

WRITTEN TESTIMONY
Kansas Senate Health Committee
In Support of Anesthesiologist Assistant Licensure (HB 2368)

March 2026

Submitted by:

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Personal Testimony — Institutional Disclaimer

The views, opinions, and positions expressed in this testimony are solely my own and are offered in my personal capacity as a physician, educator, and Kansas resident.

They do not represent, and should not be attributed to, the University of Kansas, the University of Kansas School of Medicine, Ascension Via Christi Hospitals, or any affiliated institution.

I. Who I Am

My name is James Walker. I am a native Kansan, raised in Nickerson. I completed my undergraduate education and medical school at the University of Kansas, then trained in anesthesiology, critical care, and neurocritical care medicine in Cincinnati before returning to Wichita, where I have practiced for nearly 20 years.

I am the Chair and Program Director of the Department of Anesthesiology at KU School of Medicine – Wichita, where I am responsible for the education and training of more than 20 anesthesiology residents annually. I am also the Medical Director of Neurocritical Care and Stroke at Ascension Via Christi Hospitals, where most of my clinical time is spent in the intensive care unit — not the operating room. I am triple board-certified in anesthesiology, critical care, and neurocritical care.

I write to you as someone who has no financial stake in this debate. I do not employ CRNAs or AAs. I do not own or have any financial interest in an anesthesia group. Anesthesiologist assistants would not increase or decrease my salary by a single dollar. I have trained physician residents, CRNA students, medical students, and nearly every other kind of medical learner over two decades. I understand, firsthand, what each provider brings to the table. I am therefore perhaps as unbiased an expert voice on this topic as you will encounter in these proceedings.

I also want to be transparent about where I stand more broadly. I have written to many of you about my strong opposition to other scope-of-practice expansions currently before

the Legislature — specifically efforts by naturopaths and optometrists to perform procedures for which they have not received adequate medical training. The Kansas Medical Society, the Medical Society of Sedgwick County, and my wife Kaely and I oppose those bills, not because they affect our income, but because they are not in the best interest of patients.

HB 2368 is categorically different from those expansions. **Anesthesiologist assistants are not asking to expand beyond their training. They are asking for the legal framework to practice exactly what they were trained to do — within a physician-supervised team.** That distinction matters, and I ask that this Committee weigh it carefully.

II. What Is an Anesthesiologist Assistant?

Certified Anesthesiologist Assistants (CAAs) are graduate-level, non-physician anesthesia providers who hold a master's degree from a program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). They require a premedical undergraduate background for admission — the same prerequisite academic track as medical school.

CAAs are nationally certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), which received full accreditation from the National Commission for Certifying Agencies (NCCA) in September 2025 — the gold standard for certification program oversight. CAAs must complete 50 hours of continuing medical education every two years and recertify every ten years.

Most critically: CAAs **only** practice within the anesthesia care team model under physician supervision. They do not and cannot practice independently. There is no scenario in which a CAA replaces a physician or functions outside their defined scope. This is not a matter of policy preference — it is built into the model by design.

III. National Context: States Across the Country Are Moving Forward

Kansas is not being asked to be a pioneer. It is being asked not to fall further behind. As of early 2026, CAAs are authorized to practice in 24 jurisdictions — 22 states, Washington D.C., and the U.S. Territory of Guam — including neighboring states Colorado, Missouri, and Oklahoma. Virginia and Tennessee enacted CAA licensure in 2025 alone. Washington state became the first West Coast state to license CAAs in 2024.

Kansas City University, located in Joplin, Missouri, launched a new Master of Health Science in Anesthesiologist Assistant program in January 2026. Graduates of that program — some of whom will have ties to Kansas — cannot practice in our state without passage of this bill. We are actively turning away a trained workforce that is ready to help us.

Legislators in other states are hearing the same arguments Kansas has heard — and reaching the same conclusions. The Michigan House Health Policy Committee is currently considering legislation identical in purpose to HB 2368. Tom George, M.D., CEO of the Michigan State Medical Society, testified in support, describing the legislation as:

“a safe and sustainable way to expand access to anesthesia care while maintaining — and even strengthening — the physician-led care team.”

The Michigan State Medical Society emphasized that physician-led anesthesia care teams are a proven model for high-quality surgical care, and that licensing CAAs would address workforce shortages and improve patient access while preserving physician leadership and oversight. This is the same conclusion reached by the Kansas Medical Society and the Medical Society of Sedgwick County, both of which formally support HB 2368. These societies represent physicians across our state who have no financial stake in this outcome and who have independently concluded that this bill is in the best interest of Kansas patients.

IV. The Anesthesia Provider Shortage in Kansas Is Real

The arguments against HB 2368 are theoretical. The anesthesia provider shortage in Kansas is not. Our state has experienced 100 to 200 open CRNA positions for an extended period following the COVID-19 pandemic. A current review of gasworks.com, a leading anesthesia-specific job board, reflects this reality in real time. Every Wichita-area anesthesia group I am aware of has relied on expensive, out-of-state locum CRNAs — providers with no ties to our communities — simply to maintain surgical capacity.

