SB

97

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SB 97

Revision Date:
Dept. Affected: Health and Social Services
Title: Mental Health Evaluation and Treatment and confidential mental health records
BRU: Community Mental Health Grants
Component: Designated Evaluation and Treatment
Sponsor: Senator Pete Kelly
COMPONENT SERIAL NO. 1014
Requestor: (Senate) HESS
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY00	FY01	FY02	FY03	FY04	FY05
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL		150.0	150.0	150.0	150.0	150.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,544.7	2,641.7	2,641.7	2,641.7	2,641.7
MISCELLANEOUS						
TOTAL OPERATING	0.0	1,694.7	2,791.7	2,791.7	2,791.7	2,791.7
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		1,544.7				
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health		150.0	2,791.7	2,791.7	2,791.7	2,791.7
Other (please specify)						
TOTAL	0.0	1,694.7	2,791.7	2,791.7	2,791.7	2,791.7

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY99) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

Fiscal Assumptions:
SB 97 serves two functions: It clarifies the client eligibility for Designated Evaluation and Treatment (DET) Services and establishes procedures for determining that eligibility, processing applications, and paying claims; it also creates an entitlement to those services for eligible clients.

These clarifications are necessary due to a current lawsuit related to these services and due to the downsizing of the Alaska Psychiatric Institute (API). The plaintiff in the current litigation requests that the court interpret current statutes to mean that the department must determine every patient's ability to pay; and, that if it is detrimental to the patient's rehabilitation, the department has to relieve the patient of their obligation to pay. If the court agreed with this interpretation, the department would pay for a far greater number of people than are currently eligible for this program. Additionally, the downsizing of API will require that these services be provided in Anchorage beyond those currently provided in other communities throughout Alaska. This necessary expansion will require explicit eligibility and payment procedures to maintain consistent administration of the program.

3/12/99

Prepared by: Leonard Abel,Ph.D./Gina Macdonald
Phone: 907-465-3370
Division: Mental Health and DD
Date: 03/12/99

Approved by Commissioner: Karen Perdue, Commissioner
Date: 3/15/99
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

As stated above, current plans to downsize API require that private hospitals in Anchorage provide some inpatient psychiatric services through the Designated Evaluation and Treatment program. This results in impending additional costs regardless of legislation. The lawsuit also has implications for undetermined costs as eligibility for the program could be determined (and possibly expanded) through the courts. This legislation will allow reasonable expansion of the program while establishing program controls through setting clear criteria and formalizing payment procedures. New costs to the program will be covered transitionally by federal grant funds in FY 2000. An increment will be required to enable this program to become an entitlement beginning FY 2001.

Existing Program

There is $1046.3 GF/MH in the base for the DET program. These funds provide a limited amount of 72-hour psychiatric evaluations in eight hospitals in Alaska, up to 30 days of psychiatric treatment in two hospitals, physicians' services, and transportation to the hospitals. In addition, it pays for enhanced detoxification at two facilities for persons who are intoxicated and expressing suicidal ideation. Historically, client eligibility for this program has been budget driven. The definition of an eligible client was chosen so that all eligible clients could be served within the existing budget. The law suit has demanded that, among other things, the definition of eligibility be expanded to a larger population.

Eligibility Expansion

Payment for DET services will be expanded to all persons who are a danger to themselves or others or gravely disabled due to a mental illness, who are at or below 185% of the federal poverty guidelines, and who have no other source of payment.

The FY2000 Governor's Budget includes a request of $1097.0 in federal receipt authority for a Substance Abuse and Mental Health Services Administration (SAMHSA) grant as a part of the Community Mental Health/API 2000 project. Prior experience with a larger population indicated that the expanded eligibility would result in increased cost of at least $300.0. Part of the SAMSHA federal grant will cover these increased costs and another portion would allow limited expansion of the current program. The total cost of these changes is $582.1. None of these costs are reflected in the fiscal note, but are critical to its understanding. Hospital costs are based on a rate of $930 per day, and detox costs are based on a cost of $275 per day.

Community Mental Health/API 2000 (related to downsizing API)

The Community Mental Health/API 2000 project depends upon a fully functional DET program. The current DET program operates outside of Anchorage. For the Community Mental Health/API 2000 project related to the downsizing of the Alaska Psychiatric Institute to work, the DET program must include Anchorage hospitals. The final portion of the $1097.0 in the FY2000 Governor's Budget. $514.9, expands DET services to Anchorage. Services in Anchorage will not begin until the last quarter of FY 2000 as they will coincide with the adjustment of the emergency service system to accommodate a smaller API. The annualized cost in Anchorage assumes the passage of SB 97 that establishes the entitlement and clarifies procedures by which the department pays for these services.

