

HOUSE FINANCE COMMITTEE  
April 9, 2025  
1:36 p.m.

1:36:04 PM

CALL TO ORDER

Co-Chair Foster called the House Finance Committee meeting to order at 1:36 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair  
Representative Andy Josephson, Co-Chair  
Representative Calvin Schrage, Co-Chair  
Representative Jamie Allard  
Representative Jeremy Bynum  
Representative Alyse Galvin  
Representative Sara Hannan  
Representative Nellie Unangiq Jimmie  
Representative DeLena Johnson  
Representative Will Stapp  
Representative Frank Tomaszewski

MEMBERS ABSENT

None

ALSO PRESENT

Dorene Lorenze, Chairman, Alaska State Commission on Human Rights; Representative Ashley Carrick, Sponsor; Cadence Conner, Staff, Representative Ashley Carrick Staff; Emily Ricci, Deputy Commissioner, Department of Health; Robert Lawrence, Chief Medical Officer, Department of Health.

PRESENT VIA TELECONFERENCE

Tracy Dompeling, Director, Division of Behavioral Health, Fairbanks; Robert Nave, Deputy Director, Division of Health Care Services, Department of Health.

SUMMARY

HB 23            APPLICABILITY OF HUMAN RIGHTS COMMISSION

HB 23 was HEARD and HELD in committee for further consideration.

HB 73 COMPLEX CARE RESIDENTIAL HOMES

HB 73 was HEARD and HELD in committee for further consideration.

HB 10 ADD FACULTY MEMBER UNIV BOARD OF REGENTS

HB 10 was REPORTED OUT of committee with six "do pass" recommendations, two "do not pass" recommendations, and three "no recommendation" recommendations and with one previously published fiscal impact note: FN1 (UA).

Co-Chair Foster reviewed the meeting agenda.

#hb23

HOUSE BILL NO. 23

"An Act relating to the definition of 'employer' for the purposes of the State Commission for Human Rights."

1:37:23 PM

Co-Chair Josephson briefly reviewed HB 23. He noted that the bill had a prior hearing in committee on March 27, 2025. He communicated that in current law the Alaska State Commission on Human Rights (ASCHR) employee protection did not extend to employees of Alaska's many nonprofit organizations and under the legislation nonprofits would be subject to the jurisdiction of the commission. The bill could impact the lives of 40,000 Alaskans. The bill also renamed the commission to the Alaska State Commission for Civil Rights, requiring that commissioners can only be removed for just cause, and changed the date and method of delivery for the commission's annual report. He responded to a prior question by Representative Bynum who offered a hypothetical scenario about an all-boys school and whether they would be required to employ women on the staff. He related that he sought a legal opinion from the ASCHR (copy on file) that cited the existence of a Bona Fide Occupational Qualification (BFOQ). He explained that it was a body of law from 1965 that exempted employment discrimination on the basis of sex, "when the reasonable

demands of the position do not require distinction on the basis of... sex" as stated in the statute. He noted that the memo exemplified jobs such as; prison guards, orderlies, nurses, etc. He encouraged members to read the memo. There were instances where there could be lawful discrimination based on the "essence of the employment."

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Co-Chair Foster moved to hearing public testimony.

[Secretary Note: Although not explicitly stated, public testimony was opened.]

DORENE LORENZE, CHAIRMAN, ALASKA STATE COMMISSION ON HUMAN RIGHTS, provided public testimony. She explained that the desire to change the commission's name from civil rights to human rights was due to confusion over what the commission was empowered to act on. She spoke to the date change of the annual report to November instead of January each year and the change to electronic transmission, which was due to expediency and cost effectiveness. She noted that changing to the word "employer" covered non-profits offering more employees protection under the commission. She agreed with the BFOQ exclusion. She addressed the cause for the termination change. She relayed that everyone on the commission had been appointed by the same governor. She believed that it was fair for an appointee who was removed from the position to have the opportunity to inquire about the reason for the dismissal. She relayed a story from personal experience relating to being a journalist in Pakistan. She determined that a newly elected governor could dismiss everyone on the commission and reappoint their political cronies to go after perceived political enemies or find favoritism for their political friends. In the ensuing time that it took the legislature to approve the new appointees determining who would remain or leave the committee, "there could be a lot of havoc," which should be avoided. She highlighted that the changes did not cost anything, and it would allow ASCHR to bring in more federal contracts for the non-profit status resulting in increased revenue and decreased financial dependence on the state.

