SENATE FINANCE COMMITTEE
May 12, 2022
1:05 p.m.

1:05:02 PM

CALL TO ORDER

Co-Chair Stedman called the Senate Finance Committee meeting to order at 1:05 p.m.

MEMBERS PRESENT

Senator Bert Stedman, Co-Chair
Senator Lyman Hoffman
Senator Donny Olson
Senator Natasha von Imhof
Senator Bill Wielechowski
Senator David Wilson

MEMBERS ABSENT

Senator Click Bishop, Co-Chair

ALSO PRESENT

Representative Ivy Spohnholz, Sponsor; Genevieve Mina, Staff for Representative Spohnholz; Heather Carpenter, Health Care Policy Advisor, Department of Health and Social Services; Steve Williams, CEO, Alaska Mental Health Trust Authority; Mark Regan, Legal Director, Disability Law Center.

PRESENT VIA TELECONFERENCE

April Kyle, President and CEO, Southcentral Foundation, Anchorage; Kevin Munson, CEO, Mat-Su Health Services, Wasilla; Winn Davis, Senior Policy Analyst, Alaska Native Health Board, Anchorage; Emily Nenon, Alaska Government Relations, American Cancer Society Cancer Action Network, Anchorage; Renee Gayhart, Director, Health Care Services, Department of Health and Social Services; James Cockrell, Commissioner, Department of Public Safety; Ann Ringstad, Executive Director, NAMI Alaska; Alberta Unok, President and CEO, Alaska Native Health Board; Arthur Delaune, Self, Fairbanks; Robyn Bjork, Self, Palmer; Michelle Baker, Executive Vice President, Behavior Services, Southcentral

Foundation; Shayne LaCroix, Police Officer, Palmer Police Department; Renee Rafferty, Regional Director of Behavioral Health, Providence Alaska, Anchorage; David Campbell, Deputy Chief, Juneau Police Department; Vikki Jo Kennedy, Self, Juneau.

SUMMARY

SB 124 MENTAL HEALTH FACILITIES & MEDS

SB 124 was HEARD and HELD in committee for further consideration.

CSHB 172(FIN) am
MENTAL HEALTH FACILITIES & MEDS

CSHB 172(FIN) am was HEARD and HELD in committee for further consideration.

CSHB 265(FIN)
HEALTH CARE SERVICES BY TELEHEALTH

CSHB 265(FIN) was HEARD and HELD in committee for further consideration.

#hb265
CS FOR HOUSE BILL NO. 265(FIN)

"An Act relating to telehealth; relating to the practice of medicine and the practice of nursing; relating to medical assistance coverage for services provided by telehealth; and providing for an effective date."

1:05:48 PM

Co-Chair Stedman relayed that it was the first hearing for HB 265. The intention of the committee was to hear a bill introduction and sectional analysis, take invited and public testimony, and set the bill aside for further review.

1:06:54 PM

REPRESENTATIVE IVY SPOHNHOLZ, SPONSOR, relayed that HB 265 was designed to expand the telehealth flexibilities that had been enjoyed during the Covid-19 pandemic, while

ensuring patient protection and Alaska's sovereignty as it related to licensing. She recounted that the legislature had worked for years to expanded telehealth, including Medicaid for telehealth for behavioral health in SB 74 and HB 29, which passed in 2020 and required insurance coverage for telehealth. She noted that the pandemic resulted in people using telehealth in ways that had not been imagined. She noted that Alaskan providers had invested in telehealth, and she did not want to diminish the access to care and cost savings provided by telehealth.

Representative Spohnholz continued that the state public health emergency (which had expired one year previously) and the federal public health emergency had allowed flexibility in the utilization and regulation of telehealth. She noted that the federal public health emergency would expire July 22, and there was some urgency to ensure Alaskans would get the needed care. She explained that HB 265 would create a legislative framework for continued successful delivery of telehealth while protecting patients and reducing red tape.

Representative Spohnholz continued that Alaska did not have telehealth payment parity, which was important because it caused a natural disincentive for providers to offer telehealth. She cited that 84 percent of providers that were registered in the telemedicine business registry were providers within Alaska. She noted that some services were not available via telehealth. She heard from advocates with the American Association of Retired Persons (AARP) and other organizations that telehealth flexibilities would help to increase access to care, particularly in rural Alaska. She mentioned barriers to telehealth access, including requirements for documentation of efforts to have an in-person examination. There were barriers to basic kinds of care, including renewals of controlled substances or medication for ongoing treatments. The legislation aligned with the United States Drug Enforcement Agency (DEA) regulations.

1:10:47 PM

Representative Spohnholz continued the bill introduction. She discussed the challenges of accessing care in rural parts of the state. She noted that the bill supported growth in the market of Alaska-based providers. She noted that the bill would save money for patients and the state.