DET Payments

	FY99	FY00	FY01	FY02
GF/MH				
Base	1,046.3	1,046.3	1,046.3	1,046.3
SB97	0.0	0.0	0.0	2,641.7
Federal (SAMSHA)				
Governor's FY2000 Req	0.0	1,097.0	1,097.0	0.0
SB97	0.0	0.0	1,544.7	0.0
	1,046.3	2,143.3	3,688.0	3,688.0
DET Eligibility Determination	0.0	0.0	150.0	150.0
DET Program Total	1,046.3	2,143.3	3,838.0	3,838.0

ANALYSIS (cont.):

Costs of Expansion

For FY2001, the costs in the Grants/Claims line reflect the cost of annualized DET services in Anchorage. These costs are directly related to the passage of SB 97. The costs assume full implementation of the new definition of eligibility, and serving all eligible clients as an entitlement. In addition, there is a related cost of $150.0 in GF/MH funds for the purchase of eligibility determination. A more complex eligibility process will be necessary, based on the procedures used by the DHSS Division of Public Assistance to process welfare applications. The cost assumes a large volume of applications. The costs in the "Contractual" line will be necessary to process the applications and pay the cost of processing the bills. For FY2001, all new costs are funded through federal receipts.

The expansion of DET services to Anchorage will purchase an additional 2,984.8 bed days per year, or an average of 8.2 DET patients per day. The eligibility expansion is projected to require an additional 843.6 bed days per year or an average additional 2.3 patients per day.

The costs in FY2002 and beyond are all GF/MH due to the SAMSHA grant expiration.

If SB 97 does not pass, the FY2000 funds in the Governor's Budget would cover the anticipated service demands of the new eligibility definition outside of Anchorage, and permit limited services to remain in Anchorage indefinitely. However, there would not be sufficient funds to meet the demand to allow the Community Mental Health/API 2000 project to work. Services would be suspended at the point funds were exhausted, probably in mid-spring of FY2001. The department could anticipate additional litigation regarding the responsibility of the department to pay for these services. Court actior could include further expansion of the definition of the population eligible to receive services under this program.

Alaska State Legislature

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Senate

MEMORANDUM

TO: Senator Mike Miller, Chair
Health, Education & Social Services Committee

FROM: Senator Pete Kelly Pete

DATE: March 29, 1999

RE: SB 97: Mental Health; Records; Treatment

At your earliest convenience, please schedule a hearing for Senate Bill 97, "An Act relating to confidential mental health records; relating to mental health services and programs; relating to liability for payment for mental health evaluation and treatment services; and providing for an effective date."

I have introduced this legislation on behalf of the Department of Health and Social Services. Attached please find a copy of the sponsor statement and additional back-up provided by the Department.

Thank you for your consideration of this request.

attachments

I-LS0545\G
Lauterbach
4/14/99

CS FOR SENATE BILL NO. 97(HESS

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR PETE KELLY

A BILL

FOR AN ACT ENTITLED

"An Act relating to mental health services and programs; relating to liability for payment for mental health evaluation and treatment services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 47.30.910 is repealed and reenacted to read:

Sec. 47.30.910. Liability for expense of placement in an evaluation or treatment facility. (a) A patient, the patient's legal representative acting in a representative capacity, the patient's spouse, or the patient's parents if the patient is under the age of 18 shall pay or contribute to the payment of charges for the care, transportation, and treatment of the patient when the patient is hospitalized under AS 47.30.670 - 47.30.915 at a state-operated facility, an evaluation facility, or a designated treatment facility providing services under AS 47.30.670 - 47.30.915. Charges assessed when a patient is hospitalized at a facility operated by the department or a facility designated by the department to provide services under AS 47.30.670 -

47.30.915 may not exceed the actual cost of care and treatment.