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Co-Chair Foster CLOSED public testimony.

He indicated that amendments for HB 23 were due April 15, 2025, at 5:00pm.

HB 23 was HEARD and HELD in committee for future consideration.

[1:45:16 PM](#)

#hb10  
HOUSE BILL NO. 10

"An Act relating to the Board of Regents of the University of Alaska."

Co-Chair Foster relayed that HB 10 had two prior committee hearings [March 10, 2025, and March 20, 2025].

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REPRESENTATIVE ASHLEY CARRICK, SPONSOR, briefly reviewed the bill. She summarized that the legislation would add one tenured faculty member to the University of Alaska Board of Regents for a two-year term after a thorough selection process. The addition of a faculty member would help the Board of Regents advance its mission and provide representation to this key stakeholder group.

Representative Tomaszewski asked whether she had any dialog with the regents regarding adding the faculty member and what their thoughts on the bill were. Representative Carrick responded that she had spoken to several current regents, and the opinions were "mixed." She offered that the board was slow to make changes and were "reticent" toward operative changes. She disclosed that some were in support, some were neutral, and some were opposed to the idea. Representative Tomaszewski asked if there had been any letters of support or opposition from regents. Representative Carrick answered that the board was officially neutral towards the bill.

Representative Allard voiced that she had spoken to every member of the board and maintained that the members did not agree with the legislation.

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Representative Stapp asked if anything prohibited current faculty members from being appointed to the board. Representative Carrick replied that she did not think it was restricted, but a faculty member had never been appointed, and HB 10 rectified a longstanding stakeholder input issue. The bill clarified that the legislature was in support of faculty representation. She added that the same idea had benefited the states that had adopted similar provisions. Representative Stapp was curious why a faculty member appointment had never happened. Representative Carrick responded that typically a board of trustees or a board of regents typically wanted the base of the governing body to be members of the business and professional community to promote workforce development. She expounded that a board seat was competitive, and the term lasted for 8 years in Alaska. The legislation limited the faculty member to a two year term, which was requested by the faculty. They favored turnover to afford broader representation from other campuses. She believed the longer term was positive and created stability. Representative Stapp asked if any other states mandated a faculty regent via statute. Representative Carrick answered that there were six state university systems that mandated a faculty regent. The faculty regent was a full voting member and in other states they were non-voting. The six states included: Oregon, Pennsylvania, West Virginia, Florida, Kentucky, and Tennessee.

Representative Galvin appreciated the concept brought forward around stakeholders being part of the decision making. She asked about the process regarding the decisions that must be made concerning faculty salaries. Representative Carrick deferred the question.

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CADENCE CONNER, STAFF, REPRESENTATIVE ASHLEY CARRICK STAFF, responded that there was a thorough process related to conflict of interest according to AS 39.52.220 a member of the board or commission who was involved in a prohibited matter may result in a violation. She read AS 39.52.110, "shall disclose the matter in writing and on the public record to the designated supervisor and to the attorney general." A regent would have to conform to statute regarding a conflict of interest.

Representative Carrick interjected that a conflict would likely happen very infrequently. The salary negotiations took place outside of the Board of Regents. In addition, the student regent was expected to recuse themselves of issues like a vote that might cut their program. She offered that potential for conflict issues existed and a current robust process concerning conflicts also existed.

Representative Bynum wondered whether increasing the number of members would change the requirement for a quorum and if it would have caused quorum issues in past meetings. Representative Carrick responded that typically, board meetings were fully attended and there were rarely absences. The board met infrequently and paid for travel to the meeting. She deemed it unlikely that quorum issues would arise.

Representative Johnson referenced the six states with faculty regents, and she could not find that they had full membership without restrictions. She interpreted that it was due to a general recognition of concern with a faculty member being a regent. She had concerns over the issue. Representative Carrick answered that the six states she listed were full voting members. She maintained that many states had an ex-officio or non-voting faculty member(s). She informed the committee that the structure of the board looked radically different depending on the state. She provided other states' examples. The trustee board in Pennsylvania had 38 members and one full voting faculty member that was elected by the board. House Bill 10 provided a robust process for appointment by the governor and a robust process for conflict of interests.

