

Expanding Scope of Practice for Nurse Practitioners in California: AB 890 Compromises to Permit Independent Practice

This legislative session, California Governor Gavin Newsom signed AB 890, legislation that expands the existing scope of practice laws for nurse practitioners (NPs).[\[1\]](#) The law brings California in line with over half of the states in the U.S. by permitting NPs to practice independently and to the full extent of their training and education. As demand for healthcare workers continues to surge with the number of COVID-19 cases in this country, AB 890 helps pave the way for more healthcare providers to provide crucial care where it is needed. This post discusses how NP scope of practice laws impact healthcare access, quality, and cost and examines how AB 890 changes the landscape of scope of practice law for NPs in California.

Why Scope of Practice Laws Matter

Even before the COVID-19 pandemic, many recognized that permitting nurse practitioners to practice to the fullest extent of their training and education was crucial to providing sufficient health care around the country. In recent years, there has been an influx of evidence that demonstrates the benefit of expanded NP scope of practice regarding access, quality, and the cost-effectiveness of care. Furthermore, many of the restrictions imposed on NPs limit their ability to access the market and compete with physicians and other health care providers, such as physician assistants, and may deprive patients of the benefits of competition among healthcare providers.[\[2\]](#)

Access

In California, a study found that physician supply will meet less than half of the

demand for primary care by 2030.[3] The obstacles posed by restrictive scope of practice laws, such as requiring an arrangement with a supervising physician, exacerbate provider shortages and contribute to access issues, particularly for underserved populations, by restricting how and where NPs can practice. NPs are more likely to provide care for new Medi-Cal and uninsured patients compared to primary care physicians.[4] Additionally, studies have found that NPs in states with comprehensive practice and prescribing authority are even more likely to practice in rural areas and areas with lower socioeconomic and health status.[5] The supply of NPs also grows more rapidly in states where NPs have full practice authority.[6] Luckily, the projected growth in NPs and physician assistants' supply can likely fill the expected gap in care in California. Still, for NPs to fully meet the need, scope of practice laws cannot unnecessarily limit the tasks that qualified NPs can perform or impose cumbersome and costly requirements for NPs to practice.[7]

Quality

Most proponents of restrictive scope of practice laws point to the need for restrictions, like requiring physician supervision, to ensure high quality of care. Proponents of restrictions point to the fact that NP education is shorter and more narrowly focused on primary care as compared to physicians. However, research has shown this not to be the case. NPs provide the same (and in some cases higher) quality of primary care than physicians, even when they practice without physician supervision.[8] Furthermore, other studies found that NP patients have lower rates of preventable hospitalizations, readmissions, and emergency room visits than patients managed by physicians.[9]

Cost

Research has shown that restricting NP practice could contribute to higher healthcare costs in several ways. The first is that by limiting the number of practicing NPs and reducing access to care, patients may be more likely to use more expensive services like the emergency department.[10] Second, the time physicians spend supervising NPs reduces the number of patients a physician can see, impacting their salaries and bonuses. To compensate, physicians often ask for reimbursement for their time supervising NPs, which is often passed onto payers of

health care.[\[11\]](#) Third, policies that prevent substituting NPs for physicians in overlapping areas of practice, such as primary care, contribute to healthcare costs. Numerous studies have shown that NPs' cost of services is generally less than a physician's cost for the same services.[\[12\]](#) Removing unnecessary barriers to NP practice offers a way to reduce the costs of care without compromising quality.

Existing Scope of Practice for Nurse Practitioners

Although NPs across the country must fulfill the same training and national board certification requirements, NPs in different states cannot practice at the same level because of the wide variation in scope of practice laws and regulations. NPs have full independent practice authority in more than half the country, allowing them to diagnose patients, prescribe controlled substances, and order lab work and x-rays without physician oversight. Of these states, 16 states and the District of Columbia permit NPs to practice independently as soon as they are licensed. Another 13 grant full practice and prescriptive authority after NPs finish a transitional oversight period. The remaining 22 states require NPs to have an arrangement with a supervising physician and impose additional hurdles such as limiting the number of NPs a physician may supervise or requiring NPs to operate within a certain geographic radius of their supervising physicians.[\[13\]](#)

Compared to the rest of the country, California's NP scope of practice law falls on the more restrictive end of the spectrum. NPs in California must have a written agreement with a physician and collaborate with them on treatment decisions. Specifically, the regulations promulgated by the Board of Registered Nursing (BRN) require NPs to work under a physician's supervision and adhere to standardized procedures developed through collaboration among administrators and health professionals, including NPs, physicians, and surgeons. These procedures give NPs the ability to perform tasks that would otherwise be considered the practice of medicine. NPs must also obtain additional certification from the BRN to prescribe or order drugs or devices under standardized procedures. Under these supervisory agreements, physicians shoulder the legal responsibility for the NP's practice and are expected to determine the appropriate oversight level.