This shortage has real consequences for patients: delayed surgeries, reduced operating room capacity, and higher costs. It also fuels burnout among our existing workforce, which compounds the shortage over time.

Licensing CAAs expands the pool of available anesthesia providers without removing a single CRNA from the workforce. **More providers mean fewer coverage gaps. Fewer gaps mean less reliance on expensive out-of-state locum CRNAs. Lower locum costs mean lower costs for hospitals — and ultimately for patients.** Kansas needs all hands-on-deck.

V. What About Rural Kansas? The Opposition Has This Backwards.

The most prominent argument against this bill is that CAA licensure will harm rural hospitals. This argument fails on its own internal logic.

CAAs require physician anesthesiologist supervision. Rural Kansas hospitals, for reasons explained in the next section, do not employ physician anesthesiologists. Therefore, CAAs will not practice in rural Kansas. This is not a policy choice — it is a structural reality determined by how the CAA model operates.

The opposite of the opposition’s claim is true: **every CAA who accepts a position at an urban or suburban Kansas hospital frees up a CRNA who might otherwise compete for that same role — making more CRNAs available for rural recruitment.** CAA licensure does not pull CRNAs away from rural markets. It relieves pressure on the overall workforce and creates more opportunity for rural facilities to attract local CRNAs rather than costly out-of-state locums. Rural Kansas only stands to benefit.

VI. Why Physician Anesthesiologists Don’t Work in Rural Kansas: The Medicare Reimbursement Reality

Rural hospital CEOs have expressed concern about the cost of physician anesthesiologist employment. Their concern is legitimate — but it has nothing to do with HB 2368. It is caused by a federal Medicare payment structure that creates a powerful financial disincentive for rural hospitals to employ physicians in anesthesia roles.

Because of the federal government (Medicare) rural pass-through laws, the net cost differential between employing CRNAs versus physician anesthesiologists is \$430,000 to \$655,000 annually. A rural hospital operating on a 1–3% margin cannot absorb that gap. This is not a failure of Kansas policy or physician willingness — it is a federal Medicare design flaw that structurally prevents rural Kansans from accessing physician-led anesthesia care. It is worth fighting at the federal level, but it is entirely irrelevant to HB 2368, since CAAs will not be competing for those rural positions.

VII. Point-by-Point Response to Opposition Arguments

The opposition testimony submitted by CRNA advocates makes several specific claims. I address each directly and factually.

Claim 1: “AAs will undermine CRNA training programs.”

Response: CRNA students are supervised by CRNAs. HB 2368 does not reduce the number of CRNAs in Kansas, alter their supervisory role, or affect their training infrastructure in any way. SRNA training is unaffected unless CRNAs choose to stop supervising students — a decision no one is advocating. As someone who trains anesthesiology residents daily, I can also state with full confidence that CAA licensure will have zero negative impact on resident training or employment opportunities.

Claim 2: “AAs will harm rural hospitals.”

Response: CAAs require physician anesthesiologist supervision. Rural Kansas hospitals do not employ physician anesthesiologists due to the Medicare reimbursement structure described above. CAAs will not work in rural settings in Kansas. This concern is structurally impossible, and as explained, the indirect effect of CAA licensure is to free more CRNAs for rural recruitment.

Claim 3: “AAs lack clinical experience and can enter training without patient care background.”

Response: CAA programs require a premedical undergraduate background including coursework in biology, chemistry, anatomy, and physiology — the same academic foundation required for medical school. The American Society of Anesthesiologists explicitly recognizes that CRNAs and CAAs share identical patient care responsibilities within the anesthesia care team. Both pathways produce competent, safe providers.

Claim 4: “AA licensure is about physician control and profit.”

Response: Anesthesiologists make exactly the same amount of money whether supervising CRNAs or CAAs. There is no financial benefit — not one dollar — to physician anesthesiologists from this bill. Most of my personal clinical salary comes from ICU work, where there are no CRNAs and no AAs, so my perspective is clearly NOT motivated by a desire for more money. The physicians supporting this bill are motivated by one thing:

addressing a real anesthesia provider shortage that harms Kansas patients. The Kansas Medical Society and Medical Society of Sedgwick County have reached the same conclusion independently.

Claim 5: “AAs have previously tried to circumvent the regulatory process in Kansas.”

Response: The Board of Healing Arts confirmed in 2022 that anesthesiologists already have the delegatory authority to supervise CAAs under existing Kansas law. HB 2368 does not circumvent that framework — it formalizes and strengthens it by creating an explicit licensure pathway with full regulatory oversight. That is precisely how due process is supposed to work.