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Representative Johnson asked if one of the states was Oregon and pointed out that the governor appointed the faculty member and decided if they had voting rights. She reiterated that in many states a faculty member was not equal to other members regarding voting rights. Representative Carrick affirmed that Oregon was one of the states she had listed.

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Co-Chair Schrage MOVED to report HB 10 out of committee with individual recommendations and accompanying fiscal notes.

Representative Allard OBJECTED.

Representative Tomaszewski maintained that he did not support the bill. He commented on the conflict of interest generated by the addition of a faculty member and determined that it would be a burden for regents. He believed that faculty had a way to have their voices heard through existing processes.

Representative Bynum shared that he was unsure how he would ultimately vote on the bill. He saw no harm in passing the bill out of committee.

Representative Stapp had reservations about the bill but would support moving it from committee.

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A roll call vote was taken on the motion.

IN FAVOR: Bynum, Johnson, Jimmie, Stapp, Hannan, Galvin, Schrage, Josephson, Foster

OPPOSED: Tomaszewski, Allard

HB 10 was REPORTED OUT of committee with six "do pass" recommendations, two "do not pass" recommendations, and three "no recommendation" recommendations and with one previously published fiscal impact note: FN1 (UA).

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Representative Carrick thanked the committee.

Representative Hannan and Representative Stapp made amusing closing remarks.

[2:04:53 PM](#)

#hb73

HOUSE BILL NO. 73

"An Act relating to complex care residential homes; and providing for an effective date."

Co-Chair Foster moved to the next item on the agenda.

2:05:47 PM

EMILY RICCI, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH, introduced the bill. She relayed that the bill was the result of a collaborative effort by the Department of Family and Community Services (DFCS) and the Department of Health (DOH). The bill focused on developing a new license type to fill a critical care gap in residential care in Alaska for those with complex needs.

ROBERT LAWRENCE, CHIEF MEDICAL OFFICER, DEPARTMENT OF HEALTH, introduced the PowerPoint presentation "HB 73: Complex Care Residential Homes" dated February 6, 2025 (copy on file). He continued to slide 2 titled "HB 73 Supports Alaska's System of Care:"

HB 73 strengthens Alaska's health care system, enabling Alaskans to access services in settings tailored to their specific care needs.

He explained the vision for the regulation that was developed in partnership between DFCS and DOH as part of the Complex Care Initiative. He detailed that the initiative brought together two "foundational components." The first was a case response team that met weekly to review individual cases and develop solutions for individual care needs. The second was a higher level complex care committee that met quarterly to review systems and policies from information gathered via the collaborative work of identifying systems gaps in complex cases. The bill's inception was born out of the work.

Dr. Lawrence pointed to slide 3 titled "What Is Complex Care:"

Definition: Co-occurring behavioral, medical, or disability-related needs requiring a multi-disciplinary team and multiple programs.

Vision: A coordinated system that delivers compassionate, timely, and person-centered care for the most vulnerable and complex Alaskans.

Dr. Lawrence elaborated that while services currently existed to meet the vast majority of individuals with medical or mental health conditions, the team recognized an existing gap for a subset of individuals with compounded severe or extreme behaviors in mental health or medical conditions.

Dr. Lawrence turned to slide 4 titled "What Is Complex Care?" and continued with the discussion. He expounded that the complex care committees identified patterns in the response to individuals with mental health or complex medical care needs. The individuals received care from multiple different professionals in different agencies across various systems. Without a compassionate appropriate setting the individuals often cycle through emergency departments, correctional facilities, and various hospitals. They utilize multiple different services like social services, medical care, substance abuse treatment, etc. It was often complicated by an array of medical conditions and unmanageable and disruptive behaviors making it difficult for the various staff to deal with. He felt that a Complex Care Residential Homes (CCRHS) license type was critical to build a "continuum" that allowed Alaskans with complex needs "to live their best lives in a least restrictive type setting."

