WAPA Communications Guide and Law Modernization FAQ

April 2018

The PA Abbreviation[1]

From AAPA: Use "PA" as the title of the profession in all copy, not "physician assistant." We do not use "physician assistant" any longer to refer to the profession as the name does not adequately depict the medical services PAs provide to patients every day. If you must spell it out to aid in external audience awareness, only use "physician assistant" once in parentheses after the first PA reference, i.e., PA (physician assistant). Use PA for all subsequent references.

The PA Honorific[1]

To promote uniformity of address in clinical and other settings, use PA as the honorific before the person's name, i.e., PA Pam Smith or PA Smith. Encourage the adoption of PA [surname] as the recommended address for PAs among staff and external audiences, unless a more suitable formal address is appropriate, such as military rank or academic role.

What are PAs?

PAs are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider. PAs are versatile and collaborative. They practice in every medical setting and specialty, improving healthcare access and quality.

How do PAs Work?[1]

PAs' scope of practice is determined by their education and experience. Scope of practice is also subject to state laws and facility policy. In optimal settings, PAs practice at the top of their education, training and experience, and the scope is determined at the practice level. • PAs practice medicine in teams with physicians and other healthcare professionals.

What are the PAs of Wisconsin Looking for with PA Law Modernization?

PAs want to reaffirm the collaborative relationship with physician partners which has been in place since the profession's inception. We want to insure that the way this relationship is codified in legislation will allow it to remain sustainable in today's changing healthcare marketplace. In short, we want what other medical professions already enjoy in the State: the right to govern our profession, to have our scope defined by our own training/education/practice environment, the ability to take accountability for what we do, and the right to bill for our services. PAs want to eliminate unnecessary administrative burdens that hinder access to care for a greater number of Wisconsinites and have not been shown to improve patient safety. And we want to be authorized to use our extensive training to give back to Wisconsin in volunteer and disaster situations.

Is OTP/MSL/PA Law Modernization Independent Practice?
NO! And thanks for asking! Alphabet Soup + PA Law Modernization is actually about TEAM practice—not independent practice. We are simply seeking the ability for all PAs to practice without the legal requirement to enter into an agreement with a SPECIFIC physician. We would like the relationship between the physician and PA to be defined at the PRACTICE level rather than the State level so that individual Hospitals and Clinics are able to optimize the use of PAs depending on their practice environment. PAs, like all other medical professionals in the state of Wisconsin, are held to professional and ethical standards by state regulatory authorities—under PA Law Modernization PAs will still be legally and ethically obligated to collaborate with, consult with, and refer patients to physicians based on the patient's condition, standard of care, and the PA's education/experience/training. If not, the PA will be subject to disciplinary action by the State Medical Board just as any other medical provider would be. [2]

If implemented, do these changes allow PAs to open their own practices? [2]
PAs can own practices in many states today. AAPA policy has long supported a PA's ability to participate in practice ownership, just like other health professions. Under the Optimal Team Practice framework, PAs who are practice owners will still be legally and ethically obligated to collaborate with, consult with and refer patients to physicians when indicated.

How will this new policy benefit patients? [2]
Numerous studies have shown that PAs provide high-quality patient care and are medical providers who bring value to patients and healthcare systems. When these new policies are incorporated into state laws access to care will be expanded. This is especially true for medically underserved populations and patients in rural areas, where the sudden death, disability, or retirement of a physician with whom a PA has an agreement can mean the PA can no longer practice. Further, it is expected PA licensing will be expedited, and that PAs will have increased ability to provide volunteer medical services and respond to disasters and emergencies. In addition, the elimination of the requirement to have an agreement with a specific physician will enable physicians to focus on patient care, rather than filling out unnecessary paperwork.

Will this change how PAs work with physicians? [2]
PA law modernization will not change how PAs and physicians practice together. However, it will enable them to care for patients without the unnecessary administrative burdens and without physician liability for PA provided care. The PA role is well established – no change is required or anticipated. PAs will continue to consult, collaborate with, and refer patients to physicians just as they do now.

What should PAs share with physicians about the policy changes? [2]
PAs can share with physicians that these changes are good for physicians, good for patients, and good for PAs. More physician and PA time will be spent on activities that enhance patient care. Physicians can enjoy the benefits of team practice without the regulatory burden and liability.

Will the legislative change how PAs participate in the Patient and Family Compensation Fund?
No. Under the new legislation PA employers would still be responsible for the PAs care and their participation in the fund.

Why does the policy include a recommendation regarding the state board that regulates PAs?[2]
The agency or board charged with regulating PA practice varies from state-to-state, with the most common model being PA regulation by a medical board.