She cited that between FY 20 and FY 21, the combined increase in telehealth spend and decreased Medicaid travel showed a savings of about 23 percent in combined costs for the state. She reported that elders had liked telehealth due to easy access. The bill allowed for follow-up visits with a provider outside the state if there was already an in-person examination. The exemption was designed in collaboration with the American Cancer Society and the Alaska State Medical Association.

Representative Spohnholz reported that people in rural Alaska reported that the ability to have an audio-only appointment had increased attendance in behavioral health appointments by 30 percent, which was important due to poor broadband access. She emphasized that the bill would protect the patient-provider relationship. She explained that the bill did not require patients or providers to engage in telehealth, but it did remove barriers.

Representative Spohnholz pointed out that the bill did not open up the market for non-licensed providers with the narrow exception for follow-up care. Earlier versions of telehealth legislation allowed for telehealth practice by any provider anywhere. The bill did not reduce important protections against over-prescription of controlled substances. There were prescription limits, requirements to use the Prescription Drug Monitoring Program (PDMP), and the DEA required an in-person examination first. She asserted that the bill did not reduce the quality of care in Alaska and was not a replacement for in-person care. She noted that in many parts of the state, people did not have access to care at all, and the bill was designed to provide access and improve health and wellbeing.

Representative Spohnholz thanked the 38 stakeholder organizations that had worked on the bill, as well as the Department of Commerce, Community and Economic Development and the Department of Health and Social Services. She corrected that the federal public emergency expired on July 15 rather than July 22 as previously stated.

1:15:14 PM

GENEVIEVE MINA, STAFF FOR REPRESENTATIVE SPOHNHOLZ, addressed a Sectional Analysis (copy on file):

Section 1 Adds a new section on telehealth under Title 8 for all health care providers licensed with the State of Alaska.

- Subsection (a) removes the requirement for an in-person visit prior to a telehealth appointment.
- Subsection (b) narrowly exempts physicians licensed in another state to deliver health care services via telehealth if there is an established physician-patient relationship, an in-person physical exam, and the services are related to ongoing treatment or follow-up care related to past treatment. The language also references new enforcement language in Section 2.
- Subsections (c) and (d) create limits for a telehealth appointment. If a telehealth appointment falls outside of a provider's authorized scope of practice, they may refer a patient to an appropriate clinician. The cost of a service delivered through telehealth must be the same as if it were delivered in person.
- Subsections (e), (f), and (g) ensure that only authorized providers licensed with the State of Alaska can prescribe controlled substances (e.g., buprenorphine, Adderall, etc.) via telehealth without conducting an in-person visit. These providers must comply with the state and federal laws regarding the prescription of controlled substances via telehealth.
    - o Subsection (e) pertains to providers in Title 8, Chapter 64 (Medicine) (i.e., physicians, podiatrists, osteopaths and physician assistants).
    - o Subsection (f) pertains to Advanced Practice Registered Nurses (APRNs) in Title 8, Chapter 68 (Nursing).
- Subsection (h) removes requirements to document all attempts for an in-person visit and prevents the department or board from limiting the physical setting of a health care provider delivering telehealth.
- Subsection (i) confirms that health care providers under this section are not required to deliver telehealth services.
- Subsection (j) provides definitions for all health care providers applicable to this section, specifies that the provider must be licensed in good standing, and defines telehealth.

1:17:33 PM

Ms. Mina continued to address the Sectional Analysis:

Section 2
Creates AS 08.64.33 defining the State Medical Board's authority to enforce against exempted physicians in Section 1 and ensures these providers must comply with Alaska laws for licensed physicians.

- o Subsection (a) describes the grounds for the board to sanction a physician licensed in another state providing telehealth services in Section 1: if they violate Alaska laws for Alaska-licensed physicians; exceed the defined scope of telehealth services in Section 1; or prescribe, administer, or dispense a controlled substance to an Alaska patient located in the state.
- o Subsection (b) and (c) ensures that the board can enforce exempted physicians in the same manner as Alaska-licensed physicians. In addition to this authority, they can issue a cease and-desist order and notify the licensing authority for each state the physician is licensed.
- o Subsection (d), (e), (g), and (h) details the board's disciplinary actions for exempted physicians, mirroring similar language regarding sanctions for Alaska-licensed physicians.
- o Subsection (f) ensures that the board can recover costs related to the proceedings and investigation directly from an exempted physician in Section 1.

Section 3
Amends language related to the prescription of controlled substances via telehealth under the State Medical Board. This deletes language requiring an additional health care provider to assist a patient during a telehealth appointment with a physician or physician assistant regarding the prescription, dispensing, and administration of controlled substances.

Section 4-5
Adds sections related to the prescription of controlled substances via telehealth under the Board of Nursing. This does not change the Board of Nursing's authority or the scope of practice for APRNs ensures regulatory equity between the Board of Nursing and the State Medical Board regarding the prescription

of controlled substances via telehealth for all DEA-registered practitioners.