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Ms. Ricci highlighted slide 5 titled "What Does HB 73 Do:"

HB 73 creates the necessary statutory framework to allow the Department of Health to license and regulate a new setting:

Complex Care Residential  
Homes (CCRHS)

Ms. Ricci delineated that the department envisioned a homelike setting that was specific to the different types of specialized services and populations where care needs were met through a multi-disciplinary support team and 24 hour seven (24/7) day a week care. The needs exceeded those that could be met by the current continuum of care.

Ms. Ricci discussed Slide 6 titled "CCRHS Fill a Gap in the Care Continuum:"

There is a gap in Alaska's current continuum of care for ongoing, specialized residential settings.

Ms. Ricci pointed to the graphic that illustrated the gap in care and how CCRHs would meet the gap. She pointed to the right side of the slide listing the acute settings: Residential Psychiatric Treatment Center, Skilled Nursing Facility, Inpatient Psychiatric Hospital, Assisted Living Home and General Acute Hospital. She related that the department received calls from hospitals about patients with extreme needs and they were struggling to find a placement for them. She referenced the right side of the slide that depicted the lower levels of care facilities: Foster Home, Private Residence, and Assisted Living Home. She noted that all of the facilities were supported by Home and Community Based Waiver Services. She furthered that one of the gaps identified was for a complex care individual that also had some type of cognitive impairment yet was not at the level to qualify them for intellectual and developmental disability. She reported that the department did not have the means or system to care for the individual in a long-term residential care setting. Currently, when complex care individuals were released from an acute facility their general needs were being met through the general relief program and assisted living home. The services were simply not appropriate to meet the level of care required for the special population to remain in a community based setting.

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Representative Galvin was appreciative of the bill. She pointed to the lower level care facilities and wondered what their maximum capacity was versus the maximum capacity for a CCRH. Ms. Ricci answered that she would follow up with the answer for lower level care facilities. She communicated that there were federal requirements that the CCRHs needed to comply with and there were some restrictions relative to Medicaid funding called the "Institute for Mental Disease Exclusion" (IMD). The department wanted to address the issues via regulation in terms of limitations due to the varied needs of complex care. She envisioned via regulation building out the different requirements depending on the different needs of the different populations the homes would serve. She noted that the individual needs would change over time. Representative Galvin thought it was too varied for a

specific answer the question, however, she pointed to language stating, "fewer than 15 residents" She determined that the maximum was 15 in a CCRH. She was concerned that 15 was a high number for individuals with multidisciplinary care needs. Ms. Ricci responded that the number was based on the team's interpretation of an IMD exclusion. She added that after further discussion with stakeholders it would be better address via regulation rather than statute. She heard from some providers that in order for it to be financially viable they might need more individuals, and some thought a smaller home was more appropriate. She deemed that it would be based on the type and level of complex care and reiterated that it was better addressed through regulation.

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Representative Galvin thought that there was a high number of complex care individuals, and it was not a small population. She was aware that many individuals were in continued care at Providence Extended Care because there was not another facility that could accept them, and the hospital was not allowed to send the patients off without proper placement. She asked why she referred to the population as a small number. Ms. Ricci responded that there was a large need for behavioral health support in the state. She explained that the team tried to be very specific to a narrow set of individuals whose needs were not able to be met in other settings. It was different than the need to build out existing settings. The CCRH would likely be a resource intensive setting and not everyone with complex needs required that level of care. She emphasized that it was a small subset of individuals that cycled through the various facilities and general assisted living homes. The necessary care would be long-term and substantial in order for the individuals to remain stable and in their community. Representative Galvin shared her experience visiting multiple places offering extended care that were considered residents. She relayed that there were many still living in the homes that would do better in a smaller home if it was available.

Co-Chair Josephson asked if Ms. Ricci could explain how the IMD exclusion related to CCRHs. Ms. Ricci replied that the IMD was meant to ensure that Medicaid dollars were not being used to support unnecessary institutionalization, especially for individuals with disabilities and mental

health issues. The regulation was a reaction to the number of large institutions that used to exist in the country and served the belief that individuals should receive services in their communities versus larger institutions.

