

ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

January 28, 2025

3:30 p.m.

MEMBERS PRESENT

Senator Forrest Dunbar, Chair
Senator Cathy Giessel, Vice Chair
Senator Matt Claman
Senator Löki Tobin
Senator Shelley Hughes

MEMBERS ABSENT

All members present

OTHER MEMBERS IN ATTENDANCE

Representative Maxine Dibert

COMMITTEE CALENDAR

SENATE BILL NO. 45

"An Act relating to medical assistance services; relating to parity in mental health and substance use disorder coverage in the state medical assistance program; and providing for an effective date."

- HEARD & HELD

SENATE BILL NO. 44

"An Act relating to the rights of minors undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 45

SHORT TITLE: MEDICAID MENTAL HEALTH PARITY

SPONSOR(s) : SENATOR(s) DUNBAR

01/17/25 (S) PREFILE RELEASED 1/17/25
01/22/25 (S) READ THE FIRST TIME - REFERRALS
01/22/25 (S) HSS, FIN
01/28/25 (S) HSS AT 3:30 PM BUTROVICH 205

BILL: SB 44

SHORT TITLE: MINORS & PSYCHIATRIC HOSPITALS

SPONSOR(s) : SENATOR(s) CLAMAN

01/17/25 (S) PREFILE RELEASED 1/17/25
01/22/25 (S) READ THE FIRST TIME - REFERRALS
01/22/25 (S) HSS, FIN
01/28/25 (S) HSS AT 3:30 PM BUTROVICH 205

WITNESS REGISTER

ARIELLE WIGGIN, Staff
Senator Forrest Dunbar
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Gave a brief overview of the sponsor statement for SB 45 and provided the sectional analysis.

LANCE JOHNSON, Chief Operating Officer
Alaska Behavioral Health Association
Eagle River, Alaska

POSITION STATEMENT: Testified by invitation on SB 45.

JOHN SOLOMON, CEO
AK Behavioral Health Association
Eagle River, Alaska

POSITION STATEMENT: Testified by invitation on SB 45.

CHRIS CONSTANT, Chair
Anchorage Assembly
Anchorage, Alaska

POSITION STATEMENT: Testified by invitation on SB 45.

DUSTIN LARNA, Chief Executive Officer
Residential Youth Care
Ketchikan, Alaska

POSITION STATEMENT: Testified by invitation on SB 45.

TRACY DOMPELING, Director
Division of Behavioral Health

Department of Health
Juneau, Alaska

POSITION STATEMENT: Answered questions on SB 45.

BREANNA KAKARUK, Staff
Senator Matt Claman
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Provided the sectional analysis for SB 44.

AMANDA METIVIER, Co-founder
Facing Foster Care in Alaska
Anchorage, Alaska

POSITION STATEMENT: Testified by invitation on SB 44.

CAROLINE BROWN, representing self
Fairbanks, Alaska

POSITION STATEMENT: Testified by invitation on SB 44.

ACTION NARRATIVE

[3:30:48 PM](#)

SENATOR DUNBAR called the Senate Health and Social Services Standing Committee meeting to order at 3:30 p.m. Present at the call to order were Senators Hughes, Claman, Giessel, and Chair Dunbar. Senator Tobin arrived thereafter.

SB 45-MEDICAID MENTAL HEALTH PARITY

[3:31:45 PM](#)

CHAIR DUNBAR announced the consideration of SENATE BILL NO. 45 "An Act relating to medical assistance services; relating to parity in mental health and substance use disorder coverage in the state medical assistance program; and providing for an effective date."

[3:32:42 PM](#)

ARIELLE WIGGIN, Staff, Senator Forrest Dunbar, Alaska State Legislature, Juneau, Alaska, gave a brief overview of the sponsor statement for SB 45 stating the legislature has an opportunity to increase access to behavioral health care in a way that will deeply impact many communities. She noted that nearly a quarter of Alaska residents participate in some form of Medicaid or have a family member who does. She emphasized that the difficulty of accessing behavioral health care is affecting families, communities, and schools across the state.

[3:33:01 PM](#)

SENATOR TOBIN joined the meeting.

[3:33:29 PM](#)

MS. WIGGIN paraphrased the sectional analysis for SB 45:

[Original punctuation provided.]

SECTIONAL ANALYSIS
SB 45: MEDICAID MENTAL HEALTH PARITY

Section 1: The state must provide equal coverage and access to treatment for behavioral health issues as for other medical conditions. This is a new subsection (i) to the state statute that governs services provided to Medicaid recipients (AS 47.7.030). The new subsection says the department of health must follow federal behavioral health parity statutes, which are listed in the bill.

Section 2: The commissioner of health will comply with relevant parts of the federal behavioral health law, and investigating complaints about behavioral health coverage and checking on possible unequal coverage including:

1. Reviewing state Medicaid regulations to ensure they don't cause unequal coverage of behavioral healthcare. Examples of potential regulations are listed.
2. Comparing how Medicaid coverage works for behavioral health coverage versus physical health coverage. This is a new section to State Medicaid statute (AS 47.07). The new section is 47.07.033 Parity in mental health and substance use disorder benefits.

Section 3: Creates a new reporting requirement for behavioral health and mental health parity. It instructs the Department to send a report by March 1 each year to the legislature. The report will:

1. Describe their process for what "medical necessity" means for both physical and behavioral health coverage.
2. List the rules limiting behavioral healthcare and physical healthcare, numerical or nonnumerical.