- Section 4 amends the Board of Nursing's regulatory authority to include controlled substances via telehealth in Section 5, mirroring statutory language for the State Medical Board.
- Section 5 creates a new section AS 08.68.710 defining the telehealth prescriptive authority of APRNs in statute. This section removes the regulatory in-person requirement for APRNs under 12 AAC 44.925(c), mirroring the deletion of language for the State Medical Board in Section 3.

Section 6

Adds a new section on telehealth under Title 18 for emergency medical services. This section removes the requirement for an in-person examination prior to a telehealth encounter. This section replicates the same provisions on cost, scope of services, documentation, physical setting, and patient protections as Section 1.

Section 7

Adds a new section on telehealth payment under Title 47 for Alaska Medicaid.

- Subsection (a) requires the Department of Health to pay for telehealth services in the same manner as an in person service for the following: behavioral health services, home and community based services (HCBS), services provided by a community health aide or community health practitioner, behavioral health aide or behavioral health practitioner, dental health aide therapist, chemical dependency counselor, non-HCBS services covered under a federal waiver or demonstration, other services provided by an individual or entity eligible for department certification and Medicaid reimbursement, and services provided at rural clinics and federally qualified health centers.

This subsection also allows for a telehealth visit to be conducted through any means which could be useful in a patient-provider relationship, including an audio-only (i.e., phone call) appointment.

- Subsection (b) requires the department to adopt regulations regarding payment of telehealth services. This provision also allows the department to limit or

restrict Medicaid coverage under this section if a service delivered via telehealth cannot be safely delivered according to substantial medical evidence, or if the federal government will not reimburse the delivery of the service via telehealth.

- Subsection (c) specifies that the coverage of services in Alaska Medicaid must be HIPAA compliant.

Ms. Mina continued to address the Sectional Analysis:

Section 8-9
Adds sections on telehealth under Title 47 for grantees that deliver community mental health services, or facilities approved by the department to deliver substance use disorder treatment. Both sections replicate the same telehealth provisions on cost, scope of services, patient protections, documentation, and physical setting as Section 1.

- Section 8 creates AS 47.30.585 to include entities approved to receive grant funding by the Department of Health to deliver community mental health services.
- Section 9 creates AS 47.37.145 to include public or private treatment facilities approved by the Department of Health to deliver services addressing substance use disorders.

Section 10
Provides an immediate effective date.

1:23:21 PM

APRIL KYLE, PRESIDENT AND CEO, SOUTHCENTRAL FOUNDATION, ANCHORAGE (via teleconference), spoke in favor of the bill. She explained that Southcentral Foundation was a tribal organization that served 65,000 Alaskans had 2,500 employees. She mentioned innovations in healthcare that were learned during the Covid-19 pandemic to help create a better system. She mentioned telehealth previous to the pandemic, which was not reimbursable. She mentioned the lack of video capabilities in certain areas of the state and costly and delayed care. She mentioned the flexibility of delivering telehealth, and the ability to make decisions about interventions.

Ms. Kyle continued her testimony. She wanted the committee to know that the Southcentral Foundation was concerned about young people and suicide. She emphasized the

importance of timely care, which was aided by telehealth. She emphasized the importance for reimbursable telehealth care to be available after the public health emergency ended. She thought the bill was a clinically sound bill that allowed for good care, and it was also financially responsible and cost-effective.

Senator Olson assumed the Southcentral Foundation was a 638 contractor.

Ms. Kyle answered affirmatively.

Senator Olson asked if Ms. Kyle was speaking in support of the bill on behalf of regional health corporations throughout the state.

Ms. Kyle stated that the tribal health system supported the bill, and she spoke on behalf of Southcentral Foundation.

1:27:19 PM

KEVIN MUNSON, CEO, MAT-SU HEALTH SERVICES, WASILLA (via teleconference), testified in support of the bill. He relayed that Mat-Su Health Services was a federally qualified community health center and a comprehensive community behavioral health center that serviced the greater Wasilla and Palmer Areas. He continued that Mat-Su Health Services (MHS) provided a variety of services including primary care, dental, psychiatric, behavioral health, and 1115 waiver specialty mental health services. He noted that telehealth services had been a part of MHS' delivery system for many years. He recounted that the pandemic and subsequent relaxation of regulations around telehealth had permitted the expansion of telehealth services, resulting in greater and easier access to care and other improvements. He cited that telehealth made up to approximately 30 percent of MHS's billable contact.

Mr. Munson continued his testimony and thought the bill would provide statutory framework needed to codify the lessons learned. He thought the bill would protect patient access and provide flexibility. He thought that absent the bill there would be a sizable disruption in patient care. He discussed parity reimbursement as proposed in the bill. He thought there was a mistaken notion that telehealth visits were less costly and could be reimbursed at a lower rate, which he contended was not true. He cited that the

largest component of a telehealth visit was direct personnel cost of those delivering care, followed by the cost of all the other staff. He discussed "brick and mortar" costs and emphasized that telehealth appointments were as costly as in-person appointments.