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Ms. Ricci moved to slide 7 titled "Establishing a New Residential Setting:"

1. Identify Needs and Define Scope
2. Create New License Type HB 73
3. Determine Services to be Provided
4. Establish Reimbursement Mechanisms

Ms. Ricci indicated that the slide depicted the multi-step process the departments identified to address the issue. The first step discovered the gap in care for the individuals that were not eligible for the intellectual and developmental disability waivers. She stressed that the need was prominent. The second step determined the need for a new license type. The third step would be accomplished in coordination with stakeholders and provider groups. The last step would be based on the individual and the type of services needed, which would vary. The departments wanted to take time to explore the different options for waivers and had engaged in preliminary discussions with other states. She emphasized that the departments were currently at the second step.

Dr. Lawrence continued on slide 8 titled "Who Would Benefit from CCRHs:"

Youth:

Multiple behavioral health diagnoses  
Treatment in an out-of-state facility  
Fetal alcohol and autism spectrum disorders

Adult:

Severe and persistent mental illness  
Frequent hospital visits and self-harm history  
Cognitive impairment

Senior:

Dementia with behavioral health diagnoses  
Does not qualify for Medicaid waiver services  
Highly disruptive behaviors

Dr. Lawrence discussed and exemplified the populations of individuals who would benefit from CCRH's as described on the slide. He reminded the committee that the departments wanted to establish a homelike setting that addressed the complexity of needs. He pointed out that each of the categories demonstrated distinct and costly needs that prevented those affected from currently being served appropriately. However, the conditions were not so severe to preclude a residential setting.

Dr. Lawrence examined slide 9 titled "Key Features of a CCRH:"

CCRHS will offer a new residential care setting in Alaska.

- Fewer than 15 residents
- 24/7 care from a multi-disciplinary team
- More supportive than assisted living homes and less restrictive than a psychiatric hospital
- Specialized monitoring, intervention, and/or treatment to meet the needs of residents

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Dr. Lawrence reviewed slide 10 titled "Benefits of a CCRH:"

- Improves care for Alaskans with complex needs
- Adds a license type for home-like settings that offer care in the most clinically appropriate environment
- Allows for service specialization and for specific requirements to be set forth in regulations
- Promotes community safety by offering a new service setting for individuals with complex behavioral health needs

Dr. Lawrence reiterated that the bill envisioned a home where individuals received services in a setting tailored to their specific needs in a least restrictive environment.

Ms. Ricci presented slide 11 titled "Sectional Analysis:"

Section 1. Amends AS 47.32.010(b) to add "complex care residential homes" to the list of entities regulated by the Department of Health.

Section 2. Amends AS 47.32.900(2) to update the definition of "assisted living home" to exclude complex care residential homes.

Section 3. Adds AS 47.32.900(11) to modify the definition of "hospital" to clarify that it does not include complex care residential homes.

Ms. Ricci continued with the sectional on slide 12:

Section 4. Adds AS 47.32.900(22) to introduce a new definition for "complex care residential home." It is defined as a residential setting that provides 24-hour multi-disciplinary care on a continuing basis for up to 15 individuals with mental, behavioral, medical, or disability-related needs requiring specialized care, services and monitoring.

Section 5. Amends the uncodified law by adding a new section that requires the Department of Health to submit for approval by the United States Department of Health and Human Services amendments to the state Medicaid plan or apply for waivers necessary to implement the provisions of Sections 1-4.

Ms. Ricci concluded with the remaining sections on slide 13:

Section 6. Amends the uncodified law by adding a new section specifying that sections 1-4 of the bill will only take effect if the United States Department of Health and Human Services approves the required Medicaid waivers or amendments by July 1, 2031. The commissioner of health is required to notify the reviser of statutes within 30 days once the necessary approvals are received.

Section 7. Provides that sections 1-4 take effect the day after the United States Department of Health and Human Services approves amendments to the state plan or waivers submitted under Section 5.

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Representative Bynum wondered how long it would take for an applicant to receive their license. Ms. Ricci responded the expectation was within the standard time frame for other residential licensing. She mentioned time lags due to staff turnover and she hoped the situation could be mitigated soon. Representative Bynum referenced the extreme needs of individuals with behavioral issues impacted by drug use. He asked if CCHRs would include this type of individual.