3. Decide whether the criteria, numerical and non-numerical, for behavioral health are comparable to physical health benefits, and if they are applied equally. This includes:
 - a. Decisions behind treatment limitations, including limitations that were rejected.
 - b. Evidence used to choose treatment limitations.
 - c. Comparisons between physical and behavioral health care showing that in practice the treatment limitations are evenly applied.
 - d. Share findings that indicate whether the state Medicaid system is compliant with federal parity laws.

This is a new subsection (d) to the section of state statute on reports that the Department of Health must periodically give to the legislature (AS 47.07.076)

Section 4: requires the Commissioner of Health to submit a one-time report to the legislature by March 1, 2026. The report must: 1. Explain the methodology used to evaluate if Alaska's Medicaid program complies with federal behavioral health parity law. 2. Summarize market review conducted for parity compliance. 3. Describe any steps taken to fix issues or provide education to improve compliance. 4. Be written in non-technical, plain language. 5. Be made publicly available online. This is a new section in the uncodified law.

Section 5: requires the Department of Health to submit any necessary amendments to the federal government for approval to update Alaska's Medicaid program to comply with federal behavioral health parity requirements. This is a new section in the uncodified law.

Section 6: This section specifies that Sections 1 through 4 will only take effect if the federal Department of Health and Human Services approves the state's Medicaid plan amendments by December 31, 2025. The Commissioner of Health must notify the revisor of statutes within 30 days of receiving federal approval.

Section 7: If the federal government approves the Medicaid plan amendments, Sections 1 through 4 will

take effect the day after the federal Department of Health and Human Services grants approval.

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CHAIR DUNBAR [opened invited testimony on SB 45.]

[3:36:23 PM](#)

LANCE JOHNSON, Chief Operating Officer, Alaska Behavioral Health Association, Eagle River, Alaska, testified by invitation on SB 45. He introduced himself.

[3:36:45 PM](#)

At ease.

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CHAIR DUNBAR reconvened the meeting on SB 45.

[3:38:09 PM](#)

MR. JOHNSON said that over the last couple of years, the [legislature] has discussed parity, and he expressed appreciation for the opportunity to revisit the issue. He noted that several individuals were on the phone to offer testimony, including Dustin Larna, who was expected to join the conference call. He also introduced John Solomon, CEO of the Alaska Behavioral Health Association. For the record, he clarified that although he was introduced as the Vice President of the association, he is actually the Chief Operating Officer (COO). He then invited John Solomon to introduce himself.

[3:38:54 PM](#)

JOHN SOLOMON, Chief Executive Officer, Alaska Behavioral Health Association, Eagle River, Alaska, testified by invitation on SB 45. He provided background on the Alaska Behavioral Health Association, stating that the organization represents approximately 109 member organizations across the state, most of which are direct service providers and primarily involved with Medicaid. He shared that he is a licensed professional counselor and previously worked as a quality assurance supervisor, training clinicians on regulations, and later served as Director of Behavioral Health at Maniilaq in Kotzebue. He added that he is also a person in long-term recovery, giving him a broad and varied perspective on behavioral health. He said the presentation would take a basic look at what parity is and is not.

[3:40:45 PM](#)

MR. SOLOMON moved to slide 2, What is Parity, and shared that parity ensures that behavioral health treatment has the same access and coverage as medical and surgical treatments. He said parity becomes more complex because behavioral health services occur in various settings, including hospitals, Federally Qualified Health Centers (FQHCs), and community behavioral health settings. He explained that the legislation specifically focuses on behavioral health services delivered in community settings.

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MR. SOLOMON moved to slide 3, What It Isn't, and explained that parity legislation does not limit the state's ability to regulate or manage the Medicaid program. Instead, it asks the state to analyze how it manages behavioral health services compared to how it manages medical services within Medicaid. He emphasized that the legislation does not remove oversight, accreditation standards, or change clinical practices. Any changes to work processes would aim to align standards and improve consistency. He stated that the primary goal is to help the state identify and remove barriers to care through this analysis.

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MR. SOLOMON moved to slide 4, What Do We Mean by Barriers, and said that many barriers to care in community behavioral health stem from outdated regulations rooted in the earlier model of grant-based care. Before behavioral health services could be billed to Medicaid, care was guided by prescriptive grant language that has not kept up with the shift to evidence-based, clinically driven treatment. He noted that required paperwork, oversight, and documentation standards often do not align with current clinical practices or decision-making in behavioral health.

MR. SOLOMON referred to a concept in parity legislation called non-quantitative treatment limitations—restrictions that are not based on a set number of services but instead include administrative or regulatory hurdles. He explained that these limitations often make it more difficult to access community behavioral health care compared to community health care. At a high level, he said, this stems from lingering stigma that requires behavioral health providers to justify their decisions more rigorously than other health professionals.

MR. SOLOMON emphasized that the goal is not to abandon clinical best practices but to better align regulations with actual

clinical practice, provider scope, and licensure requirements. He noted that Alaska has been flagged in a federal "warning signs" document for specific Medicaid practices and said the aim of the legislation is to give the state the ability to develop tools, regulate appropriately, and report back to the legislature on its progress.

