

MSA Minnesota Society of Anesthesiologists

- Health-care workforce shortages continue to be a major challenge for many health systems in Minnesota, and recent public and private health-care cuts could result in even greater staffing challenges, which can impact access to high-quality anesthesia care.
- Locally, there are over 200 current vacancies impacting surgical health-care services, resulting in delays, lack of access, and potential harm to patients.
- The MSA, in partnership with the national American Society of Anesthesiologists (ASA) and the American Academy of Anesthesiologist Assistants (AAAA), proposes that Minnesota create a new licensing law to allow safe, high-quality anesthesia care.
- Minnesota should join 22 other states and pass legislation to offer an anesthesia care team model that includes certified anesthesia assistants (CAAs).
- CAAs complete a bachelor's degree plus a two-year master's-level training program with 2,000+ clinical hours, and published research documents that both CAAs and CRNAs provide equally safe and effective care, without differences in cost, when working as part of the anesthesia care team model.
- Please join as a co-author of House File 4460 and Senate File 4517.
- CAA licensure legislation in Minnesota is supported by all of the following groups:



MINNESOTA
MEDICAL
ASSOCIATION

MINNESOTA
MEDICAL
ASSOCIATIONS
mnmed.org



AMERICAN ACADEMY
OF ANESTHESIOLOGIST
ASSISTANTS
anesthetist.org

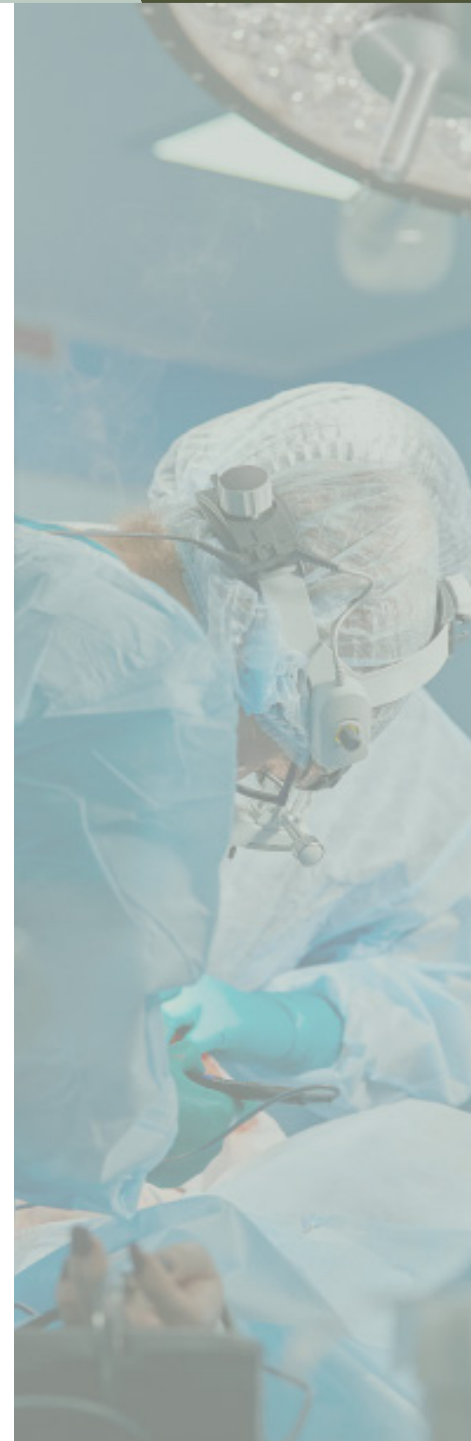


American Society of
Anesthesiologists

AMERICAN
SOCIETY OF
ANESTHESIOLOGIST
asahq.org



MINNESOTA
AMBULATORY SURGERY
CENTER ASSOCIATION
mnasca.org



For more information,
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612-596-4005



dlpollock@Locklaw.com



April 13, 2026

Dear Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Medical Association (MMA), I write to express support for HF 4460, which would establish a licensure framework for Certified Anesthesiologist Assistants (CAAs) and authorize them to practice in Minnesota.

