

**INCREASING ACCESS TO CARE IN CALIFORNIA  
BY EXPANDING MID-LEVEL PRACTITIONER SCOPE OF PRACTICE**

Ryan Davis, J.D., LL.M.

## I. INTRODUCTION

California, the most populous state in the nation with roughly forty million residents,<sup>1</sup> faces a shortage of health care providers that significantly threatens access to quality health care.<sup>2</sup> With an aging population<sup>3</sup> and declining numbers of physicians licensed by the state of California who provide 20 or more hours of weekly patient care, the state should consider all available strategies to ensure timely access to quality health care.<sup>4</sup> Unfortunately, California struggles to find the political will to address this challenge by following the national trend and permitting nurse practitioners (NPs) and physician assistants (PAs) to practice to the full extent of their training and education.

A nurse practitioner is defined by the California Code of Regulations as follows:

“. . .an advanced practice registered nurse who meets board education and certification requirements and possesses additional advanced practice educational preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary care, and/or acute care.”<sup>5</sup>

A physician assistant is described by the California Physician Assistant Board as follows:

“. . .a licensed and highly skilled health care professional. Physician assistants are academically and clinically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. Within the physician-[physician assistant] relationship, [physician assistants] make clinical decisions and provide a broad range of diagnostic, therapeutic, preventive, and health maintenance services.”<sup>6</sup>

Due to the licensure standards and scope of practice regulation of NPs and PAs being determined

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<sup>1</sup> *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2015 (NST-EST2015-01)*, U.S. Census Bureau, Population Division (Dec. 2015), <https://web.archive.org/web/20160130223507/http://www.census.gov/popest/data/state/totals/2015/index.html>.

<sup>2</sup> *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>3</sup> *Id.*, [“The supply of physicians in California may not be able to keep pace with growth in the state’s demand for medical care due to population growth and aging. As with the general population, the population of physicians is aging, and older physicians will likely continue to scale back on patient care activities.”]

<sup>4</sup> *Id.*

<sup>5</sup> Cal. Code Regs. tit. 16, §§ 1480-1486 (2019).

<sup>6</sup> *What Is A Physician Assistant*, Department of Consumer Affairs, Physician Assistant Board (2016), [https://www.pab.ca.gov/forms\\_pubs/what\\_is.shtml](https://www.pab.ca.gov/forms_pubs/what_is.shtml).

by the individual states, while training and education of NPs and PAs has consistent national standards,<sup>7</sup> the legal scopes of practice vary widely from state to state.<sup>8</sup>

The American Association of Nurse Practitioners (AANP) categorizes the varying state NP practice environments as “Full practice,” “Reduced practice,” and “Restricted practice.”<sup>9</sup> States with full practice authority permit NPs to “evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments - including prescribe medications - under the exclusive licensure authority of the state Board of Nursing.”<sup>10</sup> States with reduced practice authority are described by the AANP as reducing “the ability of NPs to engage in at least one element of NP practice. . . [requiring] a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or . . . [limiting] the setting of one or more elements of NP practice.”<sup>11</sup> Restricted practice is described as “[s]tate practice and licensure law . . . [restricting] the ability of NPs to engage in at least one element of NP practice, . . . [where the state] requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.”<sup>12</sup> The AANP encourages states to adopt full practice authority as states with restricted or reduced NP practice environments “are more closely associated with geographic health care disparities, higher chronic disease burden, primary care shortages, higher costs of care and lower standing on national health rankings.”<sup>13</sup> Conversely, the AANP states that the healthcare benefits of full practice authority include improved access to care, more efficient care as full NPs are able to provide services at the point of care, decreased costs associated with duplication of services and billing related to physician oversight, and greater provider options as patients are able to see the health care provider type of their choosing.<sup>14</sup> California is categorized by the AANP as a restricted NP scope of practice state as it requires physicians and NPs to enter into collaborative agreements, permits facility bylaws to determine the composition of medical staff, restricts NPs’ ability to make physical therapy referrals depending on the specifications of their collaborative agreements, and does not permit NPs to sign death certificates.<sup>15</sup>

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<sup>7</sup> See Loretta Colvin, M.S., A.P.R.N.-B.C., Ann Cartwright, M.P.A.S., P.A.-C., Nancy Collop, M.D., F.A.A.S.M., Neil Freedman, M.D., F.A.A.S.M., Don McLeod, P.A.-C., Terri E. Weaver, Ph.D., R.N., F.A.A.N., Ann E. Rogers, Ph.D., R.N., F.A.A.S.M. *Advanced Practice Registered Nurses and Physician Assistants in Sleep Centers and Clinics: A Survey of Current Roles and Educational Background*, Journal of Clinical Sleep Medicine, American Academy of Sleep Medicine (15 May 2014); “Both APRNs and PAs have national organizations that determine standards for competency and educational preparation. PAs have one examination, whereas, NPs take specialty-specific certification examinations. Both disciplines require maintenance of a clinical practice and the completion of continuing education and professional-development activities for recertification. PAs and APRNs are allowed to use physician-level credits to meet their continuing education requirements; although, APRNs may need a portion of their credits to be earned from approved nursing organizations at an advanced practice level.”

<sup>8</sup> *State Practice Environment*, American Association of Nurse Practitioners (Dec. 20, 2018), <https://www.aanp.org/advocacy/state/state-practice-environment>.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Issues at a Glance: Full Practice Authority: What is it?*, American Association of Nurse Practitioners (Oct. 24, 2018), <https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief>.

<sup>14</sup> *Id.*

<sup>15</sup> See *State Practice Environment*, American Association of Nurse Practitioners (Dec. 20, 2018), <https://www.aanp.org/advocacy/state/state-practice-environment>; *Nurse Practitioner Scope of Practice Laws*, Barton

Similar to their NP counterparts, PAs in California are also unable to provide care to the full extent of their training and education. The scope of practice laws regarding PAs in California have become less restrictive with recent statutory changes, but remain limited in comparison with current federal and American Academy of Physician Assistants (AAPA) recommendations.<sup>16</sup> The AAPA recommends six elements for a state regulatory scheme to adopt in order to allow PAs to “practice fully and efficiently while protecting public health and safety.”<sup>17</sup> The AAPA first recommends that states refer to PAs as “licensed” as opposed to “certified” or “registered” in order to reflect the high level of professional training and education that PAs receive, and ensure that PAs are properly included among the population of “licensed health professionals.”<sup>18</sup> Second, the AAPA recommends that states authorize PAs to prescribe all legal medications, including those medications identified as Schedule II-V controlled medications in order to ensure that patients who are seen by PAs have access to medications in a timely manner.<sup>19</sup> Third, the AAPA recommends that states permit local healthcare teams to identify the appropriate PA scope of practice instead of identifying specific lists of permissible PA services at the state level, where permissible PA services cannot be updated in an efficient manner. Fourth, PAs should be permitted to operate under adaptable collaboration agreements that do not identify specific proximity requirements or limitations on distances that physicians can be away from collaborating PAs, as modern telecommunication and telemedicine capabilities enable effective physician collaboration with PAs irrespective of the physical distance of a collaborating physician.<sup>20</sup> The fifth recommended element for a modern PA regulatory environment is the ability to determine physician collaboration co-signature requirements at the practice level, where standards for reviewing medical record entries are determined based upon the needs of the specific practice, and best suit the unique patient populations of the specific healthcare entity.<sup>21</sup> Finally, the AAPA recommends that the number of PAs a physician may collaborate with also be determined at the practice level; state laws and regulations identifying a specific number of PAs that a physician may collaborate with ignore the unique natures of different health care environments where certain settings may be appropriate for numerous PAs to collaborate with a single physician while in complex settings it may be appropriate for only one PA to collaborate with one physician.<sup>22</sup>

California’s regulatory environment relating to PAs currently meets five of the AAPA’s six recommended elements, but would benefit from adopting full practice authority. California presently uses the term “licensure,” allows PAs to prescribe medications including Schedule II-V controlled substances, permits local care teams to determine the scope of practice at the practice

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Associates (Aug. 28, 2019), <https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws>.

<sup>16</sup> See *Reforming America’s Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor (Dec. 3, 2018), <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>; *California’s Physician Assistants: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.

<sup>17</sup> *The Six Key Elements of a Modern PA Practice Act*, American Academy of Physician Assistants (Aug. 2018), <https://www.aapa.org/download/29342/>.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

level, and allows for adaptable physician collaboration agreements that permit PAs and their physician collaborators to determine how they best work together to provide care without regulatory proximity or similar requirements.<sup>23</sup> However, California continues to place limitations on the number of PAs a physician may supervise with a maximum ratio of four PAs per physician.<sup>24</sup> California recently eliminated its requirement for a physician to cosign a sampling of each PA's caseload.<sup>25</sup> Presently, California remains moderately restrictive with regard to its PA scope of practice laws in comparison with other states.<sup>26</sup>

Despite the growing need for additional healthcare providers and improved access to care, California persists in restricting the scope of practice environment for NPs and PAs. This paper explores the NP and PA scope of practice environment and advocates for expanding the roles of PAs and NPs in California's healthcare system. This paper will first discuss the provider shortage in California and corresponding disparities in access to care.<sup>27</sup> Next, the paper will explore the efficacy of care provided by NPs and PAs in comparison with care provided by physicians. Third, it will review the current legal landscape in California and efforts to expand the scopes of practice and use of NPs and PAs in California to address the growing difficulties in access to care. Finally, the paper will discuss the arguments for and against adopting full practice authority for NPs and PAs in California. The paper concludes by recommending that California amend existing law to expand the scopes of practice of NPs and PAs to the full extent of their respective training and education in accordance with national trends in order to increase access to quality healthcare and decrease costs.

## II. BACKGROUND

### a. Healthcare Workforce Shortage

As of 2015, California has roughly 124 employed clinicians<sup>28</sup> per 100,000 people while the United States has an average ratio of 143 employed clinicians per 100,000 people.<sup>29</sup> Due to the disparity in reimbursement between specialists and primary care physicians in the current health care market, new physicians are more likely to pursue specialty medicine than primary care, and California's primary care provider shortage is projected to grow unless action is taken to address

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<sup>23</sup> *California's Physician Assistants: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.

<sup>24</sup> *Id.*

<sup>25</sup> Senate Bill 697 (Ca. 2019).

<sup>26</sup> *California's Physician Assistants: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.

<sup>27</sup> *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>28</sup> In this paper, "clinicians" collectively refers to osteopathic physicians (DOs), allopathic physicians (MDs), nurse practitioners (NPs), and physician assistants (PAs).

<sup>29</sup> Janet Coffman, PhD, Igor Geyn, Kristine Himmerick, PhD, PA-C, *California's Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees*, Healthforce Center at UCSF (Feb. 16, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report\\_CA-Primary-Care-Workforce.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report_CA-Primary-Care-Workforce.pdf).

it.<sup>30</sup> Primary care providers are particularly crucial to patient access to care as they increase patient trust in providers, communication between patients and providers, the likelihood of receiving appropriate care, and decrease mortality rates.<sup>31</sup> As a geographically large state with diverse urban and rural populations, the distribution of primary care clinicians in California varies widely by location with urban counties averaging 74 primary care physicians per 100,000 people while rural counties average 55 primary care physicians per 100,000 people.<sup>32</sup>

The U.S. Department of Health and Human Services' Council on Graduate Medical Education's *Preparing Learners for Practice in a Managed Care Environment* established the recommended ratio of primary care physicians to population at “. . . 60 to 80 primary care physicians per 100,000 population (1,250 to 1,667 patients per primary care physician).”<sup>33</sup> While California's Greater Bay Area region, Sacramento Area region, and Orange region meet the Council on Graduate Medical Education's recommended ratios of 60 to 80 primary care physicians per 100,000 individuals, the vast majority of regions fall short, with some areas such as the San Joaquin Valley region and Inland Empire region with ratios as low as 45 and 39 primary care physicians per 100,000 individuals, respectively.<sup>34</sup>

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<sup>30</sup> Leiyu, Shi; The Impact of Primary Care: A Focused Review, *Scientifica* (Dec. 31, 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/>; Joanne Spetz, Janet Coffman, Igor Geyn, California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%20%20-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%20%20-%20Final_081517.pdf).

