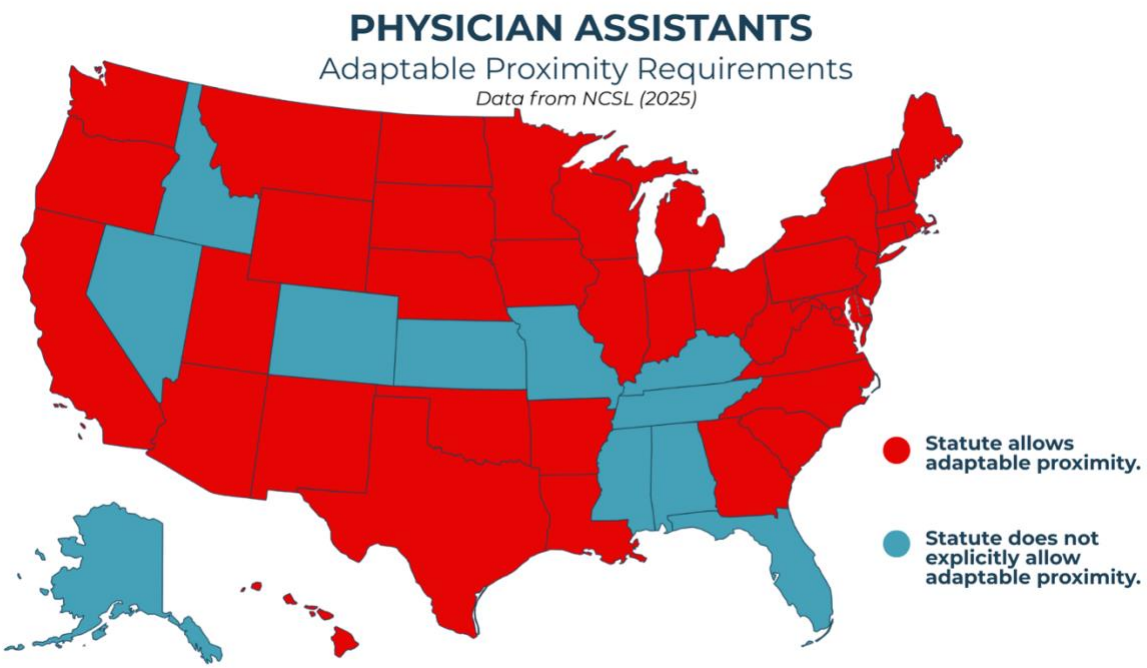
PHYSICIAN’S ASSISTANTS

Currently, most states in the region and nation require supervision by a physician or collaboration with a physician for practice and prescribing authority. The limit in the number of PAs supervised (and PAs + APRNs total supervised) varies from **10** in Florida, **8** in Georgia, **6** in South Carolina, and is determined at the practice level in Tennessee.

Whether a chart co-signature is required is mostly determined at the practice level in the region and is provided in the written scope of practice guidelines approved by the state medical examiner boards. Most states in the region have a form of *adaptive proximity* for consultation that allows the supervising physician to be available, but not necessarily physically on-site with the PA or a certain geographical distance from the PA. Florida provides some ability for a physician to delegate authority to a PA in connection with practice in a county health department.







In 2019, the South Carolina General Assembly passed **S.132** **(Act 32),** the PA Act, which generally expanded the latitude extended to PAs but strictly under practice agreements and reiterated that the PA is an agent of the supervising physician. **Act 32** listed the medical acts that could be performed by PAs, delegated by PAs, and not permitted to be performed by PAs.

The proposed **S.46** filed in the **2025-26** General Assembly would allow PAs with **2,000** hours of postgraduate clinical practice experience to perform medical acts independently, including prescribing drugs (Schedules II-V, Schedule I drugs cannot be prescribed) if he or she possesses more than **two thousand hours** of postgraduate clinical practice experience as a licensed PA and more than **one thousand hours** of practice experience gained after transitioning to a new medical specialty of practice with a supervising physician in that specialty.

What Other States Are Doing on PAs

Recent reforms in other states include:

- A recent reform passed in **Oklahoma** (**HB 2584**), allows PAs to prescribe medications, including Schedule III-V controlled substances, without a delegating physician practice agreement after completing **6,240 hours** of postgraduate clinical practice experience. The bill was passed when the legislature overrode Governor Kevin Stitt's veto. In his veto

message, Stitt reiterated that he supported full practice authority for PAs, but only for primary care, not "any and all specialties."