Minnesota law currently does not authorize CAAs, excluding the state from a rapidly growing national workforce. There are currently 23 accredited CAA programs across the United States, producing highly trained specialty clinicians each year, yet Minnesota is unable to attract these professionals under current law, placing additional strain on an already limited anesthesia workforce.

CAAs are highly educated and trained medical professionals who play a vital role in delivering safe and effective anesthesia care. CAAs complete more than 24 months of master-level training in accredited programs, focused on biomedical sciences, diagnostics, and clinical decision making, aligned with physician anesthesiologists. Their licensure serves as an appropriate example of utilizing highly trained specialists within the physician-led care teams.

As Minnesota faces growing demand for surgical services and ongoing workforce shortages, authorizing CAAs would provide critical flexibility while maintaining high standards of care. Integrating CAAs into the physician-led care team would help meet patient needs across the state, including in rural and underserved communities.

For these reasons, the MMA respectfully urges members to support HF 4460.

Sincerely,

Lisa Mattson, MD
President, Minnesota Medical Association



April 10, 2026,

Dear Co-Chair Bierman, Co-Chair Backer and Members of the House Health Finance and Policy Committee:

On behalf of the Minnesota Ambulatory Surgery Center Association (MNASCA), which represents a statewide network of ambulatory surgery centers (ASCs) dedicated to delivering high-quality, cost-effective outpatient surgical care, I am writing to express our support of HF4460 (Huot). MNASCA supports this legislation establishing licensure for Certified Anesthesiologist Assistants (CAAs) in Minnesota and believes it is an important step toward strengthening the state's anesthesia workforce and maintaining patient access to safe surgical care.

Ambulatory surgery centers across Minnesota rely on a strong and stable anesthesia workforce to provide safe, timely, and high-quality surgical care. However, like many areas of the health care system, providers continue to face workforce challenges that can impact access to care. Minnesota currently has more than 200 anesthesia-related vacancies statewide, contributing to delays in procedures and increased strain on hospitals and surgical centers. Expanding the pipeline of qualified anesthesia professionals is an important step in addressing these ongoing challenges.

Certified Anesthesiologist Assistants are highly trained anesthesia professionals who practice as part of the Anesthesia Care Team model, working in collaboration with physician anesthesiologists and other anesthesia providers. CAAs complete rigorous graduate-level education within the medical school model, including more than 2,000 hours of clinical anesthesia training, and maintain national board certification and continuing education requirements.

States that have adopted the anesthesia care team model, inclusive of CAAs, have demonstrated strong patient outcomes while improving efficiency and access to care. Evidence shows no meaningful difference in patient outcomes, length of stay, or cost when anesthesia services are delivered by qualified professionals working collaboratively within this model.

MNASCA values the critical role that both CRNAs and physician anesthesiologists play in delivering anesthesia care across Minnesota. The addition of CAAs would provide a complementary workforce option—enhancing flexibility for care teams, supporting provider sustainability, and helping ensure patients continue to receive safe, high-quality surgical care in all regions of the state.

Ambulatory surgery centers are an essential part of Minnesota's health care delivery system, providing accessible, efficient surgical care in communities statewide. Ensuring an adequate and resilient anesthesia workforce is fundamental to maintaining timely access to these services. We respectfully urge the Committee to support and advance HF 4460 and look forward to working with you and other stakeholders to support effective implementation of this legislation.

Sincerely,

A handwritten signature in cursive script that reads "Melissa Jones".

Melissa Jones,
President, MNASCA



March 4, 2026

Senator Melissa Wiklund, Chair
Senate Health and Human Services Committee
Minnesota Senate Building
Saint Paul, Minnesota 55155

Representative Jeff Backer, Co-Chair
House Health Finance and Policy Committee
Centennial Office Building
Saint Paul, Minnesota 55155

Representative Robert Bierman, Co-Chair
House Health Finance and Policy Committee
Centennial Office Building
Saint Paul, Minnesota 55155

Re: Response to “*Questionnaire A – Minnesota Society of Anesthesiologists Proposal for Certified Anesthesiologist Assistant (CAA) Licensure*”

Dear Chair Wiklund, Co-Chair Backer, and Co-Chair Bierman:

The Minnesota Association of Nurse Anesthetists (MANA) represents more than 2,300 Certified Registered Nurse Anesthetists (CRNAs) and Student Registered Nurse Anesthetists (SRNAs) who deliver anesthesia care across the state of Minnesota. MANA respectfully submits this response to the Questionnaire A filed by the Minnesota Society of Anesthesiologists (MSA). Pursuant to the legislature’s process on scope of practice proposals, opponents may respond in writing to the information stated in Questionnaire A, and this letter serves as MANA’s formal response.