(b) The department may order payment by the patient or by the person responsible for payment for the patient's care and treatment under this section if the patient is hospitalized at a state-operated facility unless the patient would meet the eligibility criteria in AS 47.31.010 but for the fact that the patient is hospitalized at a state-operated facility. The department may investigate to determine the patient's ability to pay and may require sworn statements by the patient, the patient's legal representative acting in a representative capacity, the patient's spouse, or the patient's parent regarding the income of the patient, the patient's spouse, or the patient's parent. The commissioner may impose full liability for the patient's actual cost of care and treatment on the patient, the patient's legal representative acting in a representative capacity, the patient's spouse, or the patient's parent for refusal to supply a sworn statement of income. In order to impose liability for the cost of a patient's care, an order for payment shall be issued by the department within six months after the date on which the charge was incurred. The order remains in effect unless modified by subsequent court or department order.

(c) If a person who is hospitalized under AS 47.30.670 - 47.30.915 at an evaluation facility or a designated treatment facility, a patient's spouse, or a patient's parent cannot pay or contribute to the payment of charges described in (a) of this section, the patient may apply for assistance under AS 47.31.

(d) The department may charge or accept money or property from a person for the care or treatment of a patient. Money paid by the patient or on the patient's behalf to the department under this section shall be deposited in the general fund.

(e) In this section, "actual cost of the care and treatment" means

(1) the rate provided for by a contract entered into under AS 47.30.660; or

(2) in the absence of a contract under AS 47.30.660, a daily rate determined by the department.

* **Sec. 2.** AS 47.30.915(4) is amended to read:

(4) "designated treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the

treatment or rehabilitation of mentally ill persons **under AS 47.30.670 - 47.30.915** [AND FOR THE RECEIPT OF THESE PERSONS BY COURT-ORDERED COMMITMENT,] but does not include correctional institutions;

* **Sec. 3.** AS 47 is amended by adding a new chapter to read:

Chapter 31. Mental Health Treatment Assistance Program.

Sec. 47.31.005. Applicability. This chapter applies only to those patients who have received evaluation or treatment at an evaluation facility or a designated treatment facility that is not a state-operated hospital.

Sec. 47.31.010. Eligibility for assistance. (a) The department shall provide financial assistance under this chapter to a patient who

(1) does not have the available means to pay or contribute to the payment of charges assessed by a facility;

(2) has no other third party to pay for the evaluation or treatment provided under AS 47.30; and

(3) meets the criteria in this chapter.

(b) To be eligible for assistance under this chapter, a patient must have

(1) been admitted for inpatient evaluation or treatment at an evaluation facility or a designated treatment facility other than a state-operated hospital after either

(A) an involuntary commitment under AS 47.30.700 - 47.30.915; or

(B) a voluntary commitment chosen by the patient after a determination by the patient's treating physician that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.915; and

(2) a gross monthly household income that does not exceed 185 percent of the federal poverty guideline for this state for the month in which service was provided.

Sec. 47.31.015. Application for assistance. (a) To receive assistance under this chapter, a patient or a patient's legal representative must apply in writing on a form provided by the department. A patient must apply for assistance within 180 days after the date of discharge from the facility.

(b) A patient who applies for assistance under this chapter, a patient's legal representative, a patient's spouse, or a patient's parent must agree to release to the department and the facility, if appropriate, records and information necessary to verify eligibility for the assistance.

(c) The department may accept an application submitted by an evaluation facility or a designated treatment facility on a patient's behalf if the facility shows to the department's satisfaction that the patient

(1) was incapable of applying for assistance and a legal representative was not available to apply on the patient's behalf under (a) of this section; or

(2) refused to apply for assistance for reasons related to the patient's mental illness.

Sec. 47.31.020. Decision on eligibility. (a) Within 30 days after receiving a complete application, the department shall give notice in writing of an eligibility determination to the patient or the patient's legal representative. If the patient is found ineligible, the notice must contain the reason for the denial and an explanation of the patient's right to an administrative appeal of the denial.

(b) The department shall provide a copy of the notice of eligibility or ineligibility to the facility at which the patient was treated.

Sec. 47.31.025. Eligible services; rates. The department shall identify the type and level of services for which assistance is available under this chapter. The department shall establish the rates of payment for those services.

Sec. 47.31.030. Payment. If the department determines that a patient is eligible for assistance under this chapter, the department shall provide for payment of assistance directly to the facility. By endorsing the check received from the department or authorizing the endorsement by the facility's agent, the facility certifies that the claim for which the check is payment is true and accurate unless written notice of an error is sent to the department by the facility within 30 days after the date the check is presented by the facility for payment.

