ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 18, 2025
3:18 p.m.

MEMBERS PRESENT

Representative Genevieve Mina, Chair
Representative Andrew Gray
Representative Zack Fields
Representative Donna Mears
Representative Mike Prax
Representative Justin Ruffridge
Representative Rebecca Schwanke

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

HOUSE BILL NO. 73
"An Act relating to complex care residential homes; and providing for an effective date."

- MOVED HB 73 OUT OF COMMITTEE

HOUSE BILL NO. 70
"An Act relating to emergency medical services for operational canines; relating to the powers, duties, and liability of emergency medical technicians and mobile intensive care paramedics; relating to the practice of veterinary medicine; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 27
"An Act relating to medical care for major emergencies."

- HEARD & HELD

HOUSE BILL NO. 14
"An Act repealing programs for catastrophic illness assistance and medical assistance for chronic and acute medical conditions."

- HEARD & HELD

OVERVIEW(S): CHILD ADVOCACY CENTERS

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 73
SHORT TITLE: COMPLEX CARE RESIDENTIAL HOMES
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

01/27/25	(H)	READ THE FIRST TIME - REFERRALS
01/27/25	(H)	HSS, FIN
02/06/25	(H)	HSS AT 3:15 PM DAVIS 106
02/06/25	(H)	Heard & Held
02/06/25	(H)	MINUTE(HSS)
02/18/25	(H)	HSS AT 3:15 PM DAVIS 106

BILL: HB 70
SHORT TITLE: EMERGENCY MED SVCS; OPERATIONAL CANINES
SPONSOR(s): SCHRAGE

01/27/25	(H)	READ THE FIRST TIME - REFERRALS
01/27/25	(H)	HSS, L&C
02/18/25	(H)	HSS AT 3:15 PM DAVIS 106

BILL: HB 27
SHORT TITLE: MEDICAL MAJOR EMERGENCIES
SPONSOR(s): MINA

01/22/25	(H)	PREFILE RELEASED 1/10/25
01/22/25	(H)	READ THE FIRST TIME - REFERRALS
01/22/25	(H)	HSS, FIN
02/18/25	(H)	HSS AT 3:15 PM DAVIS 106

BILL: HB 14
SHORT TITLE: REPEAL CATASTROPHIC ILLNESS/MED ASSIST
SPONSOR(s): STAPP

01/22/25	(H)	PREFILE RELEASED 1/10/25
01/22/25	(H)	READ THE FIRST TIME - REFERRALS
01/22/25	(H)	HSS, FIN
02/18/25	(H)	HSS AT 3:15 PM DAVIS 106

WITNESS REGISTER

ROBERT LAWRENCE, MD, Chief Medical Officer

Office of the Commissioner
Department of Health
POSITION STATEMENT: Co-presented HB 73 on behalf of the bill sponsor, House Rules by request of the governor.

EMILY RICCI, Deputy Commissioner
Office of the Commissioner
Department of Health
Anchorage, Alaska
POSITION STATEMENT: Answered questions during the hearing on HB 73 on behalf of the bill sponsor, House Rules by request of the governor.

REPRESENTATIVE CALVIN SCHRAGE
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: As prime sponsor, presented HB 70.

JEREMY HOUSTON, Staff
Representative Calvin Schrage
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Gave the sectional analysis for HB 70 on behalf of Representative Schrage, prime sponsor.

KERRY KIRKPATRICK
Southeast Alaska Dogs Organized for Ground Search
Juneau, Alaska
POSITION STATEMENT: Gave invited testimony in support of HB 70.

SEAN MCPECK, DVM
Tier 1 Veterinary Medical Center
Palmer, Alaska
POSITION STATEMENT: Answered questions during the hearing on HB 70.

KATY GIORGIO, Staff
Representative Genevieve Mina
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Gave the sectional analysis for HB 27 on behalf of Representative Mina, prime sponsor.

GENE WISEMAN, Chief
Section of Rural and Community Health Systems
Division of Public Health
Department of Health

Anchorage, Alaska
POSITION STATEMENT: Answered questions during the hearing on HB 27.

REPRESENTATIVE WILL STAPP
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: As prime sponsor, presented HB 14.

BERNARD OTO, Staff
Representative Will Stapp
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: On behalf of Representative Stapp, prime sponsor, gave the sectional analysis for HB 14.

DEB ETHERIDGE, Director
Division of Public Assistance
Department of Health
Juneau, Alaska
POSITION STATEMENT: Answered questions during the hearing on HB 14.

MARI MUKAI, Executive Director
Alaska Children's Alliance
Western Regional Children's Advocacy Center
Anchorage, Alaska
POSITION STATEMENT: Co-presented the Child Advocacy Centers overview.

LEIGH BOLIN, Executive Director
Resource Center for Parents and Children
POSITION STATEMENT: Co-presented the Child Advocacy Centers overview.

