Maryland CAA Statement.pdf
Uploaded by: Ashish Patel
Position: FAV

Re: Senate Bill 951/House Bill 1558 – State Board of Physicians -Anesthesiologist Assistants - Licensing

Dear Senate Finance Committee,

My name is Ashish Patel. I am a Maryland resident and a Certified Anesthesiologist Assistant (CAA) with over 25 years of experience. Throughout my career, I have always worked at Level I trauma centers. I was among the first CAAs practicing in the Washington, DC area. Despite living in Maryland, I have never been allowed to practice in my home state.

For more than two decades, I have commuted over an hour each way to work in neighboring jurisdictions. Personally, this has been tough since it has limited where my wife can work because when our kids were young she had to stay closer to home. I was at least an hour (with no traffic) away, so that limited my ability to pick up the kids, take them to practices, attending events… putting even a greater burden on my spouse. Professionally, the countless hours spent on the road and passing Maryland health facilities, meant that my skills and experience have not been available to Maryland hospitals or Maryland patients—even during these times of staffing shortages and increasing demand for surgical and procedural care. Our recent events, for example, I left the house at 4:30am to slowly and safely drive to DC in order to take care of patients. I have many examples like this over 20 years – I did gray quickly!

CAAs practice exclusively within the physician anesthesiologist–led Anesthesia Care Team model. We do not practice independently. An Anesthesiologist is required to be available somewhere within the hospital or facility. We follow the same operating room safety culture used throughout modern anesthesia practice, including checklists, escalation protocols, and immediate physician involvement for complex or emergent situations. Patient safety and physician-led care are foundational to our role.

Maryland hospitals and surgical centers are experiencing anesthesia staffing pressures that delay or limit procedures. Licensing CAAs would allow Maryland to expand anesthesia capacity within existing care team models, without changing physician leadership or hospital bylaws. Many CAAs are like myself…. already living in Maryland but are forced to commute out of state to work. Licensure would keep experienced clinicians and increase qualified anesthesia providers here at home.

CAA education is graduate-level program. We must pass a national board exam every ten years with ongoing certification and continuing education requirements every two years. Hospitals and anesthesia departments hold clinicians accountable through credentialing, peer review, etc. State licensure would add an additional layer of accountability and public protection by establishing clear and transparent standards and oversight.

CAAs are licensed in 23 states. This includes DC and Virginia. I ask for your support of the bill to license certified anesthesiologist assistants so that Maryland residents may also have access to the quality anesthesia care we provide. Thank you for your time

Sincerely,

Ashish Patel, CAA

CAAs in Maryland.pdf
Uploaded by: Ashlee Gourdine
Position: FAV

03/04/2026

Senate Finance Committee
11 Bladen Street, 3 East Miller
Senate Office Building,
Annapolis, MD 21401

Dear Senate Finance Committee,

I am writing to express my strong support for Senate Bill 951/ House Bill 1558 regarding the licensing of anesthesiologist assistants in Maryland. I am a Maryland resident and a practicing anesthesiologist, and I have firsthand knowledge of the workforce and challenges facing perioperative and anesthesiology care in our state.

The formal recognition and licensure of Certified Anesthesiologist Assistants (CAAs) would represent a meaningful and evidence-based expansion of Maryland's anesthesia workforce. CAAs are highly trained anesthesia professionals who practice exclusively within the anesthesia care team model and under the direct supervision of a licensed anesthesiologist. Their education is nationally standardized, science-based, and modeled after physician training, with rigorous clinical and didactic requirements.

Currently, CCAs are licensed and practicing safely in 23 states and the District of Columbia. In these jurisdictions, their integration into anesthesia teams has demonstrably enhanced workforce flexibility, improved operating room efficiency, and expanded access to procedural care without compromising patient safety. The benefits of their inclusion into the anesthesia team are evident in these locations, where anesthesia care remains physician-led, and quality metrics remain strong.

Maryland hospitals continue to face staffing pressures driven by rising surgical volumes, workforce shortages, and growing demands for sub-specialty care. These pressures are particularly acute in time-sensitive environments such as trauma centers, labor and delivery units, and complex surgical programs. Licensing CAAs would enable anesthesiologists to deliver high-quality anesthesia services more effectively across care settings while maintaining the safety standards Maryland patients expect.

As a Maryland resident and practicing anesthesiologist, I believe this bill will enhance access to patient care, support hospital operations, and preserve the quality of anesthesia care in our state.

I respectfully urge the committee to support Senate Bill 951/House Bill 1558. Thank you for your time and consideration.

Sincerely,

Ashlee V. Gourdine, M.D.

Senate Finance Committee.pdf
Uploaded by: Ashleigh Dechow
Position: FAV

Senate Finance Committee

11 Bladen Street

3 Easy Miller Senate Office Building

Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

As a longtime Maryland resident, I am writing in support of Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. This bill would allow for the licensure of Certified Anesthesiologist Assistants (CAAs) in the state of Maryland, adding Maryland to the 23 states where CAAs are currently licensed, including Virginia and the District of Columbia. CAAs receive a graduate level education, attain standardized national certification with ongoing continuing education and recertification requirements, and practice exclusively in the Anesthesia Care Team (ACT) model under the supervision of a physician anesthesiologist.

I have been practicing as a CAA for nine years, and thus far I have spent my entire career working in the District of Columbia. Maryland hospitals and surgery centers face anesthesia staffing pressures that limit or delay procedures, and by not licensing CAAs Maryland is preventing themselves from accessing a deep and robust talent pool from within their own state. By adding CAAs to existing ACT models, Maryland can expand capacity without altering physician leadership and allow Maryland CAAs to provide medical care to their Maryland friends and neighbors in Maryland hospitals.

In the last four years, five other states have adopted CAA licensure. I urge you to support this bill and add Maryland to that list, allowing CAAs living in Maryland the opportunity to work where they live.

Sincerely,

Ashleigh Dechow, CAA

Silver Spring, Maryland

Testimony_Beatriz Jose (1).pdf
Uploaded by: Beatriz Jose
Position: FAV

March 1st, 2026

Senate Finance Committee,
11 Bladen Street, 3 East Miller
Senate Office Building,
Annapolis, MD 21401

Dear Chair Beidle, Vice Chair Hayes and Members of the Senate,

My name is Beatriz Jose, and I am a first-year student anesthesiologist assistant projected to graduate in May 2027. As a resident of Prince George's County MD, District 4, I am writing to you regarding Senate Bill 951/House Bill 1558.

In 2006, my family moved from the Philippines to Maryland after my mom was sponsored by a local hospital to work here. This opportunity changed the trajectory of our life; it gave our family stability and the chance to build a future in this community. From that point forward, Maryland became my home.

Watching my mom leave for early morning hospital shifts and steadily build her career shaped my own path into medicine. Today, I am training to become a Certified Anesthesiologist Assistant and will soon enter the healthcare workforce. My goal is to build my career in Maryland and serve the same community that once extended opportunity to my family.

I have spent the past two decades growing up here, completing my education and building my local network through my church and community. It was here that I first volunteered in a hospital. It was also here that I first volunteered at a Gastroenterology clinic and was exposed to the field of anesthesia. These experiences reinforced my desire to remain and contribute here long term.

While I recognize that many healthcare careers require relocation, I intend to remain in Maryland or the surrounding DC area after graduation. I chose to complete my graduate training in DC so that I could stay close to the support system that continues to sustain me through the demands of an intensive anesthesia program. Remaining in Maryland is not simply a professional preference; it reflects my gratitude for the opportunities my family was given and my commitment to give back to the community that helped shape me.

Thank you for your time and thoughtful consideration of Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. I sincerely hope you will lend your support to this legislation.

Sincerely,

Beatriz Jose

Children's National Testimony - SB 951 - Brad Taic

Uploaded by: Brad Taicher

Position: FAV

111 Michigan Ave NW
Washington, DC 20010-2916
ChildrensNational.org

Testimony of Brad Taicher, DO, MBA
Chief of Anesthesiology, Pain and Perioperative Medicine
Children's National Hospital

Senate Bill 951: State Board of Physicians – Anesthesiologist Assistants – Licensing
Position: FAVORABLE
March 6, 2026
Senate Finance Committee

Chair Beidle, Vice Chair Hayes and members of the committee, thank you for the opportunity to provide written testimony in strong support of Senate Bill 951. My name is Dr. Brad Taicher, and I am the Chief of Anesthesiology, Pain and Perioperative Medicine at Children's National Hospital. As the region's only standalone children's hospital, Children's National has been serving the nation's children since 1870. For 155 years, we have delivered expert pediatric care at every milestone. Sixty percent of our patients are residents of Maryland, and we maintain a large network of community-based pediatric practices, surgery centers and regional outpatient centers in Maryland. In addition to my role at Children's National, I serve as the Associate Vice Chair for the Society of Pediatric Anesthesia's Committee on Quality and Safety, and I am a Maryland resident.

Nationally, the anesthesia workforce is experiencing a critical shortage. According to the Health Resources and Services Administration (HRSA), there is currently a shortage of 3,720 physician anesthesiologists across the country. By 2038, the shortage is projected to increase to 10,660.[1] Factors like early retirement, aging populations, and rising surgical volumes have left hospitals and providers not being able to meet the demand for anesthesia services. Maryland is not immune to this shortage. Data analysis from the Maryland Department of Labor using data from Lightcast noted that in 2019 there were 624 physician anesthesiologists in Maryland whereas in 2025 there were only 250 – a decrease of 60%.[2]

Aging is a major factor in both the workforce shortage and the rising demand for services. We know that the anesthesia workforce is aging alongside Maryland's population, and we already can't meet the demand for anesthesiologists and anesthesia services. Unfortunately,

[1] HRSA Workforce Projections: Workforce Projections
[2] See attachment A (Lightcast, a labor market analytics company)

the shortage impacts care for both ends of the age spectrum. Aging populations intensify the need for surgical care and anesthesia providers. On the other hand, there is a significant national shortage of pediatric anesthesiologists, which is expected to persist for some time. In fact, fewer medical school graduates are entering into pediatrics let alone pediatric anesthesiology as a specialty.[3]

While the shortage of physician anesthesiologists will not be resolved overnight, there is a clear and immediate policy opportunity to address this critical workforce gap and the resulting barriers to patient access to care. Through licensing Certified Anesthesiologist Assistants (CAAs) in Maryland, we can safely provide care to the greatest number of residents closest to home. Currently, CAAs can practice in 23 states and jurisdictions – a number that continues to grow each year. This includes our neighboring states of Washington DC, which licensed CAAs over two decades ago, and Virginia, which passed its licensure bill last year.

Most anesthesia care in the U.S. is provided directly by a physician anesthesiologist or by a non-physician anesthesia clinician led by a physician anesthesiologist within the Anesthesia Care Team (ACT) model.[4] Non-physician anesthesia clinicians consist of nurse anesthetists or anesthesiologist assistants. For the past 20 years, Children's National has utilized the ACT model at our main hospital in DC, allowing us to maximize our staffing resources and provide safe and efficient access to anesthesia services for our patients – the majority of whom are Marylanders.

SB 951 both helps alleviate anesthesia provider workforce shortages and increase access to anesthesia services in Maryland. Since the height of the COVID-19 pandemic, we have been unable to fully open all our operating rooms in Maryland due to ongoing staffing constraints. Currently, 43% of CAAs at Children's National live in Maryland but work in DC. If this bill passes, they would be eager to provide care for kids in Montgomery and Prince George's counties, where our Ambulatory Surgery Centers (ASCs) are located. Allowing CAAs to practice at our Maryland ASCs – as they do every day in DC – would help ensure these sites remain fully operational for Maryland patients and families while expanding our capacity to serve more children each day.

In addition to increasing access to necessary anesthesia care, SB 951 will create a new career pathway in healthcare for the state. Although the CAA profession has been established for more than 50 years, Maryland has not yet leveraged this highly specialized workforce. This is a unique opportunity because we know that there are Marylanders who were born, raised, and educated in the state who must leave the state every single day to practice as a licensed CAA.

[3] Pediatric Residents' Preparedness and Training Satisfaction: 2015 to 2022 | Pediatrics | American Academy of Pediatrics
[4] Statement on the Anesthesia Care Team

We can prevent Maryland from losing opportunities to serve patients to our neighboring states by tapping into an existing talent pool in the state to provide necessary care to Marylanders imminently to help alleviate this critical shortage.

At Children's National, we strongly believe that we need the full range of anesthesia providers – anesthesiologists, nurse anesthetists and certified anesthesiologist assistants to better serve Maryland patients and grow our health workforce. As the region's only standalone Children's Hospital we carry one of the greatest responsibilities in medicine – guiding children safely through some of the most vulnerable and challenging moments of their lives. When a child needs surgery or a complex procedure, families place extraordinary trust in us. We honor that trust by working diligently and safely to ensure the best possible care for our patients, offering expertise and compassion to address their unique medical needs and promote their health and well-being. By utilizing a physician-led anesthesia care team model, we ensure that every child receives safe, timely, and expert care.

I applaud Senator Ellis for introducing this important legislation, which will have life-long benefits for our state's youngest residents and their families and respectfully request a favorable report on Senate Bill 951. Thank you for the opportunity to submit testimony.

For more information, please contact:
Austin Morris, Government Affairs Manager
almorris@childrensnational.org

Attachment A

Nurse Anesthetists & Anesthesiologists in Maryland

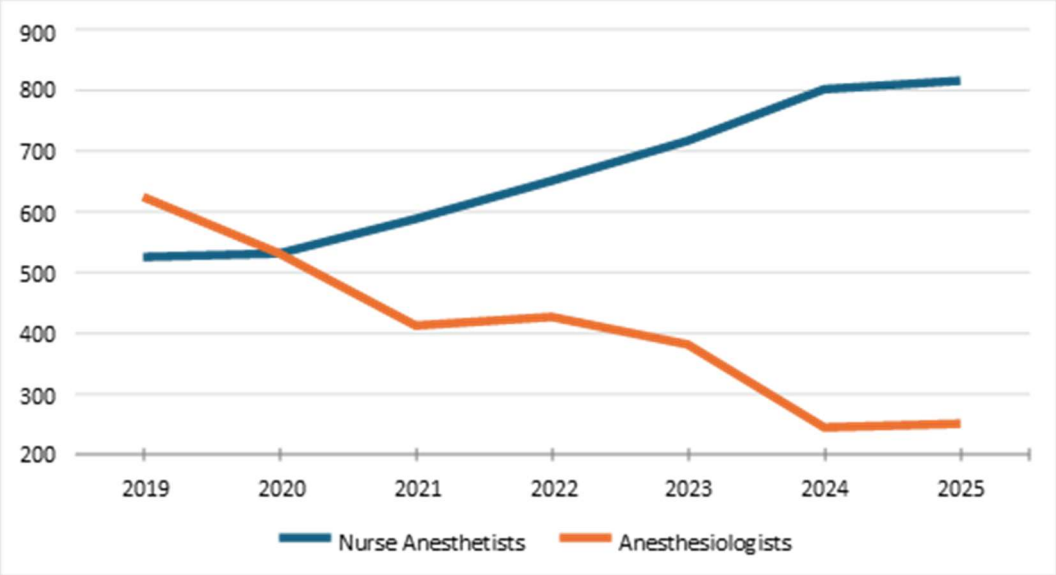
In 2025, Maryland had 815 Nurse Anesthetists and 250 Anesthesiologists. From 2019, employment for Nurse Anesthetists has increased 55%, while employment for Anesthesiologists has declined 60%. See the table and chart below for the changes in employment each year from 2019 to 2025.

Table: Employment for Nurse Anesthetists & Anesthesiologists in Maryland

Occupation	2019	2020	2021	2022	2023	2024	2025
Nurse Anesthetists	524	530	587	650	716	801	815
Anesthesiologists	624	531	412	426	381	244	250

Source: Lightcast

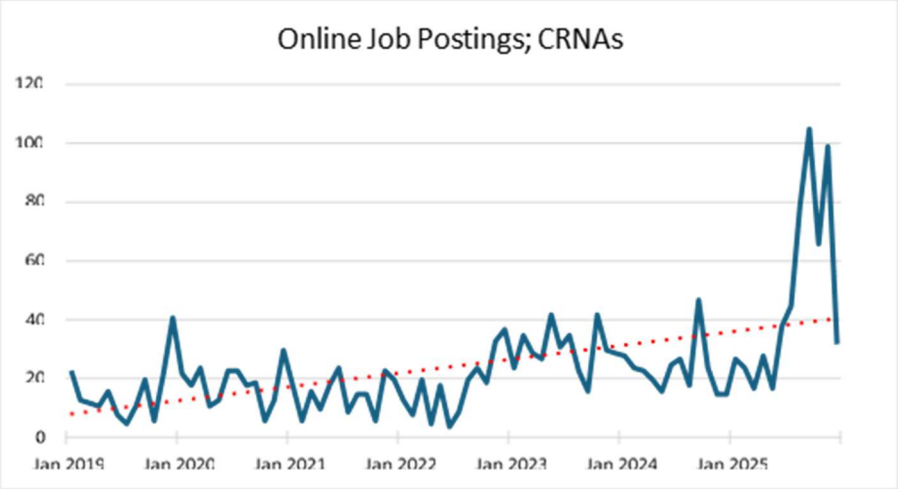
Chart: Employment for Nurse Anesthetists & Anesthesiologists in Maryland



Source: Lightcast

Online job postings data is used to gauge current demand employers have in specific fields. While there's a lag in employment data, online job postings data has a much smaller delay in data reporting. From January 2019 to December 2025, overall job postings in Maryland have increased 2.0%. Job postings data allows the ability to research job titles, while our employment data is limited to occupations (groupings of job titles with similar functions). As a result, included are job postings data for CRNAs. Job postings for CRNAs have increased 39% from Jan 2019 to Dec 2025. Demand for CRNAs outpaces all job postings for the same time period.