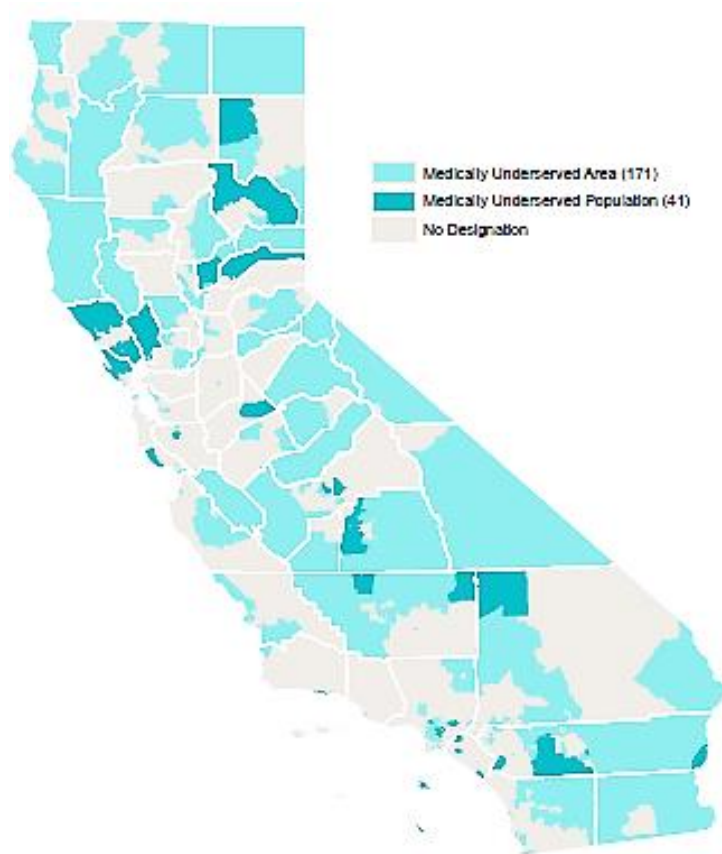
<sup>31</sup> *Access to Health Services*, Office of Disease Prevention and Health Promotion (Aug. 2, 2019), <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

<sup>32</sup> Weinberg, Micah PhD; Kallerman, Patrick, *Full Practice Authority for Nurse Practitioners Increases Access and Controls Cost*, Bay Area Council Economic Institute (Apr. 2014), <https://canpweb.org/canp/assets/File/Bay%20Area%20Council%20Report%204-30-14/BAC%20NP%20Full%20Report%204-30-14.pdf>.

<sup>33</sup> *Preparing Learners for Practice in a Managed Care Environment*, Council on Graduate Medical Education (Sept. 1997), <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/resource-papers/1997.pdf>.

<sup>34</sup> Janet Coffman, PhD, Igor Geyn, Kristine Himmerick, PhD, PA-C, *California's Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees*, Healthforce Center at UCSF (Feb. 16, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report\\_CA-Primary-Care-Workforce.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report_CA-Primary-Care-Workforce.pdf).

## II.a.1. Medically Underserved Areas and Populations<sup>35</sup>



Source: Accountability Report, University of California (2018).

Unfortunately, while the supply of primary care physicians is currently insufficient to meet California's needs, the situation is likely to deteriorate further as “. . . the numbers of new graduates [from medical school] will not be sufficient to replace all primary care physicians who are expected to retire within the next decade.”<sup>36</sup>

Specialty provider numbers in California fare little better with no or few physicians in some counties in certain specialties including endocrinology, psychiatry, pulmonary care, rheumatology, and geriatric medicine.<sup>37</sup> Nationally, the Association of American Medical Colleges predicts a shortfall of 21,100 to 55,200 primary care physicians and 24,800 to 65,800 non-primary care specialty physicians by 2032.<sup>38</sup> Physicians over the age of 60 report spending declining hours per

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<sup>35</sup> Accountability Report, University of California (2018), Workforce Development Division, 2018, <https://accountability.universityofcalifornia.edu/2018/chapters/chapter-11.html>.

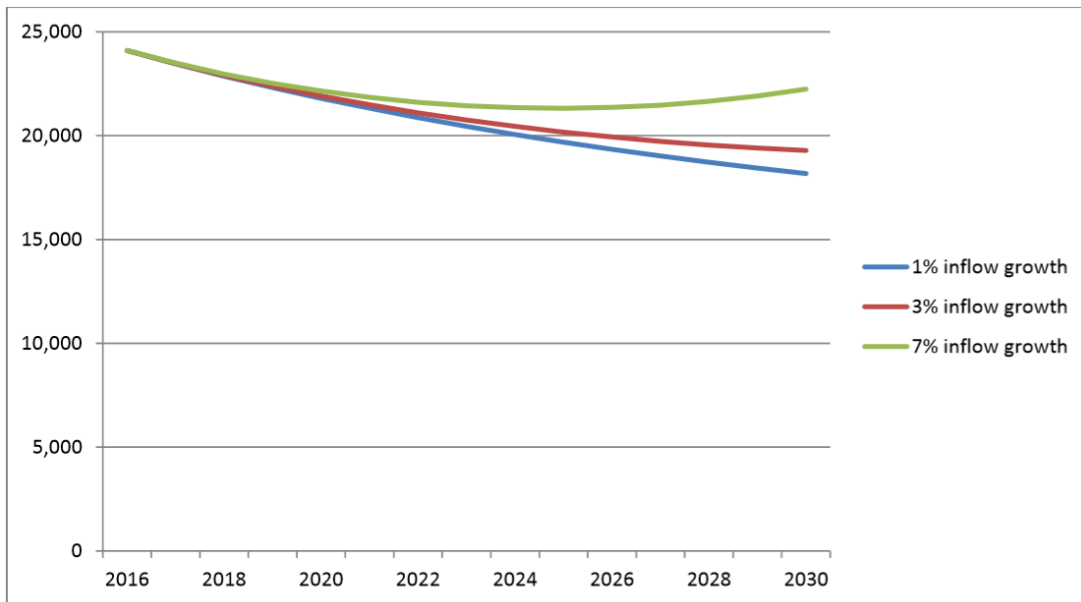
<sup>36</sup> *Id.*

<sup>37</sup> *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>38</sup> *2019 Update, The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, Association of American Medical Colleges (Apr. 2019), [https://aamc-](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-)

week on patient care and eight percent less actively provided patient care in 2015 than in 2013.<sup>39</sup> Less than half of physicians in all age groups provide 20 or more hours per week of patient care.<sup>40</sup> Importantly, over 36% of California’s physician population is over the age of 60, and there are insufficient numbers of new medical students to replace the physicians retiring and projected to retire over the coming years.<sup>41</sup>

**II.a.2. Forecasted Full-Time Equivalent Supply of Primary Care Physicians, California, 2016-2030<sup>42</sup>**



Source: California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF (Aug. 15, 2017).

294a69826650/2019\_update\_-\_the\_complexities\_of\_physician\_supply\_and\_demand\_-\_projections\_from\_2017-2032.pdf.

<sup>39</sup> *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>40</sup> *Id.*

<sup>41</sup> Janet Coffman, PhD, Igor Geyn, Kristine Himmerick, PhD, PA-C, *California’s Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees*, Healthforce Center at UCSF (Feb. 16, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report\\_CA-Primary-Care-Workforce.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report_CA-Primary-Care-Workforce.pdf).

<sup>42</sup> Joanne Spetz, Janet Coffman, Igor Geyn, *California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%202020-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%202020-%20Final_081517.pdf), [“Forecasts of the future supply of primary care physicians in California are presented in Figure [II.a.2] for the three scenarios of 1%, 3%, and 7% annual growth in new licenses. In the 1% growth model, there would be 22,538 licensed physicians in primary care specialties in 2030, resulting in 18,178 FTEs providing primary care. In the 3% growth model 23,771 physicians in primary care specialties would produce 19,289 FTEs, and in the 7% growth model 27,039 physicians would provide 22,243 FTEs in primary care in 2030. All three models project a decline in primary care physician FTEs between 2016 and 2030; forecasted growth ranges from -24.6% (1% model) to 7.7% (7% model).”]



The lack of physicians has resulted in deficiencies in access to care; the Kaiser Family Foundation reported poll results in January of 2019 indicating:

“More than four in 10 Californians (44%) say they or someone in their household delayed or skipped medical care in the past year because of the cost . . . [and nearly] a quarter (23%) of Californians say they had to wait longer than they thought reasonable to get an appointment for medical care in the past 12 months. This includes one in three (33%) Medi-Cal enrollees. . . about a third say their communities don’t have enough primary care doctors (35%) or specialists (33%) to serve local residents, and a quarter say they don’t have enough hospitals (27%).”<sup>43</sup>

The California Future Health Workforce Commission reports that “Seven million Californians. . . live in Health Professional Shortage Areas – a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers,” and that “[a]ccess to care is a major obstacle for those suffering from mental illness or drug and alcohol issues.”<sup>44</sup> California’s growing elderly population and its increasing healthcare needs<sup>45</sup> combined with its rapidly retiring physician workforce<sup>46</sup> is likely to exacerbate current access to care challenges. The California Future Health Workforce Commission goes on to report that over one third of the doctors in California are over the age of 55, and many are already partially retired, while four million new Californians will turn 65 over the next ten years, and aging Baby Boomers “are more likely to be single, childless, and live alone or in poverty than previous generations, leading to traditionally worse health outcomes.”<sup>47</sup> While the average Californian faces challenges regarding access to health care due to the physician shortages, California’s most vulnerable populations are disproportionately affected by the current health care landscape.

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<sup>43</sup> *California Poll: Access to Mental Health Care, Insurance Coverage, and Affordability Rank among Californians’ Top Health Care Priorities for the New Governor and Legislature*, Henry J Kaiser Family Foundation (Jan. 24, 2019), [kff.org/other/press-release/california-poll-access-to-mental-health-care-insurance-coverage-affordability-rank-among-californians-top-health-care-priorities-for-new-governor-legislature/](https://kff.org/other/press-release/california-poll-access-to-mental-health-care-insurance-coverage-affordability-rank-among-californians-top-health-care-priorities-for-new-governor-legislature/).

<sup>44</sup> *Meeting the Demand for Health: Fact Sheet on California’s Looming Workforce Crisis*, California Future Health Workforce Commission (Feb. 4, 2019), <https://futurehealthworkforce.org/2019/02/04/ca-looming-workforce-crisis/>.

<sup>45</sup> Berhanu Alemayehu, Kenneth Warner, *The Lifetime Distribution of Health Care Costs*, Health Research & Educational Trust (Jun. 2004), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361028/#b4>, [“[T]he typical American spends more than \$300,000 over a lifetime. . . The lifecycle timing of the bulk of those expenditures gives special pause, in light of the essential demographic phenomenon of our time: the aging of the population. We find that almost 60 percent—\$188,658—of the total lifetime cost of survivors is spent after age 65 . . . Especially striking is our finding that well over one-third of the average 85-year-old’s expenditures lies in that person’s future.”]

<sup>46</sup> Joanne Spetz, Janet Coffman, Igor Geyn, *California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%202%20-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%202%20-%20Final_081517.pdf). [“32% of California’s physicians are over 60 years old, and the number of new licensees per year is not large enough to replace these physicians as they retire.”]

<sup>47</sup> *Meeting the Demand for Health: Fact Sheet on California’s Looming Workforce Crisis*, California Future Health Workforce Commission (Feb. 4, 2019), <https://futurehealthworkforce.org/2019/02/04/ca-looming-workforce-crisis/>.