CATHY BALDWIN-JOHNSON, MD, Medical Director
The Children's Place
Wasilla, Alaska
POSITION STATEMENT: Co-presented the Child Advocacy Centers overview.

TODD KEARNS
Anchorage, Alaska
POSITION STATEMENT: Co-presented the Child Advocacy Centers overview.

ACTION NARRATIVE

3:18:41 PM

CHAIR GENEVIEVE MINA called the House Health and Social Services Standing Committee meeting to order at 3:07 p.m. Representatives Gray, Fields, Mears, Prax, Schwanke, and Mears were present at the call to order. Representative Ruffridge arrived as the meeting was in progress.

HB 73-COMPLEX CARE RESIDENTIAL HOMES

3:19:19 PM

CHAIR MINA announced that the first order of business would be HOUSE BILL NO. 73, "An Act relating to complex care residential homes; and providing for an effective date."

3:19:48 PM

ROBERT LAWRENCE, MD, Chief Medical Officer, Office of the Commissioner, Department of Health, co-presented HB 73 on behalf of the bill sponsor, House Rules by request of the governor. He reviewed that the bill would establish a new residential license type for complex care residential homes. The homes would provide long-term residential care in a home-like setting for those with complex behavioral and/or co-occurring medical and disability-related needs.

3:20:40 PM

CHAIR MINA opened public testimony on HB 73. After ascertaining there was no one who wished to testify, she closed public testimony.

3:21:16 PM

REPRESENTATIVE PRAX asked for confirmation that the proposed legislation would apply to facilities - not to the people working within them.

3:21:43 PM

EMILY RICCI, Deputy Commissioner, Office of the Commissioner, Department of Health, provided information and answered questions on behalf of the sponsor of HB 73, House Rules by request of the governor. She responded to a series of questions from Representative Prax related to the function and timing of

the proposed complex care facilities. She spoke about the need for legislation to be passed prior to creating regulation and the expressed need for the facilities prompting efficiency of putting those regulations in place get the facilities running.

3:25:18 PM

MS. RICCI, in response to Chair Mina. She said she does not think there are specific care facilities that would convert to complex care facilities under HB 73 even if they may be doing their best currently to provide needed complex care. She speculated that some of them may modify a portion of a building or home to meet these needs. She further speculated that new facilities may be built as a result of the proposed legislation.

3:26:52 PM

The committee took a brief at-ease at 3:27 p.m. [to address technical issues].

3:27:46 PM

MS. RICCI, in response to Chair Mina, explained that the 15-person limit per Alaska complex care residential home (CCRH) [proposed in Section 4 of HB 73 reflects federal law that establishes an institute for mental disease (IMD) exclusion limiting use of Medicaid dollars. She clarified, "So, that institute for mental disease prohibition against using Medicaid funds to provide long-term care residential services does not apply to facilities that are 16 beds or less."

3:30:26 PM

DR. LAWRENCE, in response to Chair Mina, said the vision is to have multi-disciplinary services on site.

3:31:27 PM

MS. RICCI, in response to a question from Representative Schwanke as to what would be gained with the proposed new license type when facilities are already treating patients with multiple conditions, proffered that the current mode of operation may not be the most effective. For example, she said, "We have this gap with individuals who need consistent support in a way that is not available through an assisted living home that is not funded or staffed at the levels of need that these individuals require, or they are receiving care or treatment in

in-patient settings that are overly restrictive and are beyond what they may need." She said HB 73 would create a facility type that could be crafted for patients with specific needs. She offered further examples.

3:35:03 PM

REPRESENTATIVE FIELDS recalled two individuals in that past that were murdered by people who likely should have been in a CCRH. He emphasized the urgency in getting this legislation passed in response to the public safety aspect of the issue.

3:35:53 PM

REPRESENTATIVE MEARS moved to report HB 73 out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, HB 73 was reported out of the House Health and Social Services Standing Committee.

3:36:14 PM

The committee took an at-ease from 3:36 p.m. to 3:39 p.m.

HB 70-EMERGENCY MED SVCS; OPERATIONAL CANINES

3:39:14 PM

CHAIR MINA announced the next order of business would be HOUSE BILL NO. 70, "An Act relating to emergency medical services for operational canines; relating to the powers, duties, and liability of emergency medical technicians and mobile intensive care paramedics; relating to the practice of veterinary medicine; and providing for an effective date."

3:39:43 PM

REPRESENTATIVE CALVIN SCHRAGE, Alaska State Legislature, as prime sponsor, gave the sponsor statement [included in the committee file], which read as follows [original punctuation provided, with some formatting changes]:

> House Bill 70 empowers Emergency Medical Services (EMS) personnel to deliver on-scene point-of injury (POI) emergency care and transport for operational canines (OpK9s).