Dr. Lawrence answered that the inquiry highlighted the broader question of who would be served in the setting. He explained that CCHR's were not meant to treat everyone with the same set of particular complex conditions but would treat a subset of those that had other underlying behavioral or health conditions. He summarized that the CCRHs would serve a subset of individuals that did not fit into the current system.

Representative Bynum was looking at the fiscal notes and wondered what the impact on Medicaid would be for providing the facilities. He inquired whether the departments anticipated that services would grow by adding the CCHR option and if there would be growth in other expenses not included in the fiscal note.

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Ms. Ricci responded that it was currently difficult to determine and definitively extrapolate the need because currently there were multiple state funding streams that were supporting the individuals including Medicaid. She added that Medicaid was the funder for long-term institutional care and Medicaid would be the funder the CCRH program. She anticipated applying for different Medicaid waivers to pay for the program. The waivers had to meet federal budget neutrality requirements to be approved. The program could not stand up a service that would increase Medicaid funding via the waivers.

Co-Chair Foster moved to the fiscal note discussion.

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TRACY DOMPELING, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, FAIRBANKS (via teleconference), explained the published fiscal impact note (FN1(DOH) allocated to the Behavioral

Health Administration. She indicated that the bill would require developing a licensing and regulatory standard requiring one full time position for a total cost of \$153.2 thousand paid for via federal receipts at \$76.6 thousand and \$76.6 thousand in undesignated general fund match (UGF). She described that breakdown of expenses as: \$128.2 thousand in Personal services, \$20 thousand in services, \$2 thousand in commodities, and \$3 thousand in one-time commodities for a computer and office equipment.

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ROBERT NAVE, DEPUTY DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH (via teleconference), reviewed the published fiscal impact from DOH (FN2(DOH)). He delineated that the Division of Health Care Services, Health Facilities Licensing and Certification section will require one Nurse Consultant 1 beginning in FY 2027. The position would assist in program development, create licensing fees and regulations, design necessary forms, provide training, and other necessary framework to support this new facility type. He broke down the costs associated with the position and the necessary support infrastructure as follows:

Personal Services: \$172.1 annually, beginning in FY2027, for one Nurse Consultant 1 (including benefits) at Range 24 in Anchorage. Services: \$20.0 annually, starting in FY2027, for office space, phone, and reimbursable service agreements to support the position.

One-Time Commodities Cost: \$3.0 one-time, in FY2027, for computer, software, and office equipment.

Travel: \$10.0 annually, starting in FY2028, for travel to license and recertify facilities.

Commodities: \$2.0 annually, beginning in FY2028, for office supplies.

Mr. Nave summarized that the costs would support the licensing and regulation of the new facilities and leverage federal funding.

Mr. Nave reviewed the zero fiscal note from DOH(FN3(DOH)) allocated to Medicaid Services. He elucidated that many

individuals who would be served by CCRHs are already accessing residential or facility-based services. In some cases, CCRH services may be more cost-effective than current options, while in others, they may be more expensive. As such, the department estimated a net zero cost impact.

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Representative Hannan asked about page 3, line 7 of the bill and cited the term "frontier extended stay clinic." She wondered what type of facility it was. Ms. Ricci would follow up. Representative Hannan speculated on what it could be. Ms. Ricci replied that frequently, when references were made to frontiers, it was likely a federal reference for a setting or clinic type that may or may not exist in Alaska. She restated that she would follow up.

Representative Galvin asked about what other states had done to meet a similar need addressed in the legislation. She wondered what happened to Medicaid costs and if the 15 limit capacity was what other states had implemented. Ms. Ricci answered that she had talked with other states and there were no states that had figured out the best way to meet the need. She communicated that the need was not unique to Alaska and was common in all states. She indicated that the department worked with Milliman [Insurance Company] who supported the 1115 Behavioral Health Waiver and asked what they saw in other states regarding the issue. She listed the states she examined: Indiana, North Carolina, Michigan, Washington, and Oregon. She discovered that they all took different approaches to meet complex care needs. However, they all utilized different combinations of waivers due to the difference in Medicaid structures among the states. She currently, did not have definitive answers to the ratios, staffing, or services and wanted to build onto those in succeeding phases working with consultants and stakeholders. Presently, the departments had identified that a new license type was necessary due to existing assisted living statutes that were insufficient for the need. She emphasized that the need was acute to fill the gap and establishing the new license type now saved time to implementation.