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MR. SOLOMON moved to slide 6, Physical Health, and said he did not want to overly simplify the issue but wanted to illustrate how current regulations affect a client walking in the door for behavioral health services. He explained that in a typical physical health setting, such as a community health center or Federally Qualified Health Center (FQHC), a patient can often receive multiple services in a single visit. For example, if someone arrives with a hurt elbow, they can complete an intake, receive a brief assessment, potentially receive immediate treatment, and begin developing a plan for ongoing care—all in one appointment. In contrast, at a community behavioral health center—sometimes located just across the street or in the same building—the process is far more rigid due to existing regulations. Clients must first complete an intake and screening, followed by a full biopsychosocial assessment. That assessment informs the treatment plan, which is a 90-day plan and includes specific signature requirements depending on whether the client is a minor or an adult. This may involve obtaining signatures from guardians or school personnel. He emphasized that only after completing all these steps is a client finally able to begin receiving treatment. He said it often takes four appointments to get to treatment.

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MR. SOLOMON moved to slide 6, Behavioral Health - Community Behavioral Health Centers, and said he did not want to overly simplify the issue but wanted to illustrate how current regulations affect a client walking in the door for behavioral health services. He explained that in a typical physical health setting, such as a community health center or Federally Qualified Health Center (FQHC), a patient can often receive multiple services in a single visit. For example, if someone arrives with a hurt elbow, they can complete an intake, receive a brief assessment, potentially receive immediate treatment, and begin developing a plan for ongoing care—all in one appointment. In contrast, at a community behavioral health center—sometimes located just across the street or in the same building—the process is far more rigid due to existing regulations. Clients must first complete an intake and screening, followed by a full

biopsychosocial assessment. That assessment informs the treatment plan, which is a 90-day plan and includes specific signature requirements depending on whether the client is a minor or an adult. This may involve obtaining signatures from guardians or school personnel. He emphasized that only after completing all these steps is a client finally able to begin receiving treatment.

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MR. JOHNSON illustrated the contrast between physical and behavioral health care by stating that, for many people, it is easier to go to the emergency room to receive help because accessing behavioral health services is too difficult due to regulatory barriers. He shared a real-world example from his 11 and a half years as Behavioral Health Services Director at an agency in Nome. During that time, a psychiatrist working on the community behavioral health side was subject to the same documentation requirements as a master's level clinician—and in some cases, a behavioral health aide—due to regulatory standards. To improve access the psychiatrist was moved to the medical side of the clinic, where patients could be seen almost immediately and where documentation requirements were significantly less burdensome. This shift allowed more people to access care efficiently compared to the heavily regulated community behavioral health side.

MR. JOHNSON also shared his personal experience with depression and anxiety. He noted that he sees a psychiatrist on the medical side for medication management, bypassing community behavioral health services because of the very barriers he described. However, he acknowledged that this setup limits access to the talk therapy he needs, which is only available on the behavioral health side. This results in two different providers operating under two different systems, creating a confusing and difficult experience for clients trying to navigate care.

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MR. JOHNSON moved to slide 6, Behind the Scenes, and discussed the challenges behavioral health providers face on the administrative side, particularly around Medicaid enrollment. He stated that enrolling in Medicaid for community behavioral health services is a convoluted process involving numerous hoops and various provider types that must be considered. He contrasted this with the medical and surgical side, where claims adjudication is often more straightforward. He explained that for behavioral health services, especially in agencies offering

both medical and behavioral care, the systems are so different that it becomes burdensome to operate under both.

MR. JOHNSON noted that because of the documentation demands, he could not allocate too much of the clinicians' time to administrative work. To manage the state's required data entry, he had to hire three full-time administrative staff, which meant reducing clinical resources. This need to balance documentation standards with client care created significant operational strain. He further explained that providers operating as both a Federally Qualified Health Center (FQHC) and a community behavioral health services provider must navigate two distinct systems of care. In addition to Medicaid complexity, he cited other behind-the-scenes challenges, such as state reporting requirements and mandatory accreditation for behavioral health providers—an unfunded mandate that can be both time-consuming and costly.

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MR. JOHNSON shared that during his last accreditation survey in Nome, he worked 31 consecutive days to prepare, noting that the process was even more complicated due to COVID-19. While he acknowledged that accreditation strengthened the organization and is valuable, he emphasized that it adds another layer of difficulty to delivering clinical services effectively.

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MR. JOHNSON moved to slides 8-10, Matrix of Non-Quantitative Treatment Limitations (AKA - Admin Burden), and explained that the red column represents the regulatory and documentation requirements for community behavioral health services, while the green columns represent requirements for Federally Qualified Health Centers (FQHCs) and health professional groups (HPGs). He noted that although this comparison was created before the state's transition to Optum as the Medicaid managed care contractor, much of the information remains accurate.

MR. JOHNSON emphasized the significant disparity in regulatory burden, pointing out that the red column is noticeably longer than the green columns, illustrating the greater number of requirements imposed on community behavioral health providers. He stated that behavioral health providers must review approximately 117 pages of service manuals for 1115 Medicaid waiver services, along with the corresponding regulations, to ensure compliance with both implementation guidelines and documentation standards. In contrast, he explained that the medical and surgical side operates under a far simpler set of

documentation rules. For example, regulation 7 AAC 105.230, which applies to medical providers, is only about a page and a half long. While behavioral health providers can also follow that regulation, they are additionally subject to a more complex set of rules under Chapter 135, which outlines further documentation obligations.