## b. California's Access to Care Disparities

Immigrants, minorities, the poor, the elderly, and less educated populations are impacted by California's access to care problem to a higher degree than the regular population. Frequently a person may fall into more than one category of individuals that are affected by access to care disparities.<sup>48</sup> The Kaiser Family Foundation reports that “[a]mong the nonelderly population, 23% of lawfully present immigrants and more than four in ten (45%) undocumented immigrants are uninsured compared to less than one in ten (8%) citizens. Moreover, among citizen children, those with at least one non-citizen parent are nearly twice as likely to be uninsured as those with citizen parents (7% vs. 4%).”<sup>49</sup> Immigrants make up roughly 27% of California's population, and those who do have insurance are more likely to use public insurance than U.S. born citizens.<sup>50</sup> While public coverage provides access to care for certain segments of the population, access is limited when compared to that afforded to those covered by private insurance, as physicians are less likely to accept new Medicare and Medicaid patients than they are to accept private insurance.<sup>51</sup>

A 2009 study funded by the Centers for Medicare & Medicaid Services and performed by California State University, Fresno's Central Valley Health Policy Institute, *The Effectiveness of a Promotora Health Education Model for Improving Latino Health Care Access in California's Central Valley*, reviewed access to care barriers for California's Central Valley immigrants, both documented and undocumented, and identified barriers to access to care as being both systemic and based in personal attitudes of immigrants as well as caregivers.<sup>52</sup> “Personal Attitude Barriers” to care were identified by the Central Valley Health Policy Institute as immigrants' lack of trust in health care providers, as well as a reluctance to follow up with immigrant patients among health care providers when compared with citizen patients.<sup>53</sup> “System Barriers” to immigrant access to care include: 1) health insurance eligibility barriers; 2) language and communication barriers with health care staff who do not understand immigrant languages; and 3) poor service, that consists of a complicated health delivery system that intimidates immigrants, case workers who are rude to immigrants, and a lack of understanding on the part of the physicians who are willing to take immigrants as patients.<sup>54</sup> When systemic and personal attitude barriers that immigrants struggle with are coupled with California's ongoing provider shortage, physician reluctance to accept

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<sup>48</sup> Shawna Nesbitt, Rigo Estevan Palomarez, *Review: Increasing Awareness and Education on Health Disparities for Health Care Providers*, Ethnicity & Disease Inc. (Apr. 21, 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4836898/>.

<sup>49</sup> *Health Coverage of Immigrants*, Henry Kaiser Family Foundation (Feb. 2019), <http://files.kff.org/attachment/Fact-Sheet-Health-Coverage-for-Immigrants>.

<sup>50</sup> *Health Care Access for California's Immigrants*, Public Policy Institute of California (May 22, 2019), <https://www.ppic.org/blog/health-care-access-for-californias-immigrants/>.

<sup>51</sup> *Primary Care Physicians Accepting Medicare: A Snapshot*, Kaiser Family Foundation (Oct. 30, 2015), <https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/>.

<sup>52</sup> *The Effectiveness of a Promotora Health Education Model for Improving Latino Health Care Access in California's Central Valley*, California State University, Fresno (2009), <https://www.fresnostate.edu/chhs/cvhpi/documents/cms-final-report.pdf>.

<sup>53</sup> *Id.*

<sup>54</sup> *The Effectiveness of a Promotora Health Education Model for Improving Latino Health Care Access in California's Central Valley*, California State University, Fresno (2009), <https://www.fresnostate.edu/chhs/cvhpi/documents/cms-final-report.pdf>.

publicly insured patients, and a statistically high rate of uninsurance,<sup>55</sup> immigrant access to care suffers, particularly among the undocumented.

Minorities as a whole suffer from disparities in access, quality, and cost of medical care.<sup>56</sup> The Institute of Medicine of the National Academies' report, *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*, states that minorities as a whole, like immigrants, and who frequently are immigrants,<sup>57</sup> face a variety of access to care barriers.<sup>58</sup> Minorities are less likely to have health insurance, and more likely to utilize publicly funded insurance.<sup>59</sup> Minorities are more likely to suffer high co-payments than their white counterparts, and "may face additional barriers to care due to other socioeconomic factors such as . . . geographic factors (for example, the relative scarcity of healthcare providers and healthcare facilities in minority communities), and insufficient transportation."<sup>60</sup> The Institute of Medicine goes on to state that such ". . . access-related factors are likely the most significant barriers to equitable care, and must be addressed as an important first step toward eliminating healthcare disparities."<sup>61</sup> Unfortunately, access-related challenges that minorities in California must overcome are further aggravated by discrepancies in the quality of care provided due to ". . . complex and multifactorial etiology for disparate treatment decisions and outcomes."<sup>62</sup> Included among various access challenges are potential biases and discrimination throughout the healthcare system that intensify the difficulties posed by ". . . the often confusing and challenging nature of the healthcare system and its legal and regulatory environment."<sup>63</sup> Such access challenges affect minority children and adults alike.<sup>64</sup>

The elderly also suffer from unique access to care challenges, and California is predicted to see a rapid expansion of its elderly population that will put additional strain on the health care

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<sup>55</sup> See Tara L. Becker, PhD; Susan H. Babey, PhD; and Shana A. Charles, PhD, MPP, *Still Left Behind: Health Insurance Coverage and Access to Care Among Latinos in California*, UCLA Center For Health Policy Research (Aug. 2019), <https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/LatinoInsurance-policybrief-aug2019.pdf>.

<sup>56</sup> Wayne J. Riley, MD, MPH, MBA, MACP, *Health Disparities: Gaps in Access, Quality and Affordability of Medical Care*, The American Clinical and Climatological Association (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/>; See also *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine of the National Academies (2003), <https://www.nap.edu/catalog/10260/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>.

<sup>57</sup> See Judy Lin, Adria Watson, *California migration: The story of 40 million*, Calmatters (Jul. 29, 2019), <https://calmatters.org/explainers/california-population-migration-census-demographics-immigration/>.

<sup>58</sup> *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine of the National Academies (2003), <https://www.nap.edu/catalog/10260/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Wayne J. Riley, MD, MPH, MBA, MACP, *Health Disparities: Gaps in Access, Quality and Affordability of Medical Care*, The American Clinical and Climatological Association (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/>.

<sup>63</sup> *Id.*

<sup>64</sup> Sweetie Baidhya, Jacquelynn Meeks, *Racial/Ethnic Disparities Related to Health Insurance Coverage, Access to Care and Ease in Health Care Services among Children in 2012 CCHAPS Data*, University of Nevada, Las Vegas, Center for Health Disparities Research (2012), <https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1273&context=jhdrp>.

system as average individual health care utilization increases.<sup>65</sup> California's senior population is forecast to roughly double between 2015 and 2030.<sup>66</sup> California is projected to have over one million seniors requiring assistance with self-care by 2030, representing an 88 percent increase over 2012 population levels.<sup>67</sup> Distinct access to care challenges faced by the elderly include both psychological and physical barriers.<sup>68</sup> Elderly individuals report doctors not being responsive to their concerns, medical bills, transportation problems, fear for personal safety from being on the streets, fear of discovery of serious illnesses, and fear of unneeded tests as primary reasons for decreased access to healthcare.<sup>69</sup> High out-of-pocket costs, lack of access to prescription drugs, and patient distrust and dissatisfaction with providers contribute to ongoing perceived unmet healthcare needs and delays in healthcare among the elderly, particularly among those dependent upon public insurance.<sup>70</sup> As California's elderly population grows the number of individuals on public insurance will continue to expand, and the overall physician per patient ratio will continue to decline; access to care challenges experienced by the publicly insured vulnerable elderly population are likely to worsen as doctors favor accepting patients with private insurance.<sup>71</sup>

Individuals with lower incomes or less than a high school education also suffer from unique access to care challenges in comparison to those with a higher income or some college education.<sup>72</sup> California has one of the highest poverty rates in the country at roughly 19%.<sup>73</sup> Californians with low incomes report a number of challenges to accessing health care. Affordability of health insurance and ability to pay medical bills are leading concerns among Californians with low incomes.<sup>74</sup> “[L]ow income Californians are twice as likely as those with higher incomes to say . . . [Medi-Cal] is important to them and their families.”<sup>75</sup> As income status and education are strongly correlated,<sup>76</sup> access to care challenges experienced by low income Californians frequently overlap with challenges experienced by individuals who have less education. The Agency for Healthcare

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<sup>65</sup> See Laurel Beck, Hans Johnson, *Planning for California's Growing Senior Population*, Public Policy Institute of California (Aug. 2015), <https://www.ppic.org/publication/planning-for-californias-growing-senior-population/>.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> Annette L. Fitzpatrick, PhD, MA, Neil R. Powe, MD, MPH, MBA, Lawton S. Cooper, MD, MPH, Diane G. Ives, MPH, John A. Robbins, MD, *Barriers to Health Care Access Among the Elderly and Who Perceives Them*, *American Journal of Public Health* (Oct. 2004), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448535/>.

<sup>69</sup> *Id.*

<sup>70</sup> Tetsuji Yamada, Chia-Ching Chen, Chiyoe Murata, Hiroshi Hirai, Toshiyuki Ojima, Katsunori Kondo, Joseph R. Harris, *Access Disparity and Health Inequality of the Elderly: Unmet Needs and Delayed Healthcare*, *International Journal of Environmental Research and Public Health* (Feb. 2015 ), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4344691/>.

<sup>71</sup> *Primary Care Physicians Accepting Medicare: A Snapshot*, Kaiser Family Foundation (Oct. 30, 2015), <https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/>.

<sup>72</sup> *Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports*, Agency for Healthcare Research and Quality (Apr. 2011), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqrdr10/minority.pdf>.

<sup>73</sup> Liz Hamel, Lunna Lopes, Bryan Wu, Mollyann Brodie, Lisa Aliferis, Kristof Stremikis, Eric Antebi, *Low-Income Californians and Health Care: Selected Findings from the Kaiser Family Foundation/California Health Care Foundation California Health Policy Survey*, Henry J Kaiser Family Foundation, California Health Care Foundation (Jun. 2019), <https://www.chcf.org/wp-content/uploads/2019/06/LowIncomeCaliforniansHealthCare.pdf>.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Unemployment rates and earnings by educational attainment*, United States Department of Labor, Bureau of Labor Statistics (Sep. 4, 2019), <https://www.bls.gov/emp/chart-unemployment-earnings-education.htm>.

Research and Quality reported in 2008 that “The percentage of people with a specific source of ongoing care was lower for people with less than a high school education and for people with a high school education than for people with at least some college education (74.2% and 82.2%, respectively, compared with 88.9%).”<sup>77</sup> Access to care challenges among low income and less educated individuals are exasperated by declining numbers of primary care physicians who are critical to quality access to care;<sup>78</sup> the Healthforce Center at the University of California, San Francisco, projects that the supply of primary care MDs will decrease between eight percent and 25% by 2030 due to insufficient numbers of primary care MDs completing residency programs.<sup>79</sup> Nonfinancial barriers to accessing medical care affect low income Californians through longer reported wait times for appointments, a distinct lack of mental health providers, and roughly four in ten report that “. . . their community lacks enough primary care doctors and specialists to meet the needs of residents.”<sup>80</sup> In 2008, the national percentage of people with “a specific source of ongoing care” was significantly lower for low income individuals than for high income individuals.<sup>81</sup> Unfortunately it is the vulnerable segments of California’s population who suffer the most from California’s provider shortage, and without action, the situation is unlikely to improve.

### c. Health Coverage Expansion and the Workforce Shortage

Changes in the health care market are likely to continue to aggravate the deficiencies in access to care caused by the current provider shortage. Implementation of the Affordable Care Act (ACA) in 2014 resulted in a dramatic increase of insured Californians with uninsured rates dropping between 5.4 and 6.9 percent between 2013 and 2015,<sup>82</sup> but the provider supply was left largely ignored by the ACA with only modest increases to graduate medical education, health center, and

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<sup>77</sup> *Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports*, Agency for Healthcare Research and Quality (Apr. 2011), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqrdr10/minority.pdf>.

<sup>78</sup> *Access to Health Services*, Office of Disease Prevention and Health Promotion (Aug. 2, 2019), <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>; Joanne Spetz, Janet Coffman, Igor Geyn, California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%202%20-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%202%20-%20Final_081517.pdf).

<sup>79</sup> Joanne Spetz, Janet Coffman, Igor Geyn, *California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees*, 2016-2030, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%202%20-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%202%20-%20Final_081517.pdf).