At the beginning of the pandemic in March 2020, Governor Newsom signed an executive order giving the California Department of Consumer Affairs (DCA) the authority to loosen restrictions on scope of practice laws for NPs temporarily. However, unlike several other states that suspended their supervision requirements in the face of COVID-19, the DCA only issued a waiver that temporarily lifted the restrictions on how many NPs a physician could oversee at once.[\[14\]](#) AB 890 now goes much further in providing two routes for NPs to practice independently and join other states in the country that permit independent practice after a transitional period.

Changes Under AB 890

Under AB 890, California joins other states that permit NPs to practice independently after finishing a transitional oversight period. The law creates two new categories of NPs to function independently; however, NPs may continue their current arrangements if they do not meet the qualifications of those two categories or choose not to pursue independent practice. The two new categories created under California Business & Professional Code sections 2837.103 and 2837.104 set out education, training, national certification, regulatory, and medical staff governance requirements. NPs under section 2837.103 (“103 NPs”) are eligible to independently practice without standardized procedures if they meet the specific requirements and work in settings where one or more physicians practice. In contrast, NPs under section 2837.104 (“104 NPs”) can practice independently without standardized procedures in settings permitted for 103 NPs as well as other settings if they meet additional criteria. This expansion means that a 104 NP may open their own practice according to existing laws. NPs who meet the requirements of either section will be able to practice to the extent of their training, including 1) conducting advanced assessments, 2) order, perform, and interpret diagnostic procedures, 3) establish primary and differential diagnoses, 4) prescribe, order, and administer pharmaceuticals, and 5) delegate tasks to a medical assistant.

The table below illustrates the differences between 103 NPs and 104 NPs under the two new sections.

	NPs under § 2837.103[15]	NPs under § 2837.104[16]
Effective Date	January 1, 2021	January 1, 2023
Authorized Settings	<p>Any of the following that has one or more physicians:</p> <ul style="list-style-type: none"> • A clinic (defined by Health & Safety code § 1200) • A health facility (defined by Health & Safety Code § 1250) <ul style="list-style-type: none"> • A medical group practice (defined by Health & Safety Code § 2406) • A home health agency (defined by Health & Safety Code § 1727) • A hospice facility (licensed under Chapter 8.5 of Health & Safety Code) 	<p>Same as § 2837.103; Additional settings outside of those permitted under § 2837.103 (e.g., can open their own practice)</p>
Transition to Practice	<p>Must complete a transition to practice in CA of a minimum of three full-time equivalent years of practice of 4,600 hours</p>	<p>Same as § 2837.103</p>
Certification	<p>Must pass a national NP board certification examination; Must hold a certification as an NP from a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the BRN</p>	<p>Same as § 2837.103</p>

Education	Must provide documentation that NP education was consistent with already existing BRN regulations (Bus. & Prof. Code § 2836)	Same § 2837.103; Must hold a valid and active RN license and a master's degree in nursing or other clinical field related to nursing or a doctoral degree in nursing
Length of Practice	N/A	Has practiced as an NP in good standing for at least three years (not including the transition to practice time)

Does AB 890 Go Far Enough?

AB 890 is not the first bill introduced by lawmakers to address nurse practitioner scope of practice in California. In 2015, the California legislature rejected a similar bill (SB 323) after stiff opposition from provider organizations like the California Medical Association that argued that permitting NP independent practice would put patients at risk because of the lack of oversight and complicated health care delivery.^[17] There was similar opposition to AB 890, but as evidence mounted that California faces a dearth of primary care providers, especially in the time of COVID-19, it seems that opponents and proponents of expanded scope of practice laws found space to compromise.

While AB 890 does provide two paths to NP independent practice, it still places several significant restrictions on doing so. While NPs can become 103 NPs at the start of 2021 and will not require direct physician supervision, they are limited to the settings in which they can practice and the requirement that a physician must also be part of the same practice. For 104 NPs, they cannot practice independently until 2023, ostensibly to permit the BRN time to issue additional regulations governing the process. Both 103 and 104 NPs must undergo a minimum of 4,600 hours of transition to practice, which falls on the longer-side of required transition to practice hours needed when compared to other states.^[18] While the new law does not give NPs as much freedom as some other states, it will serve as a test to

illustrate the effectiveness of NPs. It is a crucial first step to ensure adequate access to affordable care and help control healthcare costs for patients in California.

[1] AB 890, 2019-2020 Assem., Reg. Sess. (Cal. 2020), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890. Nurse practitioners are highly trained nurses with at least a master's degree. By comparison, registered nurses have at least an associate's degree.

[2] See Policy Perspectives: Competition and the Regulation of Advanced Nurse Practitioners, FTC (March 2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolycypaper.pdf>.

