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## **TESTIMONY IN OPPOSITION**

### **Senate Bill 0951: State Board of Physicians-Anesthesiologist Assistants-Licensing**

**TO:** Members of the Senate Finance Committee

**FROM:** Maryland Academy of Advanced Practice Clinicians (MAAPC)

**DATE:** Hearing March 6, 2026

### **POSITION: UNFAVORABLE**

The Maryland Academy of Advanced Practice Clinicians (MAAPC) respectfully submits this testimony in opposition of SB 0951.

#### **About the Maryland Academy of Advanced Practice Clinicians**

Founded in 2005, the Maryland Academy of Advanced Practice Clinicians (MAAPC) is the first organization in the nation to unite all Advanced Practice Nurses (APRN) and Physician Assistants under a single professional association. MAAPC has a sustained legislative record in Maryland, having led successful efforts resulting in full practice authority for nurse practitioners (2015) and clinical nurse specialists (2023). Membership includes nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse-midwives (CNM), nurse anesthetists (CRNA), and physician assistants (PA). MAAPC submits this testimony in opposition to SB 0951.

#### **1. Advanced Practice Registered Nurses Are the Preferred Anesthesia Workforce Model for Maryland**

Maryland's existing anesthesia delivery system is built on the APRN model — specifically the CRNA pathway — which represents the most clinically prepared, deployable, and cost-effective anesthesia provider available to the state's healthcare system.

CRNAs bring a clinical foundation that is unmatched among anesthesia providers. The pathway to CRNA licensure requires a Bachelor of Science in Nursing, active RN licensure, three to five years of high-acuity Intensive Care Unit experience, and completion of a 36-month doctoral anesthesia training program.

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Every CRNA entering practice has managed critical care emergencies independently before administering a single anesthetic. This depth of preparation is a deliberate policy safeguard, not a credential formality.

The APRN model also offers what no dependent provider model can: full geographic and operational portability. CRNAs practice collaboratively in urban academic medical centers, suburban surgical facilities, and rural Critical Access Hospitals — often as the sole anesthesia provider. This universal deployment capacity is the structural foundation of Maryland's anesthesia access model.

SB 0951 proposes to introduce Anesthesiologist Assistants (AA) — a provider category that requires a general four-year undergraduate degree with no required prior clinical healthcare experience, followed by graduate training under physician supervision. AAs are not APRNs. They do not hold nursing licensure, they do not bring ICU-level critical care preparation, and they cannot practice autonomously. Introducing this provider category alongside Maryland's established APRN workforce does not enhance the system — it adds a dependent tier that competes for the same clinical training resources while offering a narrower scope of deployment. Maryland has a functioning, scalable, and clinically superior answer to anesthesia workforce needs in its CRNA and APRN infrastructure. The legislature's policy preference should be to strengthen and expand that model, not to supplement it with a dependent provider category built on a materially different clinical foundation.

## **2. Structural Incompatibility with Maryland's Total Cost of Care Model**

Maryland operates under a unique Total Cost of Care (TCOC) model administered by the Health Services Cost Review Commission (HSCRC), under which hospitals function within global budget constraints. The AA model requires continuous physician anesthesiologist supervision, creating a structural condition in which a hospital must fund both a full AA salary and the concurrent time of a supervising physician to accomplish work currently performed by a CRNA. This labor cost structure is directly in tension with HSCRC global budget compliance.

## **3. Federal TEFRA Reimbursement Risk**

Proponents cite the federal Medicare 1:4 Medical Direction supervision ratio as evidence of operational efficiency. However, under TEFRA Medical Direction rules, the supervising anesthesiologist must remain immediately available for emergencies across all directed cases. In high-acuity environments — standard in Maryland trauma and academic medical centers — diversion of the supervising physician to

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an emergency triggers a downgrade to "Medical Supervision" reimbursement rates for the remaining cases. The 1:4 ratio collapses to 1:1 in precisely the high-volume, high-acuity settings where the efficiency argument is made. This reimbursement exposure is an inherent structural feature of the supervision model, not an edge case.

#### **4. Rural and Critical Access Hospital Inapplicability**

Because AAs require proximate physician supervision, they cannot be deployed in rural Critical Access Hospitals or settings where an anesthesiologist is not on-site. CRNAs currently serve as the sole anesthesia providers in many rural facilities. SB 0951 does not expand access to care in Maryland's most underserved geographic areas; it introduces a provider category that is structurally ineligible to serve those settings.

This limitation is compounded by workforce demographics: approximately 45.6 percent of Maryland anesthesiologists are age 55 or older. A dependent provider model tethered to a demographically contracting supervising workforce presents a long-term sustainability concern.

#### **5. Clinical Training Slot Competition**

Operating room clinical training slots represent a finite statewide resource. AA training requires 1:1 physician supervision, placing AA students in direct competition with doctoral CRNA students for the same limited OR capacity. Maryland currently supports doctoral nurse anesthesia programs at the University of Maryland, Johns Hopkins, and the Uniformed Services University — programs that produce APRN providers with the broadest geographic and operational deployment utility. Allocating training slots to a dependent provider category reduces the throughput of APRN providers from these existing state-based programs.

#### **6. Regulatory Board Position and Legislative Precedent**

The Maryland Board of Physicians has not endorsed SB 0951. Establishing a licensure and disciplinary framework for a dependent, non-physician provider role within a board that has not supported the legislation creates an administrative burden without a corresponding regulatory sponsor. The General Assembly previously declined to enact AA licensure in 2009 and 2016. The structural and demographic considerations that informed those decisions remain present in the current legislative environment.

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## **Conclusion**

Maryland's APRN workforce — and the CRNA model in particular — represents the state's most effective, scalable, and cost-efficient anesthesia delivery infrastructure. SB 0951 introduces a provider category that is structurally incompatible with Maryland's TCOC/HSCRC global budget framework, creates federal reimbursement exposure under TEFRA Medical Direction rules, does not address rural access gaps, and increases competitive pressure on existing doctoral APRN training programs.

MAAPC urges the Committee to issue an **UNFAVORABLE** report on SB 0951 and to reaffirm Maryland's commitment to the advanced practice registered nurse model as the foundation of the state's anesthesia workforce policy.

Respectfully,

A handwritten signature in black ink, appearing to read "Marie Tarleton", is written over a light-colored, textured background.

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