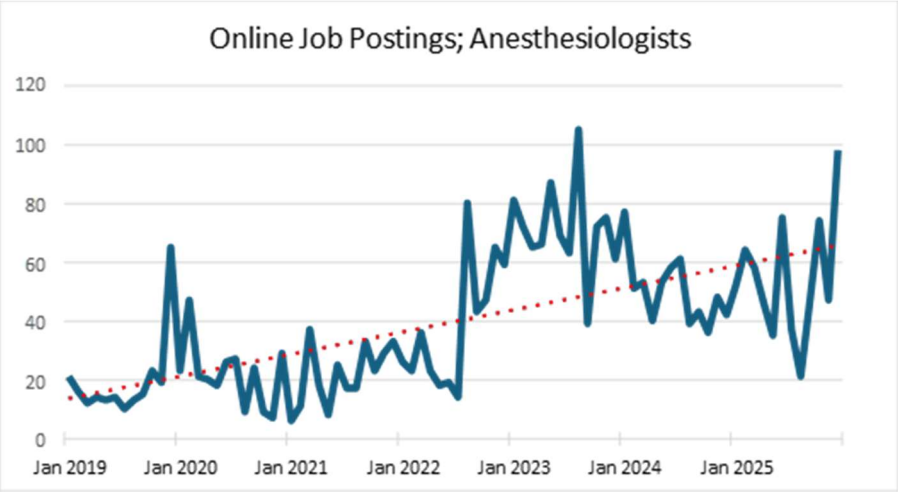
Chart: Online Job Postings for CRNAs in Maryland; Jan 2019 to Dec 2025



Source: Lightcast

Employment data shows a decline for Anesthesiologists from 2019 to 2025. Online job posting data shows the opposite. From Jan 2019 to Dec 2025, job postings for Anesthesiologists have increased 367%. This could indicate that the decline in employment/worker s for Anesthesiologists resulted in a shortage. The surge in online job postings could indicate employers trying to hire due to the increased need for Anesthesiologists.

Chart: Online Job Postings for Anesthesiologists in Maryland; Jan 2019 to Dec 2025



SB951 Favorable.pdf
Uploaded by: Catherine Bakir
Position: FAV

Senate Finance Committee

11 Bladen Street

3 East Miller Senate Office Building

Annapolis, MD 21401

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

My name is Catherine Bakir, and I am a proud Maryland resident and a licensed Certified Anesthesiologist Assistant (CAA). I have been licensed and practicing as a CAA for 7 years, caring for patients across Maryland during some of the most vulnerable moments of their lives — before surgery, during complex procedures, and throughout recovery.

Every day, I meet patients who are anxious, in pain, or facing life-changing diagnoses. I have cared for children undergoing emergency procedures, elderly patients requiring urgent surgeries, and working parents who simply want to get back home safely to their families. As part of a physician-led anesthesia care team, I work under the direct supervision of an anesthesiologist to ensure that each patient receives safe, high-quality anesthesia care. That collaborative model is not only effective — it is essential to patient safety.

Despite the growing demand for surgical and procedural services, Maryland does not currently license CAAs. Meanwhile, 23 states — including the District of Columbia and Virginia — recognize and license CAAs as part of the anesthesia care team. I see firsthand how this model increases access to care, strengthens physician-led teams, and helps address workforce shortages without compromising safety or quality.

Senate Bill 951 / House Bill 1558 — State Board of Physicians — Anesthesiologist Assistants — Licensing — represents an opportunity for Maryland to modernize its workforce policies and better serve patients. This legislation does not expand independent practice; it maintains direct physician supervision while allowing CAAs to practice within a regulated, licensed framework under the State Board of Physicians.

As someone who has dedicated my education, training, and career to safe anesthesia practice, I want Maryland patients to have every resource available to ensure timely access to surgical care. I want our hospitals to have the workforce support they need. And I want our state to remain competitive with neighboring jurisdictions that already benefit from this proven model.

I respectfully urge you to support Senate Bill 951 / House Bill 1558 and help strengthen access to safe, physician-led anesthesia care in Maryland.

Thank you for your time, consideration, and service to our state.

Sincerely,

Catherine Bakir, MSA

Certified Anesthesiologist Assistant

Maryland Resident

Senate Finance Committee Letter.pdf
Uploaded by: Daniel Pistone
Position: FAV

Daniel Pistone, CAA, MMSc
7111 Central Avenue
Takoma Park, MD 20912

March 4, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

My name is Daniel Pistone, and I am a Maryland resident, a parent of three children who attend Maryland public schools, and a Certified Anesthesiologist Assistant (CAA) with over fifteen years of experience practicing in Washington, DC. I am writing to urge your support for Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. This legislation is deeply personal to me, as it would finally allow me, and many colleagues like me, to practice our profession in the state we call home and serve Maryland patients directly.

Every time I speak with my Maryland neighbors, I am asked if I work at our local hospital. It is disappointing to explain that, despite my qualifications and commitment to patient care, I am unable to practice in Maryland due to current licensing restrictions. Instead, I commute daily to Washington, DC, which takes me away from my family and my community. As a parent, I want my three children to see that Maryland values highly trained healthcare professionals and supports those who wish to give back to their communities.

Throughout my career, I have worked closely with physician anesthesiologists and other advanced practice providers in a physician-led Anesthesia Care Team (ACT) model. Patient safety is always our top priority. As CAAs, we never practice independently; we are required by training and law to work under the direct supervision of a physician anesthesiologist. Our operating room culture emphasizes rigorous safety protocols that ensure patients receive the highest standard of care.

My education as a CAA was rigorous, culminating in a graduate degree and national certification. Like all CAAs, I meet ongoing continuing education and recertification requirements to maintain my competence and stay current with advances in the field. We are trained across all anesthesia specialties and are privileged to work wherever our supervising anesthesiologist and the facility credential us. This high level of training and oversight ensures that we are always prepared to provide safe, effective care.

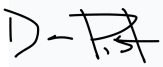
Maryland is currently facing significant anesthesia workforce shortages, which can delay or limit access to surgical and procedural care for patients across the state. By licensing CAAs, Maryland can expand its anesthesia care capacity without changing the physician-led structure that ensures quality and safety.

This bill would not create independent practice for CAAs, nor would it replace any of our anesthesia professional colleagues. It simply allows another highly trained, supervised clinician to join the team, without changing existing practice authority or hospital bylaws.

I am proud to live in Maryland and to raise my family here. I want to be able to serve my community, contribute to our hospitals, and ensure that Maryland patients have timely access to physician-led anesthesia care. Please support Senate Bill 951/House Bill 1558 and give CAAs the opportunity to practice in our home state—so that my children, and all Marylanders, can benefit from safe, high-quality anesthesia care close to home.

Thank you for your time and consideration.

Sincerely,



Daniel Pistone
Certified Anesthesiologist Assistant and Maryland Resident

MSA Testimony 2026 - Support - SB951 - State Board

Uploaded by: Daniel Shattuck

Position: FAV

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

Date: Friday, March 6, 2026
Committee: The Honorable Pam Beidle, Chair
Senate Finance Committee
Bill: **Senate Bill 951 - State Board of Physicians – Anesthesiologist Assistants – Licensing**
Position: **SUPPORT**

The Maryland Society of Anesthesiologists (MSA) is a state component society of the American Society of Anesthesiologists (ASA). The MSA is a non-profit physician organization dedicated to promoting the safest and highest standards of the profession of anesthesiology in the State of Maryland. Our purpose is to advocate on behalf of our members for their patients through policy, education, and research.

As introduced, Senate Bill 951 "establishes a licensing and regulatory system for anesthesiologist assistants under the State Board of Physicians."

Background:
The Maryland Society of Anesthesiologists (MSA) consistent with the American Society of Anesthesiologists (ASA) recognizes Anesthesiologist Assistants as highly qualified non-physician anesthesia providers who, as valuable members of the anesthesia care team[1], provide safe anesthesia care to the patient under the supervision of an anesthesiologist.

All AAs must complete a comprehensive didactic and clinical program at the graduate school level. To be admitted into an AA training program, students must have earned a baccalaureate degree with premedical coursework. AAs are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. AAs perform such tasks as administering drugs, obtaining vascular access, applying and interpreting monitors, establishing and maintaining patient airway, and assisting with preoperative assessment.

AAs currently practice in 22 jurisdictions:

1. Alabama
2. Colorado
3. District of Columbia
4. Florida
5. Georgia
6. Indiana
7. Kansas*
8. Kentucky
9. Michigan*
10. Missouri
11. Nevada
12. New Mexico
13. North Carolina
14. Ohio
15. Oklahoma
16. Pennsylvania*
17. South Carolina
18. Texas*
19. Utah
20. Vermont
21. Washington
22. Wisconsin

*States in which AAs are granted practice privilege through physician delegation. AAs may practice at any Veterans Affairs facility in all 50 states.

[1] Statement on the Anesthesia Care Team (Approved by the ASA House of Delegates on October 26, 1982, and last amended October 19, 2023) https://www.asahq.org/standards-and-practice-parameters/statement-on-the-anesthesia-care-team

The federal Centers for Medicare and Medicaid Services (CMS) recognizes both Certified AAs and Certified Registered Nurse Anesthetists (CRNAs) as non-physician anesthesia providers. Similarly, commercial insurance payers make no distinction between the two anesthetist types with regard to payments for services provided under medical direction by a physician Anesthesiologist.

AAs train and work under the supervision of physician Anesthesiologists who retain responsibility for the immediate care of the patient. The care team model expands the medical treatment provided by the physician Anesthesiologist and equips the medical facility to serve patients more effectively and efficiently. Patients will always have an anesthesiologist involved in their care who will be immediately available to respond to any complication that may arise.

Why AAs are needed now:
As demand for anesthesia services increases and will only increase more over the next 10-15 years, Maryland will only stand to benefit from the availability of the full complement of anesthesia providers, by allowing AAs to practice.

Almost half the states in the country make this provider available to their residents. As the hospitals in Maryland have so articulately made clear, now is not the time to keep the doors closed to a valued and trusted anesthesia provider that can work seamlessly and immediately with the current workforce in Maryland.

For these reasons we ask for a **FAVORABLE** report on Senate Bill 951.

Sincerely,

The Maryland Society of Anesthesiologists

cc. Dan Shattuck, Executive Director - mdsahq@gmail.com

SB951_2026_CAA Testimony.pdf
Uploaded by: Danielle Gardner
Position: FAV

Senate Bill 951
CAA Testimony

TO

Senate Finance Committee
11 Bladen St
3 East Miller Senate Office Building
Annapolis, MD 21401

MARCH 4, 2026

Dear Members of the Senate Finance Committee,

My name is Danielle Gardner. I am a Maryland resident and Certified Anesthesiologist Assistant currently practicing at a level one trauma center in Washington DC.

I am writing this letter to encourage support of **Senate Bill 951** to allow Certified Anesthesiologist Assistants (CAA) licensure in the state of Maryland. Currently, CAAs are licensed in 24 jurisdictions, including our neighboring state of Virginia, as well as Washington D.C. I moved to Maryland when I was 4 years old (I'm 33 now) and lived in Prince Georges and Charles County until I moved away for undergraduate studies. In 2019, I earned my Masters in Anesthesia and chose to work in Savannah, Georgia at a level 1 trauma center in hopes that in a few years Maryland would grant licensure for CAAs. My husband, a petty officer first class in the Navy, was assigned duty station in Virginia Beach at the time which forced us to live apart for the first four years of our marriage since Virginia also did not have licensure at the time. Our goal was to be closer to family and live in the area we met (Charles Co.). Fortunately, in 2023, my husband was assigned a new duty station at Anacostia-Bolling which meant we could finally live together. We chose to live in Southern Maryland for many reasons; however, that meant my commute would be over an hour into work and often double that on my way home.

Voting in favor of Senate Bill 951 would bring many families like mine closer together and benefit Maryland residents for several reasons too. CAAs have been in existence for nearly 60 years, working safely within the Anesthesia Care Team (ACT), a model that is physician-led and requires anesthesiologist supervision. Adding CAAs to the existing ACT model in Maryland will keep clinicians and care capacity in the state without changing physician leadership or replacing other anesthesia professional colleagues. As with many roles in healthcare, there is a shortage of anesthesia personnel. Granting licensure for CAAs in Maryland will reduce staffing pressure that many hospitals and surgical centers face, as well as reduce delays or limitations in procedures available to our communities.

CAA education is rigorous, graduate-level training that is anesthesia specific and requires standardized national certification, ongoing continuing education, and re-certification. Our profession is in high demand as medical advancements continue to immerge in the surgical and anesthesia realm. Please consider voting in favor of the bill to allow Maryland to license CAAs so that families like mine can continue to grow together and to allow more timely access to physician-led anesthesia care to Maryland residents close to home.

Thank you for your time and consideration.

Sincerely,

Danielle Gardner, CAA

DANIELLE GARDNER
Certified Anesthesiologist Assistant
dravancho04@gmail.com

sb951 Support Testimony.pdf
Uploaded by: Davion Percy
Position: FAV

Luminis Health

Dear Chair and Members of the Committee,

I am writing to express strong support for Senate Bill 951, which establishes a comprehensive licensure and regulatory framework for Anesthesiologist Assistants (CAAs) under the Maryland State Board of Physicians. This legislation is essential to strengthen Maryland's anesthesia workforce, improving patient access to timely surgical and procedural care, and ensuring that our health systems remain resilient and prepared for future demands.

Expanding Access to Safe, High-Quality Anesthesia Care

Maryland continues to experience significant anesthesia workforce shortages across hospitals, ambulatory surgery centers, and procedural environments. Senate Bill 951 creates a pathway for CAAs—highly trained, master's-level anesthesia professionals—to practice under the supervision of physician anesthesiologists, as defined in the bill (§14-5H-101–103). CAAs are already integrated into care teams in many states, where they help reduce surgical delays, expand operating room capacity, and improve patient throughput without compromising safety.

Strengthening Workforce Flexibility Across Urban and Rural Settings

The bill's supervision structure, including written supervision agreements and clear scope-of-practice parameters (§14-5H-112–113), allows health systems to deploy CAAs in a flexible, team-based model. This flexibility is especially important for rural and underserved communities, where recruiting anesthesia providers is often difficult. CAAs can help stabilize anesthesia coverage, maintain essential services, and prevent disruptions in care that disproportionately affect smaller hospitals.

Enhancing System Readiness and Surge Capacity

The COVID-19 pandemic highlighted the need for adaptable clinical staffing models. CAAs are trained in advanced airway management, perioperative evaluation, emergency response, and critical intraoperative procedures—all activities explicitly authorized under SB 951 (§14-5H-112). Licensing CAAs would strengthen Maryland's ability to respond to surges in demand, maintain continuity of operations, and ensure readiness for future public health emergencies.

Supporting Maryland's Health Systems with a Modernized Workforce Model

Senate Bill 951 aligns Maryland with national best practices by establishing clear licensure qualifications, including graduation from an accredited program and passage of a national certification exam (§14-5H-107). The bill also provides for temporary and expedited licensure pathways (§14-5H-110–111), enabling Maryland to recruit experienced CAAs from other states and integrate them efficiently into the workforce.

Ensuring Patient Safety Through Strong Oversight

The bill includes robust safeguards, including supervision requirements, limits on concurrent supervision ratios, and detailed disciplinary provisions (§14-5H-113–115). These measures ensure that CAAs practice safely, consistently, and within the anesthesia care team model led by physician anesthesiologists. This structure preserves the highest standards of patient safety while expanding access to care.

Addressing Workforce Shortages Without Expanding Independent Practice

Importantly, SB 951 does **not** authorize independent practice (§14-5H-103). CAAs function exclusively under anesthesiologist supervision, ensuring that Maryland maintains a physician-led model of anesthesia care while expanding the team to meet growing demand.

For these reasons, I respectfully urge the Committee to return a favorable report on Senate Bill 951. Establishing licensure for CAAs will expand access, strengthen workforce capacity, support rural and urban hospitals alike, and enhance Maryland's readiness for future healthcare challenges—all while maintaining the highest standards of safety and quality.

Thank you for your consideration and for your commitment to improving healthcare for all Marylanders.

Respectfully,

Mitchell Schwartz, MD
Chief Physician Executive, Luminis Health

CAA Letter.pdf
Uploaded by: Emma Reese Kelleher
Position: FAV

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

My name is Emma Reese and I am a Physician Anesthesiologist and Maryland resident. I have extensive experience working alongside CAAs during my residency training as well as in the five years of being an attending anesthesiologist.

The Certified Anesthesiologist Assistant profession is a 55 year old profession created by Anesthesiologists themselves. CAAs are highly skilled health professionals that administer anesthesia under the direction of a Physician Anesthesiologist as a part of the Anesthesia Care Team model. They can practice in 22 states including Washington D.C., and most recently Virginia. The anesthesia workforce is facing shortages nationwide, and Maryland is no exception. As a Maryland resident and Physician Anesthesiologist, I respectfully request that you vote in favor of Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing to meet patient demand in our states.

Sincerely,

Emma Reese, MD

Letter for Senate bill 951_House bill 1558.pdf
Uploaded by: Fay Horng
Position: FAV

March 3, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,
I am an anesthesiologist that is a resident of Maryland and I have been a resident here for 21 years. For the last 12 years I have been licensed to practice medicine in Maryland and Washington DC and practice in Washington DC where I have been fortunate to work with individuals who are Certified Anesthesiologist Assistants (CAAs). These CAA professionals work under the direct supervision of physician anesthesiologists in the operating room.

I would like to urge you to support the following legislation : Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing to bring Certified Anesthesiologist Assistants (CAA) to Maryland. I completed my medical school and anesthesiology residency training in Maryland and when I started work in 2012 in Washington DC I was introduced to the profession of the CAA. I was immediately impressed on how CAAs worked together in a skilled fashion with me on the anesthesia care team in the same way as CRNAs would. This means that all anesthetic plans and care are designed by the physician and CAA together so if there are any issues in care, the physician anesthesiologist is called immediately and arrives to troubleshoot together with the CAA. We have saved many lives this way in the operating room. I was struck by the investment in teamwork of this profession and how their education program at a master's level allowed them to help patients that were gravely ill obtain the necessary surgical care by providing safe anesthesia. I became involved in CAA education by teaching student CAAs in the hospital during rotations like obstetric anesthesia and general anesthesia. I also taught the students in the classroom and simulation sessions and found that the rigorous education prepared them to work on the anesthesia care team. Currently there are many CAAs that are living in Maryland that are providing their anesthesia care in Washington DC and others looking to Virginia or other states for employment since CAAs are licensed in 23 states including DC and Virginia.