<sup>80</sup> Liz Hamel, Lunna Lopes, Bryan Wu, Mollyann Brodie, Lisa Aliferis, Kristof Stremikis, Eric Antebi, *Low-Income Californians and Health Care: Selected Findings from the Kaiser Family Foundation/California Health Care Foundation California Health Policy Survey*, Henry J Kaiser Family Foundation, California Health Care Foundation (Jun. 2019), <https://www.chcf.org/wp-content/uploads/2019/06/LowIncomeCaliforniansHealthCare.pdf>.

<sup>81</sup> *Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports*, Agency for Healthcare Research and Quality (Apr. 2011), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqrdr10/minority.pdf>.

<sup>82</sup> Shana Alex Charles, Tara Becker, *Growth in Medi-Cal in 2015 Fueled Unprecedented Drop in California’s Uninsured Rate*, UCLA Center for Health Policy Research (Dec. 2016), <http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/medical2015-factsheet-dec2016.pdf>.

National Health Service Corps funding.<sup>83</sup> The ACA addressed access to care issues temporarily by increasing Medicaid payment rates to Medicare fee levels for many primary care services in 2013 and 2014.<sup>84</sup> However, while many states continued the increased reimbursement rate in support of primary care services, California did not.<sup>85</sup>

The ACA dramatically increased the number of Californians on the Medi-Cal program, but it did not sufficiently address the reimbursement disparity between private insurance and public insurance so as to effectively encourage physicians to accept Medi-Cal patients at the same rate as patients with private insurance.<sup>86</sup> Californian physicians reported in 2015 that the leading reason for limiting their number of accepted Medi-Cal patients was the Medi-Cal reimbursement rate, followed by administrative difficulties, delays in Medi-Cal payment, Medi-Cal patient complexity, having a full practice, and Medi-Cal patient disruptiveness.<sup>87</sup>

Nationally, physicians have attempted to adapt to the increase in patients brought by the ACA through increased staff, expanding health care sites, and extending office hours.<sup>88</sup> Urgent care and retail clinic numbers grew, and payment and delivery reforms increased overall efficiency.<sup>89</sup> Despite local attempts to meet the increased provider demands brought by the ACA, provider capacity gaps that lead to access to care challenges persisted, and were exacerbated by the increased patient population.<sup>90</sup> Primary care in particular was stressed by the ACA's expansion of coverage.<sup>91</sup> While increasing overall health insurance coverage rates addresses one barrier to receiving care, if the state does not have enough health care providers willing to take individuals with public insurance, unmet and delayed health care needs will persist.

California's recently enacted Senate Bill 104 expanded eligibility for Medi-Cal, the state's low-income health insurance program, to all residents age 19 to 25 irrespective of immigration

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<sup>83</sup> 2019 Update, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, Association of American Medical Colleges (Apr. 2019), [https://aamc-black.global.ssl.fastly.net/production/media/filer\\_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019\\_update\\_-\\_the\\_complexities\\_of\\_physician\\_supply\\_and\\_demand\\_-\\_projections\\_from\\_2017-2032.pdf](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf).

<sup>84</sup> Laura Snyder, Julia Paradise, Robin Rudowitz, *The ACA Primary Care Increase: State Plans for SFY 2015* (Oct. 28, 2014), <https://www.kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015/>.

<sup>85</sup> *Id.*

<sup>86</sup> *Physician Participation in Medi-Cal*, California Health Care Foundation (Jun. 2017), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-PhysicianParticipationMediCal2017.pdf>.

<sup>87</sup> *Id.*

<sup>88</sup> Jane B. Wishner, Rachel A. Burton, *How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?*, Urban Institute (Nov. 2017), [https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act\\_0.pdf](https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act_0.pdf).

<sup>89</sup> *Id.*

<sup>90</sup> Jane B. Wishner, Rachel A. Burton, *How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?*, Urban Institute (Nov. 2017), [https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act\\_0.pdf](https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act_0.pdf); See *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf> ["Although the future of health insurance remains unclear, coverage does not confer access without a health care workforce to provide care."]

<sup>91</sup> Jane B. Wishner, Rachel A. Burton, *How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?*, Urban Institute (Nov. 2017), [https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act\\_0.pdf](https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act_0.pdf).

status; however the bill does nothing to increase the current supply of providers beyond creating a commission to generally evaluate health care delivery in California.<sup>92</sup> While increasing health care coverage for individuals is a positive step and reduces a significant barrier to accessing health care, Senate Bill 104 is similar to the ACA in that it fails to address the growing shortage of health care providers while increasing the insured population which only exacerbates existing provider shortages and obstacles to accessing care. Fortunately, California has an opportunity to address the growing provider shortage and current access to care deficiencies by embracing feasible recommended strategies that include increasing the number of available providers.<sup>93</sup>

### III. USING MID-LEVEL PRACTITIONERS TO MEET PROVIDER SHORTAGES

One strategy to safely and effectively address the shortage of physicians in California is to expand the use of mid-level practitioners.<sup>94</sup> “Mid-level Practitioners” as discussed in this paper include PAs and NPs. The U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) projects that by 2025, while the demand for primary care physicians in California will continue to well outpace the supply, the state is highly likely to have a surplus of Mid-level Practitioners that can be used to “. . . augment and expand physician capacity in many care settings.”<sup>95</sup>

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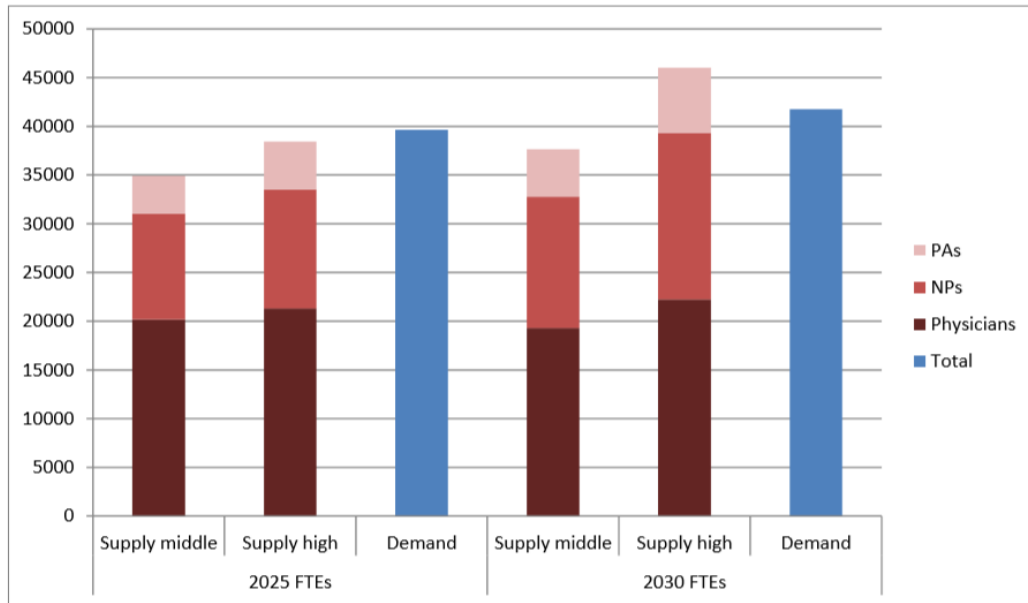
<sup>92</sup> Health, Senate Bill 104 (2019).

<sup>93</sup> See *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>94</sup> See *2019 Update, The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, Association of American Medical Colleges (Apr. 2019), [https://aamc-black.global.ssl.fastly.net/production/media/filer\\_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019\\_update\\_-\\_the\\_complexities\\_of\\_physician\\_supply\\_and\\_demand\\_-\\_projections\\_from\\_2017-2032.pdf](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf). “[P]rojected demand [for providers] exceeds supply under all scenarios modeled except the scenario that reflects the largest assumptions for the degree to which increased supply of NPs and PAs in primary care will offset demand for physicians. This “APRN/PA High” demand scenario assumes (1) that the number of new NPs and PAs trained each year will continue growing at high rates, and the proportion of new entrants choosing primary care will remain at recent levels; and (2) that NPs and PAs will offset demand for physicians at the rates modeled. The supply of PAs and APRNs is growing at about six times the rate of growth of demand for health care services, raising the question of how many PAs and APRNs the health care system needs. Employment remains strong for both new and experienced NPs and PAs, and there appears to be room for continued growth in supply. . .”]

<sup>95</sup> *National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025*, U.S. Department of Health and Human Services Administration, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis (Nov. 2016), <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf>.

### III.1. Forecasted Supply and Demand for Primary Care Clinicians Full-Time Equivalents, Statewide, 2025 and 2030<sup>96</sup>



Source: California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF (Aug. 15, 2017).

HRSA acknowledges that this would require a “reorganization of primary care and a redesign of service delivery” as well as a revision of the scope of practice laws that “. . . currently limit the services these practitioners can deliver.”<sup>97</sup> Being able to perform as much as 90% of the care provided by physicians, mid-level practitioners can assist with a variety of services including conducting exams, ordering and interpreting tests, developing treatment plans, providing preventive care, and taking medical histories.<sup>98</sup>

#### a. Development of Physician Assistant and Nurse Practitioner Occupations

The PA and NP occupations were developed in the mid-1960s to address physician shortages

<sup>96</sup> Joanne Spetz, Janet Coffman, Igor Geyn, *California’s Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*, Healthforce Center at UCSF (Aug. 15, 2017), [https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study\\_Rpt%20%20-%20Final\\_081517.pdf](https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%20%20-%20Final_081517.pdf), [“Forecasts of statewide primary care clinicians’ supply and demand are presented in Figure [III.1.] . . . [comparing] forecasts of FTEs in 2025 and . . . 2030. Demand forecasts are in blue and indicate total demand for primary care clinicians. . . The forecasts indicate that California faces a potential shortfall of primary care clinicians if growth in supply of physicians, NPs, and PAs is in the mid-range of the forecasts developed. . . If the highest supply forecasts are considered, there will be a small shortage of clinicians in 2025 and a small surplus in 2030.”]

<sup>97</sup> *Id.*

<sup>98</sup> *National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025*, U.S. Department of Health and Human Services Administration, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis (Nov. 2016),



and rising health care costs that were making health care largely inaccessible to a large number of Americans.<sup>99</sup> Similar to the challenges facing California today, American medicine in the 1960s suffered from health care access challenges and inequality.<sup>100</sup> The first NP program was developed at the University of Colorado in 1965 to increase the supply of primary care providers for rural and underserved urban areas; the program commenced in 1966.<sup>101</sup> Over the decades, over 200 NP training programs have developed nationally, and NPs have successfully helped to ensure the individuals have access to quality health care.<sup>102</sup>

Developed at almost the same time as Colorado's NP program, the first PA training program was established at Duke Hospital and saw the first class of physician assistants graduate in late 1967.<sup>103</sup> The PA program was initially based upon the military medical corps, with the intention that PAs would be able to fulfill the role of nurse or physician while requiring less training than traditional physicians.<sup>104</sup> Ultimately, the PA program successfully addressed physician shortages and extended the impact of physicians, enabling access to advanced healthcare services for low income clients and clients in community health centers.<sup>105</sup> The success of the PA program has led to the integration of the PA into the modern health care system as an important component of team-based care.<sup>106</sup> NPs and PAs have greatly improved the access to and quality of health care for millions of patients, and have successfully been used at increasing levels of responsibility to address physician shortages and access to care challenges for decades.<sup>107</sup>

#### b. Nurse Practitioner and Physician Assistant Full Practice Authority Benefits and Support

Studies indicate that mid-level practitioners are as effective at providing care as physicians despite receiving less education than their physician counterparts, and health outcomes improve with adoption of full practice authority for mid-level practitioners.<sup>108</sup> There is a strong correlation

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<https://bhwh.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf>.

<sup>99</sup> Scott Kohler, *The Development Of The Nurse Practitioner And Physician Assistant Professions: The Commonwealth Fund, Robert Wood Johnson Foundation, And Carnegie Corporation Of New York, 1965*, Duke Sanford Center for Strategic Philanthropy & Civil Society (2007), <https://cspsc.sanford.duke.edu/learning-resources/case-study-database/development-nurse-practitioner-and-physician-assistant>.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> James Cawley, MPH, PA-C, Roderick Hooker, PhD, PA-C, Donald Pedersen, PhD, PA-C, *Origins of the Physician Assistant Movement in the United States*, Department of Prevention and Community Health, School of Public Health and Health Services, The George Washington University (2012), [https://medicine.utah.edu/dfpm/physician-assistant-studies/program/files/pa\\_history\\_2011.pdf](https://medicine.utah.edu/dfpm/physician-assistant-studies/program/files/pa_history_2011.pdf).