According to the Research Summary of the Oklahoma House of Representatives, with the passage of the bill:

> *The State Board of Medical Licensure and Supervision must maintain a public list of such PAs and provide a form for reporting hours, which can be submitted electronically at no cost. PAs practicing independently must be covered by malpractice insurance. A PA may still choose to have a practice agreement with a physician. The board retains the authority to impose supervision as a disciplinary measure. PAs practicing independently may prescribe supplies, services, and drugs, including Schedule III–V controlled substances. PAs practicing under a practice agreement may additionally prescribe Schedule II drugs with written protocol determined by the delegating physician.*

- In **North Carolina**, the passage of **House Bill 67** creates a new PA category designated as "team-based physician assistant." The Team-Based PA is a PA who practices in a team setting, except in pain management, has more than **4,000 hours** of clinical practice experience, and has more than **1,000 hours** of clinical experience with a physician in a specific medical specialty. Team-based physician assistants, except in a perioperative setting, are no longer required to practice with physician *supervision*, rather they *collaborate* and *consult* with or *refer* patients to the appropriate members of the team as determined by the practice. The guardrails on the new PA category include that the level of collaboration required is set by the practice and by the state medical board, and the definition of the "team-based practice setting" is clearly defined as locations where physicians have active participation.

  Note: The North Carolina bill also: creates a new licensure pathway for international physicians, updates the interstate medical licensure compact to reduce barriers for out-of-state physicians and PAs to practice in North Carolina, sets practice criteria for Clinical Pharmacist Practitioners (including the requirement to practice under a physician's supervision) and allows pharmacists to "test and treat" (to administer flu tests and provide medication without a doctor's visit).

WHAT'S IN PLAY FOR 2025-26 IN SOUTH CAROLINA?

The Medical Affairs Marathon

The South Carolina Senate held a marathon two-day hearing session in early September 2025 in which a subcommittee of the Medical Affairs Committee heard testimony on eleven (11) bills, including S.45 and S.46. Most of the docket touched the issue of broadening healthcare access—expanding the roles of internationally trained physicians, pharmacists, dentists, physician's assistants, physical therapists, advanced practice registered nurses (including nurse practitioners), and even dieticians and veterinarians. No telemedicine, surprise billing, or bills directed primarily at CRNAs were on the agenda.

One bill, however, was swimming against the expansion tide. **S.669** calls for the practice of medicine to be conducted "as a part of a patient care team" with "APRNs, PAs, and AAs" contributing to the team but "clearly delineat[ing] how the patient care team physician will fulfill his obligations of collaboration with NPs, CNSs, CNMs, or supervision of PAs on behalf of the patient care team." This legislation doubles down on physician-led healthcare. It correctly requires that "APRNs, PAs, or AAs who have received a doctorate degree in their respective field of practice may not use the title *doctor* during a patient encounter without first informing and documenting in writing that they have advised the patient that they are not a physician…" Also included is a provision related to these healthcare professionals being supervised by or collaborating with a physician. That section of the bill sets out procedures that must be followed when a supervising physician dies, retires, or otherwise ceases to practice in that field. Currently, according to the testimony heard by the subcommittee, PAs or NPs whose doctors are no longer active can lose their practice or have their ability to practice interrupted.

So, with diametrically opposed bills in play in the Senate, what is the path forward for reform? A few questions are in order:

- *What problems are we attempting to solve?*
- *What principles should guide our thinking?*
- *What are neighboring states in the region with similar problems doing legislatively, and how can these solutions be adapted for use in South Carolina?*

PRINCIPLES AND PROBLEMS

One **problem** we are attempting to solve in South Carolina is how to provide routine primary care in the healthcare deserts where access to that care does not currently exist. More broadly, to simply maintain current practitioner-patient ratios, the Palmetto State as a whole, both rural and urban, will need a significant uptick in practitioners. Finding innovative ways to ensure that our medical program graduates choose to work and live in South Carolina could have a marked positive effect on practitioner supply. Approaches vary, but some states offer financial incentives for practitioners who agree to practice in-state after graduation.

