



### *Board of Directors*

Marie Tarleton, MS, CRNP, FNP-BC, *President*  
Paula Jo Carson, BSN, FNP-BC, *Treasurer*  
Angel Hannah, MSN, FNP, *Secretary*  
Lorraine Diana, MSN, CNP, *Legislative & Education Chair*  
Elaine M. Crain, DNP, FNP, *Media Chair*

### *Members at Large*

Angela Borger, DNP, FNP, DNC  
Elizabeth Baldwin, BSN, MSN, PNP  
Jill Burgholzer, DNP, PMH-NP, FNP  
Kelli Goldsborough, MSN, CRNP, FNP-BC  
Ptryk Madrid, DNP, FNP-C  
Sabrina Sepulveda, MSN, CRNP-PMH  
Michele Williams, DNP, CRNP, AGPCNP-BC

## **TESTIMONY IN OPPOSITION**

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

**TO:** Members of the House Health Committee

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

**DATE:** Hearing March 18, 2026

### **POSITION: UNFAVORABLE**

The Maryland Academy of Advanced Practice Clinicians (MAAPC) respectfully submits this testimony in opposition of HB 1558.

#### **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 (PA) 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 HB 1558.

#### **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

P.O. Box 37  
Prince Frederick, MD 20678  
[www.MAAPCOnline.org](http://www.MAAPCOnline.org)  
[TheMAAPC@gmail.com](mailto:TheMAAPC@gmail.com)  
Tax ID 56-2521799

**The Voice for Advanced Practice Clinicians in Maryland**



## *Board of Directors*

Marie Tarleton, MS, CRNP, FNP-BC, *President*  
Paula Jo Carson, BSN, FNP-BC, *Treasurer*  
Angel Hannah, MSN, FNP, *Secretary*  
Lorraine Diana, MSN, CNP, *Legislative & Education Chair*  
Elaine M. Crain, DNP, FNP, *Media Chair*

## *Members at Large*

Angela Borger, DNP, FNP, DNC  
Elizabeth Baldwin, BSN, MSN, PNP  
Jill Burgholzer, DNP, PMH-NP, FNP  
Kelli Goldsborough, MSN, CRNP, FNP-BC  
Ptryk Madrid, DNP, FNP-C  
Sabrina Sepulveda, MSN, CRNP-PMH  
Michele Williams, DNP, CRNP, AGPCNP-BC

Intensive Care Unit (ICU) experience, completion of a 36-month doctoral anesthesia training program and passing a national certification exam.

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 and are often the sole anesthesia provider. This universal deployment capacity is the structural foundation of Maryland's anesthesia access model.

HB 1558 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.

P.O. Box 37  
Prince Frederick, MD 20678  
[www.MAAPCOnline.org](http://www.MAAPCOnline.org)  
[TheMAAPC@gmail.com](mailto:TheMAAPC@gmail.com)  
Tax ID 56-2521799

**The Voice for Advanced Practice Clinicians in Maryland**



### *Board of Directors*

Marie Tarleton, MS, CRNP, FNP-BC, *President*  
Paula Jo Carson, BSN, FNP-BC, *Treasurer*  
Angel Hannah, MSN, FNP, *Secretary*  
Lorraine Diana, MSN, CNP, *Legislative & Education Chair*  
Elaine M. Crain, DNP, FNP, *Media Chair*

### *Members at Large*

Angela Borger, DNP, FNP, DNC  
Elizabeth Baldwin, BSN, MSN, PNP  
Jill Burgholzer, DNP, PMH-NP, FNP  
Kelli Goldsborough, MSN, CRNP, FNP-BC  
Ptryk Madrid, DNP, FNP-C  
Sabrina Sepulveda, MSN, CRNP-PMH  
Michele Williams, DNP, CRNP, AGPCNP-BC