Sec. 47.31.035. Appeals. (a) A patient or the patient's legal representative may appeal a denial of assistance by sending written notice of objection to the department within 30 days after the date of the notice of denial. The written notice

of objection must include an explanation of the reasons for the objection and may include documentation supporting the objection. AS 44.62 (Administrative Procedure Act) does not apply to the appeal.

(b) The commissioner or the commissioner's designee shall review the notice of objection and issue a decision within 90 days after its receipt. The commissioner or the commissioner's designee may request additional information on the appeal from either the patient, the facility, or department staff. A request for additional information suspends the time period for the appeal until the department determines that the additional information has been received.

(c) The decision on the appeal under (b) of this section is a final agency decision and may be appealed to the superior court under the Alaska Rules of Appellate Procedure.

Sec. 47.31.900. Regulations. The department may adopt regulations to interpret or implement this chapter.

Sec. 47.31.990. Definitions. In this chapter, unless the context otherwise requires,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services;

(3) "designated treatment facility" has the meaning given in AS 47.30.915;

(4) "evaluation facility" means a health care facility that has been designated by the department to perform the evaluations described in AS 47.30.670 - 47.30.915, including a facility licensed under AS 18.20.020 or operated by the federal government;

(5) "gross monthly household income" means all earned or unearned income from any source of a member of the patient's household;

(6) "household" means persons who reside together in one residence as a family unit;

(7) "mental illness" has the meaning given in AS 47.30.915.

* **Sec. 4.** APPLICABILITY. This Act applies to expenses incurred for mental health

services received on or after the effective date of this Act.

* **Sec. 5.** This Act takes effect immediately under AS 01.10.070(c).

Fairbanks Community Mental Health Center

ARORA Consent Form

Client #: _____ Client Name: _____

PURPOSE: The Division of Mental Health and Developmental Disabilities (DMH/DD) has asked the Fairbanks Community Mental Health Center (FCMHC) to submit certain additional data on each of FCMHC's clients. The purpose of this form is to ask you whether you authorize FCMHC to submit personal identifying information about you.

ARORA PROJECT: The DMH/DD has developed a management information system called the Alaska Recipient Outcomes Research Application (ARORA). The DMH/DD wants FCMHC and other community mental health agencies throughout the state to submit certain personal identifying data on each client.

NON-IDENTIFYING INFORMATION: The data which FCMHC will submit for the ARORA project includes non-identifying information about you, such as race, sex, marital status, income, date of birth, and diagnosis. Historically FCMHC has routinely furnished this kind of non-identifying information about FCMHC's clients to various state and federal agencies and other authorized persons for statistical analysis and other legitimate uses.

PERSONAL IDENTIFYING INFORMATION: The additional data which the DMH/DD requests for the ARORA project includes the following personal identifying information about you:

1: The first two letters of your last name.
2: The first two letters of your first name.
3: The last four digits of your Social Security Number.

Please Check One of the Following:

_____ YES, I authorize FCMHC to provide personal identifying information about me to the Division of Mental Health and Developmental Disabilities.

_____ NO, I do not authorize FCMHC to provide personal identifying information about me to the Division of Mental Health and Developmental Disabilities.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Relationship Date

_____ _____
Witness Date

NAVIGATION MENU

ARORA MENTAL HEALTH DATABASE LAWSUIT INFORMATION PAGE

This web page contains information about a lawsuit challenging the legality of the State of Alaska's ARORA mental health reporting requirements. The site is maintained by Fairbanks attorney Gail Ballou as a service to persons who are interested in learning about the ARORA database, the state's reporting requirements, the ARORA lawsuit, and related issues. The author represents plaintiff Fairbanks Community Mental Health Center in the ARORA lawsuit, but nothing at this web site is an official statement on behalf of Fairbanks Community Mental Health Center.

What is ARORA?:

ARORA is a computerized government data collection system which compiles information about mental health care consumers in Alaska. The term "ARORA" is an abbreviation for the name of the system, *"Alaska Recipient Outcome Research Application."*

Through the ARORA system, the state's Division of Mental Health and Developmental Disabilities seeks to collect detailed information about every consumer who obtains services from a mental health care provider who receives state funding through Alaska's community mental health services program. The information which the Division gathers includes a wealth of personal information as well as each consumer's specific diagnosis(es) from a checklist of mental health disorders known as the DSM-IV. In November of 1997, the state adopted administrative regulations which formally authorize the ARORA system and which require all mental health care providers who receive state grant funds to report information about their clients to the Division.