I believe we can meet the need for increasing the workforce in anesthesia in Maryland by bringing CAAs to our state, and this will include many CAAs that already reside in Maryland. This will allow costs for anesthesia to be controlled and the highest level of safe anesthesia care to be delivered via the anesthesia care team. Many physicians in Maryland like me desire to work as part of the care team to ensure the safety of our patients.

Sincerely,
Fay Horng, MD

Please Support Senate Bill 0951.pdf
Uploaded by: Galan Jones
Position: FAV

Senate Finance Committee

11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

My name is Galan Jones and I am a Certified Anesthesiologist Assistant (CAA) that resides in Maryland. I have been practicing as a CAA for 8 years. I would love to work in Prince George's County and help patients in my community access safe and timely surgical care . I currently commute 40 minutes to work in DC every day due to my inability to practice in Maryland. I have to drive past 3 Maryland hospital systems and be farther from my family.

The hospital in DC that I currently work at is a level one trauma center and I care for the sickest and most vulnerable patients in the region. At my facility I am involved in anesthesia care for all specialties. These specialties include trauma, obstetrics, pediatrics, general surgery, bariatric surgery, and neurosurgery. CAAs are members of the Anesthesia Care Team (ACT) and uphold patient safety under physician-led care. In the facilities that we currently work, we follow the same OR safety culture as all other hospitals.

Granting licensure for CAAs in Maryland will help staffing issues that many hospitals and surgical centers currently face. It does not replace other anesthesia providers, instead it adds another supervised clinician to the ACT. Maryland can expand surgical capacity by adding CAAs to existing ACT models without changing physician leadership. CAAs are ready to step in and help patients in the state of Maryland just as we have been licensed to do in Virginia, DC, and 22 other states.

Please support Senate Bill 0951 and allow hardworking CAA Maryland residents to provide safe physician-led anesthesia care, while staying close to home.

Sincerely,

Galan Jones CAA

Senate Bill 951_House Bill 1558 Testimony.pdf
Uploaded by: Hannah Hoang
Position: FAV

March 3, 2026

Chair Beidle, Vice Chair Hayes and Members of the Senate
Senate Finance Committee
11 Bladen Street, 3 East Miller Senate Office Building,
Annapolis, MD 21401

Dear Chair Beidle, Vice Chair Hayes and Members of the Senate,

My name is Hannah Hoang, and I am a first year student anesthesiologist assistant who is currently enrolled in a Master of Science in Anesthesia program in Washington, D.C. I am writing today in strong support of the Senate Bill 951/House Bill 1558 bill in hopes that the state of Maryland will license Certified Anesthesiologist Assistants (CAAs) as part of the physician anesthesiologist–led anesthesia care team.

I was born and raised in Salisbury, Maryland and attended the University of Maryland, College Park for my undergraduate education. My family has lived on the lower Eastern Shore for over 25 years, and that community has played a fundamental role in shaping the person I am today. I saw firsthand how difficult it can be to access certain types of healthcare in rural areas. While Salisbury has a strong and supportive local community, many specialty services are limited on the Eastern Shore. For more extensive care, families often have to travel at least an hour or must cross the Chesapeake Bay Bridge to receive care. These barriers can make it challenging for patients to receive timely medical treatment, prompting my interest in the medical field. I chose to attend the CAA program in Washington, D.C. because it is the closest one to my home state, as I proudly call Maryland my home.

For me, this legislation represents the opportunity to come back to the place that shaped my life and career goals. My hope is to return to the Eastern Shore and provide safe anesthesia care under the supervision of a physician anesthesiologist while addressing anesthesia workforce shortages in the rural community that supported me throughout my life.

I respectfully ask for your consideration and support of the Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. Passing this legislation would help expand access to anesthesia care and give students like myself the opportunity to return home after graduation and serve the communities that raised us. Thank you for your time and consideration.

Sincerely,

Hannah Hoang

Senate Finance Commitee Letter.pdf
Uploaded by: Heather Murray
Position: FAV

Heather Murray, Certified Anesthesiologist Assistant (CAA)
6138 Main Street
Queenstown, MD 21658
hplocinik@yahoo.com

4th March 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

I'm a Maryland resident of 16 years and a Certified Anesthesiologist Assistant (CAA) of 8 years who wants to practice at home to help Maryland patients access timely surgical and procedural care. I currently commute 1.5 hours from Queen Anne's County to Washington D.C. to provide specialized pediatric care as a CAA. CAAs are currently licensed in 23 states, including the District of Columbia and Virginia; however, I would love to bring my expertise in pediatrics back home to Maryland at any number of local hospitals that are within 20 minutes of my home.

Certified Anesthesiologist Assistants (CAAs) practice only in the physician anesthesiologist–led Anesthesia Care Team (ACT) model. We do not practice independently; anesthesiologist supervision is required. CAA education is graduate-level and anesthesia-specific, with standardized national certification. Ongoing continuing education and recertification requirements maintain competence over time.

Maryland hospitals and surgical centers are currently facing anesthesia staffing pressure that delays or limits procedures. I experienced this firsthand when I delivered my son at a local Annapolis hospital in April 2025. The anesthesiologist that performed my epidural shared that he hoped CAAs would get licensure in Maryland in the near future because his department was severely understaffed with very few clinicians specifically experienced in pediatric anesthesia.

To be clear, the Senate Bill 951/House Bill 1558 does not create independent practice for CAAs. It does not replace other anesthesia professional colleagues; it adds another supervised clinician to the team. It does not change existing practice authority or hospital bylaws; facilities decide staffing models within applicable law and policy.

Please support the **Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing** to allow Maryland to license CAAs so Maryland patients can access timely, physician-led anesthesia care close to home.

Sincerely,

Heather Murray

Heather Murray, CAA

maryland licensure pdf.pdf

Uploaded by: Iman Sandozz

Position: FAV

Senate Finance Committee
11 Bladen Street
3East Miller Senate Office Building
Annapolis, MD, 21401

Dear Members of the Senate Finance Committee

Support for SB 951 / HB 1558

My name is Iman Musah-Sandozz, MLS(ASCP)CM,CAA and I am a Certified Anesthesiologist Assistant (CAA) with 8 years of experience, specializing in safe and efficacious physician-led anesthesia care. Despite being a lifelong Maryland resident and living in Prince George's County, I am unable to practice in my home state. I currently commute to DC during the week and to Georgia every weekend to work because Maryland lacks a licensure pathway for CAAs, unlike 23 other jurisdictions, including D.C. and Virginia.

I urge your support for SB 951/HB 1558. Supporting this bill into the legislature does not create independent practice for CAAs, replace other anesthesia colleagues nor does it change existing practice authority or hospital bylaws. It does, however, add another qualified clinician to the anesthesia care team. This legislation will end the professional migration of specialized clinicians, as well as, allowing me to finally stop commuting out-of-state and instead serve the healthcare needs of my own Maryland community.

Respectfully,
Iman Musah- Sandozz
6902 stansbury lane,
Landover, MD, 20785

SB0951_Babin_Favor.pdf
Uploaded by: Jaclyn Babin
Position: FAV

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401
Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing
Position: Favorable

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

My name is Jaclyn Babin and I am a Certified Anesthesiologist Assistant. I was born and raised in the state of Maryland and have now laid down my own family's roots here in Maryland. I earned my Master of Science in Anesthesia degree from Case Western Reserve University's MSA program in Washington D.C. and have been working for almost 6 years at a Level 1 Trauma Center since I graduated in 2020, in the middle of the Covid19 Pandemic. I am currently the Student Anesthesiologist Assistant Coordinator there and the President of the Maryland Association of Anesthesiologist Assistants.

Being in healthcare was always a goal of mine and I was introduced to the profession by my uncle who was a neurosurgeon here in Maryland. When I applied for the MSA program, my first choice was to be accepted into the D.C. program so that I could be close to home and learn at the hospitals in D.C. where I would be able to work after graduation. Living and working anywhere else farther away from Maryland was not an option.

Graduating in 2020 at such an unprecedented time was intimidating. In March, before graduation, I knew my preceptors were placing themselves in harm's way and returning to their families with such little knowledge of the effects of this virus, and I wanted to be standing with them. Even in July when I started, we were intubating patients in the ICUs and spending hours wearing N95s and plastic protective gowns in the operating rooms keeping patients safe during urgent and emergent surgeries. This is still the Level 1 Trauma Center I work for today, where we do cases that range from screening colonoscopies to emergent traumas that arrive in critical condition. We provide anesthesia care for 5 minute procedures to 24 hour long surgeries, all under the direction of a Physician Anesthesiologist.

As SAA Student Coordinator for my hospital, I believe in education and opportunity for every learner, and I can tell you firsthand that this proposed bill will not remove or restrict preceptorship or opportunity for any learner. I work alongside my hospital's Student Coordinator for other anesthesia professionals. We collaborate on best practices navigating the systems access process for our students, and have open conversations. We do not displace each other's students from preceptors or specific case opportunities.

As President of the Maryland Association of Anesthesiologist Assistants, Inc., I hear many stories of long commutes, and the simple desire to help serve our communities and work with our amazing Physician Anesthesiologists. Senate Bill 951 does not reduce the role of current anesthesia professionals in Maryland hospitals. It simply adds another qualified, nationally certified member to the physician-led Anesthesia Care Team so facilities have more staffing options to meet patient demand.

I now live ten minutes from a nearby hospital, and it is actually where I was born and where I had my first healthcare shadowing experience. I pass this hospital every single day on my hour-long commute into D.C.

I'm sure with the written testimony you have all had access to, you will see the same pattern. We are here, we support Maryland and want to support our communities, and yet all of us have to cross state lines to do our job. Just like waiting for graduation during the pandemic, I and so many of us are sitting on the sidelines, waiting and ready to help with staffing shortages. I respectfully urge you to support Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing and in turn, extend access to safe anesthesia care for Maryland patients.

Thank you for your time and consideration,

Jaclyn Babin
Certified Anesthesiologist Assistant
Maryland Resident of District 19

Support of SB0951 (State Board of Physicians—Anest

Uploaded by: James Flaherty

Position: FAV

11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

3/2/2026

Dear Chair Beidle, Vice Chair Hayes and Members of the Senate,

My name is James Patrick Flaherty, and I am a Certified Anesthesiologist Assistant (CAA) with 18 years of experience in safe anesthesia practice. As a resident of Anne Arundel County for nearly two decades, I am writing to you today to express my strong and confident support for **SB0951 (State Board of Physicians—Anesthesiologist Assistants—Licensing)**.

Throughout my career, I have had the privilege of serving in high level leadership roles, including as Chief Anesthetist for multiple groups. In these positions, I have led teams of both CAAs and CRNAs, and I have sat on national leadership councils for some of the largest healthcare staffing companies in the country.

I have seen firsthand how the Anesthesia Care Team model (where physician anesthesiologists and anesthetists work together) provides the highest standard of safety and efficiency for patients.

A Proven Record of Safe, Diverse Care

My 18 year career in the District of Columbia has been defined by an unblemished record of safety across diverse clinical settings, ranging from high pressure Level I Trauma Centers to University teaching hospitals.

I have had the privilege of providing anesthesia for a vast spectrum of the human experience, caring for everyone from homeless patients to those living in million dollar homes and from vulnerable newborns to centenarians.

My clinical expertise spans the management of critically ill ICU patients and healthy elite athletes alike, treating every individual, whether an anonymous citizen or a high profile celebrity, with the same high standard of professionalism and care.

Perhaps the greatest testament to the quality and safety of my practice is that I am frequently personally requested by my own colleagues to provide anesthesia for their own family members.

I am eager to bring this same level of dedicated, safe care home to my neighbors and friends in Maryland.

Why SB0951 Matters for Maryland

Currently, I commute from my home in Annapolis to hospitals in Washington, D.C., to provide care. While I am proud of the work I do, it is a missed opportunity for our state that I cannot practice my profession in my own community. Supporting SB0951 is a vital step toward:

- **Improving Access to Care:** Marylanders deserve timely access to high quality surgical care. By licensing CAAs, Maryland can expand its healthcare workforce and reduce delays in the OR.
- **Retaining Local Talent:** There are many highly skilled professionals like myself living in Maryland who are forced to take their expertise across state lines. SB0951 allows us to stay and serve our own neighbors.
- **Strengthening the Care Team:** CAAs are highly trained at the master's level to work specifically within the Anesthesia Care Team model, ensuring a collaborative and safe environment for every patient.

Clarity on the Scope of SB0951

It is equally important to clarify what this legislation does not do. SB0951 is designed to support the existing healthcare infrastructure, not disrupt it:

- **No Independent Practice:** This bill does not create independent practice for CAAs; we will continue to work exclusively under the supervision of physician anesthesiologists.
- **Complementary to the Team:** It does not replace our anesthesia professional colleagues; instead, it adds another highly skilled, supervised clinician to the care team to meet increasing patient demand.
- **Institutional Autonomy:** It does not mandate changes to existing practice authority or hospital bylaws; individual facilities will maintain the right to decide their own staffing models within the framework of the law.

A Personal Perspective

On a personal note, this bill would be life changing for my family. My wife has been a dedicated teacher in Anne Arundel County Public School System for years and currently teaches at SOTI. We are raising our three daughters here; one is already at St. Mary's in Annapolis, with her sisters soon to follow.

Right now, my days are often consumed by the long commute around the Beltway, which regularly takes me over an hour each way. Passing SB0951 would mean that instead of spending hours in traffic, I could be practicing just 15 minutes down the road.

It would allow me to be more present for my daughters' school and sporting events and, most importantly, actually make it home in time for dinner with my family.

Thank you for your time and for your service to our district. I would welcome the opportunity to discuss this further with you or your staff.

Sincerely,

J. Patrick Flaherty, CAA
3/2/2026

SB 951 State Board of Physicians – Anesthesiologis
Uploaded by: Jane Krienke
Position: FAV

Maryland
Hospital Association

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

Position: *Support*
March 6, 2026
Senate Finance Committee

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 951.

In Maryland, anesthesia is administered directly by a physician anesthesiologist or by a certified nurse anesthetist as part of a care team led by a physician. SB 951 would close the gap between the supply of anesthesia providers and increasing demand for anesthesia services. Twenty-three jurisdictions allow another licensed health care provider—certified anesthesiologist assistants—to help expand care delivery under the same physician-supervised model.[1]

Passing SB 951 aligns with Maryland's work to modernize the health care workforce to meet the changing needs of the health care delivery system. For example, in 2024, given the growing shortage of radiologic technologists and lack of access to radiological services outside of hospitals, the General Assembly passed legislation to create the limited scope X-ray machine operator licensure exception. This allowed medical assistants, already working in urgent care centers and physician offices, to receive additional training to perform limited scope X-rays. This change allows lower acuity patients to access care in community-based settings like urgent care centers instead of higher cost settings like emergency departments.

Similarly, SB 951 will expand the ability of physician anesthesiologists to supervise additional cases, delivering care to more Marylanders in hospitals and ambulatory surgical centers. As care increasingly moves outside the hospital walls, we need to support the growth of our health care workforce to meet this demand.

Taking steps to modernize the health care workforce and ensure health care providers are practicing at the top of their scope is critical as Maryland transitions to the Achieving Healthcare Efficiency through Accountable Design Model (AHEAD). With the goal of focusing on primary and community-based care, improving population health, and containing costs, we will continue to see more care delivery outside the hospital. It is important that the health care workforce, as the backbone of the health care delivery system, is nimble and flexible to accommodate these changes.

For these reasons, we request a favorable report on SB 951.

For more information, please contact:
Jane Krienke, Assistant Vice President, Government Affairs & Policy
Jkrienke@mhaonline.org

[1] Certification Practice Map | AAAA

Kaur Testimony.pdf
Uploaded by: Jasleen Kaur
Position: FAV

March 4, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

My name is Jasleen Kaur, and I am a resident of Montgomery County in Maryland. I am also a Certified Anesthesiologist Assistant (CAA) who has been licensed and practicing for over 11 years in the District of Columbia. I am writing to respectfully ask you to support Senate Bill 951 to allow the state of Maryland to license CAAs.

I have over a decade of experience at Children's National Hospital, where I have had the privilege of serving pediatric patients across a wide range of surgical and procedural settings. During this time, I have also refined and developed a highly specialized skill set focused specifically on pediatric anesthesia care, starting from the neonate up until the young adult. However, I am unable to apply this experience and pediatric skillset towards patients in my own home community. My current institution (Children's National) has surgery centers in the state of MD, but I am unable to practice there due to lack of licensing for CAAs.

My husband is also a CAA who lives in MD, and we have an infant at home. Because Maryland does not currently license CAAs, we must commute to work in DC. Our early start times in the operating room combined with longer travel times make it impossible for us to enroll our baby in a daycare near our home in Maryland. As a result, we have had to hire a nanny, which has come at a higher financial cost for our family. We want the same option many Maryland families have - to enroll our child in a local daycare, build relationships in our community, and serve patients here at home.

Beyond the personal impact, this legislation is critical for Maryland patient care.

Hospitals and surgical centers throughout Maryland are experiencing anesthesia workforce shortages that can delay or restrict patient access to needed procedures. Because CAAs work under the supervision and direction of physician anesthesiologists, licensing CAAs in Maryland would allow for the addition of a competent and safe provider into already-existing care-team models, thus alleviating staffing shortage stress as well as maintaining the highest standard of care for our patients. It would keep Maryland clinicians and access to care within the state, rather than outsourced to other nearby jurisdictions.