MR. JOHNSON concluded by saying that this layered and compounded regulatory structure creates administrative burdens that serve as barriers to care, diverting time and resources away from clinical service delivery.

[3:53:47 PM](#)

MR. JOHNSON moved to slide 11, Ensuring Access, Why Now, and said that the federal Mental Health Parity and Addiction Equity Act of 2008 outlined several standards meant to eliminate barriers to behavioral health care, particularly through what are called non-quantitative treatment limitations. He noted that Mr. Solomon had previously mentioned this concept, which includes practices like time-based treatment plans and service authorizations—both of which the law discourages because they do not enhance care and often act as access barriers.

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MR. JOHNSON explained that service authorizations are not clinically necessary and do not provide clinical value; they are mainly used to check for fraud or waste. He commended the state for removing the requirement for service authorizations during COVID and praised the Division for continuing to limit them for most services. Time-based treatment plans, he said, also lack clinical relevance. While treatment plans themselves are important—similar to care plans on the medical side—mandating them at fixed intervals (e.g., every 90 days) does not align with clinical needs. He noted that many providers update treatment plans at each visit anyway, but under regulation, they are forced to meet rigid timeframes. If a client cannot return in time—for example, due to being away for subsistence activities—the provider may miss the window, resulting in the inability to bill for services provided, which ultimately reduces care availability.

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MR. JOHNSON emphasized that Alaska is not pioneering these efforts; other fee-for-service states like Wyoming, New Mexico, and Maine have already aligned their Medicaid systems with the federal parity law. He pointed out that while Alaska is not federally required to comply due to its payment structure, it

can choose to align its Medicaid regulations with the federal parity standards. He explained that this effort builds on momentum from last year, when a parity resolution passed encouraging the state to pursue parity reforms. The reason for introducing a bill now, he said, is twofold. First, the Alaska Behavioral Health Association has a strong working relationship with the Department of Health and the Division of Behavioral Health, and both sides acknowledge the need for change after 25 to 30 years of stagnation. Second, he stressed the importance of codifying progress in legislation so that it outlasts individual administrators and political transitions, preventing the loss of progress if leadership changes. He said the legislation ensures the work continues even after those currently serving have moved on, supporting long-term structural reform in Alaska's behavioral health system.

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MR. JOHNSON moved to slide 12, Real World Outcomes, Efficient Accessible the Alaska Solution, and said that in the long run, achieving parity and improving access to services would reduce administrative burdens and decrease reliance on emergency rooms, which are costly and not well-suited to addressing many behavioral health issues. He highlighted the impact on the correctional system, citing data from the Norton Sound region. Three years ago, 95 percent of individuals entering Anvil Mountain Correctional Center were incarcerated for substance-related violations—a figure based on data, not anecdote.

MR. JOHNSON noted the facility cost \$141 per day per bed, with 128 beds, totaling \$6.6 million in annual costs. At 95 percent, roughly \$6.3 million of that amount was spent on individuals who were not receiving the treatment they needed. He emphasized that people struggling with substance use often have only a narrow window of willingness to enter treatment, and delays can cause that opportunity to be lost. He concluded by stating that if people are diverted into treatment sooner, significant resources across the system could be freed up.

[3:59:13 PM](#)

MR. SOLOMON moved to slide 13, Components of Parity Legislation, said SB 45 allows the state to ensure compliance with standards and to make decisions based on medical necessity and appropriate oversight as it relates to medical care. He stated that this is the goal of the legislation. He expressed appreciation to the sponsor for bringing the bill forward and offered to answer any questions.

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CHAIR DUNBAR stated that the ultimate goal of SB 45 is simple but the implementation is challenging.

[4:00:49 PM](#)

CHRIS CONSTANT, Chair, Anchorage Assembly, Anchorage, Alaska, testified by invitation on SB 45. He introduced himself stating his extensive experience with behavioral health care in Alaska, including Akeela. He stated that Akeela has been providing care for the past 50 years and clarified for the record that while he is speaking on behalf of the Assembly, he would be referencing his professional experience with Akeela.

MR. CONSTANT expressed strong support for SB 45, stating that it would ensure mental health and substance use disorder benefits under Medicaid are treated with the same fairness as physical health benefits. He illustrated the real-world impact by describing Akeela's Stepping Stones program for pregnant and parenting women with young children, where mothers can remain with their children during residential treatment. Historically, treatment in this program could last six to eighteen months. However, under the managed care model, participants are limited to 90-day service authorizations, which he argued is insufficient for stabilization, treatment, and lasting recovery.

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MR. CONSTANT described the extensive intake process mothers must complete and emphasized the difficulty of expecting them, especially those dealing with opioid addiction, to achieve lasting change within 90 days. He said this harms not just the mother, but also the child and the community. He praised the 1115 Medicaid waiver for expanding provider participation and increasing access to services but noted that the waiver alone does not guarantee equitable treatment across physical and behavioral health care. SB 45, he argued, is a necessary next step in creating a truly comprehensive and equitable behavioral health system.

MR. CONSTANT noted that SB 45 would help eliminate discriminatory barriers and ensure that behavioral health care receives the same priority as physical health care. It would improve mental health outcomes across the state by increasing access and reducing the number of people turned away. He pointed out that in Anchorage, the most common "waiting room" for behavioral health services—besides jails—is the streets and parks, underscoring the urgency of the crisis.