The Division intends to keep ARORA information indefinitely and to use the information for "program planning, program evaluation, and research," including cross-referencing information with other state databases. According to a recent newspaper article, the ARORA database already contains information on 9,000 people.

What's the problem with ARORA?

Many mental health care consumers and professionals have serious misgivings about ARORA. One concern is that the ARORA regulations and reporting requirements may violate consumers' rights and providers' duties under various provisions of state and federal law, such as Alaska statutes protecting the confidentiality of therapist-patient communications and federal law governing the use of Social Security numbers. Some providers are not complying fully with the ARORA reporting

requirements because of this concern about the legal status of ARORA. Another concern is that the ARORA reporting requirements, even if legal, interfere with mental health therapy because consumers understandably do not want to divulge intimate details of their lives to therapists who must forward those details to a government computer database.

One concerned provider, Fairbanks Community Mental Health Center, recently filed a lawsuit to resolve doubts about the legality of the ARORA system. In response to the lawsuit, Senator Pete Kelly (R-Fairbanks) has introduced legislation to address some of the legal issues raised in the ARORA lawsuit.

About the ARORA lawsuit:

Case name: *Fairbanks Community Mental Health Center, Inc. v. State of Alaska*
File no.: 4FA-98-3530 Civil
Court: Superior Court for the State of Alaska, at Fairbanks
604 Barnette Street, Room 342
Fairbanks, Alaska 99701

Selected court filings as of March 15, 1999 (click on link to view document):

- Complaint for Declaratory and Injunctive Relief filed December 31, 1998
- State's Answer (on-line copy not yet available)
- State's Motion for Judgment on the Pleadings filed March 15, 1999 (on-line copy not yet available)

Senate Bill 97

Senator Pete Kelly (R-Fairbanks) has introduced legislation which proposes to solve some of the legal problems identified in the ARORA lawsuit by partially repealing existing laws which require mental health care professionals to protect consumers' privacy. The bill, known as SB 97, is currently in the senate Health, Education and Social Services Committee, of which Senator Kelly is vice chair.

To read the full text of SB 97 or to find information about the bill, visit the SB 97 Information Page.

Have an opinion about ARORA or SB 97? Use these links to contact Alaska government officials:

- Division of Mental Health and Developmental Disabilities
- Governor Tony Knowles
- Senator Pete Kelly (sponsor of SB 97 and Vice Chair, senate HES Committee)
- Other members of the senate Health, Education and Social Services Committee, which is considering SB 97:
  - Senator Mike Miller (R-North Pole) (Chair)
  - Senator Drue Pearce (R-Anchorage)

- Senator Gary Wilken (R-Fairbanks)
- Senator Kim Elton (D-Juneau)

- Other Alaska state senators
- Alaska state representatives

Updated: March 16, 1999

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Lawsuit filed over mental health reporting requirement

By Al Slavin, Staff Writer

After two years of talk, concern over a state database that contains profiles of mental health patients has escalated into a legal battle.

A local organization has filed a court challenge against a state-mandated reporting requirement because it believes the system jeopardizes patient confidentiality.

"For two years we've been trying to get this thing squared away and express our concerns and here's where we are," said Doug Pomeroy, executive director of the Fairbanks Community Mental Health Center.

State officials disagree with Pomeroy's claims regarding confidentiality and think the management information system, known as ARORA, serves a valuable purpose in formulating departmental policy and strategy.

"We have an obligation to collect data so we can do effective planning," said Karl Brimner, director of the state's Division of Mental Health and Developmental Disabilities.

The colleagues now find themselves at the opposite end of a philosophical rift. The Fairbanks Community Mental Health Center recently filed a lawsuit against the division in Fairbanks Superior Court. They have requested a court injunction that would prohibit the division from gathering or disclosing any of the data.

Pomeroy's organization had always shared case information with the state in the past. The details are used in the planning and budgetary process. The division's new management information system, called the Alaska Recipient Outcomes Research Application, reached beyond the traditional, more generic reporting requirements.

ARORA requires precise patient information to establish an algorithm, which then serves as a patient's identity. The first two letters of a patient's first and last name are designated as a label, along with the patient's date of birth and last four digits of his or her social security number.

This permits the division to determine whether services are being duplicated and gauge the effectiveness of treatment in individual cases. Pomeroy believes an individual can be identified if the labeling information is cross-referenced with other public records that are more readily available to the public.

