Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee

Maryland General Assembly

Annapolis, Maryland

Written Testimony of Shane Angus, CAA, MSA

Senate Bill 951: State Board of Physicians – Anesthesiologist Assistants – Licensing

Position: FAVORABLE

March 4, 2026

Senate Finance Committee

Chair Beidle, Vice Chair Hayes, and members of the Committee, thank you for the opportunity to provide written testimony in support of Senate Bill 951. [1]

My name is Shane Angus. I have practiced as a Certified Anesthesiologist Assistant (CAA) for more than 26 years. I am an associate professor at a school of medicine, with a professional focus on anesthesia education and patient safety. I have lived in Maryland for 13 years, but because Maryland does not license CAAs, I am not permitted to serve patients here. Instead, I have to cross into Washington, D.C. to provide anesthesia care—and many of those patients live in Maryland.

Who CAAs are, and how we are trained:

CAAs are a 55-year-old profession. CAAs are graduate-level, anesthesia-specific clinicians. CAA education is based in the medical model and designed specifically for anesthesia practice. CAAs complete a graduate anesthesia degree associated with a medical school, meet national accreditation standards, and maintain national certification. In practice, CAAs work exclusively within the physician-anesthesiologist-led Anesthesia Care Team, under anesthesiologist supervision and medical direction. This is not an independent practice model. [6]

Maryland already has a strong pipeline of future CAAs. Many CAAs are Marylanders educated at institutions across the state, including Johns Hopkins, the University of Maryland, UMBC, Towson, Salisbury, and the U.S. Naval Academy, among others. Admissions into CAA programs are selective and science-intensive, drawing from applicants with strong academic preparation for medical graduate education. In addition, many CAAs bring prior careers that

translate directly to high-acuity perioperative care—Maryland firefighter and EMTs, physician assistants, nurses and nurse practitioners, foreign-trained physicians, and researchers, including NIH researchers and other biomedical scientists. These backgrounds matter because anesthesia care depends on calm performance in complex clinical environments, strong team-based communication, and disciplined attention to safety.

A proven model next door in Washington, D.C. for over 20 Years:

For over 20 years the District of Columbia has licensed and used CAAs within anesthesiologist-led care teams, and CAAs are integrated throughout the D.C. hospital system. [6] Many Maryland-based health systems that operate in or partner with D.C. facilities already credential and rely on CAAs in their anesthesia staffing models.

Nationally, licensure for CAAs continues to expand. States have continued to adopt CAA licensure through bipartisan legislation. Most recently, Nevada, Washington State, Tennessee, and Virginia enacted CAA licensure. [3] Virginia's legislation passed by wide margins—37 to 3 in the Senate and 84 to 13 in the House—underscoring that policymakers across parties view CAA licensure as a practical, safety-focused workforce solution. [2]

What SB 951 does, and what it does not do:

SB 951 is a straightforward Maryland licensure bill. It establishes a licensing and regulatory framework for anesthesiologist assistants under the State Board of Physicians, requires graduation from an accredited anesthesiologist assistant program and passage of a national certifying examination, and keeps supervision explicit through required anesthesiologist supervision.

This legislation is important for patient access and hospital capacity. When anesthesia staffing is tight, operating rooms run below capacity, cases are delayed, and patients wait longer for surgery and procedures. SB 951 gives Maryland hospitals an additional, proven staffing option by allowing them to recruit and retain qualified, nationally certified CAAs who are already part of the regional workforce. CAAs do not replace other anesthesia professionals; they expand the pool of qualified clinicians who can support safe anesthesia services within the anesthesiologist-led care team model.

SB 951 supports workforce reassurance. Maryland will continue to rely on anesthesiologists and nurse anesthetists, and SB 951 does not reduce roles or

opportunities for any other anesthesia professional. It adds CAAs as another nationally certified clinician. In states where CAAs practice, the anesthesia workforce grows on both tracks—CAAs and CRNAs—helping meet rising surgical and procedural demand.

SB 951 does not change anesthesia billing rules or create a new reimbursement mandate. The bill is about professional licensure and supervision under the State Board of Physicians. It does not create a new payment mechanism, new payer mandate, or a new category of billed anesthesia service. Hospitals and anesthesia groups continue to operate within existing billing and reimbursement frameworks; the bill is about workforce capacity and access, not about increasing system costs through new reimbursement structures.

SB 951 expands access statewide. Adding CAAs expands anesthesia workforce options for rural hospitals, urban hospitals, and ambulatory surgery centers so they can keep operating rooms staffed and reduce delays and cancellations. Many CAAs live in Maryland communities outside the metro area but currently commute to Washington, D.C. to practice; licensure would allow more of that workforce to care for Maryland patients closer to home.

The safety case is strong. A large, peer-reviewed study of Medicare beneficiaries undergoing inpatient surgery found no significant differences in inpatient mortality, length of stay, or inpatient spending when comparing anesthesiologist-led care teams that included anesthesiologist assistants versus those that included nurse anesthetists. [5] That evidence supports what hospitals already know from daily practice: anesthesiologist-led care teams can safely incorporate both CAAs and CRNAs to meet surgical and procedural needs. [5]

For these reasons, I respectfully request a favorable report and a yes vote on Senate Bill 951.

Respectfully submitted,

Shane Angus, CAA

References

[1] Maryland General Assembly. Senate Bill 951 (SB0951) bill page and synopsis: establishes licensing and regulatory system under the State Board of Physicians.

[2] Virginia Legislative Information System. SB 882 vote history: passed Senate 37–3 and House 84–13.

[3] Recent state adoption examples (official state legislative sources): Washington State Legislature SB 5184 (Chapter 362, Laws of 2024); Tennessee General Assembly HB 979 / SB 764 (Public Chapter 509); Virginia General Assembly SB 882 (Chapter 507, 2025 Acts of Assembly); Nevada Legislature AB 270 (Chapter 247, 2023).

[4] Number of jurisdictions where CAAs are authorized: ASA overview page (varies by update; use the version current on your submission date).

[5] Sun EC, et al. Anesthesiology. 2018;129(4):700–709. Retrospective analysis of 443,098 Medicare inpatient cases comparing anesthesiologist-led teams using anesthesiologist assistants vs nurse anesthetists; no significant differences in mortality, length of stay, or inpatient spending. DOI: 10.1097/ALN.0000000000002275.

[6] Code of the District of Columbia, § 3–1206.31. Scope of practice (anesthesiologist assistants).