Mr. Munson mentioned that telehealth had costs that face-to-face care did not, including specialized training, supervision, and compliance costs. He thought the failure to reimburse for telehealth had several downsides such as disenfranchised patients, increased travel costs, and diminished access and continuity of care.

1:31:34 PM

Co-Chair Stedman OPENED public testimony.

WINN DAVIS, SENIOR POLICY ANALYST, ALASKA NATIVE HEALTH BOARD, ANCHORAGE (via teleconference), spoke in support of the bill. He explained that the Alaska Native Health Board (ANHB) was the statewide voice for the Alaska tribal health system and had been active for over 50 years in tribal health. He asserted that telehealth access during the Covid-19 pandemic had improved access to healthcare. He mentioned expanded behavioral health access and increased care in rural Alaska. He emphasized that the flexibility of telehealth had saved lives in rural Alaska. He noted that the legislation ensured Medicaid reimbursement for services provided via telehealth, such as behavioral healthcare. He discussed the importance of telephonic audio-only services in rural Alaska.

Mr. Davis continued his testimony and discussed further advantages such as a decrease in no-show rates. He discussed patients that would be without care if there were not access to telehealth. He reminded that village staff managed multiple appointments with little resources and emphasized potential real-world ramifications with the loss of telehealth access.

1:34:13 PM

EMILY NENON, ALASKA GOVERNMENT RELATIONS, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, ANCHORAGE (via teleconference), testified in support of the bill. She discussed calls from patients and patient navigators regarding the need for telehealth. She thought it was time

to modernize the state's telehealth regulations and laws. She referenced an amendment that would allow for local doctors to get more information and access for patients.

1:36:30 PM

Co-Chair Stedman CLOSED public testimony.

Senator Wielechowski asked if there was anyone from the Department of Health and Social Services available to answer questions.

Senator Wielechowski was curious about the reimbursement provision and wondered if the change would cause an increase in rates. He commented on the high medical rates in Alaska. He thought it appeared that under the provision on page 10, line 20 of the bill, would allow outside doctors to significantly increase rates. He wondered if there had been a cost analysis.

1:37:58 PM

RENEE GAYHART, DIRECTOR, HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), relayed that the payment rates for telehealth would be the same as an in-office visit. She continued that out-of-state providers were paid their own state rates rather than the Alaska rate.

Co-Chair Stedman asked committee members to look at the bill and bring forward any potential amendments for consideration by Friday, May 13.

HB 265 was HEARD and HELD in committee for further consideration.

#sb124
#hb172
SENATE BILL NO. 124

> "An Act relating to admission to and detention at a subacute mental health facility; establishing a definition for 'subacute mental health facility'; establishing a definition for 'crisis residential center'; relating to the definitions for 'crisis stabilization center'; relating to the administration of psychotropic medication in a crisis situation;

relating to licensed facilities; and providing for an effective date."

CS FOR HOUSE BILL NO. 172(FIN) am

"An Act relating to crisis stabilization centers, crisis residential centers, and subacute mental health facilities; relating to representation by an attorney; relating to the administration of psychotropic medication in a crisis situation; relating to hospitalizations for mental health evaluation; relating to licensed facilities; relating to a report to the legislature on psychiatric patients and patient rights; and providing for an effective date."

1:38:55 PM

Co-Chair Stedman relayed that it was the first hearing for SB 124. It was the committee's intention to hear a bill introduction, consider a sectional analysis and comparison of the House and Senate versions of the bill, take invited and public testimony, and set the bill aside for further review.

1:39:55 PM

HEATHER CARPENTER, HEALTH CARE POLICY ADVISOR, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced herself.

STEVE WILLIAMS, CEO, ALASKA MENTAL HEALTH TRUST AUTHORITY, showed a presentation entitled "TRANSFORMING A BEHAVIORAL HEALTH CRISIS SYSTEM OF CARE," (copy on file). He turned to slide 2, "Change is Needed":

Currently, Alaskans in crisis are primarily served by law enforcement, emergency rooms, and other restrictive environments

- Behavioral health crisis response is outside the primary scope of training for law enforcement, and reduces focus on crime prevention
- Limited Designated Evaluation & Treatment (DET) capacity in four communities: Juneau (BRH), Fairbanks (FMH), Mat-Su (MSRH), Anchorage (API)
- Emergency rooms are not designed for and can be overstimulating to someone in an acute psychiatric crisis

Mr. Williams showed slide 3, "HB172 is a Path Forward":

HB172 will:
1) Effectuate a "No Wrong Door" approach to stabilization services
2) Enhance options for law enforcement and first responders to efficiently connect Alaskans in crisis to the appropriate level of crisis care
3) Support more services designed to stabilize individuals who are experiencing a mental health crisis
- 23-hour crisis stabilization centers
- Short-term crisis residential centers

4) Protect patient rights

Mr. Williams cited that the proposed protections for patients' rights had come from advocates in the community. He continued that the bill proposed a best-practice framework that would transform Alaska's crisis care system and had been developed in collaboration with over 300 individuals, 100 organizations statewide, the department, and other key informants.