Operational canines are essential members of law enforcement, other government operations, and search-and-rescue teams. These courageous animals amplify the success of countless military, law enforcement, search-and-rescue, and humanitarian missions. Their roles even extend to police or fire chaplaincy during crises.

This bill is named "Rico's Law" in honor of Alaska State Trooper K9 Rico, whose end of watch occurred on March 26, 2017. Rico was fatally shot while heroically attempting to apprehend a suspect after a lengthy pursuit on the Parks Highway in Wasilla, Alaska.

K9 Rico, like all operational canines, demonstrated unwavering dedication, protecting, and defending his community. These animals are more than just assets or property—they are teammates, partners, and family members who deserve emergency care and transportation rights. Operational canines, especially those deployed in tactical or high-threat situations, face significant risks of injury or preventable death.

Currently, Alaska lacks statutory authority allowing EMS personnel to apply life-saving care to these animals. Under current law, providing such care could be deemed "practicing veterinary medicine without a license," a violation under AS 08.98.120, carrying severe penalties. The super-rural nature of Alaska adds another dimension of acuity for our operational canines outside of Alaska's major urban centers.

Alaska's EMS professionals already possess the equipment, supplies, and medications needed to adapt existing prehospital standards of care for human patients to operational canines. Training programs like the K9 Tactical Emergency Casualty Care (K9 TECC) course provide additional training for clinicians to confidently manage operational canine emergencies. The passage of this bill would eliminate legal barriers, allowing EMS personnel to administer life-saving care and transport injured operational canines to emergency veterinary facilities.

With minimal investment by our participating EMS services, Alaska EMS can ensure that our operational

canines have a fighting chance at survival when injured in the line of duty.

3:42:32 PM

JEREMY HOUSTON, Staff, Representative Calvin Schrage, Alaska State Legislature, on behalf of Representative Schrage, prime sponsor, gave the sectional analysis for HB 70 [included in the committee file], which read as follows [original punctuation provided, with some formatting changes]:

Section 1: Amends AS 08.98.125 exempts emergency medical technician or mobile intensive care paramedic from penalty for practicing veterinary medicine without a license when providing emergency medical services to an operational canine as provided under AS 18.08.093.

Section 2: Amends AS 18.08.075(a) to authorize emergency medical technicians and mobile intensive care paramedic to enter a building or premises where a report of an injury or illness has taken place or where there is reasonable cause to believe an operational canine has been injured or is ill to render emergency medical care and direct the removal of a motor vehicle or other thing determined necessary to prevent further harm to operational canines.

Section 3: Amends AS 18.08.086(a) to provide for civil liability protection to providers, or a director of a provider licensed under AS 18.08.082 who administers emergency medical services to an operational canine within the scope of the person's certification or licensure and if the operational canine reasonably seems to be in immediate danger of serious harm or death.

Section 4: Amends AS 18.08.087 to remove language limiting physicians, advanced practice registered nurses, or physician assistants' permission to disclose medical information of a patient to emergency medical technicians and mobile intensive care paramedics when the information is not for the purpose of evaluating the performance of an emergency medical technician, mobile intensive care paramedic or physician.

Section 5: Adds two new subsections to AS 18.08.087. The first allows licensed veterinarians to disclose medical or hospital records of an operational canine to an emergency medical technician or mobile intensive care paramedic for the purpose of evaluating the performance of an emergency medical technician or mobile intensive care paramedic. The second adds language restricting physicians, advanced practice registered nurses, or physician assistants' permission to disclose medical information of a patient to emergency medical technicians and mobile intensive care paramedics when the information is not for the purpose of evaluating the performance of an emergency medical technician, mobile intensive care paramedic or physician.

Section 6: Adds one new section to AS 18.08 with two subsections. Subsection (a) allows for an emergency medical technician to provide emergency medical services to an operational canine if 2 Tuesday, February 4th, 2025 a veterinarian is unavailable to provide emergency medical services in a reasonable amount of time, the emergency medical technician or mobile intensive care paramedic has received training on providing emergency medical services to operational canines, is trained to provide comparable medical services to humans, is authorized to provide the comparable medical service to a human under the scope of their license or certification, and has informed consent from the owner or someone authorized to make medical decisions about the operational canine or is providing medical service in accordance with a written protocol developed by a veterinarian. Subsection (b) requires the emergency medical technician or mobile intensive care paramedic to transfer the operational canine to a licensed veterinarian at the earliest practicable opportunity and comply with all laws governing the administration of drugs or biologics to a human when administering a drug or biologic to an operational canine.

Section 7: Amends AS 18.08.100(b) to clarify that if individuals licensed under this chapter determine, during a telehealth encounter, that the encounter will extend past their scope of practice they shall advise the person who is authorized to make medical decisions for the operational canine that they are not

authorized to provide the services needed, provide recommendation for an appropriate provider, and limit the encounter to the services they are authorized to provide.