His agency's attorney, Gail Ballou, conducted an experiment to that effect. Pomeroy gave Ballou 23 algorithms established under the ARORA guidelines. They were referenced against public records. Pomeroy said Ballou was able to identify 16 of those individuals [see sidebar].

Pomeroy is worried that patients will hold back on

Decoding ARORA algorithms

(this sidebar is not part of the original News-Miner article)

In the ARORA database, individual mental health care consumers are not identified by name. Instead, each consumer is assigned a fourteen-digit code which is called

disclosing information in light of the mandatory reporting requirements and it will undermine the trust relationship.

"This relationship is what mental health work is built on," Pomeroy said. "If it's a poor one, mental health work cannot occur. That's why our concerns about the management information system known as ARORA are so acute."

The lawsuit identifies a perceived conflict between the confidentiality laws that regulate such professions as psychologists, therapists and others involved in social work. At odds is an administrative regulation adopted by the division. It requires all mental health organizations to comply with the mandatory reporting requirements or they risk losing state funding. In the case of the Fairbanks Community Mental Health Center, that would translate into a $3 million loss.

"I suppose that's a possible consequence somewhere in the future," Brimner said.

Each year, the division doles out $32 million in grants to 45 mental health organizations across the state. Brimner estimated that about 20,000 individuals received services. The ARORA database was created in November 1997 and that database now includes case information on 9,000 individuals.

Brimner is not alarmed by the privacy concerns raised by Pomeroy because he believes proper safeguards are in place.

"The algorithm protects the ability to solicit that information," Brimner said. "Within my division, there are only a limited amount of people that have access to that information and they know they can be subject to prosecution or penalties."

Brimner said the information enables the division to not only ascertain the effectiveness of treatment, but locate specific areas where additional services may be required.

"The division thinks those are the links that are important to us so that we can do the best planning," Brimner said. "It tells us not only how many being served but how they are being served."

The Washington State Supreme Court had a similar opinion in a decision handed down in 1986.

an algorithm. This code, or algorithm, is supposed to protect the identity and privacy of mental health care consumers, but it does not.

The fourteen-digit ARORA algorithm consists of the first two letters of the consumer's first and last names, the consumer's date of birth, and the la four digits of the consumer's Social Security number. For example, the ARORA algorithm for a person named Jane Smith who was born on November 4, 1955 and whose Social Security number is 123-45-6789 is JASM1104556789.

Such a mixture of letters and numbers may seem impenetrable at first glance, but in fact it is easy to decode an ARORA algorithm and to determine a mental health care consumer's identity.

The fastest way to decode an ARORA algorithm is to use elementary computer search-and-sort techniques to compare an algorithm to information contained in one or more government or private computer databases which contain most Alaskans' names, birth dates, and Social Security numbers. Examples of such databases include the Permanent Fund Dividend file, law enforcement's Alaska Public Safety Information Network (APSIN), and credit reporting companies' records. By using simple search-and-sort methods, it is easy to identify every person in a database whose whose name, birth date, and Social Security number match the information contained in an ARORA algorithm. For nearly all ARORA algorithms, there will be only one match.

Since there ordinarily will be just one match, an ARORA algorithm is a highly reliable device for identifying and tracking mental health care consumers. Indeed, an ARORA algorithm is often a better identifier than is a consumer's name alone, since an algorithm contains information (birth date and part of Social Security number) which makes it possible to distinguish among people who have the same name, to track consumers whose names change (for example, women who change their names upon marriage or divorce), and to target consumers who try to protect their privacy by giving a fictitious name, incorrect birth date, or made-up Social Security number.

Of course, most people who might want to decode an ARORA algorithm do not have access to huge government or corporate databases which make it easy to decode an algorithm quickly, but access to these databases is not necessary. An average person who wants to decode an ARORA algorithm can ordinarily do so just by comparing the algorithm to information which is readily available in public records, libraries, and now on the Internet.

In the experiment mentioned in the accompanying News-Miner article, 16 of 23 algorithms were decoded in only 24 hours by one person who researched information which is available to anyone at no cost. Decoding was

A hospital and two patients challenged the legality of reporting requirements. The court ruled in favor of the state in a split decision. The decision permitted the state to gather the data, provided it was "carefully tailored to meet valid governmental interest."

stopped after 24 hours because, by then, the experiment had already demonstrated that ARORA algorithms do not protect the identity or privacy of mental health care consumers.