Claim 6: “CRNAs should be allowed to supervise AAs.”

Response: There is currently no CMS reimbursement pathway for CRNAs supervising CAAs, making this proposal financially unworkable under current federal billing rules. More fundamentally, the anesthesia care team model is built on physician leadership as its core principle — a structure that exists to protect patients and ensure the highest level of clinical oversight. That is not a threat to CRNAs. It is the model that makes the team work.

VIII. A Note on Trust and the Nature of This Debate

I have communicated with many of you directly over the past several weeks. In those conversations I have tried to make one thing clear: this issue ultimately comes down to trust — who you trust, and what information you trust.

I want to be clear about what I am not: I am not a lobbyist. I am not being paid to be here.

I am a physician who grew up in Nickerson, Kansas, went to KU for undergraduate and medical school, built a career in Wichita, and has watched this shortage worsen for years. I have offered every representative my personal cell phone number and an open invitation to call any time — day, night, or weekend — because I believe this issue deserves a real conversation, not a form letter.

Every claim I have made in my letters, emails, and this testimony can be substantiated with a literature search or a direct review of the relevant data. I have not exaggerated. I have not used fear as a tool. I have tried to provide the kind of objective, evidence-based input that elected officials deserve when making decisions that affect the health of their constituents.

I would also observe that the volume and uniformity of opposition communications reflects the organizational strength of the CRNA lobby — not the strength of their argument. *Numbers are not evidence. Fear is not data.* I ask that this Committee evaluate this bill on its merits.

IX. Patient Safety: The Evidence Supports the Physician-Led Care Team

Multiple large-scale studies, including a landmark RTI International study published in Health Affairs examining nearly 500,000 cases, have found no difference in patient outcomes between anesthesia provided by physician anesthesiologists, CRNAs, or physician-supervised care teams. A 2024 retrospective study published in Patient Safety in Surgery examining more than 15,000 surgical cases across physician-solo, physician-resident, and physician-CRNA/CAA models found no significant difference in adverse outcomes including cardiac complications, pulmonary complications, acute kidney injury, or mortality.

You may note that the Health Affairs study I refer to above has been touted by CRNAs as evidence of the superiority of the care they provide. The important conclusion to draw from both studies referenced above is that **no difference** was found between the care provided by CRNAs and physician-led teams of CAAs. This evidence does not diminish CRNAs. It confirms what I know from 20 years of clinical and academic practice: when anesthesia is delivered within a properly supervised physician-led team, it is safe. CAAs will operate within that same framework. The evidence provides no support for the safety concerns raised by the opposition.

X. A Straightforward Analogy

If you trust physician assistants to care for patients in Kansas — and our state does — then you should trust anesthesiologist assistants to do the same within their domain. **PAs practice medicine under physician supervision. CAAs practice anesthesia under physician supervision. The models are structurally identical.**

My own team in the ICU at Ascension Via Christi includes advanced practice providers — PAs and ARNPs — working alongside physicians every day, delivering excellent care. That collaboration does not diminish physicians or create confusion about who is in charge. It multiplies our capacity to serve patients. CRNAs and CAAs should be able to work side by side in Kansas operating rooms in precisely the same way.

XI. Conclusion

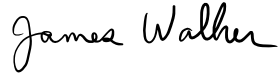
There is no one who loses if HB 2368 passes. CRNAs will continue to practice, recruit, train students, and earn competitive salaries in our state. Physician anesthesiologists gain nothing financially. Rural hospitals are unaffected and stand to benefit indirectly from a larger available CRNA pool. And Kansas patients gain access to an additional class of highly trained, fully supervised anesthesia providers who can help address a shortage that has gone unresolved for years.

Twenty-four jurisdictions have already said yes to this model. Michigan is in the process of joining them. The Kansas Medical Society supports this bill. The Medical Society of Sedgwick County supports this bill. Nearly every physician anesthesiologist in this state supports this bill. We are not asking for something extraordinary. We are asking Kansas to recognize a proven, safe, physician-supervised workforce model that the rest of the country has already embraced.

The question before this Committee is simple: will Kansas allow qualified, supervised, master's-trained anesthesia professionals to help care for our patients? If I wasn't

covering the Neuro ICU this week, I would have happily come to testify tomorrow and answer any questions. **I respectfully and strongly urge you to answer yes.**

Respectfully submitted,

A handwritten signature in cursive script that reads "James Walker".

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Postscript: A Note on Drafting Assistance

This document was drafted with assistance from Claude Sonnet 4.6, an AI model developed by Anthropic. All substantive content — including the clinical positions, factual claims, arguments, rebuttals, and personal statements — originates from the author and reflects his own views, knowledge, and experience. Claude Sonnet 4.6 was used to organize, structure, and refine the language of this testimony. The author reviewed and approved all content for accuracy prior to submission and takes full responsibility for every statement contained herein.