Section 8: Amends AS 18.08.200 to define "veterinarian" in this chapter the same as it is under AS 08.98 and "operational canine" as a dog used by law enforcement or other government operations; or in search and rescue operations.

Section 9: Sets an effective date of January 1st, 2026.

3:47:41 PM

KERRY KIRKPATRICK, Southeast Alaska Dogs Organized for Ground Search (SEADOGS), as invited testifier, introduced the committee to Bizzy, an 11-year-old search dog [seated next to her at the witness table] certified in multiple disciplines for search, including avalanche, wilderness, cadaver, and water. She stated that she has been doing this work for 30 years, often in remote areas out of reach of communication where there is no access to veterinarians. Sometimes, when working with Coast Guard or National Guard, the search team has access to emergency medical technicians (EMTs) or paramedics. She emphasized the importance of having people working with the team that have the knowledge to be able to, at the very least, stabilize an injured search animal and get them to a veterinarian. She said she thinks that whether a professional or a volunteer, anyone would do their utmost to keep a dog alive, and she hopes that anyone who made that effort would not then be held liable for attempting to help.

3:50:06 PM

MR. HOUSTON, in response to Representative Gray, explained that language from Section 4 was moved to Section 5 at the recommendation of Legislative Legal Services.

3:52:10 PM

SEAN MCPECK, DVM, Tier 1 Veterinary Medical Center, in response to a question from Representative Gray regarding when Section 7 "would come into play," surmised there could be a scenario in which a doctor is speaking to someone telephonically and "going off of the interpretation" of the person who is present [with

the injured animal]. Without diagnostics, x-ray, and hands-on examination, the doctor on the phone is guessing at the best course of treatment with limited information.

REPRESENTATIVE GRAY said he interpreted Section 7 as pertaining to a situation in which a person who is not a veterinarian is trying to provide medical advice to someone who is rendering care to a canine. Under this scenario, the person would have to disclose that they were not a veterinarian.

3:54:45 PM

REPRESENTATIVE SCHRAGE offered to get back to Representative Gray and the committee with a specific example of when Section 7 would apply. In response to Representative Gray, he said he is not aware of any case in which care was not rendered "as a result of this concern." That said, he noted that there is concern within the medical community about continuing to provide care moving forward.

3:56:03 PM

REPRESENTATIVE SCHRAGE, in response to Representative Prax, talked about the choice to call this "Rico's Law" and recognized Brian Webb, a former legislative staff and emergency medical services provider with experience with this issue, who brought the issue to Representative Schrage.

REPRESENTATIVE PRAX expressed concern that the proposed bill would open up "a can of worms."

REPRESENTATIVE SCHRAGE suggested the flip side is to question whether not addressing the issue would result in failed care of a canine in the future. The concern for this issue has already been expressed, thus the can of worms has already been opened. In response to whether he would consider expanding liability by further clarifying the bill, Representative Schrage said he worries about broadening the scope of the bill beyond "those who are reasonably assumed to have the necessary medical skills to provide care to an operation canine." He suggested his is a policy question for the committee.

4:01:54 PM

REPRESENTATIVE RUFFRIDGE observed there seems to be a need for definitions, including: what is a reasonable amount of time; who trains; and what does that training look like.

REPRESENTATIVE SCHRAGE proposed to hold a dialogue between this this bill hearing and the next to address those concerns.

4:03:15 PM

REPRESENTATIVE SCHWANKE noted that she has training in animal welfare and immobilization training, and she talked about varying schedules and reporting requirements. She noted her question mirrored that of Representative Ruffridge and is related to training.

4:04:33 PM

REPRESENTATIVE SCHRAGE referred again to Brian Webb as a source for answering questions.

MR. HOUSTON noted that there is national training course standard, called Canine TECC.

4:06:03 PM

CHAIR MINA announced that HB 70 was held over.

4:06:13 PM

The committee took an at-ease from 4:06 p.m. to 4:07 p.m.

[During the at-ease, Chair Mina passed the gavel to Representative Mears.]

HB 27-MEDICAL MAJOR EMERGENCIES

4:07:32 PM

REPRESENTATIVE MEARS announced that the next order of business would be HOUSE BILL NO. 27, "An Act relating to medical care for major emergencies."

4:07:43 PM

CHAIR MINA, as prime sponsor of HB 27, gave the sponsor statement [included in the committee file], which read as follows [original punctuation provided]:

> A coordinated statewide system of care enhances the chance of survival in life-threatening, time-critical

emergencies in adults and children. Trauma and specific medical emergencies addressed within this system ensure that Alaskans receive care from the "right person, at the right place, at the right time."