<sup>107</sup> Scott Kohler, *The Development Of The Nurse Practitioner And Physician Assistant Professions: The Commonwealth Fund, Robert Wood Johnson Foundation, And Carnegie Corporation Of New York, 1965*, Duke Sanford Center for Strategic Philanthropy & Civil Society (2007), <https://cspsc.sanford.duke.edu/learning-resources/case-study-database/development-nurse-practitioner-and-physician-assistant>.

<sup>108</sup> See Gina M. Oliver, PhD, APRN, FNP-BC, CNE, Lila Pennington, DNP, APRN, FNP-BC, GNP-BC, Sara Reville, MSN, APRN, FNP-BC, Marilyn Rantz, PhD, RN, FAAN Marilyn Rantz, *Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients*, Nursing Outlook, Vol. 62, Iss. 6 (Dec. 2014), [https://www.nursingoutlook.org/article/S0029-6554\(14\)00150-X/pdf](https://www.nursingoutlook.org/article/S0029-6554(14)00150-X/pdf); See also Arifkhanova, Aziza, *The Impact of*

between adoption of full practice authority for NPs and a reduction in preventable hospitalization rates.<sup>109</sup> Moreover, research indicates that mid-level practitioners are less likely to “. . . have made malpractice payments or have been subject to an adverse action than . . . physicians.”<sup>110</sup> Californian NPs in particular are far more likely to provide primary care than California physicians as 58.8% of NPs provide primary care in their principal NP position and 51.2% spend half their time or more providing primary care while only 16.7% of physicians are in primary care specialties.<sup>111</sup> California NPs are also more likely than physicians to see and take new Medi-Cal and uninsured patients and work in community health centers.<sup>112</sup> “In states that have granted full practice authority to NPs, the numbers of NPs providing care for underserved populations increases.”<sup>113</sup> States that have granted full practice authority to NPs have also realized greater access to and use of primary care services, and fewer avoidable hospitalizations, readmissions, and emergency department visits.<sup>114</sup>

The California Health Care Foundation and Healthforce Center at UCSF reports that among states that have implemented NP full practice authority, over the following two years,

“The probability that an adult has had a checkup in the last year increases by 3.3 percentage points. There is a 3.6% increase in the probability of having a usual source of care. There is a 4.8 percentage point increase in the probability of being able to “always” get an appointment when sick. Adults report a higher level of overall health care quality, with an 8.6% increase in the number of adults rating their health care as excellent. There is an 11.6% decrease in repeat ED visits for ambulatory care-sensitive conditions.”<sup>115</sup>

The growing need for more providers combined with the availability of an equally effective alternative to physicians is a strong argument for the greater use of mid-level practitioners as a solution to California’s access to care difficulties. Studies have also shown that “[p]atients who receive primary care from NPs are often more satisfied with the care provided than those served by physicians [,] . . . PAs provide care comparable in quality to that provided by their physician supervisors,” and a “greater presence of NPs and PAs results in equal or better quality of nursing home care, including fewer potentially avoidable hospitalizations and other favorable

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*Nurse Practitioner Scope-of-Practice Regulations in Primary Care*, RAND Corporation (2018), [https://www.rand.org/content/dam/rand/pubs/rgs\\_dissertations/RGSD300/RGSD396/RAND\\_RGSD396.pdf](https://www.rand.org/content/dam/rand/pubs/rgs_dissertations/RGSD300/RGSD396/RAND_RGSD396.pdf).

<sup>109</sup> Gina M. Oliver, PhD, APRN, FNP-BC, CNE, Lila Pennington, DNP, APRN, FNP-BC, GNP-BC, Sara Revelle, MSN, APRN, FNP-BC, Marilyn Rantz, PhD, RN, FAAN Marilyn Rantz, *Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients*, Nursing Outlook, Vol. 62, Iss. 6 (Dec. 2014), [https://www.nursingoutlook.org/article/S0029-6554\(14\)00150-X/pdf](https://www.nursingoutlook.org/article/S0029-6554(14)00150-X/pdf)

<sup>110</sup> Douglas M. Brock, Jeffrey G. Nicholson, and Roderick S. Hooker, *Physician Assistant and Nurse Practitioner Malpractice Trends*, Medical Care Research and Review, (2017), <https://assets.documentcloud.org/documents/6007291/Brock-2017-Malpractice-Comparisons.pdf>.

<sup>111</sup> *EXPANDING THE ROLE OF NURSE PRACTITIONERS IN CALIFORNIA: The Impact on Patient Access to Care*, Healthforce Center at UCSF, California Health Care Foundation (May 2019), <https://www.chcf.org/wp-content/uploads/2019/05/ExpandingNPAccessCare.pdf>.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

outcomes.”<sup>116</sup> With regard to the patient population’s potential reaction to an increase in the use of mid-level practitioners, roughly half of patients either would prefer an NP or PA to a physician, or have no preference as to whether their primary care provider is a physician, NP, or PA.<sup>117</sup> Finally, physicians and the health care industry as a whole benefit from mid-level practitioner full scope of practice authority due to decreased physician malpractice insurance rates.<sup>118</sup> While adequately increasing the supply of physicians in California to meet the growing demand for providers is not a realistic option without radical change, the use of mid-level practitioners is a realistic viable option with real-world benefits.<sup>119</sup>

California has the advantage of being able to look at the success that other states and the federal government have had with the expanded use of mid-level practitioners, and knowing that there is federal support for mid-level practitioner full practice authority. Other states and the federal government have embraced mid-level practitioners practicing to the full extent of their training and education with great success. As recently as December of 2018, the U.S Department of Health and Human Services, in collaboration with the U.S. Department of the Treasury and U.S. Department of Labor, released a report recommending that states consider changing “. . .scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.”<sup>120</sup> In October of 2019, President Donald Trump issued the *Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors*, where the Secretary of Health and Human Services was directed to propose “. . . a regulation that would eliminate burdensome. . . supervision requirements. . . and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession.”<sup>121</sup> The executive order went on to direct the Secretary of Health and Human Services to

“. . .[conduct] a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and [propose] a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and

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<sup>116</sup> Gadbois, Emily A; Miller, Edward Alan; Tyler, Denise; Intrator, Orna, *Trends in State Regulation of Nurse Practitioners and Physician Assistants, 2001 to 2010*, Medical Care Research and Review (Dec. 25, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4730953/>.

<sup>117</sup> *Id.*

<sup>118</sup> See Benjamin J. McMichael, Barbara J. Safriet, and Peter I. Buerhaus, *The Extraregulatory Effect of Nurse Practitioner Scope-of-Practice Laws on Physician Malpractice Rates*, Medical Care Research and Review (2017), <https://pdfs.semanticscholar.org/1d20/47a4f2d96e9ef0b60899b5a414cf495d6b61.pdf>.

<sup>119</sup> *2019 Update, The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, Association of American Medical Colleges (Apr. 2019), [https://aamc-black.global.ssl.fastly.net/production/media/filer\\_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019\\_update\\_-\\_the\\_complexities\\_of\\_physician\\_supply\\_and\\_demand\\_-\\_projections\\_from\\_2017-2032.pdf](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf).

<sup>120</sup> *Reforming America’s Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor (Dec. 3, 2018), <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>.

<sup>121</sup> *Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors*, President Donald J. Trump (Oct. 3, 2019), <https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/>.

nurse practitioners, [be] appropriately reimbursed in accordance with the work performed rather than the clinician's occupation.”<sup>122</sup>

The executive order was praised by both the AAPA and AANP.<sup>123</sup> The executive order represents strong federal support for mid-level practitioner full practice authority and recognition that mid-level practitioner services are of equal value to services provided by physicians as there is a call for equal reimbursement based upon services provided as opposed to reimbursement based upon a provider's title.<sup>124</sup> Federal support for full practice authority has also included resources for states to adopt full practice authority.<sup>125</sup>

The ACA supported expansion of NP scope of practice through NP initiatives that provided resources for NP practice, education, and training.<sup>126</sup> In support of access to care, the ACA included a number of financial incentives for NPs who chose to work in medically underserved areas as well as nurse-managed health clinics.<sup>127</sup> Along with providing financial support to expand the use of NPs, the ACA left the definition of a primary care provider versatile enough to permit states to use mid-level practitioners in the primary care provider context:

“a primary care provider (PCP) refers to: “a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services., developing sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority.”<sup>128</sup>

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<sup>122</sup> *Id.*

<sup>123</sup> See *Trump's Medicare Plan Gets Mixed Reviews, Attacks from the left, praise from the right, mainstream medical groups wait for details*, MEDPAGE TODAY (Oct. 4, 2019), <https://www.medpagetoday.com/publichealthpolicy/healthpolicy/82575> [“We are grateful that the president's executive order included instructions to remove unnecessary supervision requirements and other barriers to authorize PAs to practice at the top of their education, training, and experience,” said David E. Mittman, PA, DFAAPA, president and chair of the AAPA Board of Directors. “These changes will modernize Medicare and improve patient access and choice.””]; See also *American Association of Nurse Practitioners Statement on Medicare Executive Order*, American Association of Nurse Practitioners (Oct. 3, 2019), <https://www.aanp.org/news-feed/american-association-of-nurse-practitioners-statement-on-medicare-executive-order> [“We applaud the Administration's continued efforts to ensure access to high-quality care is at the center of our health care system and that care is not hampered by outdated barriers to practice. We wholeheartedly agree that all health care providers should practice at the top of their licenses, and outdated burdensome requirements can no longer stand in the way of them utilizing their full skill set,” said Sophia L. Thomas, DNP, APRN, FNP-BC, PPCNP-BC, FNAP, FAANP, president of AANP.”].

<sup>124</sup> Direct reimbursement based upon services provided would be in compliance with current recommendations from MedPAC, the Commission responsible for Advising Congress on Medicare. See *Improving Medicare's payment policies for Advanced Practice Registered Nurses and Physician Assistants*, MEDPAC (Feb. 15, 2019), <http://www.medpac.gov/-blog-/the-commission-recommends-aprns-and-pas-bill-medicare-directly-/2019/02/15/improving-medicare-s-payment-policies-for-aprns-and-pas>, [“To improve Medicare's payment policies for APRNs and PAs, the Commission recommended: 1. The Congress require APRNs and PAs to bill the Medicare program directly, eliminating “incident to” billing for services they provide; and 2. The Secretary refine Medicare's specialty designations for APRNs and PAs.”].

<sup>125</sup> See Carthon, J. Margo Brooks PhD, APRN; Barnes, Hilary, PhD, CRNP; Altares Sarik, Danielle, MSN, CRNP, *Federal Policies Influence Access to Primary Care and Nurse Practitioner Workforce*, *The Journal for Nurse Practitioners* (May 2015), [https://www.npjournals.org/article/S1555-4155\(15\)00099-9/fulltext](https://www.npjournals.org/article/S1555-4155(15)00099-9/fulltext).

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

With the need, opportunity, and ability to expand the use of its mid-level practitioner workforce, California can support its citizens by following current national scope of practice recommendations and trends.

From a legal perspective, case law and existing statutes do not interfere with the adoption of mid-level practitioner full practice authority so as to prevent its implementation, as evidenced by the growing successful enactment of full practice authority among many states across the country.<sup>129</sup> Instead, states have been left with the legal latitude to identify what constitutes appropriate scope of practice.<sup>130</sup> California case law has found functions that would traditionally be considered the practice of medicine to be appropriate mid-level practitioner functions within defined boundaries.<sup>131</sup> In *California Society of Anesthesiologists v. Brown*, the court upheld the governor's decision to request and receive a waiver of supervision requirements from the federal government for certified registered nurse anesthetists after a challenge from the California Society of Anesthesiologists and the California Medical Association; while not directly applicable to NPs and PAs, the decision is indicative of the court's recognition and support of California's ability to take advantage of legally statutorily expanded scope of practice activities for non-physician providers.<sup>132</sup> Case law of some other jurisdictions has recognized the equivalency of care provided by mid-level practitioners by imposing the same standard of care on mid-level practitioners as that applied to physicians.<sup>133</sup> In order to implement mid-level practitioner full practice authority, California would need to make statutory changes, but such amendments are unlikely to be successfully challenged or opposed in the courts.