Updated: February 28, 1999

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Senate District P

SENATE BILL 97

SPONSOR STATEMENT

"An Act relating to confidential mental health records; relating to mental health Services and programs; relating to liability for payment for mental health evaluation and treatment services; and providing for an effective date."

DHSS reimburses private community hospitals (Designated Evaluation and Treatment Facilities) throughout Alaska to provide emergency mental health inpatient evaluation and treatment services. Hospitals provide these services to individuals who are at risk of harming themselves or others, or who are so severely impaired by mental health symptoms that they are unable to care for themselves. Often these individuals are experiencing severe psychiatric symptoms, such as depressive or psychotic symptoms, and need intensive inpatient mental health services.

Senate Bill 97 seeks to clarify the state's responsibility for payment for services and the responsibility of the state to determine the ability of patients to pay for those services. The proposed legislation clarifies client eligibility for these services. Additionally, it establishes procedures for determining eligibility, processing applications, and paying claims. SB 97 creates an entitlement for eligible clients, thus allowing payment for serving those individuals whose mental illness increases their danger to themselves or others. The following are criteria for eligibility:

- A patient is determined to be "suffering from a mental illness, and as a result is likely to cause serious harm to themselves or others, or is gravely disabled." and;
- The patient's gross monthly household income falls below 185% of the federal poverty guideline.

SB 97 amends current statutes defining the state's responsibility for payment for inpatient psychiatric service for those patients needing intensive services. Historically the Department of Health and Social Services (DHSS) has reimbursed hospitals for only those patients who are committed by the courts for evaluation and treatment services. This legislation would require the department to reimburse hospitals for individuals who meet the commitment criteria, but who voluntarily admit themselves into the hospital. These individuals are therefore, not court ordered into care, but could be held under court order if they attempted to leave the hospital.

LEGAL SERVICES
DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
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130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM March 16, 1999

SUBJECT: Sectional Summary of SB 97 (Mental Health)

TO: Senator Pete Kelly
Attn: Lorna

FROM: Terri Lauterbach
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

You have not indicated that you have any legal questions about this bill, so this memorandum is very brief. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, let me know.

Section 1. Allows the disclosure of otherwise confidential patient mental health information from various licensed mental health professionals to the Department of Health and Social Services.

Section 2. Requires local community mental health programs to disclose otherwise confidential patient mental health information to the Department of Health and Social Services and to notify patients that such disclosures will be made.

Section 3. Directs the Department of Health and Social Services to monitor local community mental health programs and to review patient eligibility for mental health services under the programs.

Section 4. Authorizes disclosure of confidential mental health information to the Department of Health and Social Services.

Section 5. Directs the Department of Health and Social Services to collect patient information from mental health facilities.

Section 6. Authorizes disclosure of confidential mental health information and records to the Department of Health and Social Services.

Section 7. Requires a patient and certain relatives of the patient to contribute to the cost of the patient's care at certain mental health facilities.

Section 8. Establishes a mental health treatment assistance program.

Section 9. Effective date.

TML:jdr:glc
99-127.jdr

Resolution Concerning Management Information Systems (MIS) and Measurable Consumer Outcomes

Whereas, NAMI Alaska represents families and direct mental health consumers throughout Alaska;

Whereas, it is necessary and essential to have a fully integrated MIS to improve care, monitor quality, and control costs on behalf of consumers;

Whereas, Alaska currently has a lack of measurable outcomes on behalf of consumers;

Whereas, the Alaska Legislature and the Alaska Mental Health Trust Authority have both made it clear that work on measurable outcomes must begin in earnest;

Whereas, a failure to make progress on MIS and measurable outcomes may result in Legislatively imposed solutions;

Whereas, full consumer participation in both the MIS and measurable outcome processes have been assured by the Department of Health and Social Services, the Alaska Mental Health Trust Authority, and the Alaska Mental Health Board;

Whereas, all transferred information for MIS and measurable outcomes will be encrypted (or scrambled) so that it can not be interpreted by anyone other than the Division of Mental Health and Developmental Disabilities;

Whereas, Alaska State law and regulation provide for punishment of not more than one year in jail and up to a $5,000.00 fine for anyone who discloses this information without authorization;

Whereas, the protections provided by the Division of Mental Health and Developmental Disabilities exceed those protections when such information is provided to Medicaid or insurance companies for payment;

Whereas, consumer support of these processes is dependent on Department's guarantees that all consumer data remains confidential and protected from unauthorized sources;

Now therefore be it resolved by the NAMI Alaska as follows:

1. The State of Alaska and the Department of Health and Social Services should move immediately but no later than July 1, 1998, to bring on-line a fully functioning MIS.

