Chair Bagnall, Vice Chair Cullison, and Members of the House Health Committee

Maryland General Assembly

Annapolis, Maryland

Written Testimony of Shane Angus, CAA, MSA

House Bill 1558: State Board of Physicians - Anesthesiologist Assistants - Licensing

Position: **FAVORABLE**

March 16, 2026

House Health Committee

Chair Bagnall, Vice Chair Cullison, and members of the Committee, thank you for the opportunity to provide written testimony in support of House Bill 1558. [1]

My name is Shane Angus. I have practiced as a Certified Anesthesiologist Assistant (CAA) for more than 26 years. 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 cross into Washington, D.C. to provide anesthesia care - and many of those patients live in Maryland. Additionally, I am an associate professor within a school of medicine with a professional focus on anesthesia education and patient safety. I also work closely with CAA education programs nationally, so I am familiar with admissions standards, clinical training requirements, and workforce pipeline data.

Start with the question that matters: safety.

The most important question before this Committee is not rhetoric. It is whether anesthesiologist-led care teams that include CAAs are safe. The best comparative evidence says yes. Sun et al. studied roughly 443,000 Medicare inpatient surgical cases and found no significant differences in inpatient mortality, length of stay, or inpatient spending when comparing anesthesiologist-led teams using CAAs with anesthesiologist-led teams using CRNAs. [2] That finding should matter. If outcomes are equivalent, the responsible next question is why. The answer is that CAA education is selective, anesthesia-specific, and built for the physician-led anesthesia care team – a primary method of anesthesia care delivery in Maryland and Nationally. Importantly, malpractice insurance for CAAs is the same for CRNAs further illustrating the same safety outcomes.

What opposition testimony gets wrong about admissions.

Opposition testimony has tried to reduce CAA applicants to people with "any generic four-year degree" and no meaningful preparation. That is not how real programs work. CAA programs require heavy premedical science prerequisites - general chemistry, organic chemistry, biology, physics, biochemistry, calculus, advanced statistics, and related coursework - plus standardized testing through the MCAT or GRE. [3][4] A recent analysis shows admitted students to Master of Science in Anesthesia program with an averaged a 3.8 GPA and a 508 average

MCAT. [3] Nationally, MD matriculants average about a 3.8 GPA and a 512 MCAT, DO matriculants average about a 3.6 GPA and a 503 MCAT. Against that backdrop, CAA students entering with about a 3.8 GPA and an MCAT around 508 are clearly coming from the same rigorous premedical background.

These are not casual applicants. They come from strong and rigorous science and premedical pathways. In Maryland we consistently see future CAAs come from Johns Hopkins, the University of Maryland, UMBC, Towson, Salisbury, and the U.S. Naval Academy. Nationally, current students come from leading academic institutions. [5] Many already bring real world high acuity healthcare or research experience. [5][6] One pre-med advisor from Maryland who reviewed our prerequisite sheet said it plainly: "Wow, you have more requirements than medical school." That reaction captures how demanding this pathway actually is.

Training is anesthesia-specific from day one.

Once admitted, CAA students complete training that takes 2 years or more of graduate level anesthesia education in programs that must be based at, or affiliated with, medical schools and anesthesiology departments. Training includes more than 2,000 clinical hours, high-fidelity simulation, broad exposure across pediatric, obstetric, cardiothoracic, trauma, regional, and general anesthesia, national certification, and continuing education with periodic recertification. [7] The nearest program to Maryland is in D.C. where students rotate at MedStar Washington Hospital Center, Children's National, George Washington University Hospital, Johns Hopkins-Sibley, Howard University Hospital, and MedStar Georgetown. [6] This is not generic graduate education. It is a tightly structured, anesthesia-focused clinical pathway. CAA practice under anesthesiologist supervision and this is a strength of the profession.

Clinical minimums are much closer than opponents suggest.

Different pathways leading to similar practice. The entry point for CAAs is premedical science; the entry point for CRNAs is nursing and critical care. Those are different pathways. This is similar to PA and NP programs – unique origins, similar practice. But when you compare anesthesia-specific clinical minimums, the gap is much smaller than opponents imply. Current ARC-AA standards require 600 total anesthesia cases and 2,000 clinical anesthesia hours for CAA training. [8] COA standards for nurse anesthesia require 650 total cases and 2,000 clinical hours. [9] The exact numbers are not identical, but they are plainly in the same range. That is why the claim of a dramatic "clinical experience deficit" does not hold up when you compare the actual anesthesia training standards – and the safety outcomes from over 400,000 anesthesia cases demonstrate so.

It is also important to keep degree titles in perspective. Nurse anesthesia education has evolved over time from certificate programs, to master's programs, and now to doctoral entry. [10] The label on the degree has changed over the years, but the practical question for this bill is the amount and rigor of anesthesia training. On that measure, the minimum case and hour requirements for CAAs and CRNAs are strikingly similar. Calling CAAs anything other than a

professional colleague, is simply not supported by the outcome data, the training standards, or the CMS and payor reimbursement criteria which is identical for services provided.

Training spots are not a zero-sum fight.