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

In the United States, invoicing Medicare for professional anesthesia services requires that the anesthesiologist “personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence” (Center for Medicare Services, 2017). Any hospital or healthcare facility that employs AA is trapped into using only the costly medical direction model. 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. An anesthesiologist is medically directing if they are involved in no more than four concurrent anesthesia cases, perform certain vital tasks (like performing a pre-anesthesia examination and evaluation, prescribing the anesthesia plan and monitoring the course of the anesthesia administration) and remain physically present and available to provide immediate care if needed. In high-acuity environments, a standard in Maryland trauma and academic medical centers, diversion of the supervising physician to an emergency triggers a downgrade to "Medical Supervision" which is when an anesthesiologist oversees more than four concurrent cases or does not meet the specific requirements for medical direction. This results in lower 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. In fact, according to Epstein et al., (2012), even at a supervision rate of 1:2, lapses occurred on 35% of the days. These lapses are not in compliance with billing requirements and can result in violations, costly surgical delays or accreditation jeopardy. Facilities may be at risk for Medicare fraud for not assuring appropriate medical direction of AAs. The civil fines are up to three times the amount of damages sustained by the government and an additional charge of up to \$21,563 per false claim with criminal penalties may include fines, imprisonment or both (Department of Justice, 2016). 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. HB 1558 does not expand access to care in Maryland's most

P.O. Box 37  
Prince Frederick, MD 20678  
[www.MAAPCOnline.org](http://www.MAAPCOnline.org)  
[TheMAAPC@gmail.com](mailto:TheMAAPC@gmail.com)  
Tax ID 56-2521799

The Voice for Advanced Practice Clinicians in Maryland



## *Board of Directors*

Marie Tarleton, MS, CRNP, FNP-BC, *President*  
Paula Jo Carson, BSN, FNP-BC, *Treasurer*  
Angel Hannah, MSN, FNP, *Secretary*  
Lorraine Diana, MSN, CNP, *Legislative & Education Chair*  
Elaine M. Crain, DNP, FNP, *Media Chair*

## *Members at Large*

Angela Borger, DNP, FNP, DNC  
Elizabeth Baldwin, BSN, MSN, PNP  
Jill Burgholzer, DNP, PMH-NP, FNP  
Kelli Goldsborough, MSN, CRNP, FNP-BC  
Ptryk Madrid, DNP, FNP-C  
Sabrina Sepulveda, MSN, CRNP-PMH  
Michele Williams, DNP, CRNP, AGPCNP-BC

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 HB 1558. 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, the CRNA model in particular, represents the state's most effective, scalable, and cost-efficient anesthesia delivery infrastructure. HB 1558 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.

P.O. Box 37  
Prince Frederick, MD 20678  
[www.MAAPCOnline.org](http://www.MAAPCOnline.org)  
[TheMAAPC@gmail.com](mailto:TheMAAPC@gmail.com)  
Tax ID 56-2521799

**The Voice for Advanced Practice Clinicians in Maryland**



### *Board of Directors*

Marie Tarleton, MS, CRNP, FNP-BC, *President*  
Paula Jo Carson, BSN, FNP-BC, *Treasurer*  
Angel Hannah, MSN, FNP, *Secretary*  
Lorraine Diana, MSN, CNP, *Legislative & Education Chair*  
Elaine M. Crain, DNP, FNP, *Media Chair*

### *Members at Large*

Angela Borger, DNP, FNP, DNC  
Elizabeth Baldwin, BSN, MSN, PNP  
Jill Burgholzer, DNP, PMH-NP, FNP  
Kelli Goldsborough, MSN, CRNP, FNP-BC  
Patryk Madrid, DNP, FNP-C  
Sabrina Sepulveda, MSN, CRNP-PMH  
Michele Williams, DNP, CRNP, AGPCNP-BC

MAAPC urges the Committee to issue an **UNFAVORABLE** report on HB 1558 and to reaffirm Maryland's commitment to the advanced practice registered nurse model as the foundation of the state's anesthesia workforce policy.

Respectfully,

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

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

P.O. Box 37  
Prince Frederick, MD 20678  
[www.MAAPCOnline.org](http://www.MAAPCOnline.org)  
[TheMAAPC@gmail.com](mailto:TheMAAPC@gmail.com)  
Tax ID 56-2521799

The Voice for Advanced Practice Clinicians in Maryland