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MR. CONSTANT recalled his early career experience during the 2015 "summer of spice," when people were cycling between shelters and hospitals multiple times a day, and drew parallels to the underinvestment in community-based supports that followed the construction of the Alaska Psychiatric Institute (API). While the hospital was successfully established, he said, the promised expansion of community support services never fully materialized. He stated that SB 45, combined with the 1115 waiver, brings the state closer to fulfilling that promise.

MR. CONSTANT emphasized the importance of reducing stigma, explaining that the complexity of accessing services—such as requiring four appointments just to begin treatment—can be overwhelming, especially for those new to the system. He cited Akeela's recent effort to offer "after-hours assessments" through opioid mitigation funding as an example of trying to meet people where they are, noting that no other provider currently offers assessments after 5 p.m. or on weekends.

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MR. CONSTANT said SB 45 would also benefit providers by streamlining oversight and compliance, reducing burdensome administrative requirements, and preventing situations like those under the Xerox billing system, when Akeela had to take out a \$1 million line of credit to stay operational. He noted that aligning behavioral health regulations with those governing physical health care would improve efficiency and accountability.

MR. CONSTANT added that SB 45 would also help grow Alaska's behavioral health workforce by reducing the administrative burden that drives away clinical professionals. He explained that current staffing challenges are not about lacking physical space or beds, but about lacking professionals to operate them. He spoke to the bill's benefits for local governments, saying untreated behavioral health needs place significant strain on public systems, including emergency response, shelters, and jails. SB 45, by ensuring timely access to treatment, would help reduce those pressures and generate long-term cost savings.

MR. CONSTANT concluded by saying the bill would position Alaska to align with federal parity laws, potentially increasing federal funding and improving transparency in how Medicaid dollars are spent. He urged the passage of SB 45, noting that while there may be differences between the administration and legislature, collaboration and thoughtful review of the regulations can improve the outcome. He stated that the SB 45

will make Alaska's streets safer and improve quality of life for all residents.

[4:13:11 PM](#)

DUSTIN LARNA, Chief Executive Officer, Residential Youth Care, Ketchikan, Alaska, testified by invitation on SB 45. He voiced clear support for SB 45 and shared his background in providing children's behavioral health services in Ketchikan for over 20 years, working with youth and families from across Alaska. He noted his experience with multiple administrations and initiatives, such as Bring the Kids Home, aimed at improving behavioral health care. He stated his belief that SB 45 has the potential to make a greater impact on behavioral health access and services than anything he has previously been involved in.

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MR. LARNA emphasized the importance of evaluating parity, describing current regulations as outdated and rooted in a time when mental health and substance use services were stigmatized and often viewed as ineffective. He said many of these rules were developed during an era when people were reluctant to seek help and mental health was not part of an open public conversation. While incremental updates have been made, he argued that the current approach has not been effective in producing meaningful change.

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MR. LARNA stated that SB 45 presents an opportunity to reexamine the foundational regulations, asking whether certain rules actually contribute to the delivery of quality care. This would help uncover non-quantitative treatment limitations that hinder access and effectiveness. He provided an example from his experience: the extensive documentation requirements for providing behavioral health services to youth and families. He explained that these burdensome requirements significantly increase costs, discourage providers from accepting Medicaid, and in some cases, reduce service quality.

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MR. LARNA focused in particular on treatment plans, calling them a long-standing concern. He explained that current Medicaid rules require treatment plans to include detailed information—such as every specific service to be provided, the number of units, and billing codes—often resulting in documents up to 15 pages long. He said such plans are not meaningful to youth and families, who are asked to sign off on them, and that the

documents primarily serve as compliance tools for audits rather than communication tools for care.

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MR. LARNA further pointed to the low number of private practice behavioral health providers who accept Medicaid in Alaska—reportedly just eight out of more than 300 licensed providers. He called this alarming, particularly given the known shortage of behavioral health services in the state. He attributed the lack of Medicaid participation to low reimbursement rates and administrative burdens, including enrollment and billing processes. He concluded by saying this disconnect in the system reflects serious structural problems that SB 45 seeks to address.

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SENATOR GIESSEL said she would like to verify the last statistic that was mentioned.

[4:20:25 PM](#)

TRACY DOMPELING, Director, Division of Behavioral Health, Department of Health, Juneau, Alaska, answered questions on SB 45. She said she was unsure of the accuracy of the specific statistic mentioned but stated that her office could provide the committee with the number of behavioral health providers currently operating in Alaska. She acknowledged that Medicaid reimbursement rates are indeed lower than what most private organizations receive for comparable services, and that this is a barrier to provider participation. She added that simply being a Medicaid provider exposes individuals and organizations to potential audits, and noted that providers face the risk of having funds "clawed back" if inaccuracies are later found in claims. These challenges, she stated, are particularly difficult for private providers, though not unique to Alaska.

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SENATOR GIESSEL said the state is undergoing [Medicaid] rebasing and asked how close the process is to completion and when the new fee and reimbursement schedules will be established.