Trauma, strokes, and heart attacks represent the leading causes of death in Alaska. In 2022 alone, 744 Alaskans died from trauma, 217 died from strokes, and 510 died from died from cardiovascular disease such as a heart attack. By enabling a statewide systems of care approach for major emergencies, death rates caused by these time-sensitive emergencies can improve. Importantly, these are conditions for which interventions exist that can markedly alter their otherwise dismal prognoses.

HB 27 seeks to expand the scope of the Section of Rural and Community Health Systems within the Department
of Health to include strokes and severe heart attacks in:

• Developing training programs for ambulance and first responder services on a standardized protocol.
• Communicating the urgency of the patient's condition to the local receiving hospital or clinic.
• Assist in establishing statewide guidelines, helping physicians and advanced practice practitioners
determine if local treatment is appropriate or to expedite transport to the suitable treatment facility.

This legislation also focuses on expanding AS 18.08.010 and AS 18.08.200, allowing the Department of Health (DOH) to replicate those systems and processes that have improved trauma care and apply those principles to stroke and severe heart attacks.

With the success of the Trauma Center program, HB 27 will ensure that the receiving specialty hospitals meet DOH-adopted national criteria for being a voluntary stroke or heart attack center. It also establishes a registry specific to these major emergencies, a means to measure outcomes, and guide changes that will inevitably be needed.

The overall goal of HB 27 is that a trauma, cardiac, or stroke patient returns home as a functional member

of the community and embraces life changes that will improve their future health.

4:12:35 PM

KATY GIORGIO, Staff, Representative Genevieve Mina, Alaska State Legislature, on behalf of Representative Mina, prime sponsor of HB 27, gave the sectional analysis [included in the committee file], which read as follows [original punctuation provided]:

Section 1. Amends AS 18.08.010

Section 1, subsections 1-3 adds "major emergencies" to the existing emergency medical services (EMS) system. Currently, only trauma care appears in statute, and the addition of "major emergencies" will allow the Department of Health (DOH) to include time-sensitive emergencies such as heart attacks and strokes to their EMS review system.

Section 1, subsection 4, addresses the trauma center designation status for hospitals and clinics and gives the statutory authority for DOH to adopt criteria for those health centers to represent themselves as being capable of treating major emergencies.

Section 2. Amends AS 18.08.200 by adding a new paragraph:
This is the definition section for the chapter, and "major emergency" is added and defined as heart attack and stroke.

4:13:37 PM

REPRESENTATIVE MEARS invited committee questions.

4:13:52 PM

REPRESENTATIVE RUFFRIDGE said he understood why heart attack and stroke were chosen as major medical emergencies, as they are clear options. He then cited the current statutory definition of medical care as "services utilized in responding to a perceived need for medical care to prevent loss of life". He questioned the need to define major emergency as being just two types of medical situations.

CHAIR MINA replied, "My understanding is that what we have in statute for the duties and responsibilities of the Office of EMS is only situated to what is in statute. And so, to be able to clearly define the different instances of major medical emergencies, like strokes and heart attacks, I think we do have to put that in statute clearly." That said, she deferred to Gene Wiseman.

4:15:39 PM

GENE WISEMAN, Chief, Section of Rural and Community Health Systems, Division of Public Health, Department of Health (DOH), noted that AS [18.08.010] specifies "trauma" [in relation to emergency medical services]. He stated, "At the time of the writing of that statute, trauma had known outcome for coordinated care." He spoke about the finite timeframes related to heart attack and stroke "that require a higher level of system coordination to occur." He offered further details.

REPRESENTATIVE RUFFRIDGE summarized that Mr. Wiseman had said that because trauma care is specifically defined, then major emergencies also must be specifically defined, which led him to ask whether the statute could be broadened by replacing "trauma care" and "major emergencies" with "plan and deliver emergency medical services".

MR. WISEMAN responded that EMS responds to all emergencies. He indicated that the statute facilitates the building of a system of care that encompasses trauma, stroke, and heart attack. This requires collaboration, subject experts, and monitoring. He offered examples. He concluded, "Without it being in there, ... potentially, it doesn't allow us ... that focus on the collaboration."

4:22:08 PM

REPRESENTATIVE GRAY proffered that HB 27 is more of a "clean-up bill," because it is proposing to put into statute "that which we are already do." He remarked that he knows no one in the field of medicine who will say, "Well, now that it's in statute, we'll start taking strokes and heart attacks seriously." That, he emphasized, has already been happening for decades.

4:23:26 PM

REPRESENTATIVE MEARS announced that HB 27 was held over.

4:23:36 PM

The committee took an at-ease from 4:23 p.m. to 4:24 p.m.

[During the at-ease, Representative Mears handed the gavel back to Chair Mina.]