CAAs do not replace other professional colleagues, nor do they practice independently; they simply add another qualified, supervised ACT member, which allows for expanded capacity within the state. CAAs are already licensed to practice in 23 states, including neighboring Virginia and DC.

In conclusion, I respectfully ask for your support of the CAA licensure bill: Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing. This legislation is not only about allowing qualified professionals like myself to serve in our home state, it is about strengthening patient safety, expanding access, and improving workforce stability. Support of the licensure bill allows Maryland patients to benefit from the safe, team-based anesthesia care model that CAAs have successfully provided across the country. Thank you for your time and consideration.

Sincerely,

Jasleen Kaur, CAA
Takoma Park, MD

Maryland CAA.pdf
Uploaded by: Jenny Lee
Position: FAV

Senate Finance Committee

11 Bladen Street

3 East Miller Senate Office Building

Annapolis, MD 21401

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

My name is Jenny Lee, and I am a Maryland resident living in Montgomery County. I am a Certified Anesthesiologist Assistant (CAA) who has been licensed and practicing for almost nine years, currently working in Washington, DC. I am writing in strong support of Senate Bill 951 / House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing.

I am a Maryland resident and CAA who wants to practice at home to help Maryland patients access timely surgical and procedural care. At my current hospital, we serve patients for different specialties like orthopedics, neurosurgery, pediatrics, transplant, obgyn, and more. Although I live in Montgomery County, I must commute to DC for work because there are limited opportunities for CAAs to practice in nearby Maryland hospitals. Many Maryland hospitals are closer to my home and would greatly benefit from the ability to employ experienced CAAs like myself. Licensure would allow clinicians who already live here to contribute to Maryland's healthcare workforce and keep care capacity in-state.

CAAs practice exclusively within the physician anesthesiologist–led Anesthesia Care Team (ACT) model. We do not practice independently; anesthesiologist supervision is required. We follow the same operating room safety culture as every other member of the anesthesia team, including standardized checklists, clear escalation pathways, and immediate physician involvement for complex or emergent events. This bill does not create independent practice for CAAs and does not change physician leadership of anesthesia care.

Maryland hospitals and surgical centers face anesthesia staffing pressures that can delay or limit procedures. This legislation would help expand access to anesthesia services and strengthen the perioperative workforce by allowing CAAs to be added to existing ACT models—without changing physician oversight. At a time of increasing

surgical demand, this is a practical, patient-centered solution that helps patients receive timely care close to home.

CAA education is graduate-level and anesthesia-specific, with standardized national certification. We complete rigorous didactic and clinical training across anesthesia subspecialties and maintain competence through required continuing education and recertification. We practice only where the supervising anesthesiologist credentials us and where the facility grants privileges based on demonstrated competency.

This licensure does not replace other anesthesia professional colleagues; it adds another supervised clinician to the team.It does not change existing practice authority or hospital bylaws; facilities retain authority to determine staffing models within applicable law and policy.

As a Maryland resident who is trained, experienced, and committed to patient safety, I respectfully ask you to support Senate Bill 951 / House Bill 1558 and allow Maryland to license CAAs so Maryland patients can access timely, physician-led anesthesia care close to home.

Thank you for your time and thoughtful consideration.

Respectfully,

Jenny Lee

Montgomery County, Maryland

Certified Anesthesiologist Assistant

Paterakis CAA Testimony 2026.pdf
Uploaded by: Jorjetta Paterakis
Position: FAV

Dear members of the Senate Finance Committee,

I am a Maryland resident and a Certified Anesthesiologist Assistant (CAA) with 10 years of experience practicing in Washington, DC hospitals. I am writing to respectfully ask for your support of legislation that would allow for the licensure and employment of CAAs in the State of Maryland.

Although I proudly serve patients every day in DC, Maryland is my home. I commute over an hour each way to work and I would greatly value the opportunity to serve Maryland patients closer to home and contribute to improving access to timely surgical and procedural care in our communities.

CAAs practice exclusively within the physician anesthesiologist–led Anesthesia Care Team (ACT) model. Our work is fully integrated into the operating room's culture of safety, including preoperative assessments, intraoperative management, standardized checklists, and immediate physician involvement for complex or emergent situations. This model preserves physician leadership while expanding the team's capacity to safely care for more patients.

Maryland hospitals and surgical centers face increasing anesthesia staffing pressures, which can delay or limit needed procedures. Allowing CAAs to practice under anesthesiologist supervision would expand capacity within existing ACT models—without changing physician authority or hospital governance. Many CAAs already live in Maryland but must commute to DC or other jurisdictions to work. Licensure would keep skilled clinicians—and care capacity—within our state.

CAA education is graduate-level and anesthesia-specific, with standardized national certification requirements—which we maintain through continuing education and recertification. In addition to rigorous didactic studies, we are trained across anesthesia specialties and practice in facilities around the country. We are licensed in 23 states including the District of Columbia and Virginia.

As someone who has dedicated a decade to providing safe, physician-led anesthesia care—including caring for trauma/obstetric/cardiac/ neurologically compromised patients—I want to bring that experience home. I want to serve Maryland families, reduce my daily commute, and make myself more available to Maryland facilities that need anesthesia professionals.

As a Maryland resident, I respectfully ask for your support in licensing CAAs in Maryland. I want nothing more than to serve patients in my own community, closer to my family and home. Thank you for your time and consideration.

Sincerely,
Jorjetta Paterakis, CAA
Howard County, MD

Joshua Starost Testimonial.pdf
Uploaded by: Joshua Starost
Position: FAV

Dear Members of the Senate Finance Committee,

My name is Joshua Starost, and my family and I are members of District 19. I am a Student Anesthesiologist Assistant at Case Western Reserve University's Master of Science in Anesthesia Program Washington D.C. campus. I am writing to alert you of a bill that is currently scheduled for a hearing. Number SB0951, titled State Board of Physicians - Anesthesiologist Assistants - Licensing.

This Bill is important to me as I am a senior in my program and graduating in May of 2026. I would love to live and work near my family and community, but because CAAs are not licensed in Maryland, I cannot do so.
I've met my friends from attending K-12 throughout Maryland, and we would meet anywhere from the Germantown library to Lake Needwood. I also fondly remember working my first jobs in Rockville and Gaithersburg. I've always wanted to stay here in Maryland.

I would like to help fill the shortage in anesthesia staff here in my home State. Our profession is strictly physician led with a supervising attending anesthesiologist. We do not practice independently and follow the same culture of safety: checklists, escalation, immediate physician involvement in complex or emergent events. This bill will improve regulation and protect the public further on. Hospitals already credential and privilege anesthesia clinicians through a rigorous, high quality peer reviewed system. Licensure will be able to add a further level of accountability, providing a clear pathway rather than leaving Maryland without this supervised workforce option.
This bill does not create independence nor change existing hospital bylaws. It also does not displace any other current professional anesthesia clinicians, but rather adds another supervised clinician to the team.

My graduate level learning environment has been very anesthesia specific and is standardized across the nation. Giving the option to stay within our school area or the ability to visit a large multitude of different states and cities, diversifying our experiences.

Please consider supporting this Bill and please let me know if there is any other information you would like me to supply for more context.

Thank you for your time,
Joshua Starost

Kaitlyn Denicola Testimony.pdf
Uploaded by: Kaitlyn Denicola
Position: FAV

March 4th, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

My name is Kaitlyn Denicola, and I am writing to express my strong support for Senate Bill 951/House Bill 1558 — State Board of Physicians — Anesthesiologist Assistants — Licensing. I am a lifelong resident of Howard County, Maryland and have completed my undergraduate education in Maryland. I am currently an anesthesiologist assistant student enrolled in a Master of Science in Anesthesia program in Washington, DC. Following graduation, I would strongly prefer to practice in Maryland if licensure were available.

Certified Anesthesiologist Assistants (CAAs) practice exclusively in the anesthesiologist led Anesthesia Care Team (ACT) model. We do not practice independently. During my training as a student, I have had first hand experience in this model. At multiple locations I have witnessed the delivery of safe, high quality anesthesia care in the ACT model across many surgical settings. Throughout my training, I gain experience across a wide range of specialties, including cardiac, neuro, obstetrics, trauma, pediatrics, and other complex surgical services which prepare me to care for diverse patient populations in high-acuity settings.

CAAs are currently licensed in 23 states as well as the District of Columbia and Virginia. However, despite being a Maryland resident, I must leave the state in order to train and would need to leave the state for practice following graduation. Licensure would allow qualified, highly trained clinicians to remain in-state and expand access to surgical care while maintaining physician-led oversight. It would strengthen Maryland's healthcare workforce by allowing hospitals and surgical centers to incorporate CAAs into the existing care models.

As a Maryland resident, I am deeply invested in serving the communities and patients that have shaped who I am as a person. I respectfully urge you to support Senate Bill 951/House Bill 1558 so that Maryland residents may return home to provide safe, physician-led care to Maryland patients. Thank you for your time and consideration.

Sincerely,
Kaitlyn Denicola
Maryland Resident

SB 951 - State Board of Physicians Anesthesiologi
Uploaded by: Kimberly Routson
Position: FAV

MedStar Health

9 State Circle, Ste. 303
Annapolis, MD 21401
C 410-916-7817
kimberly.routson@medstar.net

Kimberly S. Routson
Assistant Vice President,
Government Affairs - Maryland

SB 951 - State Board of Physicians – Anesthesiologist Assistants – Licensing
Position: ***Favorable***
Senate Finance Committee
March 6, 2026

MedStar Health is the largest healthcare provider in the Maryland and Washington, D.C. region. MedStar Health offers a comprehensive spectrum of clinical services through over 500 care locations, including 10 hospitals, 33 urgent care clinics, ambulatory care centers and an extensive array of primary and specialty care providers. As a not-for-profit healthcare system, MedStar Health is committed to its patient-first philosophy, emphasizing care, compassion, and clinical excellence, supported by a dedicated team of more than 35,000 physicians, nurses, and many other clinical and non-clinical associates.

SB 951 establishes licensure for Certified Anesthesiologist Assistants (CAAs) under the State Board of Physicians. Establishing a formal licensure and regulatory framework enhances patient safety, clarifies professional standards, and ensures appropriate oversight and accountability within the anesthesia care team. CAAs are highly educated and rigorously trained professionals who practice under the direction of physician anesthesiologists and function as integral members of a coordinated, physician-led anesthesia model.

Maryland continues to experience workforce shortages that limit hospitals' ability to fully staff anesthesia care teams and meet increasing surgical and procedural demand. MedStar Health currently has open anesthesia positions that cannot be filled by the existing in-state workforce supply. At the same time, a significant number of CAAs reside in Maryland but are unable to practice here due to the absence of licensure authority. Additionally, the Washington, D.C.-based educational pipeline produces highly qualified clinicians, many of whom are from the region and wish to remain here to practice. In the absence of licensure, Maryland loses these trained professionals to neighboring jurisdictions. MedStar Health hospitals in Washington, D.C. have successfully integrated CAAs into care teams for more than a decade, employing nearly 100 CAAs who contribute meaningfully to patient care. Increasingly, Maryland residents trained as CAAs are leaving to practice in the District of Columbia and Virginia, which authorized CAAs last year.

SB 951 focuses on workforce retention and expanding capacity, not workforce displacement. CAAs enhance the anesthesia care team under physician supervision and increase access to timely, high-quality surgical services. Because both the District of Columbia and Virginia authorize CAA practice, Maryland hospitals are at a competitive disadvantage in recruiting and retaining qualified anesthesia professionals.

SB 951 modernizes Maryland's healthcare workforce framework, strengthens regional competitiveness, and preserves a trained pipeline of clinicians committed to serving Maryland patients.

For the reasons above, MedStar Health urges a ***favorable*** report on **SB 951**.

Maryland Senate Finance Committee SB 951 Testimony
Uploaded by: Layne DiLoreto
Position: FAV

Senate Finance Committee

Testimony of Layne DiLoreto, Certified Anesthesiologist Assistant

March 4, 2026

In support of SB 0951

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

My name is Layne DiLoreto and I am a Certified Anesthesiologist Assistant (CAA) as well as a new resident of Maryland. My family purchased a home in Lothian, Maryland this month. I have been licensed and practicing as a CAA for 17 years living nearby in Virginia and practicing my profession in Washington, DC. I respectfully urge you to support Senate Bill 0951—State Board of Physicians—Anesthesiologist Assistants—Licensing so that I may continue to raise my family in Maryland and practice my profession here as well.

For my entire career, I have been forced to drive across state lines to practice my profession. For 17 years, I have worked at various hospitals and surgery centers in Washington, DC because my home state of Virginia was only a recent addition to the list of states licensing CAAs. While I am proud to serve patients in DC, it has always been difficult knowing that I cannot provide the same care to patients in a location I would prefer to live. My career has involved leaving my home to care for patients elsewhere, simply because state regulations are slow to recognize the value my professional already brings to patients across the country.

As a CAA, I work under the direct supervision of a board-certified anesthesiologist as part of the anesthesiologist-led care team model. My training included rigorous graduate-level medical education and thousands of hours of clinical anesthesia experience. Every day, I help care for patients during some of the most vulnerable and critical moments of their lives—whether they are undergoing major surgery, welcoming a child into the world, or facing an unexpected emergency procedure. Patient safety is always our top priority, and the physician-led team approach ensures collaboration, oversight, and high-quality outcomes.

Any claim that CAA's are not fully educated and trained to provide safe and effective quality acre is entirely false, as has been proven across our nation for years. CAAs are licensed in 23 states, including the District of Columbia and Virginia—both of which border Maryland. Maryland residents already receive safe anesthesia care from CAAs when they cross into neighboring states for medical services. It is frustrating and disheartening that Maryland continues to lose experienced providers like me to surrounding jurisdictions.

Senate Bill 0951 would allow Maryland to license CAAs under the State Board of Physicians, strengthening our anesthesiologist-led teams and helping address workforce needs without compromising safety. It would allow professionals like me to serve patients in our own communities and reduce unnecessary cross-state commuting that has defined my entire career.

I would welcome the opportunity to practice in the state I now call home. I respectfully ask you to vote favorably on Senate Bill 0951.

Thank you for your time and consideration.

Senate Bill 951 Testimony.pdf
Uploaded by: Lily Bahmanyar
Position: FAV

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee,
My name is Lily, and I am a Maryland resident, homeowner, and Certified Anesthesiologist Assistant (CAA). I was born and raised in Maryland, my family resides here, and I attended the University of Maryland all before graduating from CAA school in May 2025. I have been licensed and practicing as a CAA at a pediatric hospital since July 2025. I respectfully urge your support for Senate Bill 951/ House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing.
As a CAA, I work under the direct supervision of an anesthesiologist as part of the physician-led Anesthesia Care Team. Our education is rigorous and clinically based, specifically designed to prepare us to deliver high-quality anesthesia care in collaboration with anesthesiologists while following the same safety practices in the operating room. In practice, CAAs perform comprehensive patient assessments, develop and implement anesthesia plans with the supervising physician, manage airways, administer anesthesia, monitor patients throughout procedures, and provide post-operative care, with immediate physician involvement as needed in any setting. This team-based model enhances efficiency, improves operating room throughput, and maintains the highest standards of patient safety without compromising physician leadership.
Currently, CAAs are licensed in 23 states, including the District of Columbia and Virginia with standardized national certification and recertification processes. Because Maryland does not yet license CAAs, I must commute out of state to practice. My commute is at least one hour each way. This daily travel prevents me from fully investing my time and resources into my local Maryland community, including supporting neighborhood shops, restaurants, and small businesses near my home. As a Maryland homeowner, I am deeply committed to building my life and long-term career here, and I want my professional work to reflect that same investment in our state.
I currently work at a pediatric hospital, where I have the privilege of caring for a diverse population of children undergoing complex surgery and procedures. Providing anesthesia for pediatric patients requires specialized skills, careful attention, and close collaboration within the care team. It is incredibly meaningful work that I am grateful to do, however, I live close to multiple medical institutions in Maryland, including pediatric surgical centers, and would welcome the opportunity to serve the children and families in my own community rather than commuting across state lines to do so.
Licensing CAAs under the State Board of Physicians would provide clear regulatory oversight, strengthen Maryland’s anesthesia workforce, and help address growing surgical demand. By

formally recognizing CAAs, Maryland can expand access to safe, physician-led anesthesia care while maintaining strong patient protections and professional accountability. This legislation would also help retain Maryland-trained healthcare professionals who are eager to practice and remain in the state long term.

As someone who has built both my personal and professional life in Maryland, I respectfully request a favorable report on Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. Thank you for your time, consideration, and commitment to strengthening healthcare access in our state.

Sincerely,

Lily Bahmanyar, MSA, CAA

Lifelong Maryland Resident and Homeowner

CAA in Maryland.pdf
Uploaded by: Marian Sherman
Position: FAV

March 4, 2026

Dear Members of the Senate Finance Committee,

I am a Maryland resident and have practiced as an anesthesiologist for 26 years. I have supervised Certified Anesthesiologist Assistants within the anesthesia care team model at several practice locations (academic and private practices), and my experience with CAAs has been excellent.

In the context of the current anesthesia provider shortage, the licensure of CAAs in Maryland would help provide Maryland residents with safe and timely care. Please support Senate Bill 951 (State Board of Physicians – Anesthesiologist Assistants – Licensing).

I would be happy to provide additional background and/or testimony should you find such information helpful.

Thank you for your time.

Sincerely,

Marian Sherman, MD

Senate Bill 951 Testimony.pdf
Uploaded by: Mark Coelho
Position: FAV

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401
Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing
Position: Favorable

Dear Members of the Senate Finance Committee,

My name is Mark Coelho and I am a Certified Anesthesiologist Assistant (CAA) and lifelong Maryland resident. I have been working for 5 years and have worked in St. Louis, Missouri, and I currently work in Washington, D.C. I love my job because I get to play a crucial role in physician-led anesthesia care. Everyday, my Ravens and Orioles scrub caps serve as a reminder that I have strong Maryland pride. As much as I love working in DC, I would love to work in my hometown state. There is a huge need for anesthesia providers in Maryland and I would love to help take care of the patients in need of urgent surgeries.