Ms. Carpenter showed slide 4, "Building Blocks of Psychiatric Crisis System Reform":

1) SB74 – Medicaid Reform (2016)
- Improve Access, quality, outcomes, and contain costs

2) 1115 Behavioral Health Waiver
- Targets resources and services to "super utilizers"
- Provides flexibility in community behavioral health services and supports
- Creates new crisis service types that promote interventions in the appropriate settings and at the appropriate levels

3) System must be intentionally designed and promote a "no wrong door" philosophy

Ms. Carpenter described the "no wrong door" philosophy as a robust crisis response system for those experiencing a mental health crisis and unable to seek care voluntarily.

1:44:05 PM

Mr. Williams referenced slide 5, "GOAL: Design and implement a behavioral health crisis response system analogous to the physical health system," which showed two graphical flow charts. He described that the graphics [on the first flow chart] were to illustrate what the current medical/physical health system looked like. He asserted that the same structure needed to be available for those in a mental health crisis, to provide an appropriate response and level of care or resolution. He noted that the model [on the second flow chart] had been examined by the department and the trust and was operated in other states around the country. He mentioned Maricopa County in Arizona, and visits to learn about its existing system that was hoped to be modelled and implemented in Alaska.

Mr. Williams tuned to slide 6, "Stakeholder Engagement":

Healthcare Providers
State Agencies
Law Enforcement and First Responders
Beneficiary Advocates and Nonprofits
Local Governments

Ms. Carpenter addressed slide 7, "Enhanced Psychiatric Crisis Continuum of Care," which showed a graphic depicting where the proposed new services fit into the existing continuum of care. She highlighted that under the 1115 Medicaid waiver, the mobile crisis teams, the 23-hour stabilization, and the short-term stabilization were all Medicaid billable services.

1:46:55 PM

Mr. Williams spoke to slide 8, "Crisis Stabilization Center (23 hour)":

Provides prompt, medically monitored crisis observation and psychiatric stabilization services

- No wrong door - walk-in, referral, and first responder drop off
- Staffed 24/7, 365 with a multi-disciplinary team
- High engagement/Recovery oriented (Peer Support)
- Immediate assessment and stabilization to avoid higher levels of care where possible

- Safe and secure
- Coordination with community-based services

Mr. Williams dicussed the scenario of law enforcement interfacing with someone in a behavioral health crisis. In such circumstances, if the individual was taken to an emergency room, they would be taken in handcuffs. Additionally, while waiting to be admitted, the individual would wait in the squad car and it could take several hours for the law enforcement to be able to return to duties.

Mr. Williams displayed slide 9, "Short-Term Crisis Residential Stabilization Center":

> A 24/7 medically monitored, short-term, crisis residential program that provides psychiatric stabilization
>
> - Safe and secure – serves voluntary and involuntary placements
> - High engagement/Recovery oriented (Peer Support)
> - Multi-disciplinary treatment team
> - Short-term with 16 or fewer beds
> - Stabilize and restore – avoid need for inpatient hospitalization where possible
> - Coordination with community-based services

Mr. Williams showed slide 10, "Enhanced crisis response would reduce the number of people entering the most restrictive levels of care," which showed a graphic depicting a snapshot of ten years of data from Georgia, a state which operated the full continuum of care. He described that of 100 calls to the crisis care line, 90 were resolved over the phone. He reminded that the individuals on the phone were licensed professionals. He described mobile crisis teams, equipped with a mental health professional and a peer. He noted that there were mobile crisis teams operating in Fairbanks and Anchorage. He discussed success of the mobile crisis team in Georgia. He summarized that the robust continuum of care showed that instead of using emergency services as the default treatment, it was possible to triage the system and avoid using higher levels of care.

1:51:04 PM

Ms. Carpenter spoke to slide 11, "Alaska Statute Title 47":

Collaborative Approach to Transforming our Response to Alaskans in a Behavioral Health Crisis

HB172 Mental Health Facilities & Meds

Ms. Carpenter highlighted that in the fall of 2018 the Alaska Psychiatric Institute (API) was in a crisis and the census was greatly reduced. At the time, individuals having a psychiatric crisis (but having committed no crime) were being held at correctional facilities due to no capacity at API or other hospitals, and the Disability Law Center and the Public Defender Agency had then sued the department. The judge had found against the state in 2019, and the process of coming to a settlement was begun. Part of the ruling and settlement was the need to seek alternatives in places to provide 72-hour evaluations in less restrictive settings such as crisis stabilization centers and crisis residential centers that the Crisis Now model would allow.