HB 14-REPEAL CATASTROPHIC ILLNESS/MED ASSIST

4:24:47 PM

CHAIR MINA announced the next order of business would be HOUSE BILL NO. 14, "An Act repealing programs for catastrophic illness assistance and medical assistance for chronic and acute medical conditions."

4:25:06 PM

REPRESENTATIVE WILL STAPP, Alaska State Legislature, as prime sponsor of HB 14, gave key points from the sponsor statement [included in the committee file], which read as follows [original punctuation provided]:

> Although housed in Division of Healthcare Services, the Division of Public Assistance (DPA) is responsible for administering the Catastrophic Illness and Chronic or Acute Medical Conditions program. In FY21, FY22, and FY23, the DPA has collectively processed thousands of applications and only two qualifying applicants that did receive assistance within the year of 2021.
>
> The program began in 1986. Recipients were mainly those too young for Medicare and with incomes too high to qualify for Medicaid. Those who were either not covered by health insurance or whose insurance was inadequate to brace a catastrophic illness event without endangering their financial resources, subsistence and essential assets. Due to the expansion of Medicaid under the Affordable Care Act put into effect within Alaska in late 2015, the increase in coverage for Medicaid recipients grew nearly 145,000 people. Since that time, the number of qualifying recipients has dramatically declined to the numbers we see today. However, as a statutory program, the division must administer it, which is costing the state over $150,000 a year and countless hours of

administrative work that could otherwise be spent on other such programs.

As a statutory program, the division was administering [Chronic and Acute Medical Assistance] CAMA program until FY 24 costing the state over $150,000 a year. Funding for the program was discontinued in the FY25 budget and remains unfunded in the FY26 budget. The division had also provided countless hours of administrative work that would alternatively have been used to process applications for more utilized programs within their division such as Supplemental Nutrition Assistance Program (SNAP) to prevent backlogs in assistance funding. The Catastrophic Illness and Chronic or Acute Medical Conditions program has since become obsolete and House Bill 14 aims repeal the program from state statute.

4:26:47 PM

BERNARD OTO, Staff, Representative Will Stapp, Alaska State Legislature, on behalf of Representative Stapp, gave the sectional analysis for HB 14 [included in the committee packet], which read as follows [original punctuation, with some formatting changed]:

Section 1
AS 36.30.850(b)(11) amended
Deletes reference to Catastrophic Illness Assistance from service providers

Section 2
AS 47.05.085 amended
Deletes reference to Catastrophic Illness Assistance from evidence in connection with investigation under the administration

Section 3
AS 47.05.200(d) amended
Deletes Catastrophic Illness Assistance from obtaining payment from providers

Section 4
AS 47.05.210(a) amended
Deletes reference to Catastrophic Illness Assistance from medical assistance fraud

Section 5
AS 47.05.240 amended
Deletes reference to Catastrophic Illness Assistance commissioner excluding applicant from medical assistance program

Section 6
AS 47.05.290(9) amended
Deletes Catastrophic Illness Assistance from the definition of "medical assistance program"

Section 7
AS 47.05.290(10) amended
Deletes Catastrophic Illness Assistance from the definition of "medical assistance provider"

Section 8
AS 47.05.290(17) amended
Deletes Catastrophic Illness Assistance from the definition of "medical assistance services"

Section 9
AS 47.05.330(a) amended
Modifies reference to Catastrophic Illness Assistance as "former"

Section 10(a)
AS 47.08.010 – 47.08.140 Repeal
Repels all references to Catastrophic Illness Assistance within statute

Section 10(b)
AS 47.08.150 Repeal
Repeals reference to Medical Assistance for Chronic or Acute Medical Conditions within statute

Section 11 Uncodified Law/Add new section
Allows the Department of Health to create an initial case if fraud is found within previous program of Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions

Section 12 Uncodified Law/Add new section
Allows the Department of Health to issue subpoenas and further investigate with necessary records or evidence

4:27:42 PM

CHAIR MINA invited questions from the committee.

4:27:58 PM

REPRESENTATIVE FIELDS asked for confirmation that even if U.S. Congress is successful in gutting Medicaid, "we would want to then continue covering people under Medicaid and not CAMA."

4:28:26 PM

REPRESENTATIVE STAPP replied that it is hard for him to imagine that "even if they did cost-shift 100 percent of the cost of the Medicaid program back on to the state, that they'd still qualify for CAMA." He deferred to Deb Ethridge.

4:29:16 PM

DEB ETHERIDGE, Director, Division of Public Assistance, Department of Health (DOH), stated that the division does not anticipate "any additional eligibility if there's any effect."

4:29:42 PM

CHAIR MINA asked if the funds would be returned to the [undesignated general fund] (UGF).

REPRESENTATIVE STAPP answered yes, they would be available to spend on other things because they would be returned to the [general fund] (GF).

4:30:03 PM

CHAIR MINA announced that HB 14 was held over.