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Representative Galvin appreciated the answer. Ms. Ricci commented that every state was struggling with the issue and attempting to figure it out. Representative Galvin asked whether the emphasis was to create more placements for the specific complex care population addressed while maintaining the current number of care providers in existing assisted living facilities. She asked whether it was a balance the departments were attempting to work out. Ms. Ricci responded in the affirmative. She explained that individuals in the population were accessing services in a way that did not meet their needs. She described situations where current assisted living facilities could not meet the needs of the patient and where health care workers and the other residents were negatively impacted as well.

Co-Chair Josephson wanted more information about what other states were doing. He deduced that Alaska did not invent the term "complex care residential homes." He thought that there was some sort of model somewhere the state was aware of. Ms. Ricci replied that the term existed in other formats in other states but did not necessarily mean the same thing as Alaska's term. She elaborated that the departments went through a lengthy process for naming the residential homes and it changed many times behind the scenes before deciding on CCRH. She relayed that it was difficult for her to acknowledge that a clear solution did not exist elsewhere that could be leveraged in Alaska. She stressed that an exact model that would work in Alaska did not exist.

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Representative Bynum asked about zoning and mentioned possible push back from the community. He asked whether the departments engaged in discussions about zoning and the CCRHs. Ms. Ricci answered in the negative. Representative Bynum asked if it had been a consideration in other states. Ms. Ricci was unaware of any discussion on the topic. Representative Bynum wondered if the bill was to pass but the fiscal notes were not accepted and there were no resources added to the department, could the mission still be carried out. Ms. Ricci responded that it would be very difficult. She commented that the Health Facilities Licensing and Certification section had taken on a tremendous amount of work over the last many years. In addition, the residential licensing team in the Division of Health Care Services was arduously working to meet the

demand that was increasing as the state's population aged, and more residential homes were opening. She furthered that the current behavioral health team lacked a staff position to carry out developing the certification and working on the necessary Medicaid waivers. The department would prioritize currently existing programs versus building out a new program. Representative Bynum inquired whether there would be a positive economic impact to the communities where the homes were located. Ms. Ricci replied that she had not done an economic analysis but shared that many hospitals relayed positive feedback regarding the concept and were eager to see the program implemented. In addition, existing assisted living homes offered positive responses on the concept since they were unable to provide adequate care for the individuals within the existing structure. She deemed that there would be positive community feedback. Some of the individuals displayed disruptive behaviors in public and there was a community safety element to the concept. She mentioned that in Washington and Oregon some of their programs were called "Community Safety Programs."

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Representative Tomaszewski asked about carceral system involvement. He wondered how that would work with zoning and in the community. Ms. Ricci answered that the bill did not address the issue of secure vs unsecured or locked versus unlocked, but the topic was discussed. The statutes did not address it for any existing license types. She shared that one of the things that they had heard was when the individual received the appropriate level of additional, consistent, support and medical care the level of disruptions decreased, and consistent behaviors increased. She deduced that it likely reduced the need for the security measures necessary when the patient was highly agitated. She shared discussions with other providers who confirmed that appropriate support and care helped the patient remain stable, lowering the security need. The CCRH model had 24/7 monitoring built into it and she reported that the security issue was still being figured out along with how to build it into the regulations.

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Dr. Lawrence responded that it was important to separate what was meant by carceral setting versus CCRH. He pointed out that carceral settings were correctional facilities and

the services provided were completely different than what would be provided in a CCRH. He wanted to clarify that a CCRH concept would not be set up in a correctional facility. He added that involuntary placement was not envisioned for a CCRH. He reiterated that regulation would address many of the details that were not yet figured out.

Representative Tomaszewski thought it was good to hear, and he would not think anyone in a cul-de-sac would want a locked-down facility next door. He believed that zoning was a critical need to address.

HB 73 was HEARD and HELD in committee for further consideration.

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Co-Chair Foster reviewed the agenda for the following day's meeting. Some discussion ensued regarding the upcoming agenda.

#

ADJOURNMENT

[3:07:53 PM](#)

The meeting was adjourned at 3:07 p.m.