Ms. Carpenter turned to slide 12, "Key Takeaways":

HB172 Does:

- Create a "no wrong door" approach to providing medical care to a person in psychiatric crisis
- Provide law enforcement with additional tools to protect public safety
- Expand the number of facilities that can conduct a 72-hour evaluation
- Add a new, less restrictive level of care
- Facilitate a faster and more appropriate response to a crisis, expand the types of first responders that can transport an individual in crisis to an appropriate crisis facility

HB172 Does Not:

- Interfere with an officer's authority or ability to make an arrest
- Change who has the current statutory authority to administer crisis medication
- Change current statutory authority for who can order an involuntary commitment
- Reduce the individual rights of the adult or juvenile in crisis; the parents' rights of care

for their child; or existing due process rights of the individual in crisis

Ms. Carpenter listed Emergency Medical Technicians (EMTs), paramedics, and firefighters as the types of first responders that could transport an individual in crisis to a crisis center. She noted that under the bill, crisis medication could only be prescribed by a physician, an advanced nurse practitioner, or a physician's assistant.

Mr. Williams addressed slide 13, "Current Flow for Involuntary Commitment," which showed a flow chart that illustrated the current system. He drew attention to the bottom left corner, which showed that hospital emergency rooms and jails were used, with law enforcement as the primary response.

1:55:00 PM

Mr. Williams showed slide 14, "Flow for Involuntary Commitment with Statutory Changes," which showed a flow chart. He drew attention to the lower left of the slide, which showed the addition of mobile crisis teams, crisis stabilization centers, and additional crisis residential centers.

Ms. Carpenter displayed slide 15, "HB 172 Committee Substitute Highlights (ver. D.A)":

Key Improvements
1) Adds new language for a "health officer", newly defined in Section 26
2) Changes length of stay from up to 5 days to up to 7 days at a Short-term Crisis Residential Center

3) Adds provisions for protecting patient rights
- 72 hrs. clock for an ex-parte hearing starts when a person (respondent) is delivered to a Crisis Stabilization or Crisis Residential Center;
- Attorney is appointed for the respondent;
- Court shall notify the respondent's guardian, if any
- Computation for seven-days at a Short-term Crisis Residential Center includes, time the respondent was receiving care at a Crisis Stabilization Center, if applicable

4) Adds a new section (Sec. 30) directing the Department of Health, Department of Family and Community Services, and the Alaska Mental Health Trust Authority to submit a report and recommendations to the Legislature regarding patient rights.

- Patient grievance and appeal policies
- Data collection on patient grievances, appeals and the resolution
- Patient reports of harm, restraint and the resolution
- Requirements that could improve patient outcomes and enhance patient rights

Ms. Carpenter showed slide 16, "HB 172 Committee Substitute Highlights (ver. D.A)":

Key Improvements Continued

5) Adds requirement that notifications in the alternative to arrest statutes also go to the peace officer's employing agency to ensure victim notification will happen even if the arresting officer is off duty. (Sections 4, 6, and 10)

6) Addresses statutes found unconstitutional by the Alaska Court System to align with the court rulings.

- Amends the definition of "gravely disabled" in AS 47.30.915(9) (Section 24)
- Clarifies standards for court to order administration of non-crisis medication (Sections 20 & 21)

7) New section that clarifies the Public Defender statutes and their role as the attorneys the Court will appoint in all proceedings under AS 47.30.

8) Amended the computation of time for both hospitals and crisis residential centers to have the evaluation period end at 5:00 pm the next business day after Saturdays, Sundays and legal holidays if a patient would be held longer than 72 consecutive hours (Sections 14 & 18)

2:00:10 PM

JAMES COCKRELL, COMMISSIONER, DEPARTMENT OF PUBLIC SAFETY (via teleconference), spoke in support of the bill. He stated that the department was supportive of the bill, and he was in support of the bill personally and professionally. He thought the bill was a step forward and

would be long-lasting progress towards handling mental health issues in the state. He described that often times law enforcement officers were called upon to address mental health crises and were ill equipped. He continued that many times officers ended up putting individuals in patrol cars and sometimes spent hours trying to find a place for an individual to receive care. He emphasized that additional resources were needed. He believed in the direction that the department was taking with the bill.

2:02:08 PM

MARK REGAN, LEGAL DIRECTOR, DISABILITY LAW CENTER, testified in support of the bill. He wanted to explain how current law had worked and how it had broken down leading to the bill proposal to improve things under the Crisis Now system. He asserted that current law did not provide for short-term mental health treatment. Instead, the law asked people to be held and brought to a facility for a 72-hour evaluation, after which a person could go in for a 30 day or longer civil commitment. He thought the system had not worked well because of the lack of facilities outside of API and hospitals in Juneau and Fairbanks.