Another opposition argument is that CAA students will "take" training spots away from student nurse anesthetists. That is not how anesthesia education works. Strong anesthesia departments routinely train multiple learners at the same time - medical students, residents, CAAs, CRNAs, nurses, paramedics, ER residents and other clinical staff. It is notable that there are 1,000 CRNAs in Maryland and each is a qualified educator. Adding CAA students does not displace SRNAs. It is not a zero-sum game, and nor should it be. We need all healthcare providers at the bedside to support the growing patient population.

CAA education is scalable.

Maryland also needs to think about future needs. There are now more than 4,000 active CAAs nationally, and CAA education spans more than 26 accredited programs. [7][12] Based on profession-wide admissions tracking CAA applications has increased dramatically over the last decade - roughly 925% overall, averaging about 33% annual growth - and national seat capacity is on track to approach 1,000 annually by 2027 – that is a 250% increase is seats over the past 10 years. This is exactly the kind of scalable workforce pipeline Maryland should want to support surgical access and hospital capacity.

Florida is a useful example of coexistence, not displacement. It is one of the major practice states for both professions, with nine accredited nurse anesthesia programs and six CAA campuses. [12][13] The lesson from Florida is not that one profession crowds out the other. The lesson is that high-demand states with growing and aging populations need both.

Maryland already knows this model.

This issue is also not theoretical for Maryland. The District of Columbia has licensed and used CAAs within anesthesiologist-led care teams for more than 20 years. [14] Many Maryland-based hospitals and health systems already know this model through their D.C. relationships and operations. I am one of the Maryland residents who has had to cross the line into D.C. to care for patients because Maryland still does not provide licensure. Nationally, states continue to adopt CAA licensure through bipartisan legislation, including Nevada, Washington State, Tennessee, and Virginia. [15]

What HB1558 does, and what it does not do.

HB1558 is a straightforward licensure bill. It creates a licensing and regulatory framework under the State Board of Physicians for nationally trained, nationally certified CAAs who practice under anesthesiologist supervision. [1] It does not create independent practice. It does not change CRNA law. It does not create a new billing code, a new reimbursement mandate, or a requirement that any hospital hire CAAs. It does not change TEFRA, Medicare payment policy, or

Maryland's Total Cost of Care model. It simply gives Maryland hospitals and anesthesia groups the option to recruit another proven anesthesia professional into the anesthesia care team.

I recognize that the Maryland Board of Physicians has raised concerns about timing, drafting, and administrative implementation. Those concerns deserve attention, and technical issues can be addressed. But those are implementation questions. The Board's letter focuses on process, regulatory alignment, and fiscal setup. [16] Those are all aspects that can be addressed. The regional experience next door in D.C. demonstrates how the CAA workforce can support Maryland directly, as CAAs are already caring for Maryland residents outside of Maryland, CAAs should be able to care for patients inside Maryland.

Maryland needs more anesthesia capacity, not fewer options.

When anesthesia staffing is tight, operating rooms run below capacity, cases are delayed, and patients wait longer for surgery and procedures. HB1558 is additive. It does not replace anesthesiologists. It does not replace CRNAs. It allows Maryland to add another rigorously selected, rigorously trained anesthesia professional to help meet demand. That is the practical effect of this bill.

For these reasons, I respectfully request a favorable report and a yes vote on House Bill 1558.

Respectfully submitted,

Shane Angus, CAA, MSA

References

[1] Maryland General Assembly. House Bill 1558 bill page, synopsis, fiscal note, and House Health Committee hearing materials.

[2] Sun EC, Miller TR, Moshfegh JM, Baker LC. Anesthesia Care Team Composition and Surgical Outcomes. Anesthesiology. 2018;129(4):700-709. DOI: 10.1097/ALN.0000000000002275.

[3] Master of Science in Anesthesia Program. Student Body Profile and admissions metrics pages.

[5] MSA Program. Current student profiles and biographies.

[6] MSA Program. Washington Clinical Partners, Program Overview, and Primary Affiliates pages.

[7] ARC-AA / CAAHEP and national CAA education materials describing program structure, accreditation, and continuing education requirements, including the ARC-AA / CAAHEP Standards and Guidelines for Anesthesiologist Assistant Programs and AAAA 2025 education materials.

[8] ARC-AA / CAAHEP Standards and Guidelines for Anesthesiologist Assistant Programs, clinical content outline requiring 650 total anesthesia cases and 2,000 clinical anesthesia hours.

[9] Council on Accreditation of Nurse Anesthesia Educational Programs (COA). Standards for Accreditation of Nurse Anesthesia Programs - Practice Doctorate, current clinical minimums requiring 2,000 clinical hours and 650 total cases.

[10] American Association of Nurse Anesthesiology. "How to Become a CRNA" and related education materials.

[11] MSA Program. Clinical Instructors page.

[12] Association of Anesthesiologist Assistant Education Programs (AAAEP). Members page and related CAA program materials.

[13] Council on Accreditation of Nurse Anesthesia Educational Programs. List of Accredited Educational Programs.

[14] Code of the District of Columbia, Sec. 3-1206.31. Scope of practice.

[15] Official recent state legislative sources: Nevada AB 270 (2023); Washington SB 5184 (2024); Tennessee HB 979 / SB 764 (2024); Virginia SB 882 (2025).

[16] Maryland Board of Physicians. 2026 session position paper on SB 951 and December 23, 2025 letter regarding proposed CAA licensure legislation.