Maryland Association of Nurse Anesthetists

TO: Members of the Senate Finance Committee
FROM: Maryland Association of Nurse Anesthetists (MANA)
RE: UNFAVORABLE – SB 0951: State Board of Physicians – Anesthesiologist Assistants – Licensing
POSITION: **UNFAVORABLE**

On behalf of the Maryland Association of Nurse Anesthetists (MANA), we respectfully submit this testimony in **strong opposition** to SB 0951.
Maryland currently operates under a structurally superior "Gold Standard" of anesthesia care, relying on two fully licensed, independent providers: Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs).

We have this gold standard today because the General Assembly made a deliberate, successful policy decision in 2016. By rejecting this exact legislation, the legislature recognized that highly trained, independent providers are the true solution to healthcare access.

This current legislation seeks to dismantle that standard by introducing a dependent, less qualified provider, the Anesthesiologist Assistant (AA). This model will increase healthcare costs, create operational bottlenecks, and threaten Maryland's Nurse Anesthesia schools, which provide a vital training pathway for Registered Nurses to become Certified Registered Nurse Anesthetists—all while offering zero solutions for access to care.

We urge an unfavorable report based on the following structural, economic, and operational incompatibilities:

1. The Clinical Experience Deficit and False Economic Equivalency

Maryland’s current model relies on rigorous experience as a fundamental policy safeguard.

- **The CRNA Standard:** The foundation of a CRNA's expertise begins with a Bachelor of Science in Nursing (BSN) and licensure as a Registered Nurse. From there, they are required to obtain 3 to 5 years of high-acuity Intensive Care Unit (ICU) experience before they are even eligible to begin their 36-month doctoral anesthesia training. Every independent provider in the room has a deep clinical background and has managed life-and-death crises before ever delivering anesthesia
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- **The AA Deficit:** In stark contrast, Anesthesiologist Assistants can enter training with any generic four-year degree and **zero clinical healthcare experience**. SB 0951 asks the state to replace highly seasoned critical care experts with providers who have no prior medical background.

- **Equivalent Cost for Inferior Qualifications:** Despite having zero prior clinical healthcare experience, AAs command Nurse Anesthesiologist-level salaries and bill at the exact same rates as CRNAs. This legislation forces the state to accept a less-qualified provider without offering a single dollar of cost savings to the patient or the healthcare system.

- **Anti-Competitive Financial Control, Not Access to Care:** The primary advocates for this legislation are physician anesthesiologist groups. Under federal billing rules, an anesthesiologist can concurrently bill for overseeing up to four AAs. This legislation is not designed to expand rural access or lower healthcare costs; it is a workforce design explicitly built to allow physician groups to capture the revenue of four operating rooms simultaneously, while suppressing the utilization of fully independent, competing CRNAs.

2. The "Supervision Tax" and Hospital Bottlenecks

Introducing a dependent role like the AA creates a "bottleneck tier" of providers who cannot legally make independent decisions.

- **Statutory Tethering:** AAs require strict, physical proximity to a supervising anesthesiologist. If an anesthesiologist is diverted to an emergency, the AA's authority to practice is legally suspended. This statutory rigidity creates involuntary interruptions in service, backing up operating rooms and delaying surgeries.

- **The Federal TEFRA "Acuity Trap":** Proponents cite a 1:4 supervision ratio. However, under federal Medicare TEFRA (Tax Equity and Fiscal Responsibility Act) rules for Medical Direction, the anesthesiologist must be immediately available for emergencies. In high-acuity cases—which are standard in Maryland trauma centers—if the physician is pulled away to a trauma, they legally fail TEFRA requirements. Facility reimbursement is slashed to "Medical Supervision" rates, and the AA is left practicing outside their authorized scope. The 1:4 ratio instantly collapses to 1:1, stranding the other three operating rooms.

- **The TCOC "Utilization Tax":** Under Maryland's unique Total Cost of Care (TCOC) model regulated by the Health Services Cost Review Commission (HSCRC), hospitals operate on strict global budgets. Because of the tethering requirement, hospitals must pay a full AA salary *plus* the expensive time of a supervising physician to accomplish the work of a single independent CRNA. Inflating labor costs with top-heavy, dependent providers directly threatens a hospital's ability to stay under its global budget.

3. Demographic Incompatibility and Rural Access Failure

This legislation offers no solution for Maryland's most vulnerable geographic areas.

- **Useless in Rural Areas:** Because AAs must remain tethered to an anesthesiologist, they cannot deploy to rural Critical Access Hospitals where independent CRNAs often serve as the sole anesthesia providers.

- **The Demographic Cliff:** Approximately **45.6% of Maryland anesthesiologists are age 55 or older**. Given this rapidly aging workforce, the legislature's 2016 decision to reject dependent care was the right policy decision. It is fundamentally unsound to build a new workforce (AAs) that is legally tethered to a shrinking pool of physicians.

- **A Failed National Model:** AAs were first licensed in 1969, yet after nearly 60 years, there are only ~4,000 practicing in the U.S., with nearly 50% concentrated in just two states (Georgia and Florida). In stark contrast, there are over 75,000 licensed CRNAs practicing in every state across the country. The AA model has failed to scale because dependent models do not work in modern healthcare and current demographics.

4. A Threatens MD's Own Nurse Anesthesia Programs

The legislature's rejection of the 2016 AA bill was a powerful statement supporting independent practice and our indigenous educational pathways.

- **The Market Has Spoken:** As a direct result of that 2016 decision, Johns Hopkins—who had previously supported the AA bill—recognized the future of anesthesia care and opened its own Nurse Anesthesia program. Today, with elite doctoral programs at the University of Maryland, Johns Hopkins, and the Uniformed Services University, we are successfully meeting the needs of the state's healthcare system.
- **Displacing Doctoral Nurse Anesthesia Students:** Operating Room (OR) training slots are a finite, "zero-sum" state resource. Every clinical slot allocated to an AA student (who requires 1:1 physician supervision) is a slot directly stolen from a doctoral CRNA student. Maryland’s priority must be maximizing the output of independent providers who offer the highest geographic and operational utility.

5. Regulatory Mismatch and Forced Oversight

The legislature has repeatedly rejected this model (in 2009 and 2016) for good reason. Furthermore, the proposed licensing body—the **Maryland Board of Physicians — does not support this legislation**.

Regulatory boards exist to protect the public, not to incubate new professions at the behest of special interest groups. Forcing the Board of Physicians to build a regulatory framework, disciplinary matrix, and oversight committee for a dependent, non-physician role it explicitly declined to endorse creates an unfunded mandate on state resources and establishes a "regulatory orphan."

Conclusion

SB 0951 is a trade-down for Maryland. It replaces a highly efficient, cost-effective "Gold Standard" of independent care with a dependent model that inflates global budgets, worsens hospital bottlenecks, and fails to expand access to care.

We have the gold standard of care; CRNAs are filling the need, and we will continue to do so in the future because of our schools and our independent model.

For these reasons, the Maryland Association of Nurse Anesthetists strongly urges an UNFAVORABLE report on SB 0951.

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