The American Association of Nurse Anesthesiology (AANA), representing more than 61,000 CRNAs nationally, opposes Certified Anesthesiologist Assistant (CAA) licensure. In every state where CAA licensure legislation has been introduced, state CRNA associations have opposed it.

MANA’S POSITION

The MSA’s questionnaire, in response to item 7(c), which requests that sponsors list any organizations who have indicated concerns or opposition to the proposal or who are likely to have concerns or opposition, states “We have not received information regarding any opposition to the proposal.” Consistent with the position of the AANA and the experience of every other state where CAA licensure has been proposed, MANA is opposed to CAA licensure in Minnesota.



MANA opposes CAA licensure because it does not address Minnesota's anesthesia workforce needs. After review of the MSA's questionnaire responses and the realities of anesthesia delivery in Minnesota, MANA has identified the following concerns.

ACCESS TO CARE

CAAs require the supervision of a physician anesthesiologist. The MSA's questionnaire itself acknowledges that the proposal "does not contemplate special geographic areas or populations." The physician anesthesiologist workforce in Minnesota is heavily concentrated in a small number of counties. Of the hospitals providing anesthesia services in Minnesota, hospitals operating under the anesthesia care team model in which a physician anesthesiologist supervises non-physician providers are located in just 21 of the state's 87 counties. These are the only hospital settings in which CAAs could practice.

CRNAs, by contrast, provide anesthesia in every county where hospital-based anesthesia services exist (75 of 87). In 54 of those counties, CRNAs are the sole anesthesia providers. Ninety-seven percent of Minnesota's Critical Access Hospitals operate on a CRNA-only model, with no physician anesthesiologist involvement, meaning no CAA practice. The MSA's questionnaire states that addressing anesthesia care workforce vacancies would have "important benefits in terms of improved access to care in Greater Minnesota." MANA agrees that addressing vacancies improves access to care across the state. This proposal does not accomplish that objective.

WORKFORCE

The MSA's questionnaire references "workforce challenges," "workforce vacancies," "workforce options," and "workforce needs" throughout its filing. These references form the foundation of the MSA's case for CAA licensure in Minnesota. However, the questionnaire provides only one quantitative claim to support this core argument, that "Minnesota currently has more than 200 anesthesia-related full-time employment vacancies."

The most recent publicly available workforce vacancy data comes from the Minnesota Department of Employment and Economic Development's Job Vacancy Survey. The 2024 survey results identify 78 CRNA vacancies and 22 physician anesthesiologist vacancies statewide, for a combined total of 100. For context, the same survey reports 172 Nurse Practitioner vacancies, 379 Physician Assistant vacancies, 1,677 Licensed Practical Nurse vacancies, 3,295 Registered Nurse vacancies, and 3,896 Nursing Assistant vacancies.

DEED survey data from 2018 through 2024 shows that combined anesthesiologist and CRNA vacancies have consistently accounted for between 0.6% and 1.7% of total vacancies among the 35 diagnostic and treatment health care providers tracked by the survey. Whether the number of anesthesia vacancies is 100 or 200, the data does not identify a workforce gap that CAA licensure would address.

DEMAND FOR CAA PRACTICE IN MINNESOTA

The MSA's questionnaire states that there are "over 4,000 practicing CAAs, more than 200 of whom are licensed in Wisconsin," and that "many of these CAAs seek to live and practice in Minnesota, and to provide care in our communities." Wisconsin passed CAA licensure in 2012. After 13 years, and despite bordering Illinois, home to one of the largest CAA training programs in the country, Wisconsin only has approximately 200 licensed CAAs. That level of adoption does not suggest the demand the MSA describes. As to the claim that "many" CAAs seek to practice in Minnesota, the questionnaire does not quantify how many, does not provide supporting evidence, and does not identify which communities they would serve.