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MS. DOMPELING said that within the next month or two, the department expects to have updated numbers available for behavioral health, which can then be shared with providers and reviewed internally. She noted that the original goal was to have those numbers ready before the legislative session began. However, feedback from the Alaska Behavioral Health Association

indicated that the surveys and other data collection tools sent to providers were lengthy and detailed, and providers faced competing priorities at the time. Because of this, providers requested additional time to complete the information. She explained that although the department had hoped to use that data earlier to build momentum during the session, it ultimately chose to prioritize supporting providers and ensuring the collection of comprehensive information for the rate methodology review.

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SENATOR GIESSEL asked if the [Department of Health] said it could provide the committee with the number of available clinicians.

MS. DOMPELING replied she could share with the committee the number of behavioral health Medicaid providers currently enrolled.

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SENATOR GIESSEL asked whether it would be possible to provide the number of behavioral health providers broken down by category, such as clinical counselors, social workers, and advanced practitioners.

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MS. DOMPELING responded yes, and noted that the breakdown could likely go even further due to the structure of the 1115 demonstration waiver. She explained that in addition to clinical counselors, social workers, and advanced practitioners, the provider categories also include behavioral health clinical associates and individuals certified and enrolled as peer support specialists. She confirmed that the department can provide a detailed breakdown across these categories.

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MR. LARNA said the current administration has been supportive but emphasized the importance of moving forward with the legislation. He stated that SB 45 provides a necessary framework to ensure the effort continues beyond the current administration and through future leadership transitions.

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SENATOR HUGHES said the topic is both compelling and timely but expressed concern that the issue has been left unaddressed for so long, noting that federal parity laws have been in place for 17 years. She found it striking that the state is only now

confronting noncompliance and acknowledged that there are systemic problems with reimbursement and processing. She mentioned hearing from the medical side earlier in the day about unresolved reimbursement issues dating back to 2022 and emphasized that, while this legislation is not a cure-all, it is a necessary step—especially given the urgency of youth behavioral health needs.

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SENATOR HUGHES acknowledged and appreciated the sponsor's efforts but pointed out that SB 45 essentially directs compliance with a federal law that has already been in effect for nearly two decades. She summarized the bill's requirements as mandating a one-time report, followed by annual reports, with reviews of existing regulations and the need to seek changes through the state Medicaid plan. She asked the director whether this bill is truly necessary to solve the problem or whether the department could have—and should have—been making these adjustments over the past 17 years.

SENATOR HUGHES also raised concerns about the fiscal note, which includes an annual cost of approximately \$325,000 to support assessments and reporting. She questioned whether this amount would be sufficient in the first year, given that the one-time report also includes a more comprehensive market analysis. She asked whether additional resources might be required initially, since the first report involves more work than the annual reports that follow.

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MS. DOMPELING responded that the key question is whether the legislation is necessary to do the work, and she acknowledged that, technically, it is not. However, she said she understands the concerns raised by providers—namely, that while she, Commissioner Hedberg, and Deputy Commissioner Ricci are all currently committed to this issue, leadership could look very different in two years. For that reason, she recognized the desire to codify the Department's obligation to evaluate parity through statute. She explained that part of the complexity lies in the federal parity regulations being based on a Medicaid managed care organization structure, whereas Alaska operates under a fee-for-service Medicaid model. This creates challenges in applying the federal parity framework directly, especially when attempting to go line by line, since not all elements are comparable between the two systems. She said the chair has asked the Department to work closely with the Alaska Behavioral Health Association to identify priorities and to thoroughly review the

regulations. The goal is to pinpoint areas where amendments could strengthen and formalize the state's commitment to continuing this work, both now and in the future.

[4:28:38 PM](#)

SENATOR HUGHES asked whether the \$325,000 allocated for the annual reports is sufficient to cover the additional work required for the one-time report.

MS. DOMPELING said that at this point, the department does consider the current funding sufficient. She explained that they reached out to two contractors who assist with Medicaid-related activities—one provided a lower estimate and the other a higher one, so the department used a mid-range figure for the fiscal note. She stated that, based on her understanding of the SB 45, the report in question is a one-time report. For that reason, she believes the funding is adequate for a full, in-depth review. However, if the reporting is intended to continue in future years, she noted that the amount may need to be updated.

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SENATOR DUNBAR held SB 45 in committee.

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At ease

SB 44-MINORS & PSYCHIATRIC HOSPITALS

[4:30:52 PM](#)

CHAIR DUNBAR reconvened the meeting and announced the consideration of SENATE BILL NO. 44 "An Act relating to the rights of minors undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date."

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SENATOR MATT CLAMAN speaking as sponsor of SB 44 stated that in 2022, the United States Department of Justice (DOJ) investigated Alaska's behavioral health care system for youth and found an overreliance on institutionalization to treat minors with behavioral health disabilities. In response to the DOJ's findings, the Department of Health launched the Behavioral Health Roadmap project for Alaska youth in the fall of 2023. He acknowledged and appreciated the efforts made by the department,

behavioral health providers, and stakeholders who contributed to regional meetings and the drafting of the report. He expressed hope that through continued collaboration, meaningful progress could be made to provide care for Alaska's youth in the most appropriate settings along a full continuum of care.