Physicians and nurses are assured that their regulatory boards have current knowledge of their profession, but PAs have no such assurance. The typical state medical board that regulates PAs is made up of a majority of physicians, who may not have current knowledge of PA practice.
PAs should be regulated by PA boards, or by medical or healing arts boards that have PAs and physicians who practice with PAs as full voting members.

Why is it important for PAs to have the option to receive direct payment?[2]
PAs are the only health professionals who bill Medicare that are not entitled to direct reimbursement. Medicare allows physicians, advanced practice registered nurses (APRNs), and other health professionals who bill Medicare to receive payment directly. Nearly all third-party payers reimburse for medical services and procedures provided by PAs. However, most payers require that payment be made to the PA's employer, which can unintentionally limit PA employment opportunities with staffing companies and certain practice arrangements.

Because PAs can't receive reimbursement directly, they can't re-assign their reimbursement in the same manner as physicians and APRNs. Even with direct reimbursement, most PAs will have their reimbursement assigned to their employer. As the healthcare system continues its rapid transformation toward more innovative care models, PAs must have the same reimbursement flexibility as other health professionals in order to maximize PA practice.

Will Medicare reimbursement be an issue if states use a term other than "supervision" to define the PA-physician relationship?[2]
Medicare policy says that "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 define a PA's professional relationship with a physician. As PA state laws describing that professional relationship continue to evolve, moving away from the word and concept of "supervision," Medicare rules must also change. AAPA is advocating for these changes and encouraging the Centers for Medicare and Medicaid Services to embrace state law changes that reflect a new, more efficient model. In the 5 states that currently use the term collaboration reimbursement has not been an issue.

Is Wisconsin the only State updating its practice laws?
No! In the 2017 legislative session, lawmakers in more than 20 states introduced legislation similar to WAPA's proposed bill. Wisconsin is actually behind the times.

Last year, Illinois, New Mexico and West Virginia updated their state laws to include PA-physician collaboration. Alaska has used "collaboration" since the 1980s. PAs in Michigan now practice with a "participating physician," which is analogous to collaborative practice.

In 2016, Florida and Maine updated their law to allow full prescriptive authority for PAs. A total of 43 states have full prescriptive authority for PAs.

Also in 2016, Minnesota removed the state's physician-to-PA ratio requirement. North Carolina, New Jersey and South Dakota removed co-signature and/or on-site requirements for supervising physicians. New Jersey and Florida's 2016 legislation also allows scope of practice to be determined at the practice level. Determining the scope of practice at the practice level gives PAs and physicians the flexibility to customize clinical roles to best benefit patients, expand health care access, and utilize individual PAs' education and experience.

In December 2016, the Federal Trade Commission (FTC) submitted comments supporting the Iowa PA Board's proposed rule that defines supervision and specifies that a supervising physician need not be physically present for every task delegated to a PA. In contrast, Iowa's Board of Medicine had adopted a rule creating minimum standards for supervision including two mandatory face-to-face physician-PA meetings per year and chart reviews. The FTC's comments supported the PA Board's new proposed rule instead of the Board of Medicine's adopted rule, writing that the Board of Medicine's requirements could be costly and confusing to implement and could decrease health care access in Iowa. The FTC said Iowa should adopt the PA Board's rule that reduces unnecessary requirements and restrictions and gives individual practices flexibility without reducing quality of care.

In 2014, Minnesota, North Dakota, Ohio, Rhode Island, Tennessee, and Utah adopted regulations allowing PAs to treat opioid-related overdoses more easily.

Also in 2014, Connecticut, Kansas, Kentucky and West Virginia modernized PA practice regulations by increasing ratios, reducing chart co-signature requirements, and repealing other unnecessary requirements. The same year, Oregon passed legislation adding PAs to 75 statutes that reference "physician."

WAPA would like to see Wisconsin become the preeminent employer of PAs so that Wisconsin citizens can benefit from this uniquely flexible workforce and tax base while enjoying increased access to high quality healthcare.

What are the next steps?

WAPA is currently having conversations with stake holders across the State to gather input and develop legislative language. Our goal is to bring legislation with strong support from our partners to the Wisconsin Legislature in Spring of 2019. We are asking PAs of Wisconsin to spread the word on what we are trying to accomplish so that PAs, physicians, employers, and patients can support this legislation that will benefit them all.

Who can I contact for questions?

The WAPA Board is here for you: Info@WAPA.org. You can also visit WAPA.org for more information.

1: https://www.aapa.org/wp-content/uploads/2017/02/PA-Communications-Guide.pdf
2: https://www.aapa.org/wp-content/uploads/2018/01/Core-FAQ.pdf