PATIENT HARM

The questionnaire states that "in the absence of CAA licensure, patient harm will continue to occur." The word "continue" implies that patient harm is presently occurring in Minnesota. MANA is unaware of any such harm. The questionnaire cites no incidents, no facility reports, and no data to substantiate this claim.

COST AND PATIENT OUTCOME

The questionnaire states that "there is no difference in cost to the patient when the non-physician anesthesia provider is a CAA or CRNA," and cites research confirming that "perioperative outcomes were the same regardless of whether the anesthesiologist supervised a CAA or a CRNA." This proposal, by the MSA's own account, produces no cost savings and no improvement in patient outcomes.

PRIOR BILL INTRODUCTION

The questionnaire states that "The bill was introduced in prior sessions." MANA is not aware of any prior introduction of a CAA licensure bill in the Minnesota Legislature.


WHERE WE STAND

MANA does not dispute that CAAs are trained professionals who provide anesthesia services in other states. The question before the Legislature is whether CAA licensure addresses a genuine need in Minnesota. Based on the information presented in the MSA's own questionnaire, CAAs offer no improvement in patient outcomes and no cost savings. And because CAAs are entirely dependent on physician anesthesiologists who are concentrated in a small number of Minnesota counties, they offer no expansion of access to care, especially in Greater Minnesota.

MANA urges the Legislature to carefully evaluate whether this proposal addresses a genuine need in Minnesota.

MANA is prepared to provide data and analysis to support its position and welcomes any questions.

Respectfully submitted,



Robyn Finney, DNAP, CRNA, APRN, FAANA
President, Minnesota Association of Nurse Anesthetists
10700 Hwy 55, Suite 275
Plymouth, MN 55441





Dear Chair Backer, Chair Bierman, and Members of the Committee:

The Minnesota Association of Nurse Anesthetists (MANA) represents more than 2,300 Certified Registered Nurse Anesthetists (CRNAs) and Student Registered Nurse Anesthetists (SRNAs) who deliver anesthesia care across Minnesota. MANA strongly opposes House File 4460 (Huot), which would authorize licensure of Anesthesiologist Assistants (AA) in Minnesota.

CRNAs are independently practicing, doctoral-level providers who deliver the full scope of anesthesia services without physician supervision. They are the backbone of Minnesota's anesthesia workforce, providing care in 75 of the state's 87 counties, serving as the sole anesthesia providers in 54 of those counties, and staffing 97% of Minnesota's Critical Access Hospitals without any physician anesthesiologist involvement. HF 4460 offers nothing to those hospitals or the communities that depend on them for care.

This legislation does not expand access to care. AAs cannot practice without the direct supervision of a physician anesthesiologist at all times. Minnesota's anesthesiologists are involved in hospital-based anesthesia delivery in only 21 of Minnesota's 87 counties and are heavily concentrated in just five of those counties. HF 4460 does not extend anesthesia services into a single new community because AAs can only practice where anesthesiologists already are. It adds a physician-dependent, master's-level provider to locations that already have both anesthesiologists and CRNAs.

The workforce data does not support this proposal. The Minnesota Society of Anesthesiologists' (MSA) questionnaire references workforce challenges throughout its filing but provides only one quantitative claim: that Minnesota has "more than 200 anesthesia-related full-time employment vacancies." The most recent DEED Job Vacancy Survey identifies 78 CRNA vacancies and 22 physician anesthesiologist vacancies, a combined total of 100. For context, the same survey reports 3,295 Registered Nurse vacancies and 3,896 Nursing Assistant vacancies. Whether the number is 100 or 200, the data does not identify a workforce gap that AA licensure would address.

Wisconsin's experience does not demonstrate demand. Wisconsin passed AA licensure in 2012. After 13 years Wisconsin has approximately 200 licensed AAs. That level of adoption does not reflect the demand the MSA describes.

By the proponents' own account, this proposal produces no clinical or financial benefit. The MSA's questionnaire acknowledges that there is no difference in patient

outcomes and no cost savings when comparing AA and CRNA care. The questionnaire also claims that patient harm will "continue" without AA licensure, implying harm is currently occurring in Minnesota. MANA is unaware of any such harm, and the questionnaire cites no incidents, no facility reports, and no data to support this claim.