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SENATOR CLAMAN emphasized the urgent need for transparency and increased parent or guardian involvement at psychiatric hospitals that serve Alaskan youth with behavioral health needs. He explained that Senate Bill 44 aims to enhance and protect the rights of these young patients and outlined its four main objectives. First, the bill ensures youth patients have access to at least one hour of communication with a parent or legal guardian each week. Second, it requires the Department of Health to conduct biannual, unannounced inspections of facilities providing residential psychiatric treatment for youth, during which 50 percent of all youth patients must be interviewed about their experiences. Third, the bill mandates that any use of seclusion or restraint on a youth patient must be reported within 24 hours to both the Department of Health and the patient's parent or guardian. Fourth, it enhances transparency by requiring the Department of Health to publish an annual report on minors in psychiatric hospitals and make it publicly accessible.

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BREANNA KAKARUK, Staff, Senator Matt Claman, Alaska State Legislature, Juneau, Alaska, provided the sectional analysis for SB 44:

[Original punctuation provided.]

Senate Bill 44
Sectional Analysis – Version A

Section 1

AS 47.30.840 Right to privacy and personal possessions; other rights. Adds a new section to ensure a minor undergoing evaluation or inpatient treatment at a psychiatric hospital has the right, unless otherwise prohibited by law or court order, to have confidential video communication at least once each week for at least one hour with the minor's parent or legal guardian, which will be facilitated by the psychiatric hospital.

Section 2

AS 47.32.030 Powers of the Department of Health and the Department of Family and Community Services; delegation to municipality. Adds a new subsection (e) and (f). Subsection (e) requires the Department of Health to prepare an annual report regarding minors in psychiatric hospitals, to publish the report on the department's website, submit to the Senate Secretary and Chief Clerk of the House of Representative, and notify the Legislature of its availability. Subsection (f) requires the Department of Family and Community Services to collect data on minors who receive residential psychiatric care at psychiatric hospitals and to submit it to Department of Health for their report.

Section 3

AS 47.32.110 Right of access and inspection. Amends subsection (c) to authorize the officer or employee of a department with licensing authority to enter for any purposes described in new subsection (d).

Section 4

AS 47.32.110 Right of access and inspection. Adds a new subsection (d) to require a designated agent or employee of the Department of Health to conduct, at least twice a year, unannounced inspections of each psychiatric hospital where minors undergo evaluation or inpatient treatment in which a minor has spent more than three nights in the preceding year. At these inspections, the designated agent or employee must interview at least 50 percent of the patients.

Section 5

AS 47.32.200 Notice required of entities. Adds a new subsection (g) to require a psychiatric hospital to send written notification of each use of seclusion or restraint on a minor, including the use of a chemical, mechanical, or physical restraint, to the Department of Health and the minor's parent or guardian within one business day after the use of seclusion or restraint.

Section 6

Sets the effective date of July 1, 2025

[4:36:00 PM](#)

SENATOR TOBIN asked a question regarding the definition of "physician" in SB 44, page 2, line 1, which mentions the overseeing physician. She said she was unclear whether this definition includes clinical psychologists or advanced nurse practitioners with psychiatric training who may be responsible for overseeing care in these facilities. She asked whether the definition is inclusive of those professionals who might also be involved in monitoring the treatment of youth patients.

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SENATOR CLAMAN asked for clarification of the question. He stated the question asked is not specifically about the definition of "physician" itself, but rather about the meaning of the term "overseeing physician" as modified by the word "overseeing." He sought to confirm whether the question was focused on that modifier and its implications for who qualifies as overseeing care.

SENATOR TOBIN clarified her question by referencing the phrase "approved by the overseeing physician" in SB 44. She asked what is meant by "overseeing physician" and what the definition includes. She wanted to know whether it is inclusive of all professionals who might be identified as overseeing care in treatment facilities, such as a clinical psychologist who may be responsible for treatment oversight. She noted that such individuals are not necessarily licensed under the State Medical Board but may instead be licensed under the State Board of Psychologists and Psychological Associate Examiners. She asked whether those individuals are included in the definition.

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SENATOR CLAMAN responded that this may be an area where further discussion is needed. He explained that, as currently drafted, the term "overseeing physician" in the bill likely refers to the physician in charge of medical care at the facility level, rather than the individual overseeing the care of a specific patient. For example, at the Alaska Psychiatric Hospital—one of the facilities to which this legislation would apply—the overseeing medical professional has historically been a physician. He clarified that while clinical psychologists or other providers may be responsible for direct care of individual patients, the bill appears to require that any decision to restrict a youth's communication with their parent would need to be approved by the physician overseeing the facility's operations, not just the provider managing day-to-day care. He added that if there is interest from the committee in allowing a mid-level clinical provider who supervises a specific patient's

care to make that determination, it would be a reasonable consideration. However, as drafted, the bill assigns that authority to the physician in charge of the facility.

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SENATOR TOBIN explained that she raised the question because SB 44, page 1, line 11, the language states that the "overseeing physician" may determine whether communication with a parent is "therapeutically unadvisable." In her interpretation, that decision would likely come from someone directly overseeing the child's care—someone with firsthand insight into the therapeutic needs of the patient. She noted that this person might not necessarily hold an MD degree but could hold another other degrees.

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SENATOR GIESSEL noted that about four or five years ago, the state expanded the types of clinicians authorized to provide care in psychiatric hospitals to include physician assistants and advanced nurse practitioners. She suggested reviewing the definition of "physician" in SB 44, and if the intent is to limit it to physicians only, an amendment could be offered.