4:30:10 PM

The committee took an at-ease from 4:30 p.m. to 4:32 p.m.

OVERVIEW(S): CHILD ADVOCACY CENTERS

4:32:25 PM

CHAIR MINA announced that the final order of business would be the Child Advocacy Centers overview.

4:33:02 PM

MARI MUKAI, Executive Director, Alaska Children's Alliance (ACA), Western Regional Children's Advocacy Center (WRCAC), as co-presenter of the Child Advocacy Centers overview, brought to the table the subject of child abuse. She began a PowerPoint [hard copy included in the committee file], titled "Alaska Children's Alliance & Child Advocacy Centers As an introduction," on slide 2, stating that there are wide-ranging consequences of child abuse, not only medical but also mental illness, substance abuse, and [negative] socio-economic outcomes. Added to that are the expenses related to those outcomes. She reported that Alaska's rate of child abuse and neglect is among the highest in the country.

MS. MUKAI discussed slide 3, "Child Advocacy Centers (CACs): Frontline Coordinated Response to Child Abuse," which read as follows [original punctuation provided]:

> A CAC is a neutral, safe place where a child and non-offending caregiver can receive comprehensive services following a concern of abuse such as: sexual abuse (including commercial sexual exploitation, trafficking, and child sexual abuse materials), physical abuse, witnessing violence (such as domestic violence and homicide), and extreme neglect.

MS. MUKAI, while displaying slide 4, highlighted some of the reasons CACs are critical. For children and families, CACs are "the most trauma-informed way" to ensure they get access to needed services and justice for crimes committed against them. For professionals, CACs assist with coordinating services. For Alaska, CACs provide a good return on investment. On slide 5, Ms. Mukai showed a map with the locations of 20 CACs throughout the state.

4:36:33 PM

LEIGH BOLIN, Executive Director, as co-presenter of the Child Advocacy Centers overview, picked up the PowerPoint on slide 6, which depicts a pie chart with the percentages of CAC funding, the primary topic on which the presentation is based. Slide 6 shows that one half of the funding comes from a combination of private/foundations [4 percent]; fundraising and earned income [17 percent]; federal grants/"other" [15 percent]; and Victims of Crime Act of 1984 (VOCA) [14 percent]. She said 50 percent of funding to CAC comes from Temporary Assistance to Needy Families (TANF) [31 percent] and a grant from the U.S.

Department of Justice (DoJ) [19 percent], and she emphasized that both the TANF and DoJ funds will be gone in fiscal year 2026 (FY 26). She underscored how detrimental it would be without CACs.

4:38:08 PM

MS. BOLIN responded to questions from the committee. To Representative Gray, she explained the reasons that CACs do not qualify for TANF. To Representative Ruffridge she said it looks as though TANF funds are being "cracked down upon" nationwide, and she mentioned there are four criteria related to TANF. Not every state was using TANF; there has been funding through DoJ's Office of Victim's rights.

4:41:15 PM

MS. MUKAI, in response to Representative Fields, remarked on the topic of congressional support, noting that U.S. Senator Lisa Murkowski has been an advocate in finding a fix related to the VOCA grant.

4:42:10 PM

MS. BOLIN responded that "we" had met with Senator Dan Sullivan last year, and Senator Murkowski is aware of the situation. She explained that the DoJ funding was Alaska-specific.

4:43:42 PM

MS. BOLIN, in response to Representative Prax, offered details related to VOCA, described the connection between the Alaska Children's Trust and ACA, and clarified her affiliation.

4:47:44 PM

BOLIN returned to the presentation, to slide 7-8, which read as follows [original punctuation provided]:

Imminent Funding Concern

ACA/CACs face a dramatic drop-off of federal funds in FY26: $3.4M TANF + $2M DOJ = $5.4M

Alaska Children’s Alliance sought and secured intent language in the FY25 budget that directs the State to “ensure CAC services are not interrupted due to the

loss of federal funds in FY26." Nevertheless, despite legislative intent and Alaska Statute AS 47.17.033 that requires OCS to refer child abuse cases to CACs, they were not included in the proposed FY26 budget.

ACA/CAC FY26 Request

Requesting operating funds to DFCS in the FY26 State budget: $5.4M to the base

MS. BOLIN emphasized that the "ask" is not an increase but merely to maintain current service levels.