I really love providing anesthesia for patients and I thrive in the anesthesia care team model. Along with the guidance of an anesthesiologist, we are able to take care of very sick patients and help them get through their toughest of battles. It is my dream to work in Maryland and that would be possible with your support of Senate Bill 951. This bill would allow for more anesthesia providers to be available to Maryland residents, like my parents, and they would have the guidance of anesthesiologists. As CAAs, we would continue to have supervision and we would be able to help with the growing need of anesthesia providers. Not far away, CAAs are able to work in DC and recently, Virginia.

CAAs must complete a graduate level program that is anesthesia specific. While in school, we learn from CAAs and anesthesiologists. I currently precept many students and I help many students from Maryland apply to CAA schools. Upon completion of our training, we serve as patient advocates while patients are under anesthesia. I have had the pleasure to take care of many patients and help them on their road to recovery.

I kindly ask that you please support the bill to allow Maryland to license CAAs so Maryland patients can access timely, physician-led anesthesia care close to home.

Sincerely,

Mark Coelho, CAA

Ellicott City, Maryland

Written testimony for Sb951.pdf
Uploaded by: Megan Szczukowski
Position: FAV

Senate Finance Committee March 4, 2026

11 Bladen Street,

3 East Miller Senate Office Building,

Annapolis, MD 21401

Dear Chair Beidle, Vice Chair Hayes, and Members of the Senate:

My name is Megan Szczukowski, and I am a Maryland resident, a constituent of District 37B, and a Certified Anesthesiologist Assistant (CAA). I respectfully submit this testimony in strong support of Senate Bill 951 / House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing. This legislation would allow me to practice safely and legally in the state where I live, raise my family, and serve Maryland patients who need timely access to surgical and procedural care.

My family and I made an intentional decision to settle in Easton, Maryland, where my husband is from and where we plan to remain long term. My husband is a practicing anesthesiologist, and through his work at our local community hospital, he has seen firsthand the growing shortages of anesthesia providers. These shortages strain physician teams and can delay necessary surgeries and procedures for Maryland patients. Despite living in this community and being fully trained to help meet these needs, I am unable to practice in Maryland because CAAs are not currently licensed.

CAAs practice exclusively within the physician anesthesiologist–led Anesthesia Care Team (ACT) model. We do not practice independently. Anesthesiologist supervision is required at all times, and our work follows the same safety culture used throughout operating rooms nationwide—standardized protocols, safety checklists, clear escalation pathways, and immediate physician involvement for complex or emergent situations. This model is well established, safe, and already used successfully across the country.

Importantly, CAAs are already licensed in 23 states, including the District of Columbia and Virginia, where they practice safely within physician-led care teams. As a result, Maryland trains and houses clinicians who cross state lines each day to provide anesthesia care in neighboring jurisdictions while Maryland facilities remain understaffed.

I have practiced safely for ten years in states such as Florida, North Carolina, and the District of Columbia, providing anesthesia care in high-acuity settings. My experience includes obstetric anesthesia, pediatric cases, and cardiovascular procedures; skill sets that are essential to maintaining access to care, particularly in community hospitals. Maryland could directly benefit from clinicians with this training who are ready to work under physician leadership within existing anesthesia care teams.

I currently commute out of state to provide anesthesia for medically complex surgical cases at a large academic hospital in Washington D.C., often spending more than four hours a day in my car. This has real personal and professional consequences. I am the mother of a seven month old boy and a two year old girl and I am currently breastfeeding, which adds another layer of logistical and physical complexity to an already long commute. The hours I spend driving each day is time I could otherwise spend being present for my family or caring for Maryland patients. Licensure would allow myself and many other Maryland-resident CAAs to keep our skills and availability in-state.

From a workforce and access perspective, Senate Bill 951 / House Bill 1558 offers a practical solution. Maryland hospitals and surgical centers are experiencing anesthesia staffing pressures, yet this bill allows the state to expand capacity by adding CAAs to existing ACT models without changing physician leadership or supervision. Facilities would retain full discretion over staffing decisions, and it is important to note that no existing anesthesia professionals would be displaced.

Maryland's healthcare system is facing increasing procedural backlogs, workforce shortages, and growing pressure on hospital operating margins, particularly in community and regional hospitals. At the same time, neighboring jurisdictions such as the District of Columbia and Virginia already license CAAs and are benefiting from this physician-led workforce while Maryland residents commute out of state to meet those needs. Senate Bill 951 / House Bill 1558 offers a timely, cost-effective opportunity to expand anesthesia capacity using an already trained, nationally certified, and supervised workforce—without creating new independent practice, altering physician leadership, or requiring new training pipelines. Delaying action continues to export Maryland clinicians and limits patient access to timely care when a safe, proven solution is readily available.

It is important to be clear about what this bill does not do. It does not create independent practice for CAAs. It does not replace physician anesthesiologists or other anesthesia professionals. It does not mandate staffing models or alter hospital governance. It simply allows Maryland to license a trained, supervised, and nationally certified clinician who is already practicing safely across the country.

At its core, this legislation is about access, safety, and keeping care close to home. As a resident of District 37B, I want to work in Maryland, serve my community, and contribute to the healthcare system where my family lives. I respectfully ask the Senate Finance Committee to support Senate Bill 951 / House Bill 1558 so that Maryland patients can access timely, physician-led anesthesia care from clinicians who are already trained, experienced, and eager to serve their community.

Thank you for your time and consideration,

Megan Szczukowski, CAA

Maryland Anesthesiologist Assistant Association

Maryland Testimony.pdf
Uploaded by: Michael Timmer
Position: FAV

Chair and Members of the Committee,

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

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

I strongly support the licensure of Anesthesiologist Assistants in Maryland. My name is Michael Timmer, and I am a lifelong Maryland resident and a current Anesthesiologist Assistant (AA) student training in Washington, DC. I am writing to express my strong support for Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing, and I respectfully ask for your support for this important legislation.

Becoming an AA has required years of rigorous medical education, long clinical hours, and a deep commitment to patient safety. I chose this profession to serve patients safely within the physician anesthesiologist–led Anesthesia Care Team (ACT) model. CAAs do not practice independently. We practice exclusively within the physician-led Anesthesia Care Team model, collaborating closely with anesthesiologists to ensure safe, high-quality care for every patient. In states where AAs are licensed, we also help improve operating room efficiency, reduce surgical delays, and expand access to anesthesia services. Overall, strengthening the delivery of surgical care.

For me, this issue is personal. Maryland is my home and I have lived here my whole life. My family, my wife, and closest friends are here, and this is the community that supported me throughout my education. After dedicating so much time and effort to this profession, it is difficult to accept that I would have to leave my home state, move away from my support system, and start over somewhere else just to practice the career I've worked so hard to achieve. I want the opportunity to give back to the hospitals and communities that helped shape me. Additionally, I commute 45 minutes each way to practice and learn in D.C. Licensing AAs in Maryland would not only strengthen the healthcare workforce and support hospitals facing staffing challenges, but it would also allow Maryland students like myself to stay close to our families and serve the communities we care about most. I respectfully ask you to support this bill so Maryland can license CAAs and ensure patients have access to timely, safe, physician-led anesthesia care close to home.

Sincerely,

Michael Timmer

Written Testimony -- Final.pdf
Uploaded by: Millicent Kihiuria
Position: FAV

March 1, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

I was born and raised in Salisbury, Maryland, and growing up on the Eastern Shore was a gift. I spent countless hours outdoors with my younger brothers, enjoying everything our area has to offer—from the beaches of Ocean City to the natural beauty of Assateague. After high school, I attended the University of Maryland in College Park, where I studied public health. Following graduation, I spent a year conducting research on opioid use disorder in Federalsburg, MD.

When it came time to choose a career path, discovering the Certified Anesthesiologist Assistant (CAA) profession felt like striking gold. Now, with less than two months remaining in my training, I can confidently say that it truly was. The CAA profession is an ideal fit for me. I find deep fulfillment in caring for and advocating on behalf of patients during some of the most stressful and vulnerable moments of their lives. This career offers everything I hoped to find—except for one important piece: the opportunity to practice back home in Maryland.

Returning home to be near my parents means more to me than I can fully express. There is a unique comfort and sense of belonging that only home provides. As a lifelong Salisbury resident and a graduate of the University of Maryland, this state is not just where I'm from—it's who I am. Over the past two years as an AA student, I have cared for patients in Washington, D.C., where CAAs are licensed to practice. Many of those patients are Maryland residents. If I am entrusted to care for Marylanders in D.C., why can't I care for my fellow Marylanders in our home?

Having lived in Salisbury and conducted research in Federalsburg, I have seen firsthand the impact that healthcare workforce shortages have on our communities. The shortage of anesthesia professionals in Maryland is particularly concerning, as

it limits patients' access to timely surgical care. Expanding CAA licensure to Maryland would help address this gap—improving access for patients while also allowing Marylanders like myself to return and serve the communities that shaped us.

While I am excited to begin my career as a CAA in Washington, D.C. in the coming months, I remain hopeful for a future in which I can practice in Maryland. I respectfully urge you to support Senate Bill 951 to allow Maryland to license CAAs, ensuring that Maryland residents have access to timely, physician-led anesthesia care close to home.

Sincerely,

Millicent Kihiuria
Second-Year Student Anesthesiologist Assistant

MAAA testimony.pdf
Uploaded by: Morgan Kim
Position: FAV

Morgan Lee Kim, CAA
8032 Park Overlook Dr
Bethesda, MD 20817
(607)237-7112
MORGANLEEKIM@Gmail.com

March 4, 2026

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: Support for Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing

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

My name is Morgan Lee Kim and I am writing to you as a resident of Bethesda and a Certified Anesthesiologist Assistant (CAA) to express my strong support for **Senate Bill 951/House Bill 1558**. I have been practicing as a CAA since graduating from my medical training in Florida in 2017, and I am eager for the opportunity to finally provide care to patients within my home state of Maryland.

My family and I moved to Montgomery County in 2019. Like many of my neighbors, we chose Bethesda as our home because it is an exceptional place to raise our son, particularly due to the superb reputation of the public school system. However, for the last seven years, I have had to take my clinical expertise across state lines. I currently commute into Washington, D.C., to work at a Level 1 Trauma Center, where I manage some of the highest-acuity patients in the country. While I take great pride in that work, it is a daily frustration that I must leave Maryland to provide the very care our own local hospitals and surgical centers so desperately need to address their staffing pressures.

Maryland is currently an outlier in our region; CAAs are already licensed in 23 states, including the District of Columbia and, soon, our neighbors Virginia. By passing this legislation, Maryland would align with these neighboring jurisdictions, allowing clinicians like myself to stay in-state. This would immediately help expand surgical capacity and reduce procedural delays for Marylanders without changing the fundamental leadership of our anesthesia departments.

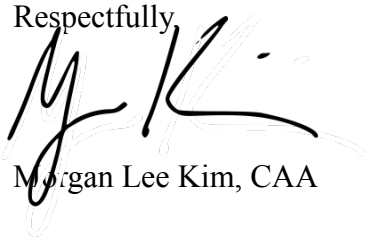
It is important to emphasize that CAAs practice exclusively within the physician anesthesiologist-led Anesthesia Care Team (ACT) model. We do not practice independently; physician supervision is a core requirement of our profession. In the operating room, we follow a rigorous safety culture centered on checklists, clear escalation protocols, and immediate

physician involvement for any complex or emergent event. My education is graduate-level and anesthesia-specific, and I maintain my competence through standardized national certification and ongoing continuing education.

Licensure under the State Board of Physicians would provide a transparent framework for oversight, establishing clear eligibility standards and enforceable practice rules that protect the public. I want to be clear that this bill does not create independent practice, nor does it seek to replace our valued colleagues in nursing. It simply adds another qualified, supervised professional to the team, giving Maryland hospitals the flexibility to choose the staffing models that best serve their patients.

I love living in Bethesda, and I want to be able to contribute my skills to the health and well-being of my own community. I respectfully urge a favorable report on Senate Bill 951/House Bill 1558 so that Maryland patients can access timely, physician-led anesthesia care close to home.
Sincerely,

Respectfully,



Morgan Lee Kim, CAA

SB 951 _ State Board of Physicians – Anesthesiolog
Uploaded by: Olivia Farrow
Position: FAV

Ascension Saint Agnes

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

Position: Support

March 4, 2026
Senate Finance Committee

Ascension Saint Agnes Hospital respectfully submits this statement in strong support of legislation to authorize the licensure of Certified Anesthesiologist Assistants (CAAs) in Maryland. While our hospital currently maintains adequate anesthesia staffing, we recognize a growing statewide workforce crisis that is already disrupting surgical care at many hospitals across Maryland — and that will affect all health systems, including our own, in the years ahead.

A Worsening Anesthesia Workforce Crisis

The U.S. faces a projected shortage of 12,500+ anesthesia professionals by 2033.[1] Recruiting and retaining Certified Registered Nurse Anesthetists (CRNAs) has become extraordinarily — and unsustainably — expensive. Sign-on bonuses, relocation packages, elevated wages, and costly *locum tenens* contracts are now standard. For Maryland hospitals operating on thin margins, this bidding war is not merely a budget challenge; it is a threat to their ability to keep operating rooms open at all. For rural hospitals, when it loses its one or two CRNAs, surgeries are delayed or cancelled, patients must travel hours for procedures that should be available locally, and the hospital's financial viability is placed at risk.

Why CAAs Are Part of the Solution

CAAs are master's-prepared anesthesia professionals trained exclusively for the physician-led Anesthesia Care Team model. Their advanced education makes them ideal partners for both physician anesthesiologists and CRNAs:

- Master's-level preparation equips CAAs to manage complex anesthesia cases under physician supervision, enabling anesthesiologists to direct multiple concurrent cases and meaningfully increase surgical capacity.
- CAAs complement existing CRNA teams, relieving scheduling pressure, reducing burnout, and improving staff retention.
- Adding CAAs to a rural team with a single supervising physician or CRNA allows that facility to expand Operating Room hours and restore surgical access — without competing in the costly CRNA market alone.

[1]Becker's ASC Review, "Anesthesia Workforce Under Pressure: Shortages, Pay Cuts, Burnout" (2025): nearly 30% of anesthesiologists are projected to leave by 2033, leaving an anticipated shortfall of 12,500 providers. See also: Becker's ASC Review, "The Anesthesia Workforce Shortage Demystified" (2025), reporting a projected shortage of approximately 12,500 CRNAs by 2033, representing nearly 22% of the current workforce.

CMS recognizes CAAs and CRNAs equally as qualified anesthesia providers, and commercial insurers make no reimbursement distinction between the two under physician direction.[2] CAAs are authorized at all VA facilities nationally.[3]

Proven in Ascension States — Including Our Neighbors

CAAs are now licensed in 24 jurisdictions.[4] Critically, the states where Ascension Health System operates have already demonstrated the model works:

- Virginia enacted CAA licensure in early 2025 — effective July 1, 2025 — driven by the same rural access concerns Maryland faces, leaving Maryland the only state in the immediate region without CAA authorization.[5]
- Tennessee signed CAA licensure into law in May 2025, with Ascension Saint Thomas facilities positioned to benefit.[6]
- Texas, Indiana, and Wisconsin, — all states with Ascension presence — already license CAAs within physician-led teams.

Ascension's operational experience across these states confirms that integrating CAAs into anesthesia teams does not compromise patient safety, disrupt existing professional relationships, or change how care is billed and reimbursed.

Ascension Saint Agnes' Position: Act Now, Before the Need Is Urgent

Ascension Saint Agnes does not currently face an anesthesia staffing crisis — but responsible health system management requires building the regulatory framework before one arrives. The demographic pressures driving today's rural hospital shortages will reach all Maryland hospitals in the coming decade. Without CAA licensure in place, we cannot recruit or credential CAAs quickly when circumstances change. As we grow and expand surgical services, the ability to integrate master's-prepared CAAs into our physician-led teams will give us the staffing flexibility and financial sustainability to do so without compromising care.

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[2]American Society of Anesthesiologists (ASA), "Statement on Certified Anesthesiologist Assistants (CAAs): Description and Practice" (asahq.org): "CMS recognizes CAAs as qualified non-physician anesthesia providers, just like their nurse anesthetist (CRNA) counterparts." Under medical direction, CMS treats CAAs and CRNAs identically for reimbursement purposes within the Anesthesia Care Team model. See also: American Society of Anesthesiologists, "Certified Anesthesiologist Assistants" (asahq.org/advocating-for-you/anesthesiologist-assistants, updated September 2025).

[3]U.S. Department of Veterans Affairs, VHA Directive 1123, Anesthesia Service (VA.gov). The Veterans Health Administration Handbook 1123 includes anesthesiologist assistants as recognized allied health professionals. CAAs are authorized to practice at any Veterans Affairs facility in all 50 states. See also: Wikipedia, "Certified Anesthesiologist Assistant," citing VA/DoD TRICARE authorization effective December 22, 2006.

[4]American Society of Anesthesiologists, "Certified Anesthesiologist Assistants" (asahq.org/advocating-for-you/anesthesiologist-assistants, updated September 2025). As of 2025, CAAs may practice in 24 jurisdictions: Alabama, Colorado, District of Columbia, Florida, Georgia, Kansas, Kentucky, Indiana, Michigan, Missouri, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

[5]American Society of Anesthesiologists, News Release, "Certified Anesthesiologist Assistants Now Authorized to Practice in Virginia" (March 25, 2025, asahq.org): Virginia Gov. Glenn Youngkin signed Senate Bill 882 into law, effective July 1, 2025. See also: LegiScan, VA SB882, 2025 Regular Session.

[6]American Society of Anesthesiologists, News Release, "Certified Anesthesiologist Assistants Authorized to Practice in Tennessee" (May 23, 2025, asahq.org): Tennessee Gov. Bill Lee signed House Bill 979 into law on May 21, 2025. See also: Chambliss, Bahner & Stophel P.C., "Tennessee Law Now Allows for Licensure and Employment of Anesthesiologist Assistants" (chamblisslaw.com, 2025).