Legislation restricting the use of non-compete agreements in the Palmetto State and another round of tort reform to more fully protect healthcare professionals from South Carolina's (still) trial lawyer-friendly civil liability system would help. Access to care can also be increased by adopting broader approach to telemedicine that would allow full participation across state lines.

SIGNALS FROM WASHINGTON

On September 15, 2025, the Trump Administration's Centers for Medicare & Medicaid Services (CMS) announced a Rural Health Transformation Program (RHT) that would fund **$50 billion** in federal grants to "empower states to transform the existing rural health care infrastructure and build sustainable health care systems that expand access, enhance quality of care, and improve outcomes for patients."

CMS announced that funding would be allocated to approved states over **five** years, with **$10 billion** available each year beginning in federal fiscal year **2026**. **Half** of the funding would be evenly distributed to **all** states with an approved application. The other **half** would be awarded to approved states based on individual state metrics and applications that reflect the greatest potential for and scale of impact on the health of rural communities.

The five goals of RHT that states are expected to address in their applications are: **innovations to promote preventative health, long-term access to care (sustainability), recruitment & retention of providers, innovative technologies, and innovative care models**. CMS describes the innovative care as projects that: "[s]park the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements."

According to the Administration, the scoring in the grants competition and funding awards decisions will, in part, be based on State Policy-Based Factors. Here is a portion of the scoring criteria from CMS:

Appendix C: State Policy-Based Factors

Health and Lifestyle*
Whether a state requires schools to reestablish the Presidential Fitness Test.

SNAP Waivers
Whether a state has a USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items.

Nutrition Continuing Medical Education
Whether a state has a requirement for nutrition to be a component of continuing medical education.

Certificate of Need (CON)
Based on a state's ranking in the Cicero Institute report, *A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Need Laws in All 50 States*.

Licensure Compacts
Whether and to what extent a state has adopted the Interstate Medical Licensure Compact, NLC Nurse Licensure Compact, EMS Compact, Psychology Interjurisdictional Compact, and/or Physician Assistants (PA) Compact.

Scope of Practice
Based on practice environments for Physician Assistants, Nurse Practitioners, Pharmacists, and Dental Hygienists, according to the AAPA PA State Practice Environment, American Association of Nurse Practitioners State Practice Environment, *Cicero Institute 2025 Policy Strategies for Full Practice Authority*, and *Oral Health Workforce Research Center Variation in Dental Hygiene Scope of Practice by State*, respectively.

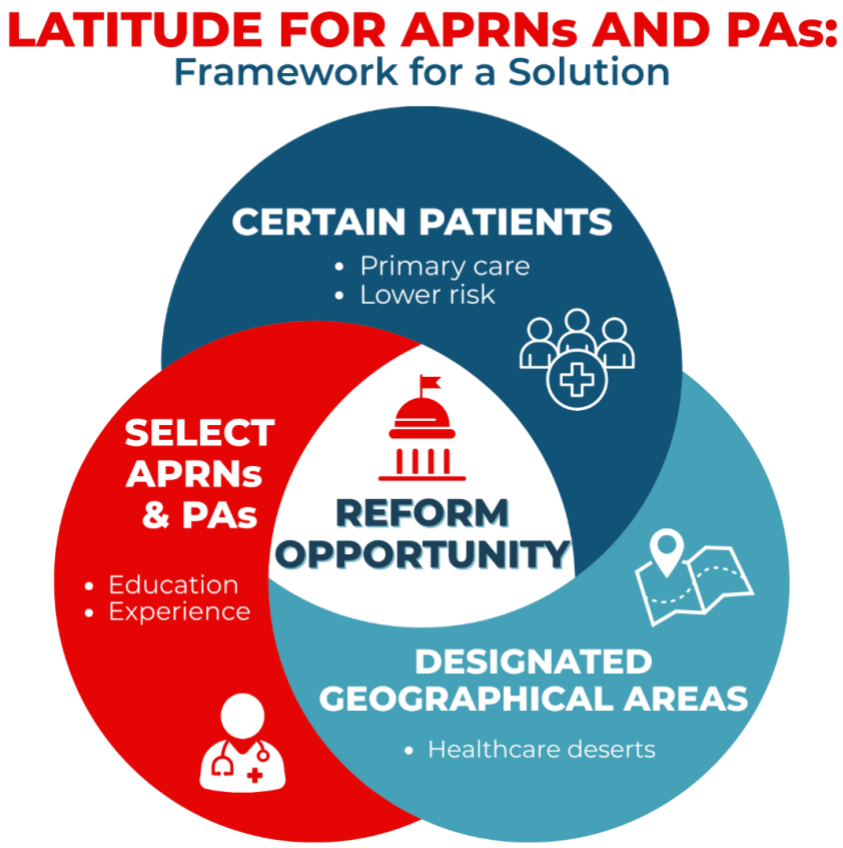
Short-term, Limited Duration Insurance
Whether STLDI plans are restricted in the state beyond the latest federal guidance.