States that have followed the ACA's recommendations of full practice authority for mid-level practitioners have experienced decreases in physician malpractice insurance rates as high as

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<sup>129</sup> Gadbois, Emily A; Miller, Edward Alan; Tyler, Denise; Intrator, Orna, *Trends in State Regulation of Nurse Practitioners and Physician Assistants, 2001 to 2010*, Medical Care Research and Review (Dec. 25, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4730953/>.

<sup>130</sup> See *Changes In Healthcare Professions' Scope of Practice: Legislative Considerations*, National Council of State Boards of Nursing (Oct. 2009), [https://www.ncsbn.org/ScopeofPractice\\_09.pdf](https://www.ncsbn.org/ScopeofPractice_09.pdf).

<sup>131</sup> Nosal-Tabor v. Sharp Chula Vista Medical Center, 239 Cal.App.4th 1224 (2015), ["To that end, Business and Professions Code section 2725 permits nurses to perform certain functions that would otherwise be considered the practice of medicine, when such functions are performed pursuant to properly adopted "standardized procedures."].

<sup>132</sup> Federal law provides for a state's governor to request that a state opt out of physician supervision requirements necessary for Medicare reimbursement; the Court found that "federal regulations provide that a state's governor has the discretion to make a request on behalf of the state to opt out of the physician supervision requirement after concluding, among other things, that the opt out is "consistent with State law, . . . [and] former Governor Arnold Schwarzenegger (the Governor) exercised his discretion under federal law and opted California out of the federal physician supervision Medicare reimbursement requirement." *California Society of Anesthesiologists v. Brown*, 204 Cal.App.4th 390 (2012).

<sup>133</sup> See *Cox v. M.A. Primary and Urgent Care Clinic*, 313 S.W.3d 240 (2010), ["A few jurisdictions have nevertheless imposed on physician assistants the same standard of care as that required of medical doctors. For instance, a Michigan statute provides that "[a] physician's assistant shall conform to minimal standards of acceptable and prevailing practice for the supervising physician or supervising podiatrist." Mich. Comp. Laws Ann. § 333.17078(2) (West, Westlaw through P.A.2010, No. 78 (except 75 & 77), of 2010 Reg. Sess.). Wyoming's Board of Medicine Rules and Regulations provide that "a physician assistant is expected to perform with similar skill and competency and to be evaluated by the same standards as the physician in the performance of assigned duties." Wyo. Bd. of Med. R. & Regs., ch. 5 § 4(d) (2009). See also *Cleveland v. United States*, 457 F.3d 397, 404-05 (5th Cir.2006) (opining that, under Louisiana law, the standard of care applicable to a physician is also applicable to a physician assistant); *Andrews v. United States*, 548 F.Supp. 603, 611 (D.S. C.1982) (applying standard of care applicable to physicians under South Carolina law to physician assistant)."].

31%.<sup>134</sup> States with moderate physician supervision requirements (requiring that physicians supervise NPs only when they are prescribing medications) experience malpractice rates 26% lower than states requiring complete physician supervision.<sup>135</sup> Interestingly, expansion of NP scope of practice laws is much more effective in reducing physician malpractice rates than enacting noneconomic damage caps, with resulting rates dropping up to 31% in comparison to 13% with damage caps.<sup>136</sup> Studies also suggest that physicians who are not required to supervise NPs provide more care due to a lower risk of malpractice liability.<sup>137</sup> Additionally, where physicians face increased malpractice risk due to NP supervision requirements, they may restrict NP practice to a greater extent than state law requires in order to reduce liability.<sup>138</sup> Consequently, expanding NP scope of practice to the full extent of an NP's training and education in California, and not requiring physicians to supervise their NP counterparts is likely to both decrease costs to physicians, and also increase the quality of, and access to, care provided by physicians and NPs alike.<sup>139</sup>

The federal Department of Veterans Affairs (VA) implemented full practice authority for advanced practice registered nurses with great success in late 2016.<sup>140</sup> The VA's expansion to allow advanced practice registered nurses to work "to the full extent of their education, training, and certification" without physician supervision addressed access to care challenges that more than nine million veterans faced where seven percent of patients were waiting 30 days or longer for appointments.<sup>141</sup> The VA reported in early 2019 that a recent study performed by the JAMA Network found that 2017 wait times for VA appointments were generally "equal to or better than those found in the private sector," as opposed to 2014 wait times, and on average, VA wait times were roughly 12 days shorter than those found in the private sector.<sup>142</sup> The JAMA study also found that the VA was seeing more patients than in 2014 and patient satisfaction scores had improved.<sup>143</sup> The VA's adoption of full practice authority for advanced practice registered nurses was supported by various associations including the American Hospital Association, American Veterans, Military Officers Association of America, and Paralyzed Veterans of America.<sup>144</sup> However, despite a

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<sup>134</sup> Benjamin J. McMichael, Barbara J. Safriet, and Peter I. Buerhaus, *The Extraregulatory Effect of Nurse Practitioner Scope-of Practice Laws on Physician Malpractice Rates*, Medical Care Research and Review (2017), <https://pdfs.semanticscholar.org/1d20/47a4f2d96e9ef0b60899b5a414cf495d6b61.pdf>.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> Department of Veterans Affairs; Advanced Practice Registered Nurses, 81 Fed. Reg. 90,198 (Dec. 14, 2016) (codified at 38 C.F.R. Pt. 17.415). ["In this rulemaking, VA is exercising Federal preemption of State nursing licensure laws to the extent such State laws conflict with the full practice authority granted to VA APRNs while acting within the scope of their VA employment. Preemption is the minimum necessary action for VA to allow APRNs full practice authority. It is impractical for VA to consult with each State that does not allow full practice authority to APRNs to change their laws regarding full practice authority."]

<sup>141</sup> Sofer Dalia, *VA Grants Most APRNs Full Practice Authority*, The American Journal of Nursing (Mar. 2017), [https://journals.lww.com/ajnonline/FullText/2017/03000/VA\\_Grants\\_Most\\_APRNs\\_Full\\_Practice\\_Authority.9.aspx](https://journals.lww.com/ajnonline/FullText/2017/03000/VA_Grants_Most_APRNs_Full_Practice_Authority.9.aspx)

<sup>142</sup> *VA wait times for new appointments equal to or better than those in private sector*, U.S. Department of Veterans Affairs (Jan. 18, 2019), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5184>.

<sup>143</sup> *Id.*

<sup>144</sup> Sofer Dalia, *VA Grants Most APRNs Full Practice Authority*, The American Journal of Nursing (Mar. 2017), [https://journals.lww.com/ajnonline/FullText/2017/03000/VA\\_Grants\\_Most\\_APRNs\\_Full\\_Practice\\_Authority.9.aspx](https://journals.lww.com/ajnonline/FullText/2017/03000/VA_Grants_Most_APRNs_Full_Practice_Authority.9.aspx)

growing national trend and pressure to adopt full scope of practice authority for PAs and NPs,<sup>145</sup> California continues to maintain historical practices of limited mid-level practitioner utilization.

#### **IV. CALIFORNIA DOES NOT PERMIT NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO WORK TO THE FULL SCOPE OF THEIR TRAINING AND EDUCATION**

California limits the scope of practice authority given to mid-level practitioners, requiring different degrees of physician oversight for NPs and PAs. In California, NPs are required to work in collaboration with physicians, developing standardized procedures for treatment where “physicians take legal responsibility for the NP’s practice and are expected to determine the appropriate level of supervision, communicate regularly with the NP, and oversee the NP’s practice and quality of care.”<sup>146</sup> California limits a single physician to supervising no more than four PAs, and requires the physician to review a sample of each PA’s caseload on a monthly basis.<sup>147</sup> The Institute of Medicine of the National Academies reports that restrictive physician supervision requirements create an unnecessary bottleneck in health care systems that interferes with the number of providers available to the public despite recognition that expanded scope of practice laws would help alleviate the problem.<sup>148</sup>

##### **a. The Nursing Practice Act**

California’s governing NP statutes are found in the Nursing Practice Act<sup>149</sup> and do not yet adopt full practice authority for California’s NP population. Originally enacted in 1939, the Nursing Practice Act establishes the California Board of Registered Nursing as the entity responsible for identifying the appropriate responsibilities and scope of practice for registered nurses in the state of California.<sup>150</sup> The Board of Registered Nursing makes specific the scopes of practice for the various types of registered nurses in California at Division 14 of Title 16 of the

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<sup>145</sup> E. Kathleen Adams, Sra Markowitz, *Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*, The Hamilton Project; Brookings Institute (Jun. 2018), [https://www.brookings.edu/wp-content/uploads/2018/06/AM\\_Web\\_20190122.pdf](https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf).

<sup>146</sup> Cal. Code Regs. tit. 16, §§ 1480-1486 (2019); *California’s Nurse Practitioners: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/NursePractitionerScopePracticeLaws.pdf>.

<sup>147</sup> Cal. Bus. & Prof. Code §§ 3500-3503.5 (West 1996); Cal. Code Regs. tit. 16, sections 1399.540-1399.547 (2013).

<sup>148</sup> *The Future of Nursing: Leading Change, Advancing Health*, Institute of Medicine of the National Academies (2011), <https://www.nap.edu/read/12956/chapter/1> [“The growing use of APRNs and physician assistants has helped ease access bottlenecks, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases (Canadian Pediatric Society, 2000; Cunningham, 2010). This is true of APRNs in both primary and specialty care. In orthopedics, the use of APRNs and physician assistants is a long-standing practice. NPs and physician assistants in gastroenterology help meet the growing demand for colon cancer screenings in either outpatient suites or hospital endoscopy centers. Because APRNs and physician assistants in specialty practice typically collaborate closely with physicians, legal scope-of-practice issues pose limited obstacles in these settings.”].

<sup>149</sup> California Business and Professions Code section 2700 et seq. (2019).

<sup>150</sup> *Nursing Practice Act*, California Board of Registered Nursing (2019), <https://www.rn.ca.gov/practice/npa.shtml>.

California Code of Regulations.<sup>151</sup> Article 8 of the Nursing Practice Act was added in 1977 to address nurse practitioners specifically, and make standard the term “nurse practitioner” and its associated qualifications for California’s public.<sup>152</sup> California’s Nursing Practice Act has remained fairly unchanged since its inception in 1977. The Nursing Practice Act was amended in 2008 to establish minimum educational requirements that include holding a nursing license, possessing a master’s or graduate degree in nursing or a related nursing field, and completing a nurse practitioner program approved by the Board of Registered Nursing.<sup>153</sup> The Nursing Practice Act has also seen changes related to the furnishing or ordering of drugs and devices as various amendments have been made to permit NPs to order drugs for their patients.<sup>154</sup> However, such changes have not yet given NPs full practice authority as NPs are still required to operate “under collaboration with a physician,” abiding by “standardized procedures” developed with health entity administrators and physician collaborators, and complying with unique buprenorphine restrictions.<sup>155</sup>

b. Attempts to Expand Nurse Practitioner Scope of Practice in California

The political climate in California is largely to blame for the continued resistance to full scope of practice authority for NPs; the California legislature has rejected a variety of bills over the past decade attempting to address the problem. Attempts to broaden the NP scope of practice failed in 2013,<sup>156</sup> 2015,<sup>157</sup> and are once again being opposed in 2020.<sup>158</sup> While adopting full scope of practice authority for NPs receives large support from patient advocacy and nursing associations, physician associations invariably oppose such bills and have historically done so with great success, generally arguing that health care quality will suffer with the expanded use of NPs.<sup>159</sup>

In 2013, Senate Bill 491, Nurse practitioners, unsuccessfully attempted to remove “the requirement that nurse practitioners perform certain tasks pursuant to standardized procedures and/or consultation with a physician or surgeon and [authorize] a nurse practitioner to perform those tasks independently.”<sup>160</sup> Senate Bill 491 was specifically proposed to address California’s ongoing primary care provider workforce shortage that was exasperated by the expansion of coverage brought on by the ACA, recognizing “poor distribution” of the existing primary care

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<sup>151</sup> Cal. Code Regs. tit. 16, § 1400 et seq. (2019).