Mr. Regan continued his testimony. He discussed people in crisis being brought to Anchorage from rural Alaska to find API at capacity, necessitating a transfer to other cities. He discussed difficulties that resulted in individuals having to wait in custody in hospital emergency rooms or correctional facilities. He described the inadequate condition of the facilities as the reason the Disability Law Center had sued the department. He asserted that the Crisis Now system would provide places for short-term facilities for those experiencing a mental health crisis that was much better than what was previously available.

2:06:21 PM

Senator Wilson asked about the possibility of further action by the Disability Law Center if the bill was not to pass.

Mr. Regan noted that the settlement of the lawsuit was based on existing law, and the law center would continue to try and enforce the settlement and ensure that the 72-hour evaluations could be done in other places. He emphasized that the center would deeply regret if the bill were not to

pass and stressed the importance of having a place to be for the 72-hour evaluation. He theorized that with an appropriate place, individuals in hub communities could set up short term treatment centers allowing for people to stay in their home area.

2:08:07 PM

ANN RINGSTAD, EXECUTIVE DIRECTOR, NAMI ALASKA (via teleconference), spoke in favor of the bill. She explained that NAMI was part of the National Alliance on Mental Illness, the nation's largest grassroots mental health organization. She cited that mental illness affected one in five adults in the United States, which equated to over 108,000 individuals. She referenced the inadequate system of care. She shared a story from the director of the national NAMI, who spoke of her daughter's long journey with mental illness. The daughter had had a mental health crisis and there had been a profound lack of resources that had a dire outcome. She summarized that if a behavioral health crisis response system was in place, the story would have had a different outcome. She summarized that the No Wrong Door approach to providing care would provide a faster and more appropriate response to behavioral health crises. She thought the legislation would ensure people got appropriate care swiftly, keep people out of jail and emergency rooms, and minimize the impact on first responders. She stated that NAMI strongly supported the bill.

2:11:20 PM

Co-Chair Stedman OPENED public testimony.

ALBERTA UNOK, PRESIDENT AND CEO, ALASKA NATIVE HEALTH BOARD (via teleconference), testified in support of the bill. She explained that the Alaska Native Health Board (ANHB) was the statewide voice on the entire Alaska tribal health system and worked with all tribal health organizations on collective priorities. She asserted that the programs and services needed to be stood up across Alaska as soon as possible, especially considering the mental health impacts of the pandemic. She contended that Alaskans in a psychiatric emergency faced long waits in the emergency department or jail when there was not room at API. She thought the services proposed in the bill would address

major gaps in the continuum of care and give Alaskans the care they need in a supportive environment.

Ms. Unok highlighted that ANHB supported HB 172's definition of "health officer" to be updated to match the definition found in the Senate version of the legislation, which includes community health aide programs. She explained that as a federally certified healthcare provider, community health aides and behavioral health aides were frequently first responders that encountered crises in their communities and played an important role in mental health care. She urged the passage of the legislation in the current session.

2:14:05 PM

ARTHUR DELAUNE, SELF, FAIRBANKS (via teleconference), spoke in support of the bill. He recounted the story of his son, who experienced fetal alcohol spectrum disorder and co-occurring mental health disorders. He discussed his son's mental health struggles and reported a two-week wait for services. He discussed a wait in a padded room before being admitted to the behavioral health ward. He discussed his son's release from treatment and subsequent attempts to receive services. It had taken 41 days after being suicidal to receive services. He emphasized the importance of the passage of the bill in order to have the state be more responsive to mental health crises.

2:16:52 PM

ROBYN BJORK, SELF, PALMER (via teleconference), testified about her concerns with the bill. She was concerned that the previous testimony had not accurately addressed provisions in the bill. She referenced Section 14 under Article 9 relating to involuntary admission for treatment. She expressed concern that first responders be utilized for taking people into custody for involuntary admission. She agreed that crisis stabilization centers were needed.

Ms. Bjork expressed concern about the definition of "health officer," which she thought was nebulous. She had concerns that the bill poorly defined "evaluation facility," and that the bill could be weaponized against mentally well Alaskans. She suggested that the committee engage an outside legal expert to review the bill provisions.

2:20:34 PM

MICHELLE BAKER, EXECUTIVE VICE PRESIDENT, BEHAVIOR SERVICES, SOUTHCENTRAL FOUNDATION (via teleconference), spoke in favor of the bill. She explained that the Southcentral Foundation, in partnership with the Alaska Native Tribal Health Consortium (ANTHC), was planning on opening an adult crisis stabilization center on the Alaska Native Health Campus. There was space identified and the agencies were ready to invest. She discussed the increase in mental health needs across the state. She asserted that using the Crisis Now model and the "No Wrong Door" approach would provide less costly services in a more therapeutic and appropriate environment.