The question before this committee is whether HF 4460 addresses a genuine need in Minnesota. Based on the evidence, including the MSA's own submissions, it does not – and it does not improve access to care. MANA respectfully and firmly urges the committee to oppose this bill.

MANA is prepared to provide additional data and analysis and welcomes any questions.

Respectfully submitted,

Robyn Finney APRN, CRNA, DNAP, FAANA
MANA President

Subject:**Please Oppose The Certified Anesthesiologist Assistant (CAA) Bill (HF 4460)**

Dear Co-Chair, Representative Jeff Backer and Co-Chair, Representative Robert Bierman,

My name is Sabrina DeBlaere, and I am a Student Registered Nurse Anesthetist (SRNA) at Saint Mary's University of Minnesota. As a nurse anesthesia student, I want to share why HF4460, the Certified Anesthesiologist Assistant Licensure Bill, could potentially diminish, not expand, our pipeline of anesthesia providers in Minnesota.

Doctorate Nurse Anesthesia Student Training Impact

The introduction of an additional anesthesia provider role that does not expand access to care may unintentionally hinder clinical training opportunities for students enrolled in Minnesota's four established doctoral nurse anesthesia programs. Doctorally prepared CRNA students cannot be trained by Certified Anesthesiologist Assistants (CAAs), which creates a limitation in already competitive clinical environments.

In medically directed anesthesia care models, Physician Anesthesiologists are restricted in how many learners they can supervise. By law, they may supervise no more than two student learners at a time and can medically direct a maximum of four operating rooms simultaneously. The inclusion of CAAs within these models would further constrain available training opportunities by occupying operating rooms that would otherwise serve as essential learning environments for CRNA students working alongside CRNAs.

With four CRNA programs in Minnesota, access to clinical placements—particularly in specialized areas such as cardiac, trauma, pediatrics, and obstetrics—is already highly competitive. Any reduction in available training sites may significantly impact students' ability to meet their educational requirements. If students lose access to these experiences, this could potentially affect the number of CRNA students that programs in Minnesota are able to graduate each year. Additionally, these programs currently graduate approximately 100 CRNA students a year, with programs attempting to expand numbers each year to meet evolving needs. Expansion cannot happen if clinical opportunities are reduced.

Consideration for Quality and Experience of Anesthesia Providers

Additionally, there are important differences in prerequisite training between CAAs and CRNAs. Doctorally prepared nurse anesthesia students are required to have prior experience as intensive care unit (ICU) registered nurses before entering their programs,

with most programs requiring a minimum of two years of critical care experience. Many students exceed this requirement. This hands-on experience caring for critically ill patients provides a strong clinical foundation that enhances patient safety and contributes to high-quality anesthesia care.

In contrast, CAA training programs do not require prior healthcare experience before admission. As a result, CRNAs bring a unique depth of bedside experience and clinical judgment that positions them as strong patient advocates and leaders in patient safety. Comparatively, CAAs must spend a portion of their training just getting acquainted with basic healthcare skills, instead of focusing on learning the complexities of anesthesia care.

We have four doctorate nurse anesthesia programs in Minnesota. To support access to safe and high-quality anesthesia care for Minnesotans, we should do whatever we can to support the learning and growth of CRNA student clinical experiences. For these reasons, I respectfully urge you to reject this bill and continue supporting CRNAs and SRNAs in delivering safe, high-quality anesthesia care to communities across Minnesota.

Actual Solutions

Please oppose HF 4460. Minnesota cannot afford legislation that mandates the most expensive anesthesia delivery model, benefits highly compensated physician anesthesiologists, and cannot reach over 75% of the state. If the Legislature wants to meaningfully expand anesthesia access, it should focus on removing artificial barriers that prevent CRNAs from practicing to the full scope that state law already authorizes.

Thank you for your time. I welcome the opportunity to discuss this further.

Respectfully,

Sabrina DeBlaere BAN, RN, SRNA

Saint Mary's University of Minnesota Doctorate Nurse Anesthesiology Program

Class of 2026

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