1. **What exactly is Optimal Team Practice?**

Optimal Team Practice occurs when PAs, physicians, and other medical professionals work together to provide quality care without burdensome administrative constraints. To support Optimal Team Practice, states should eliminate the requirement that each PA have an agreement with a specific physician, and end the disparities between PAs and other medical providers in professional regulation and payment arrangements.

2. **Why do PAs want to practice without a physician agreement?**

PAs are seeking flexibility to practice effectively in today’s healthcare environment.

When the PA profession was created more than 50 years ago, most PAs and physicians worked together in a solo or small private practice. Today, many physicians and PAs work in group practices or hospital settings where laws that require PA-physician agreements interfere with their ability to make practice-level decisions about patient care teams. When a PA isn’t tethered to a specific physician by a rigid agreement, PA employers (health systems, hospitals, and group practices) can be more flexible in determining healthcare teams. This will allow them to more effectively meet patient needs.

Eliminating the requirement for an agreement with a specific physician will make it easier for PAs to practice in medically underserved communities where there are not enough physicians (and in some cases, no physicians) to care for patients. PAs would also be able to provide volunteer medical services and respond to disasters and emergencies – situations in which physicians might not be available or willing to enter into agreements with PAs, but immediate care is needed.

3. **Why do PAs want to be eligible for direct payment from Medicare and insurers?**

Allowing PAs to be eligible for direct payment will eliminate an important disparity between PAs and other providers, particularly nurse practitioners (NPs). Unlike physicians and advanced practice registered nurses (APRNs), which include NPs, PAs are not eligible for direct payment from Medicare and nearly all commercial insurance payers. Most payers require that payment be made to a PA’s employer, which can unintentionally limit PA employment opportunities with staffing companies and in certain practice arrangements.

As the healthcare system continues its rapid transformation toward more innovative care models, PAs must have the same reimbursement flexibility enjoyed by other medical professionals, so they are not disadvantaged in the marketplace. Read more.

4. **Why do PAs want changes to the boards that regulate PA practice?**

Today, physicians are regulated by state medical boards composed of physicians. Nurses are regulated by boards made up of nurses. Only PAs are regulated by boards that often have no members actively
working in their own profession. This means the boards that regulate PA practice may lack knowledge of current PA practice or how rules and regulations may affect PA practice. This dearth of insight can lead to unnecessary restrictions and administrative burdens for PAs, physicians, and employers.

PAs deserve what physicians and nurses already have: regulatory boards with current knowledge about their profession. States can determine whether this is best accomplished by creating separate PA boards or by adding PAs and physicians who work with PAs to medical or healing arts boards. Read more.

5. Why are these changes good for patients?

Numerous studies have shown that PAs provide high-quality patient care and bring value to patients and PA employers. Currently, the retirement or sudden relocation, disability, or death of a physician with whom a PA has an agreement can mean the PA can no longer provide healthcare services to patients, even if the PA has been their primary care provider. Ultimately, when state laws and regulations remove the requirement for a PA/physician agreement, patients will have greater access to care, especially for medically underserved populations and patients in rural areas.

6. Why are these changes good for healthcare employers?

When PAs aren’t tethered to a specific physician by rigid agreements, their employers can be more flexible in creating healthcare teams, allowing them to more effectively meet patient needs and reduce provider burnout. Ending the agreement also removes physician liability for the care that PAs provide when physicians are not involved, and reduces physician and employer risk of disciplinary action for administrative reasons. Also, allowing PAs to receive payments directly will expand the number of available providers through the use of healthcare staffing companies and other business arrangements that require PAs to reassign insurance payments.

7. Why are these changes good for physicians?

Physicians will benefit from these changes in many ways. First, the elimination of agreements with PAs would mean that physicians will no longer be responsible for care provided by the PA when the physician is not involved. This could substantially reduce physician exposure to liability. Second, healthcare teams could be determined on a case-by-case basis at the practice level, allowing physicians to work with different PAs on different cases. Third, it would allow physicians to work with PAs more easily when they are employed in hospitals, health systems, and other corporate structures that use staffing companies. Currently, PAs are often prevented from participating in these staffing arrangements since, unlike NPs, they are not eligible for direct payment, and, therefore, cannot reassign their insurance reimbursements to the staffing company.

8. Are PAs ready to practice without physician agreements?

Absolutely. PA practice has been extensively studied and evaluated and PAs have been found to provide high-quality patient care. Even under existing administratively burdensome laws and regulations, many – if not most – PAs have their own panels of patients and often serve as a patient’s primary healthcare provider. State laws and regulations have simply not kept pace with the changes in the healthcare marketplace or the changing needs of patients and PA employers.
Whether a PA is highly experienced, a new graduate, or changing the specialty area in which they work, they would continue to practice in teams with physicians, and their scope of practice would be determined at the practice level. PAs will still be legally and ethically obligated to collaborate and consult with physicians, and make referrals based on the patient’s condition, the standard of care, and the PA’s education and experience. If they don’t, that PA will be subject to disciplinary action by the state medical board, just as any other medical provider would be.

Under Optimal Team Practice, a newly licensed PA would be able to report to or be supervised by a physician, a senior PA, or a chief PA rather than having an agreement with a specific physician. Every PA and PA employer will continue to be responsible for assuring that there is adequate access to consultation and back-up. Removing the requirement for a PA to have an agreement with a specific physician does not diminish those responsibilities.

9. Is Optimal Team Practice the same as Independent Practice or Full Practice Authority sought by NPs?

The PA profession’s commitment to team practice is powerful. The PA and physician who work together get to keep all the benefits of the team, without the legal risks and administrative burdens that agreements entail. In addition, employers will have access to a wider range of providers, and won’t have to file unnecessary paperwork. Everyone wins.

The reality is that, in today’s healthcare environment, there is no such thing as “independent practice.” Gone are the days of the solo practitioner, working completely alone. Just like physicians, PAs will continue to collaborate with, consult with, and refer patients to other healthcare providers whenever the patient’s condition falls outside of their education, training, and experience.

10. Will federal laws and regulations also require changes?

Medicare policy says: “State law or regulation governing a PA’s scope of practice in the State where the services are performed applies.” However, the current Medicare statute uses the word “supervision” to describe how physicians work with PAs. Medicare rules must also change as state laws describing team practice continue to evolve, moving away from the word and concept of “supervision.” AAPA is advocating for these changes and encouraging the Centers for Medicare and Medicaid Services to update its guidelines and regulations to reflect this new model.