Conclusion

Many of Maryland's hospitals need this now. Maryland's larger health systems will need it soon. Twenty-four jurisdictions have already acted. We urge the Maryland General Assembly to pass CAA licensure legislation and ensure that every patient in this state has access to the surgical care they need, close to home.

For these reasons, we request a favorable report on SB951

Olivia Farrow
V.P., External Affairs
Ascension Saint Agnes Hospital

Parth_Kalola_Updated_Written_Testimony_SB0951.pdf
Uploaded by: Parth Kalola
Position: FAV

Parth Kalola, CAA
Frederick, Maryland District 3
Pkalola91@gmail.com
609 350 3027

Senate Finance Committee
11 Bladen Street, 3 East Miller Senate Office Building
Annapolis, MD 21401

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

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

My name is Parth Kalola. I am a Maryland resident and a Certified Anesthesiologist Assistant living in Frederick since 2021. My wife and I have built our life here. Two of our three children were born in Frederick, and we plan to raise our family here long term.

I have been nationally certified and practicing as a CAA for several years. I currently practice anesthesia in Washington, DC because Maryland does not license CAAs. While I am grateful for the opportunity to work there, the daily commute is demanding and takes time away from my family and from the community I call home.

I am writing in strong support of Senate Bill 951 and House Bill 1558 State Board of Physicians Anesthesiologist Assistants Licensing.

Certified Anesthesiologist Assistants practice exclusively within the physician anesthesiologist led Anesthesia Care Team model. We do not practice independently. Anesthesiologist supervision is required. We function within the same operating room safety culture as physician anesthesiologists, including standardized checklists, continuous monitoring, structured escalation pathways, and immediate physician involvement for complex or emergent situations.

This legislation does not create independent practice. It preserves physician leadership while allowing hospitals to add a supervised anesthesia professional to their teams.

Maryland hospitals and surgical centers face anesthesia staffing pressure that can delay or limit procedures. As our population grows, especially in regions like Frederick, access to timely surgical and procedural care becomes increasingly important. Licensing CAAs would expand capacity within existing physician led models without changing physician oversight or hospital authority.

Many CAAs already live in Maryland but commute to DC or other jurisdictions to work. Licensure would keep clinicians and care capacity in state and allow professionals like me to serve the communities where we live.

CAA education is graduate level and anesthesia specific, with standardized national certification, continuing education requirements, and periodic recertification. Hospitals credential and privilege anesthesia clinicians through peer review and quality systems, and state licensure would add an additional layer of public accountability and oversight.

Maryland patients deserve timely access to safe, physician led anesthesia care close to home. I respectfully urge you to support Senate Bill 951 so Maryland can license Certified Anesthesiologist Assistants and expand access to care while preserving patient safety.

Thank you for your time and consideration.

Respectfully,

Parth Kalola, CAA

SB 951.pdf
Uploaded by: Robert Jacobson
Position: FAV

Robert Jacobson, MD
1211 Cresthaven Drive
Silver Spring, MD 20903

March 3, 2026

Testimony in support of SB 951

Senate Finance Committee

Dear Members of the Senate Finance Committee:

I am a resident of Montgomery County, Maryland and I am a physician specializing in anesthesiology . I am writing in support of SB 951 which supports the licensing of anesthesiology assistants in Maryland. I have worked for many years supervising anesthesiology assistants in Washington, DC. These professionals are a valued member of our team in the operating rooms. Anesthesiology assistants are currently licensed in 23 states, including Virginia and DC. They work under direct supervision of physician-anesthesiologists. If licensed in Maryland, they would provide much needed staffing and professional services to Maryland residents.

Sincerely,

Robert Jacobson, MD

President

DC Society of Anesthesiologists

Support for Senate Billl 951_House Bill 1558.pdf
Uploaded by: Rosa Scholl
Position: FAV

Senate Finance Committee
11 Bladen St.,
3 East Miller Senate Office Building
Annapolis. MD, 21401

Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing
Position: Favorable

Dear Members of the Senate Finance Committee,

My name is Rosa Scholl, and I'm a Certified Anesthesiologist Assistant (CAA) in Washington D.C. I've been licensed and working as a CAA since I graduated from the Masters of Science in Anesthesia Program at Case Western Reserve University in summer of 2023. I'm writing to you today to ask for your support for Senate Bill 951/House Bill 1558 - State Board of Physicians - Anesthesiologist Assistants - Licensing. While I attended graduate school in Washington D.C. and currently still live there, my fiance and I are currently house shopping in Maryland. I grew up in Montgomery County and my parents live in Potomac, so I'd like to be close to them. Additionally, I used to be a career Firefighter/Paramedic at Sykesville Fire Department in Carroll County, and am currently still a volunteer Firefighter/Paramedic at Branchville Volunteer Fire Department in Prince George's County. For these reasons, Maryland is very close to my heart. Serving my community as a career and volunteer firefighter was one of the most rewarding experiences of my life. Unfortunately, the schedule and work life balance was not feasible for me in the long run, but thankfully the fire department introduced me to the excellent career I am a part of now, Certified Anesthesiologist Assistants. Similarly to when I was a paramedic, CAAs work under the direction of a supervising anesthesiologist, so we are part of a care team. This enhances patient safety and improves the level of care our patients receive. In addition to being board certified after completing a Master's Degree, CAAs also complete continuing education requirements every 2 years and recertify with a licensing exam every 10 years, contrary to some of our counterparts in anesthesia. I would love to extend this level of safety to Maryland, and provide more access to comprehensive, patient centered, physician-lead care. Currently, CAAs like me are licensed in 23 states, including Virginia and Washington D.C. Maryland could be the fortunate 24th state to license CAAs and improve the anesthesia workforce shortages with safe, highly-skilled anesthesia providers. This would allow people like me to more easily move back to Maryland and directly contribute to the Maryland health system instead of driving past its hospitals facing workforce shortages to get to another state that we can work in. Without replacing any of the existing anesthesia professionals, CAA's could help support the Maryland workforce! Please consider supporting Senate Bill 951/House Bill 1558 and approve licensure for Certified Anesthesiologist Assistants in Maryland.

Sincerely,
Rosa Scholl
240-487-3873
rosa.scholl97@gmail.com

MD Testimony.pdf
Uploaded by: Saral Patel
Position: FAV

2748 Weatherstone Dr
Ellicott City, MD 20142

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401
March 4, 2026

Dear Chair Beidle, Vice Chair Hayes, and Members of the Senate:

My name is Saral Patel, and I am a resident of Howard County, Maryland. I have proudly called Maryland home since 2002. I am a Certified Anesthesiologist Assistant currently practicing in Washington, DC. I completed my Master's level training at Emory University in 2000, and for nearly 25 years, I have provided safe, effective anesthesia care under the medical direction of physician anesthesiologists in DC.

For almost my entire career, I have commuted across state lines to work in Washington, DC. I am grateful for the opportunity to practice in our Nation's capital, but my home and my heart are in Maryland.

I work in DC because I must provide for my family, but I choose to live in Maryland because of the quality of life it offers. My family has built deep roots here in Howard County. My 4 children have attended the Howard County Public School System their entire lives. They have played baseball at Kiwanis-Wallas Park for more than a decade, and some of my most cherished memories are sitting at the fields cheering them on. I walk regularly at Centennial Lake, ride my bike at Rockburn Park, and dine out at the Merriweather District. These are not merely places for my family, they are the community that has shaped us, the foundation that grounds us, and the home we have worked so hard to build and preserve.

However, the commute is taking a significant toll. What was once about an hour each way has now become 1.5 to 2 hours each way since the return to in-person work following COVID. The drive from Ellicott City to the surgery center in NW Washington, DC is long, exhausting, and increasingly unsustainable. Over 24 years, I have spent thousands of hours on the highway, which is time away from my family, my community, and, quite frankly, has a negative impact on my wellness. The commute is not only draining, but it is my only option to continue practicing the profession to which I have dedicated my life, a profession that promotes education and patient safety for over 50 years.

People often ask why I do not simply move to DC and shorten the commute. I have considered it. But doing so would mean uprooting my children from their schools, their friends, and the only community they have ever known. It would mean leaving behind the safe, family-centered

environment that drew us to Maryland in the first place. It is heartbreaking to feel forced to choose between my profession and the community my family loves.

Senate Bill 951 represents an opportunity to change that. Supporting this bill would allow certified anesthesiologist assistants like me to practice in Maryland under the medical direction of physician anesthesiologists, just as we safely and effectively do in Washington, DC, and in 22 other states. It would expand access to high-quality anesthesia care for Maryland patients while allowing experienced professionals to serve the communities in which we live.

I respectfully urge you to support Senate Bill 951. Your support would be for Maryland families like mine, for healthcare professionals who want to serve their home communities, and for the patients who deserve access to safe, team-based anesthesia care.

Thank you for your time and consideration.

Sincerely,

Saral Patel, CAA

FINAL Maryland Senate Committee Hearing Letter.pdf
Uploaded by: Scott Plunkett
Position: FAV

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401

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

My name is Scott Plunkett, and I am a Maryland resident living in Takoma Park in Montgomery County and a Certified Anesthesiologist Assistant (CAA). I respectfully urge your support for Senate Bill 951/House Bill 1558—State Board of Physicians—Anesthesiologist Assistants—Licensing.

I have been licensed and practicing as a CAA for nearly 12 years. Throughout my career, I have worked at Children's National Medical Center in Washington, DC, where I provide anesthesia care for some of the most medically complex pediatric patients in the region. My work includes caring for neonates, children undergoing complex pediatric surgery, and patients with congenital heart disease. This care is delivered as part of the physician anesthesiologist–led Anesthesia Care Team (ACT) model. CAAs practice only within this model under the direct supervision of physician anesthesiologists and do not practice independently. The ACT structure emphasizes patient safety through established operating room safety practices, team-based care, and immediately available physician involvement.

Although I live in Maryland, I am unable to practice my profession in my home state due to current licensing restrictions. Each day I commute from Takoma Park to Washington, DC to provide care. My wife is also a CAA and a Maryland resident, and she faces the same limitation. We moved to Maryland in recent years and are raising our family here. Maryland is where we have chosen to build our family's future, and we would welcome the opportunity to also practice here and contribute to Maryland's healthcare system.

Beyond my clinical work, I am also involved in educating the next generation of anesthesia professionals. I serve as co-director for didactic education for the Case Western Reserve University Master of Science in Anesthesia Program in DC. In that role, I help train future CAAs through a graduate-level, anesthesia-specific curriculum that includes rigorous academic preparation, standardized national certification, and ongoing continuing education and recertification requirements throughout a clinician's career.

Maryland hospitals and surgical centers face ongoing anesthesia workforce pressures that can delay or limit access to surgical and procedural care. Allowing licensure for CAAs would expand the available workforce within the existing physician-led ACT model without changing physician leadership or hospital governance. CAAs are currently licensed in 23

states, including neighboring Virginia and the District of Columbia, where they help support access to safe, physician-led anesthesia care.

This legislation would establish a clear regulatory framework under the State Board of Physicians with defined eligibility standards, oversight, and accountability. Importantly, the bill does not create independent practice for CAAs and does not alter existing physician supervision requirements or hospital staffing decisions. It simply allows Maryland to license a supervised anesthesia professional who is already practicing safely across much of the country.

As a Maryland resident, educator, and practicing clinician, I respectfully ask the committee to support Senate Bill 951/House Bill 1558 so that professionals like me who live in Maryland can also care for Maryland patients.

Thank you for your time and consideration.

Sincerely,

Scott Plunkett, CAA
Takoma Park, Maryland

SB951 FavorableWrittenTestimony-ShaneAngus.pdf
Uploaded by: Shane Angus
Position: FAV

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).

CAA testimony.pdf
Uploaded by: Sheby Thomas
Position: FAV

Sheby Thomas
839 Rockwell Ave
Gaithersburg, MD 20878
SST8909@gmail.com
469-688-6532

March 4, 2026

RE: SUPPORT for **HB 1558 / SB 951** – State Board of Physicians – Anesthesiologist Assistants – Licensing

The Honorable Joseline Peña-Melnyk, Chair, House Health and Government Operations Committee
The Honorable Pamela Beidle, Chair, Senate Finance Committee

Dear Chairs Peña-Melnyk and Beidle, and Members of the Committees,

My name is Sheby Thomas. I have been a Certified Anesthesiologist Assistant (CAA) for nine years, and I am a proud resident of the Crown subdivision in Gaithersburg. I am writing to you today with a sense of urgency and deep conviction to ask for your favorable report on **HB 1558** and **SB 951**.

For nearly a decade, I have dedicated my career to keeping patients safe during their most vulnerable moments. Yet, every single morning, I am forced to drive past Maryland hospitals (facilities in my own backyard that are struggling with critical anesthesia staffing shortages) to practice in Washington, D.C. It is disheartening to live in a state that experiences a "brain drain" of its own healthcare professionals simply because we lack a common-sense licensure pathway.

I want to bring my expertise skills, not limited to, home. I have spent nearly a decade mastering the complexities of anesthesia. My clinical experience is not just broad; it is specialized in the areas Maryland needs most. I provide critical care for pediatric and NICU patients, and I am skilled in OB, orthopedics, spine, and ENT procedures.

Let me be clear: my profession is built on the foundation of the Anesthesia Care Team (ACT). We do not seek, nor do we want, independent practice. We believe in physician-led care because it is the gold standard for patient safety. By law and by passion, I work under the direct supervision of physician anesthesiologists. This model ensures that while I am at the bedside providing continuous care, a physician is always there for complex decision-making. This isn't just a workflow; it’s a safety net for every Marylander who goes under anesthesia.

Maryland's healthcare system is under immense pressure. We see the headlines: surgeries are delayed, procedural centers are strained, and patients are waiting longer for life-saving or life-improving care. By licensing CAAs, Maryland can:

- **Stop the Talent Flight**: Stop forcing Maryland residents like me to take our expertise to D.C. or Virginia.
- **Expand Surgical Capacity**: We are ready-made, highly trained clinicians who can immediately plug into existing hospital teams to get more patients into the OR safely and efficiently.
- **Ensure Accountability**: This bill brings us under the direct oversight of the State Board of Physicians, providing the transparent regulation and public protection that our citizens deserve.

This legislation doesn't replace anyone, and it doesn't change how medicine is practiced; it simply removes a barrier to entry for a supervised workforce that is already helping solve the national anesthesia crisis.

I live in the heart of District 17. I see the growth in our community, and I see the need for robust healthcare. I am asking for the opportunity to serve the patients in my own neighborhood. Please support **HB 1558** and **SB 951** and help us keep Maryland's best clinicians right here at home.

Sincerely,
Sheby Thomas, CAA
Resident, District 17

MAryland letter.pdf
Uploaded by: Vinayak Shanbhag
Position: FAV

Senate Finance Committee
11 Bladen Street
3 East Miller Senate Office Building
Annapolis, MD 21401
Senate Bill 951—State Board of Physicians—Anesthesiologist Assistants—Licensing
Position: Favorable

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

My name is Vinayak Shanbhag, and I am a board-certified Physician Anesthesiologist and Maryland resident. I have practiced anesthesiology for **30** years across multiple healthcare systems. Throughout my career, I have worked extensively within the Anesthesia Care Team model alongside Certified Anesthesiologist Assistants (CAAs).

CAAs are highly trained anesthesia professionals who complete rigorous graduate-level education and clinical training specifically in anesthesiology. They practice exclusively under the medical direction and supervision of a Physician Anesthesiologist. In my experience, CAAs are skilled, knowledgeable, and integral members of the anesthesia care team. They contribute meaningfully to patient safety, efficiency in operating rooms, and access to timely surgical care.

The Anesthesia Care Team model is a physician-led system of care that has been utilized safely and effectively for decades. It allows anesthesiologists to extend high-quality anesthesia services to more patients while maintaining direct physician oversight. This model supports complex surgical services, obstetric anesthesia, trauma care, and ambulatory procedures in a coordinated and collaborative manner.

The Certified Anesthesiologist Assistant profession was established over 55 years ago by anesthesiologists to strengthen and support physician-led anesthesia care. Today, CAAs practice safely in 22 states, including the District of Columbia and most recently Virginia. Maryland is currently at a competitive disadvantage in recruiting and retaining anesthesia providers due to its lack of licensure for CAAs.

Like many states, Maryland faces increasing demand for surgical and procedural services alongside ongoing anesthesia workforce pressures. Licensing CAAs would allow physician anesthesiologists to better meet patient needs, reduce delays in care, and support hospital systems

across our state — all while maintaining the highest standards of safety through physician supervision.

As a Maryland resident and practicing Physician Anesthesiologist, I respectfully urge you to vote in favor of Senate Bill 951 — State Board of Physicians — Anesthesiologist Assistants — Licensing. This legislation strengthens patient access, supports our healthcare workforce, and preserves the physician-led anesthesia care model that prioritizes safety and quality.

Thank you for your consideration.

Vinayak Shanbhag, MD

SB0951 and HB1558 Testimony .pdf
Uploaded by: Yanyun Lin
Position: FAV

Senate Finance Committee
11 Bladen Street,
3 East Miller Senate Office Building,
Annapolis, MD 21401

Dear Members of the Senate Finance Committee,

My name is Yanyun Lin, and I am a resident of Crofton, Maryland, in Maryland Legislative District 21. I am writing to respectfully ask for your support and a “yes” vote on SB0951 and HB1558 to authorize the practice of Certified Anesthesiologist Assistants (CAAs) in Maryland.

Certified Anesthesiologist Assistants are highly trained anesthesia providers who work under the supervision of licensed anesthesiologists. CAA education maintain rigorous academic and clinical standards. All candidates must hold a Bachelor of Science degree background and complete extensive graduate-level medical education, including more than 1,000 hours of hands-on clinical anesthesia training prior to graduation.

I moved to Maryland six years ago to pursue my career as a CAA. With a background as a respiratory therapist, I am proud to serve as a CAA at a Level I Trauma Center in Washington, DC. However, due to current Maryland regulations, I am unable to practice in the state where I live.