<sup>152</sup> California Business and Professions Code section 2834.

<sup>153</sup> California Business and Professions Code section 2835.5.

<sup>154</sup> California Business and Professions Code section 2836.1.

<sup>155</sup> *California’s Nurse Practitioners: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/NursePractitionerScopePracticeLaws.pdf>.

<sup>156</sup> Nurse practitioners, Senate Bill 491, (2013).

<sup>157</sup> Nurse practitioners: scope of practice, Senate Bill 323, (2015).

<sup>158</sup> Nurse Practitioners Scope of Practice: Unsupervised Practice, Assembly Bill 890, (2019).

<sup>159</sup> See Assemb. Comm. on Bus. & Professions, SB 491 (Hernandez) (Apr. 16, 2013), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201320140SB491](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201320140SB491); Assemb. Comm. on Bus. & Professions, SB 323 (Hill) (Apr. 20, 2015), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201520160SB323](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520160SB323); Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 22, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>160</sup> Assemb. Comm. on Bus. & Professions, SB 491 (Hernandez) (Apr. 16, 2013), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201320140SB491](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201320140SB491).



physician workforce resulting in “less than one third of Californians [living] in a community where they have access to adequate health care services.”<sup>161</sup> Despite the compelling need for full scope of practice authority described by Senate Bill 491 and the support given to the bill by numerous health care organizations, the bill was opposed by a number of physician groups and ultimately failed to escape the California Assembly.<sup>162</sup>

California’s restricted scope of practice environment was again raised in 2015 with Senate Bill 323, Nurse practitioners: scope of practice, where California again failed to address the problem.<sup>163</sup> Senate Bill 323 aimed to authorize “. . . a nurse practitioner who holds a national certification to practice without physician supervision in specified settings.”<sup>164</sup> Such settings were broad in nature, including clinics, general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, intermediate care facilities, hospice facilities, county medical facilities, accountable care organizations, group practice environments, and different medical groups.<sup>165</sup> The bill notably required NPs to refer patients to a physician in the event that the patient’s needed care was beyond the scope of the NP’s training or education.<sup>166</sup> Similar to Senate Bill 491 in 2013, Senate Bill 323 in 2015 also highlighted the primary care provider workforce shortages throughout the country and the merits of permitting NPs to assist with the primary care shortage by practicing to the full extent of their training and education.<sup>167</sup>

Senate Bill 323 was intended to directly address access to care challenges, in particular among Medicare patients, pointing out a 2013 study that found “Relaxing state restrictions on NP practice should increase the use of NPs as primary care providers, which in turn would reduce the current national shortage of primary care providers.”<sup>168</sup> Targeting full practice authority as advocated by the American Association of Nurse Practitioners in order to obtain “access to high quality primary care,” Senate Bill 323 received significant support from numerous advocacy groups throughout the state, including the AARP, the California Association for Nurse Practitioners, the California Hospital Association, the University of California, and SEIU California.<sup>169</sup> However, NP full practice authority again failed to find sufficient support to pass in California due to opposition brought by physician associations including the American College of Cardiology, the American College of Emergency Physicians, the California Medical Association, and the Medical Board of California, among others.<sup>170</sup> While Senate Bill 323 would have required NPs to adhere to patient

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<sup>161</sup> *Id.*

<sup>162</sup> Groups in support of SB 491 included “Nursing groups; health facilities including the California Primary Care Association, California Hospital Association, and University of California; the California Association of Physician Groups; the BRN; and some labor groups. . .” Groups in opposition to SB 491 included “The California Medical Association, California Association of Family Physicians, Osteopathic Physicians and Surgeons of California, and numerous other physician associations, as well as some labor groups, [and] the Consumer Attorneys of California.” (Assemb. Comm. On Approp., SB 491 (Hernandez) (Aug. 14, 2013), [http://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill\\_id=201320140SB491](http://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=201320140SB491)).

<sup>163</sup> Nurse practitioners: scope of practice, Senate Bill 323, (2015).

<sup>164</sup> Assemb. Comm. on Bus. & Professions, SB 323 (Hernandez) (Apr. 20, 2015), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201520160SB323](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520160SB323).

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> Assemb. Comm. on Bus. & Professions, SB 323 (Hernandez) (Jun. 28, 2016), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201520160SB323](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520160SB323).

<sup>170</sup> *Id.*

protection requirements including continuing education and the maintenance of professional liability insurance appropriate to their respective practice settings similar to requirements for independent physicians in order to ensure the safety of California’s patient population, opponent physician associations successfully stopped the bill.<sup>171</sup> Opponent groups argued that the bill

“ . . . would fracture health care teams comprised of multiple health care providers working together to provide coordinated care. . . [as] Nurse practitioners are an important part of . . .health care delivery teams working in conjunction with supervising physicians. Nurse practitioners however, do not have sufficient education and training to examine and diagnose completely independent of physicians and such a practice puts patients at risk.”<sup>172</sup>

Opposition groups also argued that NPs having full practice authority would result in conflicts of interest that undermine California’s ban on the corporate practice of medicine as NPs are not currently covered by the ban, and NPs health care entities would be “. . .incentivized to hire non-physicians in order to direct those employees to maximize profits.”<sup>173</sup>

California’s legislature is once again considering expanding the NP scope of practice to adopt full practice authority under Assembly Bill 890, but the bill is being opposed for similar reasons as Senate Bills 491 and 323.<sup>174</sup> Assembly Bill 890, Nurse practitioners: scope of practice: unsupervised practice, permits NPs “to provide specified medical services, without physician supervision, if the [nurse practitioner], among other things, works in a specified integrated or organized health setting or the [nurse practitioner] meets specified education requirements and completes a 3 year transition to practice program.”<sup>175</sup> Like the previous similar bills, Assembly Bill 890 is intended to address California’s ongoing access to care and affordability of health care difficulties through the expanded use of NPs.<sup>176</sup> Committee analysis of the bill recognizes that less than half of California’s licensed physicians are actively engaged in patient care, and efforts to increase the supply of physicians are insufficient to meet the public’s health care needs.<sup>177</sup> Supporters of Assembly Bill 890 argue that it will increase “. . .access to care, reduce paperwork burdens for NPs and physicians and promote high-quality primary health care.”<sup>178</sup> Supporters of the bill include the California Association of Nurse Practitioners, the California Hospital Association, AARP, and the Association of California Healthcare Districts, among others.<sup>179</sup> Various physician associations oppose Assembly Bill 890 including California chapters of the American College of Cardiology and American College of Emergency Physicians, the California Medical Association, the California Orthopedic Association, the California Society of Plastic

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<sup>171</sup> Sen. Comm. on Bus. & Professions, SB 323 (Hernandez) (Apr. 20, 2015), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201520160SB323](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520160SB323).

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> Assemb on Bus. & Professions, AB 890 (Wood) (Apr. 9, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>175</sup> *Id.*

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> Assemb. Comm. on Appropriations, AB 890 (Wood) (May. 16, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>179</sup> Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 22, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

Surgeons, and Physicians for Patient Protection.<sup>180</sup> The opposition to Assembly Bill 890 argues that, as written, it would permit NPs to practice medicine without an equivalent competency review to that of physicians, thus “diminishing the quality of care for and lowering the standards for licensed individuals practicing medicine in the state.”<sup>181</sup> The opposition goes on to argue that the bill would permit nurses to practice medicine in violation of California’s ban against the corporate practice of medicine, stating that the bill “must also comply with [the corporate bar’s] important consumer protections.”<sup>182</sup>

### c. The Physician Assistant Practice Act

PAs in California are licensed under the Physician Assistant Practice Act at Business and Professions Code section 3500 et seq. and have slowly been granted a broader scope of practice, but are still yet to be given full practice authority. The Physician Assistant Board is located within the jurisdiction of the California Medical Board, and the Physician Assistant Practice Act is implemented along with section 1399.500 et seq. of the California Code of Regulations.<sup>183</sup> The Physician Assistant Practices Act was initially passed in 1975, and is introduced with a declaration of legislative intent that states:

“In its concern with the growing shortage and geographic maldistribution of health care services in California, the Legislature intends to establish in this chapter a framework for development of a new category of health manpower - the physician assistant. . . This chapter is established to encourage the utilization of physician assistants by physicians, and by physicians and podiatrists practicing in the same medical group, and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services.”<sup>184</sup>

The legislature clearly intended to take advantage of the benefits of the PA workforce in California, and adoption of full practice authority maximizes such benefits. Despite the intent to “encourage the utilization of physician assistants” without legal constraints that would be unnecessary burdens “to the more effective provision of health care services,” the adoption of full practice authority is yet to occur.<sup>185</sup>

### d. Attempts to Expand Physician Assistant Scope of Practice in California

The expansion of the PA scope of practice had some limited success in California with the passage of Assembly Bill 3 in 2007.<sup>186</sup> Assembly Bill 3 changed the physician to PA ratio from

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<sup>180</sup> *Id.*

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

<sup>183</sup> *California’s Physician Assistants: How Scope of Practice Laws Impact Care*, California Health Care Foundation (Sept. 2018), <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.

<sup>184</sup> California Business and Professions Code section 3500 (1996).

<sup>185</sup> *Id.*

<sup>186</sup> Physician assistants, Assembly Bill 3, (2007).

up to two PAs per physician to up to four PA's per physician;<sup>187</sup> however, such statutorily established ratios ignore the recommendations from the American Academy of Physician Assistants,<sup>188</sup> the American College of Physicians,<sup>189</sup> and the American Osteopathic Association that recommend allowing practice-level determinations of appropriate ratios.<sup>190</sup> Assembly Bill 3 also removed the prohibition against PAs issuing a drug order for specified classes of drugs if the PA had completed specific education courses, and required PAs and their supervising physicians and surgeons to establish supervisory guidelines and protocols. Assembly Bill 3 also specified the services provided by a PA as being covered benefits under the Medi-Cal program,<sup>191</sup> and while a move in the right direction toward PA full practice authority, the U.S. Department of Health and Human Services in collaboration with the U.S. Department of the Treasury and U.S. Department of Labor also indicate that the PA scope of practice would benefit from allowing PAs to be paid directly for their services.<sup>192</sup>

Assembly Bill 3 met its goal of enhancing the role of physician assistants in order to address California's access to care challenges by eliminating some unnecessary supervision requirements and administrative burdens.<sup>193</sup> Assembly Bill 3 analysis explains that by delegating more decision making authority to local practices, supervising physicians who are taking "full professional and legal responsibility for the care rendered by the physician assistant, . . . would have every incentive to exercise prudence in making [such] decisions."<sup>194</sup> Assembly Bill 3 was passed in 2007 with strong support from the California Academy of Physician Assistants, American College of Emergency Physicians, Medical Board of California, Kaiser Permanente, United Nurses Association of California, and the Union of Health Care Professionals.<sup>195</sup> Assembly Bill 3 was only opposed by the California Department of Consumer Affairs, but without arguments in opposition.<sup>196</sup>

Assembly Bill 3 was generally successful in incrementally expanding the PA scope of practice in California toward full practice authority. However, it only slightly increased the number of PAs

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<sup>187</sup> *Id.*

<sup>188</sup> *The Six Key Elements of a Modern PA Practice Act*, American Academy of PAs (Jan. 2017), [https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief\\_Six-key-elements\\_0117-1.pdf](https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Six-key-elements_0117-1.pdf).

<sup>189</sup> M. R. Zerehi, E. Rathfon, *Internists and Physician Assistants: Team-Based Primary Care*, American College of Physicians (2010), [https://www.acponline.org/system/files/documents/advocacy/current\\_policy\\_papers/assets/internists\\_asst.pdf](https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/internists_asst.pdf).