SENATOR CLAMAN stated that he would look into the definition issue further. He emphasized that while he is not committed to requiring approval from the physician overseeing the entire facility, he supports having a higher-level sign-off when a treatment provider deems parental contact therapeutically inadvisable. He noted this would serve as a check and balance, ensuring such decisions are not made routinely or without thorough consideration.

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SENATOR HUGHES questioned the rationale for limiting youth communication with parents or guardians to no more than four occasions per week in SB 44. She asked whether this restriction would prevent more frequent contact, such as daily video communication, if recommended by the supervising provider. She sought clarification on the intent behind the statutory limit.

SENATOR CLAMAN clarified that the language in SB 44 sets a minimum standard for youth communication with parents or guardians, not a maximum. He stated that care providers could allow more frequent contact if appropriate. The intention is to ensure that youth receive at least the minimum required contact.

SENATOR HUGHES said she understands that the one-hour requirement is intended as a minimum but expressed concern that the phrase "over not more than four occasions" imposes a limit. She questioned whether this language would prevent a clinician from allowing more frequent contact, such as daily communication. She suggested that the limiting phrase be removed to avoid unintended restrictions.

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SENATOR DUNBAR said he may be misinterpreting the language, but noted that on line 10 the SB 44 grants the minor "the right," which he interpreted as a minimum or floor. He stated that, as written, the bill gives the minor the right to at least one hour or four occasions but does not prevent the facility from allowing more contact. He asked if Senator Claman has the same interpretation.

SENATOR CLAMAN replied he was in exact agreement but acknowledged it was worth further discussion offline. He stated that everyone seemed aligned on the intent. He agreed with Senator Hughes that the language should not imply a maximum number of visits or establish a ceiling for communication allowed by the facility.

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SENATOR HUGHES asked about the practicality of the requirement in Section Four, page three, for unannounced inspectors from the Department of Health to interview at least 50 percent of minor patients. She noted the value of the information that could be gathered but questioned whether some youth, particularly those who are severely traumatized, would be in a condition to participate in interviews. She asked if providers had been consulted and whether meeting this requirement would be reasonable.

SENATOR CLAMAN said that in developing the SB 44 similar laws in other states were reviewed and providers were consulted. He stated that interviewing 50 percent of current patients appears reasonable, emphasizing that the requirement applies only to those in the facility and not those in the facility over the course of the year. He noted it is unlikely that a majority of youth in a facility would be in such an acute psychiatric state that they could not communicate at all. He acknowledged that some may have communication challenges but said it is rare for 50 percent to be entirely unable to participate.

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SENATOR HUGHES said it would be helpful to hear from someone with direct experience working in a psychiatric hospital on the practicality of interviewing patients. She referred to Section 5 and noted the sponsor's statement cited 261 incidents of restraint within three months, which she described as startling. She acknowledged the concern families may have and the importance of ensuring restraints are only used when appropriate. She asked whether current procedures require video documentation during such incidents, whether parents have a right to view that footage, and whether video access could help confirm that restraints were used appropriately and not abusively.

SENATOR CLAMAN said further research is needed to determine the current use of video monitoring during restraints. He noted that in psychiatric treatment environments, constant camera surveillance could pose clinical concerns, particularly for patients experiencing paranoia. He acknowledged the potential complications and stated interest in hearing directly from providers on the issue. He agreed to follow up with more information.

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SENATOR TOBIN referenced earlier testimony related to the Indian Child Welfare Act (ICWA) and tribal children in psychiatric systems. She highlighted language in SB 44 on page two, line one, regarding "other adults" and asked whether the bill ensures that, in cases involving unaccompanied minors who are tribal members, a tribal representative or designated tribal authority would have access to the child. She requested clarification on whether ICWA responsibilities are reflected in the bill.

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SENATOR CLAMAN expressed willingness to talk more about the concern.

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CHAIR DUNBAR announced invited testimony on SB 44.

[4:49:12 PM](#)

AMANDA METIVIER, Co-founder, Facing Foster Care in Alaska, Anchorage, Alaska, testified by invitation on SB 44. She stated that Facing Foster Care in Alaska, a youth-led nonprofit, supports SB 44 and that the bill addresses long-standing issues faced by minors in residential psychiatric treatment. She explained that many foster youth, particularly Alaska Native and American Indian children under the Indian Child Welfare Act

(ICWA), are impacted by psychiatric placement, often far from their communities and with limited external communication. She emphasized that access to phone contact can be restricted as punishment or incentive, and that chemical and physical restraints, including sedation, are commonly reported.

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MS. METIVIER supported SB 44's transparency measures—including inspection requirements and communication rights—as a critical step toward reform and urged the committee to pass the bill.

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CAROLINE BROWN, representing self, Fairbanks, Alaska, testified by invitation on SB 44. She expressed strong support for SB 44 and shared her personal experience as a foster and adoptive parent of a child with significant behavioral health needs. She described the challenges of navigating psychiatric care, including residential treatment, and emphasized the critical role of regular communication between children and their families during hospitalization. She noted that while her family has generally maintained contact with their son, this access often required intense advocacy, which not all families can provide. She highlighted the bill's provision for timely notification of seclusion or restraint, underscoring how important it is for parents to be informed in order to help their children process those experiences.

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SENATOR DUNBAR concluded invited testimony on SB 44 and [held SB 44 in committee.]

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There being no further business to come before the committee, Chair Dunbar adjourned the Senate Health and Social Services Standing Committee meeting at 4:59 p.m.