Ms. Baker noted that it was important for people to receive both voluntary and involuntary services in a crisis stabilization center. She offered her support HB 172's definition of "health officer" to be updated to match the definition in the Senate version of the bill, to include Community Health Aid Practitioner as a federally certified healthcare provider. She reminded that many communities had no Village Public Safety Officer (VPSO) or Alaska State Trooper, and the only place to receive care was in the health clinic.

Ms. Baker continued that the Crisis Now framework had widespread support across stakeholders. She noted that the legal framework was necessary to support the planned crisis stabilization center. She asserted that if the bill did not pass it would greatly affect how the foundation designed the program and would result in increased stress and cost on the health care system.

2:23:58 PM

SHAYNE LACROIX, POLICE OFFICER, PALMER POLICE DEPARTMENT (via teleconference), testified in favor of the bill. He expressed the Palmer Police Department's support for the legislation. He mentioned how mental health crises affected first responders. He emphasized that the biggest part of the problem was that people in the community experiencing behavioral health crises were not getting the help that was needed. He discussed the lack of facilities and discussed the advantages of the Crisis Now model.

2:25:22 PM

RENEE RAFFERTY, REGIONAL DIRECTOR OF BEHAVIORAL HEALTH, PROVIDENCE ALASKA, ANCHORAGE (via teleconference), spoke in support of the bill. She shared that Providence Health and Services Alaska had one of the largest behavioral health offerings in the state, and provided services in Anchorage, Mat-Su, Kodiak, and Valdez. She noted that Providence had been collaborating for the previous four years with many of the stakeholders that had previously testified. The design behind the collaboration was in aid of strategic planning.

Ms. Rafferty thought it was evident that the bill was well thought out and presented needed changes. She cited that Providence was ready to open a crisis stabilization center in 2023, and the services would increase access to those that were currently being directed to jails and emergency services. She opined that additionally, the bill would allow for collaboration, data gathering, and system change that had never been seen before. She urged the bill be passed during the current session to provide the regulatory framework to build a system of care for vulnerable Alaskans. She mentioned that the current system provided costly and ineffective care.

2:27:12 PM

DAVID CAMPBELL, DEPUTY CHIEF, JUNEAU POLICE DEPARTMENT (via teleconference), testified in support of the bill. He relayed that police officers often encountered situations with people in crisis that did not rise to the level that warranted a Title 47 hold. He discussed a lack of options, and the occasion when people were arrested for low-level offenses. He described officers having to have repeat contacts with individuals that were not able to receive services or treatment. He relayed that the Juneau Police Department was very supportive of HB 172, which he thought would fill a services gap.

2:29:21 PM

VIKKI JO KENNEDY, SELF, JUNEAU (via teleconference), spoke in support of the bill. She thought that some provisions needed to be removed from the bill before it was passed. She mentioned the testimony of Ms. Bjork. She thought the bill was badly needed. She thought the legislature had been working on the bill for four years. She thought the bill needed to be amended. She discussed officers from the

Juneau Police Department diffusing a situation with an individual. She thought the pandemic had added to the problem. She mentioned her nephew had taken his own life. She did not support the mention of federally recognized providers. She thanked the committee for its work.

2:32:25 PM

Co-Chair Stedman CLOSED public testimony.

Senator Wilson asked if Mr. Gottstein could provide written commentary as to if he supported the bill in its final version after amended.

Senator Wilson asked Ms. Carpenter to comment on the different versions of the bill. He understood the provision related to the federal officer could reference those that might be working on a military base or the Public Health Service Corps, which often worked in tribal health facilities.

Ms. Carpenter affirmed that the definition for health officer differed in the two bills. She recounted that there had been feedback in the Senate Judiciary Committee that the definition should be cleaned up. Tribal partners had recommended using the term "federally certified provider," because tribal health employees were considered federal employees because of the Indian Health Service. The term found in the Senate version would cover the community health aides and behavioral health aids as mentioned in testimony by the Southcentral Foundation and the Alaska Native Health Board. She stated that the department would support the Senate version of the definition.

Ms. Carpenter addressed the definition of "evaluation facility," that mentioned a facility operated by the federal government. She explained that the term referred to tribal-operated facilities by Indian Health Services. Technically the term could also include military bases, but she had never seen bases offer the evaluation services. The definition clarified with new language "that performs evaluations" referenced the evaluations found in the section of statutes and would necessitate a facility that could do the 72-hour evaluations.

Senator Wilson thanked Ms. Carpenter for the clarification.

Co-Chair Stedman asked if Ms. Carpenter wanted to make a final statement.

Ms. Carpenter noted that she had shared a document that provided a comparison of the two bills (copy on file).

Co-Chair Stedman set the bill aside for further review. He asked members to provide suggested amendments by noon on Friday, May 13.

SB 124 was HEARD and HELD in committee for further consideration.

HB 172 was HEARD and HELD in committee for further consideration.

Co-Chair Stedman discussed the agenda for the following day.

#
ADJOURNMENT
2:37:14 PM

The meeting was adjourned at 2:37 p.m.