Remote Care Services*
Based on Medicaid payment for live video, store and forward, and remote patient monitoring, whether there are any exceptions to the in-state licensing requirement, and whether the state has a telehealth license/registration process.

**Score will be based on both state policy factors and initiative-based factors.*

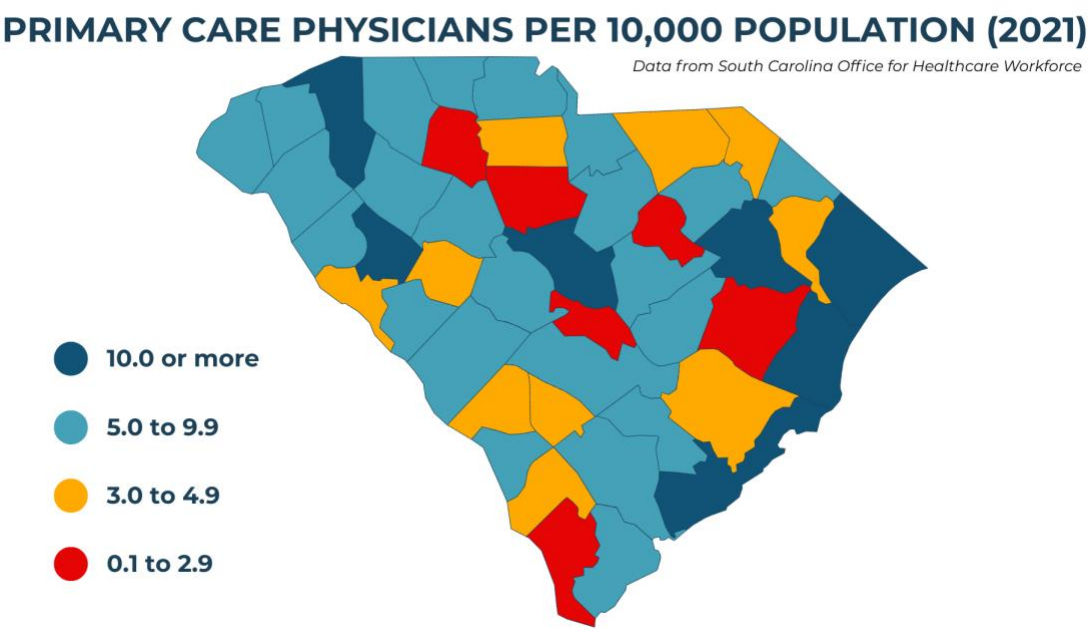
According to the scoring, “expanding access” and “innovative care models” mean the administration will look favorably upon proposals from states that have, in some manner, empowered APRNs and PAs. Though the deadline for applications for this particular grant is November 5, 2025, in the long term, innovation could lead to more investment from Washington.

CONCLUSION



Although staff of Palmetto Promise Institute does not include a physician or full-time health policy professional, the comprehensive testimony provided to the Senate Medical Affairs Committee in September 2025 and the text of the proposed legislation seem to suggest a framework for progress on this issue, combining elements of recent actions by neighboring states. Such a reform could be accomplished through legislation that would pilot a program to allow a ***very select*** **group of APRNs and PAs in** ***designated*** **areas serving** ***certain*** **types of patients to enjoy independent practice authority.**

After all, we know where the deserts are.



APRNs and PAs are not physicians, but in many instances, consultation with a physician may not be required. The South Carolina General Assembly should bring APRNs and PAs with *exceptional* qualifications into *limited* geographical locations for *lower-risk* patients to assist with filling the present and future healthcare gap in South Carolina. This would be a measured, initial approach to **expanding practice authority and increasing healthcare access in our state**.

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