<sup>190</sup> E. Rathfon, N. A. Schilligo, *Osteopathic Physicians and Physician Assistants: Excellence in Team-Based Medicine*, American Osteopathic Assn. and American Academy of Physician Assistants (Jul. 2013), <https://www.aapa.org/news-central/2013/08/osteopathic-physicians-pas-emphasize-team-based-approach-to-healthcare-healthcare/>.

<sup>191</sup> Sen. Comm. on Bus. & Professions, AB 3 (Bass) (Jul. 9, 2007), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=200720080AB3](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=200720080AB3).

<sup>192</sup> *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor (Dec. 3, 2018), <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>.

<sup>193</sup> Sen. Comm. on Bus. & Professions, AB 3 (Bass) (Jul. 9, 2007), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=200720080AB3](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=200720080AB3).

<sup>194</sup> *Id.*

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

a physician could supervise,<sup>197</sup> and did not eliminate the need for a supervising physician to review and countersign a sample of each PA’s medical records, as required in order to adopt full practice authority as identified by the American Academy of Physician Assistants.<sup>198</sup>

Senate Bill 697 was passed in October of 2019 to further expand PA scope of practice in California, taking the state one step closer to PA full practice authority.<sup>199</sup> Senate Bill 697 finally removed the requirement for a supervising physician to conduct a medical records review of each collaborating PA on a monthly basis.<sup>200</sup> Senate Bill 697 also permitted multiple physicians and surgeons to supervise a PA, and “. . . generally allows supervising physician and surgeons to determine the appropriate level of supervision for PA practice. . .”<sup>201</sup>

Senate Bill 697 received strong support from various sources including the California Academy of PAs, California Hospital Association, California Medical Association, the Medical Board of California, and the Physician Assistant Board.<sup>202</sup> However, Senate Bill 697 was also opposed by the California Chapter of the American College of Emergency Physicians, California Rheumatology Alliance, and California Society of Plastic Surgeons, with opposition to the bill requesting that the bill require physicians to review PA medical records – a requirement that must be eliminated in order to meet the AAPA’s six elements of PA full practice authority.<sup>203</sup>

Senate Bill 697 brought California closer to permitting PAs to practice to the full extent of their education and training, but in order to adopt full practice authority, the cap on the number of PAs a physician may supervise must be removed.<sup>204</sup> As such, additional legislation is needed in order for California to take full advantage of its PA workforce.

## V. DISCUSSION

The arguments in favor of California adopting mid-level practitioner full practice authority are compelling while the arguments against implementing full practice authority are, in the author’s opinion, unpersuasive. California has a strong need to augment its provider population in order to address growing access to care challenges, but the state has been unable to embrace full practice authority despite national trends and recommendations because of strong lobbying efforts led by physician groups when bills are introduced.<sup>205</sup> Physician groups argue that expanding mid-level practitioner scope of practice would compromise the quality of care that patients receive because

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<sup>197</sup> See Senate Bill No. 697 (Ca. 2019), [“Except as provided in Section 3502.5, a physician and surgeon shall not supervise more than four physician assistants at any one time.”]

<sup>198</sup> *The Six Key Elements of a Modern PA Practice Act*, American Academy of Physician Assistants (Aug. 2018), <https://www.aapa.org/download/29342/>.

<sup>199</sup> Senate Bill 697 (Ca. 2019).

<sup>200</sup> *Id.*

<sup>201</sup> Sen. Rules Comm., SB 697 (Caballero) (Sept. 9, 2019), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200SB697](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB697).

<sup>202</sup> *Id.*

<sup>203</sup> Sen. Rules Comm., SB 697 (Caballero) (Sept. 9, 2019), [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200SB697](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB697); *The Six Key Elements of a Modern PA Practice Act*, American Academy of Physician Assistants (Aug. 2018), <https://www.aapa.org/download/29342/>.

<sup>204</sup> *The Six Key Elements of a Modern PA Practice Act*, American Academy of Physician Assistants (Aug. 2018), <https://www.aapa.org/download/29342/>.

<sup>205</sup> See Sen. Rules Comm., SB 697 (Caballero) (Sept. 9, 2019); Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 9, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

mid-level practitioners do not have a physician's education and training.<sup>206</sup> This argument flies in the face of over 100 studies that have shown that patient outcomes from care provided by mid-level practitioners are equal to or better than care provided by physicians.<sup>207</sup>

Physician groups also argue that expanding mid-level practitioner scope of practice would undermine California's ban against the corporate practice of medicine, thereby allowing persons to make decisions that affect the provision of medical services without understanding the quality of care implications of those decisions, having a professional ethical obligation to place the patient's interest foremost, or falling under the critical enforcement powers of the Medical Board of California.<sup>208</sup> This argument is also unconvincing because the ban against the corporate practice of medicine in California is already subject to numerous exemptions that reflect its relative unimportance in California's health care market;<sup>209</sup> even if found by the legislature to be relevant, the legislature could easily create parallel language that bans the corporate practice of medicine by mid-level practitioners with similar enforcement mechanisms to those of the Medical Board of California being placed in the applicable regulatory boards.

A third argument raised by physician groups is that expanded mid-level practitioner scope of practice would compromise physician-led team-based patient care, and that allowing mid-level practitioners to operate without physician supervision does not combine the skills of physicians and mid-level practitioners to ". . . maximize the talents of the complementary skill sets" of the different team members.<sup>210</sup> This objection is also without empirical support. States that have implemented full practice authority have not experienced reduced quality of care among unsupervised mid-level practitioners; rather, they have seen increased access to care and better outcomes.<sup>211</sup> Instead of fracturing existing health care teams, mid-level practitioners who are given full practice authority would be empowered to provide care in the remote parts of California where there currently are not enough physicians to create the supervised team environments that are currently mandated. Such flexibility would increase access without decreasing quality. The arguments against full practice authority that are raised by physician groups are unpersuasive and unsupported by scientific research. Full practice authority should be embraced in order maximize access to care, address the growing provider shortage, and enable the health care system to evolve to meet the needs of the public.

The national trend toward mid-level practitioner full practice authority is growing because the health care system lacks sufficient physicians to meet the needs of the public, and NPs and PAs offer a feasible solution to the problem that carry many benefits in addition to increasing access to

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<sup>206</sup> Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 9, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>207</sup> *Clinical Outcomes: The Yardstick of Educational Effectiveness*, American Association of Nurse Practitioners (2017), <https://www.aanp.org/advocacy/advocacy-resource/position-statements/clinical-outcomes-the-yardstick-of-educational-effectiveness> ["Head-to-head comparison of educational models is not the appropriate measure of clinical success or patient safety. The appropriate measure is patient outcomes."]

<sup>208</sup> Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 9, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>209</sup> *The Corporate Practice of Medicine in a Changing Healthcare Environment*, California Research Bureau (Apr. 2016), <https://sbp.senate.ca.gov/sites/sbp.senate.ca.gov/files/CRB%202016%20CPM%20Report.pdf>.

<sup>210</sup> *Physician-led health care teams*, AMA Advocacy Resource Center, American Medical Association (2018), <https://www.ama-assn.org/system/files/2018-09/physician-led-teams-campaign-booklet.pdf>.

<sup>211</sup> *EXPANDING THE ROLE OF NURSE PRACTITIONERS IN CALIFORNIA: The Impact on Patient Access to Care*, Healthforce Center at UCSF, California Health Care Foundation (May 2019), <https://www.chcf.org/wp-content/uploads/2019/05/ExpandingNPAccessCare.pdf>.

care. As noted previously, adopting full practice authority is likely to decrease physician malpractice payment rates.<sup>212</sup> Currently, mid-level practitioners provide equal services at a lower reimbursement rate than their physician counterparts, and Congress is being encouraged to adopt direct billing for NPs and PAs that would “produce program savings and reduce beneficiary cost-sharing.”<sup>213</sup> Additionally, mid-level practitioners are significantly more cost effective for health care entities to employ than physicians.<sup>214</sup> There are numerous benefits to California’s adoption of mid-level practitioner full practice authority while the arguments against it are not scientifically supported.

## VI. CONCLUSION

To increase access to quality healthcare and decrease costs, California should amend existing law to expand the scopes of practice of NPs and PAs to permit them to provide care to the full extent of their training and education in accordance with national trends. California has a significant growing health care provider shortage with a huge population that suffers from many unique access to care challenges, and a responsibility to facilitate access to care for all Californians.<sup>215</sup>

Senate Bill 697<sup>216</sup> and previous changes to the Physician Assistant Practice Act addressed many of the deficiencies in California’s PA scope of practice laws, but further amendments are needed to realize the full benefits of California’s PA workforce. Assembly Bill 890<sup>217</sup> attempts to address the shortcomings in California’s NP scope of practice laws, but faces political opposition that may once again block expansion of the NP scope of practice in California.<sup>218</sup>

Other states have benefited in a number of ways through implementation of full scope of practice authority for mid-level practitioners, including 24 having granted NPs the authority to practice without physician involvement in diagnosis and treatment, and 17 states increasing the prescriptive authority of PAs between 2001 and 2010.<sup>219</sup> The overall national trend has been

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<sup>212</sup> See Benjamin J. McMichael, Barbara J. Safriet, and Peter I. Buerhaus, *The Extraregulatory Effect of Nurse Practitioner Scope-of-Practice Laws on Physician Malpractice Rates*, Medical Care Research and Review (2017), <https://pdfs.semanticscholar.org/1d20/47a4f2d96e9ef0b60899b5a414cf495d6b61.pdf>.

<sup>213</sup> *Improving Medicare's payment policies for Advanced Practice Registered Nurses and Physician Assistants*, MEDPAC (Feb. 15, 2019), <http://www.medpac.gov/-blog-/the-commission-recommends-aprns-and-pas-bill-medicare-directly-/2019/02/15/improving-medicare-s-payment-policies-for-aprns-and-pas>

<sup>214</sup> *Nurse Practitioner Cost Effectiveness*, American Association of Nurse Practitioners (2013), <https://www.aanp.org/advocacy/advocacy-resource/position-statements/position-statements>; Roderick S. Hooker, *A Cost Analysis of Physician Assistants in Primary Care*, JAAPA: Official Journal of the American Academy of Physician Assistants (Dec. 2002), [https://www.researchgate.net/publication/10998438\\_A\\_Cost\\_Analysis\\_of\\_Physician\\_Assistants\\_in\\_Primary\\_Care](https://www.researchgate.net/publication/10998438_A_Cost_Analysis_of_Physician_Assistants_in_Primary_Care).

<sup>215</sup> *California Physician Supply and Distribution: Headed for a Drought?*, California Health Care Foundation (Jun. 2018), <https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf>.

<sup>216</sup> Physician Assistants: Practice Agreement: Supervision, Senate Bill 697, (2019).

<sup>217</sup> Nurse Practitioners Scope of Practice: Unsupervised Practice, Assembly Bill 890, (2019).

<sup>218</sup> See Assemb. Comm. on Bus. & Professions, SB 697 (Caballero) (Jul. 1, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200SB697](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB697); See also, Assemb. Comm. on Appropriations, AB 890 (Wood) (Apr. 22, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).

<sup>219</sup> Gadbois, Emily A; Miller, Edward Alan; Tyler, Denise; Intrator, Orna, *Trends in State Regulation of Nurse Practitioners and Physician Assistants, 2001 to 2010*, Medical Care Research and Review (Dec. 25, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4730953/>.

movement toward less restrictive scope of practice regulations while having greater educational requirements.<sup>220</sup>

Benefits of full practice authority include decreased morbidity and mortality, a reduction in hospitalizations, and decreased overall costs.<sup>221</sup> Importantly, NPs and PAs practice in primary care in high numbers where physicians are increasingly less likely to practice, and mid-level practitioners are able to help fill the resulting gap in access to care in such areas.<sup>222</sup> While the benefits and state and federal trends toward mid-level practitioner full practice authority are obvious and compelling, physician groups have successfully lobbied against its implementation for years, and efforts are again underway.<sup>223</sup> California should finally implement mid-level practitioner full practice authority in order to put its patient population's access to quality health care ahead of lobbying interest groups.

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<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> Assemb. Comm. on Bus. & Professions, AB 890 (Wood) (Apr. 22, 2019), [https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201920200AB890](https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB890).