There is a critical shortage of anesthesia providers nationwide, including in Maryland. My daily commute to DC takes two hours in heavy traffic, while Anne Arundel Medical Center is only 20 minutes from my home. As a mother of two young children, this long commute significantly reduces the time I can spend with my family. I would love the opportunity to serve the patients in my community rather than spending hours on the road each day.

Authorizing CAAs in Maryland would help address the anesthesia workforce shortage, improve patient access to care, and allow qualified professionals like myself to contribute fully within our home state.

I respectfully ask that you take a close look at SB0951 and HB1558 and vote in favor of these important bills. Your support would mean a great deal to my family and to many healthcare providers and patients across Maryland.

Thank you very much for your time and consideration.

Sincerely,
Yanyun Lin

Oral Testimony_Jacqueline C. Mitchell-3.4. 26.pdf
Uploaded by: JACQUELINE MITCHELL
Position: UNF

UNIVERSITY of MARYLAND
SCHOOL OF NURSING

Jacqueline C. Mitchell, PhD, CRNA, FAANA
Assistant Program Director/Director of Clinical Education
Jacqueline.mitchell@umaryland.edu

Organizational Systems and Adult Health
655 West Lombard Street
Baltimore, MD 21201
410 706-1825

March 4, 2026
Oral Testimony

My name is Jacqueline C. Mitchell, and I am a Certified Registered Nurse Anesthetist with eighteen years of clinical practice. I come before you in strong opposition to Senate Bill 0951 from several professional perspectives: as a retired Army Colonel, a military CRNA, a Clinical Director, an educator, and a frontline clinician caring for some of Maryland's sickest patients.

Theme: Demographic Incompatibility: Building a Dependent Model on a Retiring Foundation

The Anesthesiologist Assistant (AA) anesthesia care model is fundamentally flawed, and I would like to offer four reasons:

First, it has failed to scale.
AAs were first licensed in 1969, yet there are only about 4,000 practicing in the United States, with nearly half concentrated in just two states; Georgia and Florida. The model has struggled to grow because it is entirely dependent on anesthesiologists for supervision.

Second, Maryland faces a demographic cliff.
Approximately 45.6% of anesthesiologists in Maryland are age 55 or older. It is fundamentally unsound policy to build a new workforce that is legally dependent on a provider group that is approaching retirement.

Third, it is an economic dead end.
This legislation diverts attention and resources from a workforce that already exists and is expanding; Certified Registered Nurse Anesthetists. Nearly six decades and the AA model has still failed to meaningfully scale nationwide.

Fourth, it provides no solution for rural Maryland.
Because AAs must be tethered to an anesthesiologist, they cannot practice in rural critical access hospitals, where independent CRNAs often serve as the sole anesthesia providers.

In closing, Maryland already has the gold standard of anesthesia care. CRNAs are filling the need today and will continue to do so through our educational programs and our independent practice model.

For these reasons, I respectfully urge you to **oppose Senate Bill 0951**.

Sincerely,

Jacqueline C. Mitchell

Jacqueline C. Mitchell, PhD, CRNA, FAANA

Written Testimony_Jacqueline C. Mitchell-3.4.26.pd
Uploaded by: JACQUELINE MITCHELL
Position: UNF

UNIVERSITY of MARYLAND
SCHOOL OF NURSING

Jacqueline C. Mitchell, PhD, CRNA, FAANA
Assistant Program Director/Director of Clinical Education
Jacqueline.mitchell@umaryland.edu

Organizational Systems and Adult Health
655 West Lombard Street
Baltimore, MD 21201
410 706-1825

March 4, 2026

My name is Jacqueline C. Mitchell**,** and I am a Certified Registered Nurse Anesthetist with eighteen years of clinical experience. I respectfully submit this testimony in strong opposition to Senate Bill 0951**,** informed by my professional roles as a retired Army Colonel, military CRNA, Clinical Director, educator, and frontline clinician caring for Maryland's most critically ill patients**.**

I served 30 years with active and reserve military service and deployed to Afghanistan (2002 and 2008), Kuwait, Honduras, the Dominican Republic, and South Africa. In those environments, I provided critical care and anesthesia services in high-acuity and resource-limited combat settings.

In the combat zone, there is no one to medically direct you. The model must work autonomously, and it does.

Anesthesiologist Assistants are not utilized as anesthesia providers in the U.S. military because a provider model requiring medical direction does not align with operational realities. If a model does not work in war, it should not be adopted in rural Maryland.

As an Army Nurse Corps officer, I trained at the University of Maryland Baltimore Nurse Anesthesia Program through military funding. After 28 months of rigorous preparation, I graduated in December 2007 and deployed to a combat zone five months later, practicing independently in one of the most demanding clinical environments imaginable.

Licensing AAs in Maryland would directly impact nurse anesthesia education. Because AAs cannot train Student Registered Nurse Anesthetists (SRNAs), expanding AA positions in clinical training sites reduces case availability and hands-on learning directly impacting Maryland's long-term anesthesia workforce, including those preparing for military service and rural practice.

CRNAs are highly academically and clinically prepared autonomous anesthesia providers who are a critical part of healthcare access for the most underserved populations in this country. CRNAs must obtain a doctoral degree, either a Doctor of Nursing Practice (DNP) or a Doctor of Nurse Anesthesia Practice (DNAP), which are three-year intensive full-time programs. After securing their degree, Student Registered Nurse Anesthetists (SRNAs) must pass the National Certification Examination (NCE) administered by the National Board of Certification and Recertification for Nurse Anesthetists to gain licensure. CRNAs must complete continuing education and recertification every four years to maintain that licensure. While all CRNAs begin their career as critical care Registered Nurses (RNs), CRNAs practice the distinct advanced practice profession of nurse anesthesia

As a Clinical Director/Assistant Director at the University of Maryland, School of Nursing, a Doctor of Nursing Practice program, I oversee a three-year curriculum grounded in evidence-based practice. Our students enter with extensive ICU experience and graduate with more than 2,000 clinical hours and 700–900 anesthesia cases. This workforce pipeline is designed to produce autonomous providers capable of practicing in any setting such as urban, rural, military, or independent facilities.

In my clinical practice, I precept SRNAs caring for patients with multi-system organ failure, traumatic injuries, and life-threatening comorbidities. These cases demand advanced decision-making and independent judgment when seconds matter. Decades of peer-reviewed research demonstrate that CRNAs provide safe, high-quality anesthesia care with outcomes comparable to physician-led models.

From a workforce perspective, Maryland faces anesthesia shortages, particularly in rural and underserved areas. CRNAs are often the sole anesthesia providers in critical access hospitals. AAs must practice under anesthesiologist supervision and therefore cannot expand access in areas where anesthesiologists are not present. This proposal risks increasing system costs without solving the access problem.

For reasons of patient safety, workforce efficiency, military readiness, rural access, and preservation of educational integrity, I respectfully urge this committee to oppose Senate Bill 0951.

Thank you for your time and for your commitment to Maryland patients.

Sincerely,

Jacqueline C. Mitchell

Jacqueline C. Mitchell, PhD, CRNA, FAANA

SB951_KenRadford_Unfavorable.pdf
Uploaded by: Kennett Radford
Position: UNF

MARYLAND ASSOCIATION OF NURSE ANESTHETISTS

Advancing Excellence in Anesthesia Care for Maryland

March 2026

Senator Pam Beidle, Chair
Senate Finance Committee
Maryland General Assembly
Annapolis, Maryland

RE: Written Testimony in Opposition to SB 951 – Anesthesiologist Assistants

Dear Chair Beidle, Vice Chair, and Members of the Senate Finance Committee:

My name is Ken Radford and I reside in Frederick, Maryland, Legislative District 4. I am the President of the Maryland Association of Nurse Anesthetists (MANA), and I submit this written testimony in opposition to SB 951, which would license Anesthesiologist Assistants (AAs) in Maryland.

Maryland Already Has the Gold Standard of Anesthesia Care

Maryland already has a gold standard anesthesia care model—one that is efficient, safe, and proven. Our system relies on two highly trained providers: physician anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs). Both are fully licensed. Both are trained to make immediate, life-critical decisions. And both are legally empowered to act when seconds matter.

This structure is not accidental—it is a **policy safeguard**.

The Unique Qualifications of Maryland's CRNAs

CRNAs are required to have three to five years of high-acuity critical care nursing experience before entering anesthesia training. That means every CRNA practicing in Maryland has already managed ventilators, vasoactive infusions, cardiac arrest, and unstable critically ill patients long before stepping into the operating room. This depth of clinical experience is unmatched and irreplaceable.

Independent Collaborative Care Creates System Elasticity

Independent collaborative care creates system elasticity. Because every anesthesia provider in Maryland's current model is a decision-maker, hospitals can move cases efficiently, respond to emergencies, and adapt in real time—especially in community and rural settings where flexibility is critical to patient safety.

Introducing AAs Creates a Bottleneck—Not Better Access

Introducing a dependent-assistant provider role, such as Anesthesiologist Assistants, does the opposite. AAs cannot legally proceed without physician anesthesiologist supervision, which:

- Reduces operational flexibility in hospitals already under staffing pressure;
- Slows care delivery in a system that is already meeting Maryland's needs; and
- Expands regulatory burden without expanding patient access to care.

Maryland does not have a shortage of anesthesia providers that requires the creation of a new dependent provider category. What Maryland needs is to protect what is already working.

MARYLAND ASSOCIATION OF NURSE ANESTHETISTS

Advancing Excellence in Anesthesia Care for Maryland

Nearly 80 Years of Safe Anesthesia Care in Maryland

Since 1946—the founding year of the Maryland Association of Nurse Anesthetists—CRNAs have stood as trusted partners in delivering safe anesthesia care for Marylanders. We have served this state for nearly 80 years and will continue to do so well into the future.

Conclusion

We already have the gold standard of anesthesia care in Maryland—CRNAs and Physician Anesthesiologists working together for Maryland patients. SB 951 introduces a third provider type that only expands regulatory burden without expanding access to care for the patients we serve today and in the future.

I respectfully urge this Committee to oppose SB 951.

Respectfully submitted,

Ken Radford, Ph.D., CRNA
President, Maryland Association of Nurse Anesthetists
State President 2025–2026
Frederick, Maryland – Legislative District 4

MAAPC written testimony UNFAVORABLE SB 0951 copy.p
Uploaded by: Marie Tarleton
Position: UNF

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.

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

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

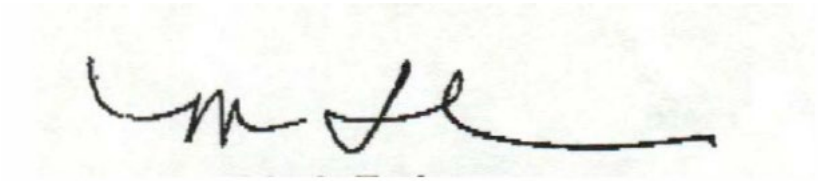
The Maryland Board of Physicians has not endorsed SB 0951. Establishing a licensure and disciplinary framework for a dependent, non-physician provider role within a board that has not supported the legislation creates an administrative burden without a corresponding regulatory sponsor. The General Assembly 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.

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,



Marie Tarleton, MS, CRNP, FNP-BC
President, The Maryland Academy of Advanced Practice Clinicians

SB951_MatthewDAngelo_Unfavorable.pdf
Uploaded by: Matthew D'Angelo
Position: UNF

TESTIMONY in response to SB951: Matthew D'Angelo, DNP, CRNA, MHPE, MSS, FAANA

Chair, Vice Chair, and Members of the Committee, thank you for the opportunity to testify.

My name is Matthew D'Angelo, and I am an Associate Professor and Director of the Johns Hopkins University Nurse Anesthesia Program.

Maryland maintains one of the most robust nurse anesthesia education infrastructures in the country. We house elite doctoral programs at Johns Hopkins, the University of Maryland, and the Uniformed Services University—programs that consistently produce highly skilled, fully autonomous anesthesia providers who serve every region of our state. And when previous efforts to advance Anesthesiologist Assistant licensure were unsuccessful, Johns Hopkins responded by creating its own Nurse Anesthesia program to increase the nurse anesthesia pipeline and support the needs of our state. That decision reflected a clear reality: the marketplace, our clinical partners, and the state's needs all align behind the nurse anesthesia model.

A central challenge in this discussion is clinical training capacity. Operating room training slots and preceptors are a finite resource. Every slot assigned to an AA student is a slot taken directly away from a doctoral Nurse anesthesia student. When we redirect these scarce training opportunities toward dependent trainees, we reduce our ability to educate the nurse anesthesia workforce Maryland relies on.

Our priority must be maximizing utility for the state. CRNAs practice throughout the state, serving in rural and underserved regions, and provide the greatest adaptability across all care settings. The AA model, by contrast, remains dependent, geographically constrained, and has not meaningfully scaled in clinical practice over sixty years. Investing Maryland's limited educational and clinical resources into a workforce that cannot practice independently is strategically shortsighted.

In closing: Maryland already has the gold standard of anesthesia care. CRNAs are filling the need now, and we will continue to do so because of our outstanding schools, our rigorous training, and our proven practice model. What is needed is support from our legislators to improve clinical access to training so we can increase the pipeline and the development of future CRNAs.

Thank you for your time.

Testimony for the Senate Finance Committee Hearing
Uploaded by: Matthew Zinder
Position: UNF

Testimony for the Senate Finance Committee Hearing Strategy: SB 951

To: Members of the Senate Finance Committee

From: Matthew Zinder, DNAP, CRNA

Date: 3/6/26

RE: Opposition regarding the licensing and utilization of Anesthesiologist Assistants (AAs)

Introduction

Good morning members of the Senate Finance Committee. My name is Matthew Zinder, and I am a Certified Registered Nurse Anesthetist (CRNA) with 22 years of experience serving patients in Maryland.

I am here today to address a dangerous misconception: the idea that Anesthesiologist Assistants (AAs) provide an equivalent value to the state's healthcare infrastructure. The reality is that AAs represent a "false equivalency"—they are less qualified than CRNAs, yet they create an unnecessary and redundant financial burden on our facilities and taxpayers.

1. The Experience Deficit

When we discuss patient safety, training and experience is the only currency that matters. A CRNA enters anesthesia training only after obtaining a Bachelor of Science in Nursing and working for 3+ years in high-acuity critical care units. We have managed ventilators, titrated life-saving drips, handled crises, and taken care of critically ill patients long before our first day of anesthesia school.

In contrast, an AA can enter training with any four-year degree and **zero clinical healthcare experience.** We are comparing professionals who have spent years at the bedside to students who may have never touched a patient before their graduate program.

2. Salary Equivalence vs. Redundant Costs

There is no "discount" for the lesser experience of an AA. AAs command salaries equivalent to Nurse Anesthetists and bill for services at the same rates. However, because AAs lack the ability to practice independently, the facility must pay:

1. A full AA salary, **PLUS**
2. The expensive, prorated time of a physician anesthesiologist who must medically direct all aspects of their practice.

This is an unnecessary "utilization cost." A single independent CRNA can do the same work without the redundant overhead of a second provider, saving the state and our hospitals significant resources.

3. The Financial "Acuity Trap"

Proponents of the AA model often point to a 1:4 supervision ratio as a sign of efficiency. This is a mathematical illusion. In high-acuity cases—the very cases where patient safety is most at risk—federal rules require the anesthesiologist to be personally present for key portions of the procedure.

When this happens, the ratio instantly **collapses from 1:4 to 1:1.** At that moment, the cost to the facility effectively doubles for a single patient. This "Acuity Trap" makes the AA model an inefficient and fragile staffing solution for high-stakes surgical environments. It also contributes to Medicare fraud as it is impossible for one anesthesiologist to be in 4 rooms as once. This means it is impossible to fulfil the necessary Medicare regulations for Medical Direction, the model which AA's must practice under.

Closing

In Maryland, we already have the gold standard of care. CRNAs are currently filling the needs of our urban and rural communities alike. We will continue to do so because of our robust schools and our proven independent model. We do not need a more expensive, lesser trained, and a more restricted tier of providers.

I urge this committee to protect our state's fiscal health and patient safety standards by rejecting SB 951.

Thank you,

Matthew Zinder, DNAP, CRNA

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Position: UNF

GEORGETOWN UNIVERSITY
Berkley School of Nursing

March 1, 2026

Chair Pam Beidle
Maryland Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

Dear Chair Beidle,

My name is Carrie Bowman Dalley, PhD, CRNA, and I am an Associate Professor and the Director of Georgetown University's Doctor of Nurse Anesthesia Practice (DNAP) Program in the District of Columbia. I am writing in strong opposition to Senate Bill (SB951). My testimony is grounded in 20 years of Georgetown faculty experience and my roles as Assistant Program Director (2018–2021) and Program Director (2022–present). I have witnessed firsthand what happens when anesthesiology assistants (AAs) enter a market: they do not create new clinical training capacity. They consume the capacity that already exists for nurse anesthesia students. I am deeply concerned that Maryland will experience the same consequences.

The Central Problem: AAs Redistribute Clinical Spots, They Do Not Create New Ones

This is the critical point the legislature must understand. There are a finite number of clinical training slots in any hospital system. When AAs occupy those slots, Student Registered Nurse Anesthetists (SRNAs) are displaced. Maryland is not gaining anesthesia providers by introducing AAs. It is simply redirecting existing training opportunities away from CRNAs, who practice independently and collaboratively, toward AAs, who cannot practice without physician supervision. The net effect on provider availability is, at best, neutral. The net effect on workforce development is demonstrably harmful.

1. Clinical Opportunity Reduction: The Georgetown Experience

Our clinical placement data over the past decade provide a stark illustration of this dynamic. Since the introduction of AAs into the DC market, SRNA placements at flagship hospitals, including MedStar Georgetown University Hospital and MedStar Washington Hospital Center, have decreased by up to 50%. These were not slots that disappeared because of reduced surgical volume or institutional downsizing. They disappeared because AAs filled them.