[3] Joanne Spetz & Ulrike Muench, *California Nurse Practitioners Are Positioned to Fill the Primary Care Gap, But They Face Barriers to Practice*, 37 Health Aff. 1466, 1466 (2018), <https://www.healthaffairs.org.uchastings.idm.oclc.org/doi/10.1377/hlthaff.2018.0435>.

[4] Joanne Spetz, *Expanding the Role of Nurse Practitioners in California: The Impact on Patient Access to Care*, California Health Care Found. & Healthforce at UCSF (May 2019), <https://canpweb.org/advocacy/grassroots-resource-center/ab-890-background/reports/california-health-care-foundation-report/>.

[5] See Peter I. Buerhaus et al., *Practice Characteristics of Primary Care Nurse Practitioners and Physicians*, 63 Nursing Outlook 144 (March/April 2015), <https://pubmed.ncbi.nlm.nih.gov/25261383>; Matthew A. Davis et al., *Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status*, 33 J. General Internal Med. 412 (April 2018), <https://pubmed.ncbi.nlm.nih.gov/29362958/>.

[6] Spetz & Muench, *supra* note 3; Spetz, *supra* note 4.

[7] 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

[8] See Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 *Nursing Economics* 230 (Sept./Oct. 2011), <https://pubmed.ncbi.nlm.nih.gov/22372080/>; Julie Stanik-Hutt et al., *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 *J. for Nurse Practitioners* 492 (Sept. 2013), [https://www.npjjournal.org/article/S1555-4155\(13\)00410-8/fulltext](https://www.npjjournal.org/article/S1555-4155(13)00410-8/fulltext).

[9] Peter Buerhaus et al., *Quality of Primary Care Provided to Medicare Beneficiaries by Nurse Practitioners and Physicians*, 56 *Medical Care* 484 (June 2018), <https://insights.ovid.com/medical-care/mcar/2018/06/000/quality-primary-care-provided-medicare/5/00005650>.

[10] Perri A. Morgan, *Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients*, 38 *Health Aff.* 1028 (June 2019), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00014>; Peter Buerhaus, *Nurse Partitioners as an Underutilized Resource for Health Reform: Evidence-Based Demonstrations of Cost-Effectiveness*, *Am. Acad. of Nurse Practitioners (AANP) News* (2010), <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1745-7599.2010.00498.x>.

[11] Market data shows that practices offer physicians payments ranging from \$5,000 to \$15,000 per year for NP supervision. Joanne Spetz, *California's Nurse Practitioners: How Scope of Practice Laws Impact Care*, California Health Care Found. & Healthforce at UCSF 12 (May 2019), <https://www.chcf.org/wp-content/uploads/2018/09/NursePractitionersScopePracticeLaws.pdf>.

[12] <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1745-7599.2010.00498.x>; <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0544>.

[13] *Nurse Practitioners Overview, Scope of Practice Pol’y* (2020), <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/>.

[14] Order Waiving Nurse Practitioner Supervision Requirements. State of California Dept. of Consumer Aff. (April 14, 2020), https://www.dca.ca.gov/licensees/nurse_practitioner_supervision_requirements.pdf. During Spring 2020, New York, New Jersey, Louisiana, Wisconsin, and Kentucky suspended all written practice or collaborative agreement requirements. Hayley Germack et al., *Surge in Policies Expanding Nurse Practitioner Scope of Practice in Response to COVID-19 Provide an Important Research Opportunity*, Academy Health (May 5, 2020), <https://www.academyhealth.org/blog/2020-05/surge-policies-expanding-nurse-practitioner-scope-practice-response-covid-19-provide-important-research-opportunity>;

[15] Cal. Bus. & Prof. Code § 2837.103.

[16] Cal. Bus. & Prof. Code § 2837.104.

[17] Elizabeth Aguilera, *Nurse Practitioner Autonomy Bill Fails in State Assembly (Updated)*, KPCC (June 30, 2015), <https://www.scpr.org/news/2015/06/30/52800/nurse-practitioner-autonomy-bill-fails-in-state-as/>; *Urge Gov. Newsom to Reject Bill That Would Create Two-Tiered Health System*, California Med. Ass’n. (Sept. 1, 2020), <https://www.cmadocs.org/newsroom/news/view/ArticleId/49008/Urge-Gov-Newsom-to-reject-bill-that-would-create-two-tiered-health-care-system>.

[18] States with transitional oversight periods vary in their requirements. Length requirements range from two to five years and 2,080 to 9,000 hours. See Joanne Spetz, *Expanding the Role of Nurse Practitioners in California: Physician Oversight in Other States*, California Health Care Found. & Healthforce at UCSF (May 2019), <https://canpweb.org/events/lobby-day/lobby-day-resources/physician-oversight-in-other-states/>.