4:49:02 PM

CATHY BALDWIN-JOHNSON, MD, Medical Director, The Children's Place, as co-presenter, gave the next portion of the Child Advocacy Centers overview. She brought attention to slides 10-11, which read as follows [original punctuation provided]:

Child Abuse and Health

- Multiple studies link poor health and social outcomes for childhood adversity
- Landmark Adverse Childhood Experiences study
    - >17,000 middle aged adults, most with college education, most employed
    - 10 categories: Before age 18 experienced sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, household member who abused substances or went to prison or was mentally ill, witnessed violence against mother, or lost a parent
    - "ACE Score" 0-10
    - Higher the score, higher the risk of all of the most common causes of adult illness and death in the US
- Additional studies indicate onset of health problems in childhood/adolescence
- It is never just one bad thing
- Multiple studies demonstrate polyvictimization during childhood and extending into adulthood
- Resulting in higher and higher ACE accumulation
- And higher and higher costs for healthcare and social ills
- CACs offer the opportunity to interrupt the cycle

DR. BALDWIN-JOHNSON concluded her portion of the presentation on slide 12, which read as follows [original punctuation provided]:

The Medical Role in CACs

- It's never just one bad thing: research shows a significant percentage of children presenting to CACs for sexual abuse have multiple unmet health needs
- Medical providers at CACs work in partnership with the rest of the multidisciplinary team:
    - Gather pertinent health information from the forensic interview and medical history
        - Children may reveal more to a health professional during an exam
    - Provide medical evaluations as indicated
    - Gather forensic evidence as indicated
    - Diagnose and treat as indicated
        - Differentiate between abuse and medical problems or accidental injuries
    - Provide reassurance for children and their families
    - Testify in court as needed

4:52:37 PM

TODD KEARNS, as co-presenter of the Child Advocacy Centers overview, specified that he was not speaking on behalf of the Anchorage Police Department (APD) but as an invited testifier with experience working in a CAC. He covered slides 14-15, which read as follows [original punctuation provided]:

MDT Partner Perspective: Law Enforcement

Child Advocacy Centers: national best practice model provides a safe place for kids to talk

- Non-police facility
- Audio/Video recorded per Alaska Statute AS 47.17.033
- They receive a medical evaluation
- Mental health care available
- Advocacy from start to finish
    - Disclosure to trial Build stronger cases with a "team concept"
- Trauma informed trained investigators
- Advocates for the family
- Trained interviewers
- Medical experts in the child maltreatment field

- DNA evidence collection
- Sexual related injuries

- Expert courtroom testimony
- Allows LE to focus on the criminal investigation while other team members focus on the other needs of the victim: Hold offenders accountable

- CACs in Rural Alaska ○ The child and family are local ○ The family does not have to travel ○ Large delay in treatment due to logistics ○ Local follow up and mental health treatment ○ Cost savings of travel

4:57:12 PM

MS. BOLIN concluded the presentation with a recap of the deficit going into 2026.

4:57:22 PM

DR. BALDWIN-JOHNSON, in response to Representative Schwanke, explained why billing third-party payers for medical evaluations is not a realistic way to support the medical aspect of these programs. Some CACs are under the auspices of tribal entities and their ability to survive in rural areas of the state is limited by what the tribal entities are able to provide. To a follow-up question regarding support from Native consortiums, she offered her understanding regarding some support the Southcentral Foundation through the Alaska Native Health Consortium.

5:00:21 PM

MS. BOLIN, in response to Representative Mears, offered her understanding that [CACs] are not included the current state budget. In response to a follow-up question from Chair Mina, she offered her understanding that CACs were funded by the State of Alaska until FY 15 and have been under TANF for the past decade. She surmised that the move to TANF was an "avenue" for sustainable funding.

5:02:33 PM

MS. BOLIN, in response to Representative Prax, confirmed that referrals can come from the Office of Children's Services and the Department of Public Safety. In response to Representative Fields, she confirmed that [CACs] gather information that helps to apprehend more predators.

5:05:40 PM

MS. BOLIN, in response to Chair Mina, described the effects of loss of funding, including diminished staffing.

5:06:23 PM

DR. BALDWIN-JOHNSON added that adequate funds allow for providing on-site mental health services; many children seen are in crisis.

5:08:04 PM

MS. BOLIN, in response to Chair Mina, talked about having a neutral space, working with law enforcement, bringing families in from remote areas, doing outreach and education, collaborating with partners in community work, and providing core services in response to child maltreatment.

5:09:14 PM

DR. BALDWIN-JOHNSON, in response to Representative Schwanke, described the process before the advent of CACs and called it a disservice to children. They were interviewed in interrogation rooms by police. Regarding the attempt to coordinate mental health services for these children, she stated that "people weren't sitting down and talking to each other about these cases; there was information that was lost; and families got discouraged with the whole process and would just give up - not follow through; and cases would just sit; and offenders went unpunished; and kids ended up without the treatment that they needed."

5:11:33 PM

SARGEANT KEARNS, in response to Representative Fields, said CACs help because of the team concept involved where the team is accustomed to working together; action is taking immediately 24/7; and information is received from the child, who has to tell their story only once.

5:13:43 PM

CHAIR MINA thanked the presenters.

5:13:51 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:14 p.m.