As a direct consequence, students who chose Georgetown specifically to train and ultimately work in the DC region are now being sent as far as Richmond, Baltimore, and Charlottesville to obtain the clinical experiences required for graduation and CRNA certification. This is not an expansion of opportunity. It is a displacement of it, and it carries serious long-term workforce consequences addressed below.

2. AAs Do Not Address Provider Shortages, They Deepen Them

AAs operate exclusively under medical direction, meaning every AA requires a supervising physician anesthesiologist. Introducing AAs does not add independent anesthesia providers to the Maryland workforce. It creates additional demand on the same physician anesthesiologists who are already stretched thin. Maryland would not be solving its anesthesia provider shortage. It would be adding a category of provider that structurally depends on the very resource that is already scarce.

CRNAs, by contrast, are educated and licensed to practice independently. Every clinical training slot that produces a CRNA yields a provider who can deliver anesthesia services without requiring physician oversight. When those slots are reappropriated for AA training, Maryland loses the opportunity to develop self-sufficient anesthesia providers and gains providers who perpetuate dependence on physician supervision.

3. The Unmet Demand for CRNA Training Is Enormous

The argument for AAs is particularly difficult to justify given the extraordinary unmet demand that already exists for CRNA training in this region. In our most recent admissions cycle (Fall 2025), Georgetown received over 340 qualified applications from experienced ICU nurses with the academic credentials and clinical backgrounds to succeed, for only 35 available clinical training slots. We turned away more than 300 qualified candidates, not because of any shortage of academic faculty, classroom space, or didactic resources, but solely because we do not have enough clinical training slots to accommodate them.

This is the opportunity cost the Maryland legislature must not overlook. Every AA placed in a clinical training slot that could have been filled by a nurse anesthesia student represents a qualified CRNA who was never trained. Maryland does not have a shortage of candidates who want to become independent anesthesia providers. It has a shortage of clinical training capacity, and AAs make that shortage worse, not better.

4. Displacement Has Compounding Long-Term Workforce Consequences

The harm extends beyond training. Students displaced from their preferred DC clinical sites and sent to Baltimore, Inova Fairfax, Richmond, or Charlottesville frequently accept employment at those sites upon graduation rather than returning to DC to practice. This accelerates the erosion of the CRNA workforce in the very region experiencing the shortage, which in turn reduces the availability of experienced CRNA preceptors at DC sites, which further limits our ability to train future CRNAs there – this same experience will happen in Maryland as Maryland programs send

students out of Maryland training sites – these students will most likely not return to the Maryland workforce. The introduction of AAs sets this cycle in motion and sustains it.

Additionally, hospitals that overhire AAs tend to reduce CRNA staffing ratios over time. Fewer CRNAs on staff means fewer preceptors available for SRNA students, compounding the clinical placement crisis further.

5. The Solution Is to Expand CRNA Training Capacity, Not Redirect It

The qualified candidates exist. The faculty exists. The classroom infrastructure exists. What is lacking is sufficient clinical training slots, a solvable problem that does not require introducing a provider category that would make it worse.

I urge the Maryland legislature to reject SB951 and instead explore meaningful solutions to the anesthesia provider shortage, including incentives for CRNA programs to expand clinical training partnerships with Maryland hospitals, loan forgiveness or stipend programs to encourage Maryland residents to pursue CRNA careers and return to practice in the state, and support for CRNA independent practice models that maximize the workforce impact of every provider trained. Invest in the current and proven anesthesia provider pathway in Maryland – the CRNA workforce.

The data from the District of Columbia are clear. AAs do not expand anesthesia provider capacity. They reappropriate the limited clinical training infrastructure available to providers who can practice independently, leaving the healthcare system with fewer self-sufficient anesthesia providers. Maryland deserves a workforce strategy that genuinely increases provider availability. SB951 does not accomplish that goal.

Please feel free to contact me if you require any additional information.

Sincerely,

Carrie C. Bowman Dalley, Ph.D., CRNA, FAANA
Program Director, DNAP Program and Associate Professor
Berkley School of Nursing at Georgetown University

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Uploaded by: Shannon Seifert
Position: UNF

Shannon M. Seifert, MS, CRNA
Laurel, MD
smseifert@gmail.com
240-603-7987

Bill Number: SB 951

Position: UNFAVORABLE

Hearing Date: March 6, 2026

Madame Chair, ladies and gentlemen of the committee, My name is Shawn Seifert. I was an Army Nurse Corps Captain assigned to Walter Reed AMC. I completed my Masters in Nurse Anesthesia at Georgetown University and have spent the last 22 years of practice in hospitals across Maryland from Annapolis to Hagerstown, Baltimore to Silver Spring. I have been the Chief CRNA of many hospitals including the system chief of a network of hospitals and surgicenters throughout Maryland and DC so I have led and managed teams including both CRNAs and AAs

From the systems level perspective, Maryland's current system already is the gold standard in anesthesia. We have care teams of physicians and CRNAs in the appropriate settings, and physician only or CRNA only care in others. This flexibility allows us to provide care in urban and rural settings and is a cost effective strategy for Maryland patients.

Adding AAs wont expand the workforce. It will only add more non clinical physicians, increasing costs while not directly providing care to patients. With mandated direction ratios, AAs ensure that physicians are unavailable for direct patient care while relegated to a supervisors role.

If a physician is supervising four rooms, and there is an emergency in one, the other three rooms have to run independently now. CRNAs that have been educated and experienced to collaborate directly with the surgeon have no trouble in this scenario. AAs as mandated dependent providers are effectively prevented from starting the next case without the physician. This creates gridlock in the operating room: both inefficient and expensive.

Collaborative practice models are the future. AAs will trap us in the past when Maryland needs to move forward. This year, Kansas voted against AA licensure. Ohio just removed physician supervision of CRNAs. CRNAs continue to be the right solution for Maryland. I ask for an unfavorable ruling on SB951.

Thank you for your time.

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Position: UNF

Maryland
DEPARTMENT OF HEALTH

Board of Physicians

Wes Moore, Governor · Aruna Miller, Lt. Governor · Harbhajan Ajrawat, M.D., Chair

2026 SESSION
POSITION PAPER

BILL NO.:	**SB 951 - State Board of Physicians – Anesthesiologist Assistants – Licensing**
COMMITTEE:	**Finance**
POSITION:	**Letter of Opposition**

POSITION AND RATIONALE:

The Maryland Board of Physicians (the Board) shares the proponents and sponsors' goal of expanding Maryland's healthcare workforce and values the potential contributions of Certified Anesthesiologist Assistants (CAAs). However, to ensure that any new licensure group is fiscally sustainable and aligned with health care safety standards, the Board respectfully submits this Letter of Opposition regarding Senate Bill (SB) 951. The bill seeks to establish a licensing and regulatory system for anesthesiologist assistants under the Board. The bill also seeks to authorize CAAs to perform complex surgical tasks, including administering anesthesia and advanced airway management, under an anesthesiologist's supervision.

Background

The Board's mission is to assure quality health care in Maryland through the efficient licensure and discipline of healthcare practitioners. Rigorous research and evaluation of new healthcare professions seeking regulatory oversight by the Board require time that can't be compressed into the ninety-day legislative session. While the Board values workforce expansion and is actively working on other legislation to address workforce shortages in Maryland, the full Board voted on December 17, 2025, to not support the licensure of CAAs during the 2026 Legislative Session. This decision was then sent in a formal letter to the bill's House sponsor and other stakeholders on December 23, 2025 (Attachment 1).

The Board's position is based on, but not limited to, the limited information received prior to the session. Proponents did not first engage the Board regarding this specific proposal until November 7, 2025. As currently drafted, SB 951 does not align with the uniform standards, codified language, and revisions the Board established through the recently enacted Senate Bill 423 / House Bill 776 - Maryland Medical Practice Act and Maryland Physician Assistants Act - Revisions ("General Revisions") (2025), which standardized the Board's statutes. Specifically, the bill text lacks fundamental components essential to the Board's mission of public protection, as it fails to incorporate mandated employer reporting, specific notification requirements for name or address

changes, internet profile requirements, and alignment with the Board's established disciplinary processes. The bill also mandates that CAAs practice under the direct supervision of a licensed anesthesiologist. The Board believes this requirement ensures patient safety through existing delegated oversight, proving that there is no immediate risk to the public if CAAs remain unlicensed.

Fiscal and Economic Impact

The Board is concerned about the significant administrative burden and fiscal impact the bill would present. Before implementing this licensure category, numerous tasks will require extensive Board resources. Tasks such as drafting regulations requiring legal consultation, developing applications, making modifications to the Board's IT system and website, and advising national and federal entities about the new licensure group. Board staff will also need additional time to research accredited anesthesiology assistant programs and review national certification standards.

The bill mandates that the Board establish reasonable fees to cover the costs of maintaining licensure. With only an estimated 50 potential CAA licensees in Maryland, the profession wouldn't generate enough revenue to remain self-sustaining. This would then lead the Board to either charge the 50 practitioners high fees to operate under the Board or inappropriately increase physician licensure fees to support this new licensure group. Additionally, the Board notes a lack of demonstrated need for this licensure category, as proponents have not provided data showing how the 50 practitioners would significantly impact Maryland's practitioner workforce shortages beyond billing and reimbursement concerns.

As of 2024, Maryland is ranked #4 among states with the highest per capita number of anesthesiologists.[1] With a total population exceeding 6 million and 1,284 active anesthesiologists, the state is a high-density hub for anesthesia services. This high density suggests a saturated market in which competition is already strong among highly trained physicians, further questioning the immediate need for an additional licensed profession in this field.

Other State Regulatory Models

CAA data from other states also support the Board's concern regarding the limited impact of this licensure category on Maryland's healthcare workforce. A workforce survey completed by the D.C. Board of Medicine (DC Board) found that, while 147 board-licensed anesthesiologist assistants were active, only 72 reported providing direct clinical care. The study also detailed that no practitioner reported plans to increase practice hours or add new practice locations in D.C. With a small clinical footprint in a neighboring jurisdiction whose licensing history for this profession began in 2005, the study further supports the Board's concerns over the lack of demonstrated need for licensing this profession in Maryland.

Licensure is the most restrictive form of regulation, and other options exist to protect consumers and maintain standards. Notably, other jurisdictions successfully utilize different regulatory systems that do not require independent licensure for CAAs. For example, Kentucky and Washington provide specific pathways for Physician Assistants to practice in anesthesia roles through delegated duties, provided they have met specific academic and clinical training requirements in anesthesiology.

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[1] **Becker's ASC Review, "States ranked by anesthesiologists per capita," February 27, 2024.** https://www.beckersasc.com/anesthesia/states-ranked-by-anesthesiologists-per-capita/

Given the limited research and evaluation time, the Board strongly requests the opportunity to explore these and other regulatory models to determine whether a less restrictive or more administratively efficient approach could protect the public while avoiding the fiscal burden of establishing a new regulated profession.

Unresolved Questions for Stakeholders

Given the limited research and evaluation time currently permitted, the Board has been unable to fully review this profession to determine whether the Board is the right fit for CAAs. The Board values making mindful decisions when taking on new licensure groups, as demonstrated through previous efforts with Limited X-Ray Machine Operators (LXMOs), Genetic Counselors, and Naturopathic Doctors. These groups provided the thorough information and research the Board needed to make an informed decision on regulatory oversight.

If amenable to the proponents, stakeholders, and sponsors, the Board would value addressing the following questions to support a more comprehensive evaluation. These questions include:

1. Market Density vs. Shortage Trends
    - How do the proponents reconcile Maryland's #4 national ranking in anesthesiologists per capita with the claim of a critical shortage?
2. Fiscal Sustainability
    - The proponents estimate approximately 50 Maryland licensees in the first year. Given the Board's experience with implementation costs, how will CAAs remain fiscally self-sustaining without inappropriately shifting the regulatory cost to physicians?
3. Alternative Regulatory Models
    - Have proponents and stakeholders explored other regulatory models used in states like Kentucky and Washington, where certain anesthesia duties can be delegated to qualified professionals without requiring a new, independent licensure category?
    - Have other types of regulation been considered (title protection, registration, or an exception to licensure)?
4. Board Alignment and Nexus to Physicians
    - Given that CAAs practice exclusively within an anesthesiologist-led care team, have proponents met with other specialized boards, such as Occupational Health or Behavioral Health, to determine if those entities provide a more appropriate regulatory home for this profession?

The Board's Commitment to Collaboration

The Board is committed to a collaborative and evidence-based approach to the licensing of CAAs. While proceeding with SB 951 in its current form would create immediate regulatory inconsistencies and fiscal risks, the Board views this as the beginning of a productive dialogue with proponents and stakeholders for this licensure group.

Rather than proceeding with licensing that may inadvertently burden the very practitioners it seeks to license, the Board formally requests that this legislation not proceed during the 2026 session. Instead, the Board commits to performing a thorough interim evaluation of this profession. To ensure transparency throughout this process, upon completion of the evaluation, the Board will notify the sponsors, proponents, and stakeholders of the outcome.

Thank you for your consideration. For more information, please contact Oriell Harris, Health Policy Analyst, at OriellT.Harris@maryland.gov.

Sincerely,

Harbhajan Ajrawat, M.D.
Chair, Maryland Board of Physicians

The opinion of the Board expressed in this document does not necessarily reflect that of the Maryland Department of Health or the Administration.

Attachment 1:

Maryland Board of Physicians

Response Letter (December 23, 2025)

Maryland
DEPARTMENT OF HEALTH

Board of Physicians

Wes Moore, Governor · Aruna Miller, Lt. Governor · Harbhajan Ajrawat, M.D., Chair

December 23, 2025

Delegate Jamila J. Woods
Maryland House of Delegates
District 26

Subject: The Maryland Board of Physicians Position and Concerns Regarding Proposed Legislation on Certified Anesthesiologist Assistant Licensure

Dear Delegate Woods,

The Maryland Board of Physicians (the Board) would like to thank you for providing the proposed bill text for establishing licensure for Certified Anesthesiologist Assistants (CAAs).

During the Board's meeting on December 17, 2025, the Board voted not to support the licensing of CAAs. This decision was based on the insufficient information received by the Board to make a well-informed assessment of the appropriate regulatory oversight for this profession. At this time, the Board strongly requests that this legislation not proceed in the upcoming session, allowing for substantive discussions with your office, the proponents, and other key stakeholders over the interim.

Evaluation of New Professions for Licensure and the Board's Commitments for 2026

This coming legislative session, following work with proponents and stakeholders throughout the interim, the Board has committed to expanding the limited x-ray machine operator (LXMO) registration and creating a licensure pathway for foreign-trained physicians. The Board also participated in meetings and discussions this interim with two other professions seeking our regulatory oversight. Both provided documentation about the scope of practice, the number of potential licensees, the risk of harm to the public, types of employers, and supervision required. Providing this information is critical so that we approach each new addition to the Board thoughtfully and with a comprehensive understanding of that profession.

During its December meeting, the Board re-adopted objective criteria for evaluating new professions for licensure. Groups seeking licensure under the Board will be requested to complete an application and provide supporting information to facilitate a thorough and considered evaluation.

The Board currently regulates physicians and 14 allied health professions, representing over 50,000

licensees. Implementing a new profession requires significant resources, including additional staff to process applications, draft regulations, forms, and applications, as well as staffing an advisory committee following the recruitment of its members, and making modifications to the Board's licensing system. With limited resources, the Board must carefully evaluate which professions will best serve Maryland's healthcare workforce needs while ensuring we maintain our established standards of oversight.

CAA Timeframe and Lack of Engagement by the Proponents

During the summer, the Board contacted the Maryland Hospital Association (MHA) to inquire whether any legislation was being considered for this profession. The Board subsequently gained a clearer understanding of the legislative intent during a meeting with Children's National Hospital on November 7, 2025, at which time we learned that draft bill language had been submitted to the Department of Legislative Services (DLS). Following that discussion, the Board requested additional information about the profession from the proponents, but has yet to receive any materials. Therefore, the Board has been unable to conduct the thorough review that the Board's oversight of this profession would require.

Proposed Bill and Regulatory Concerns

The Board is concerned by the lack of proactive engagement by the proponents, which, in turn, provided no opportunity for collaboration during the drafting phase of this bill.

The Board received its first copy of the bill text on December 2, 2025, following a meeting with your office on November 25, 2025. Our preliminary review identified several areas where the proposed bill text does not align with the Board's recently enacted legislation, **SB 423 / HB 776 - Maryland Medical Practice Act and Maryland Physicians Assistants Act - Revisions**, which standardized language across all allied health statutes under the Board. Key concerns include:

1. Statutory Inconsistency: The bill does not reflect the recent revisions made to the Board regulations through SB 423/HB 776.
2. Missing Provisions: The draft does not incorporate essential public protection requirements, such as disciplinary grounds, mandated employer reporting, notification requirements for name/address changes, and internet profile requirements.

These components are fundamental to the Board's mission to protect the safety and welfare of Maryland residents. Proceeding with this bill as currently drafted would create immediate regulatory conflict, procedural inconsistencies, and implementation challenges.

Conclusion

Based on the recent decision by the Board, which voted not to support CAA licensure at this time, the Board is formally requesting that the legislation regarding Certified Anesthesiologist Assistant (CAA) licensure not proceed in the upcoming session.

The Board is open to working constructively with your office, the bill's proponents, and other stakeholders if similar legislation is proposed in the future with sufficient notice, collaboration, and

outreach.

We look forward to the January 2026 meeting as an opportunity to discuss these concerns and explore solutions that will position any future legislation for success.

Sincerely,

Harbhajan Ajrawat, M.D.
Chair, Maryland Board of Physicians

c: Bonnie Cullison, Vice Chair, HGO
Samuel Rosenberg, HGO, Chair, Health Occupations And Long-Term Care Subcommittee
Senator Pamela Biedle, Chair, Finance Committee
Senator Antonio Hayes, Vice Chair, Finance Committee

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Position: UNF

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
  .
- **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.

William Kress, Esquire

Legislative Counsel for MANA