2. The Department of Health and Social Services should immediately redouble it's efforts to implement a measurable outcome based system to measure the quality of care received by consumers.

3. As part of the MIS and measurable outcome processes, a statewide and uniform process and program for measuring outcomes and consumer satisfaction should be established in the next year.

4. Finally, consumers and family members must be involved not only in providing input and feedback but also in the design, operation, evaluation and governance of these processes. The most reasonable and rapid way to assure consumer and family members' involvement is to create incentives for all community mental health centers and other DMHDD grantee agencies to meaningfully involve consumers in all program development and change activities.

5. This resolution should be personally conveyed to the Commissioner, Department of Health and Social Services, the Alaska Mental Health Trust Authority, and the Alaska Mental Health Board.

6. All parties should know this resolution was fully supported at the statewide annual meeting of families and consumers May 9, 1998.

Dated this 18th day of May, 1998.

Jeanette Grasto

Jeanette Grasto,

President, NAMI Alaska

DISABILITY LAW CENTER OF ALASKA

JUNEAU
230 South Franklin
Suite 209
Juneau, AK 99801
(907) 586-1627
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April 6, 1999

By hand delivery

Sen. Mike Miller
Chair, HESS Committee
Alaska Legislature
Capitol Room 119
Juneau, Alaska

Sen. Pete Kelly
Vice Chair, HESS Committee
Alaska Legislature
Capitol Room 510
Juneau, Alaska

Re: **SB 97: Mental Health Information and Liability for Involuntary/Voluntary-in-Lieu admissions**

Dear Senators Miller and Kelly:

Enclosed please find my testimony regarding SB 97. In our view, the legislation is a good step, but there are certain changes that could be made to improve the bill. In particular:

Mental Health Information Gathering: the bill should:

- **require Departmental tracking of involuntary commitments**
- **require Departmental tracking of temporary holds in jails**

Liability for mental health commitment charges: the bill should:

- **clarify eligibility for relief to cover "voluntary-in-lieu" admissions**
- **be refined to accomplish its purpose**

We have worked with representatives of the Knowles Administration and mental health providers to narrow the range of dispute regarding this bill, and I am hopeful that with further work we can come closer to a consensus bill. I look forward to discussion regarding the bill at tomorrow's hearing. To the extent that this office may be of assistance in refining the language of the bill, do not hesitate to call us at 586-1627.

Very truly yours,

/s/ RBB

Robert B. Briggs
Staff attorney

cc: (w/ encl.)

Elmer Lindstrom, DHSS
Shannon O'Fallon, Dept. of Law
Pat Clasby
Walter Majoros, AMHB
Jeff Jesse, AMHTA
Robin Henry, AKAMI
Rick Tessandore, exec. dir., DLC - Anchorage
client C.D.

Statement of Robert B. Briggs
Staff Attorney, Disability Law Center of Alaska, Inc.

Testimony before the Senate HESS Committee

Hearing on S.B. 97:
Mental Health Records; Liability for Involuntary/Voluntary-in-Lieu Treatment

Mr. Chairman Miller, Senator Kelly, and other members of the HESS Committee, thank you for this opportunity to provide input on a subject of importance to people who have mental disabilities, and their families.

MENTAL HEALTH INFORMATION GATHERING

The Disability Law Center supports the concept of information gathering by the Department of Health and Social Services (DHSS) to support decision making regarding delivery of mental health services in the state, so long as client confidentiality is protected. We therefore support the elements of S.B. 97 that expand and more affirmatively state the Department's mandate to gather information from providers who receive State funds. However, I believe there are some ways the bill could be improved regarding information gathering.

- **The bill should require Departmental tracking of involuntary commitments**

Currently, there is no method of tracking and counting the number of involuntary mental health commitments that occur statewide as a result of judicial orders. So far as we are aware, there are only two sources of any information the Department has regarding DET services: (1) the information gleaned from claims for relief from liability submitted to the Department under AS 47.30.910, and (2) information provided by hospitals who provide involuntary treatment.

As the state proceeds with implementation of the plan to reduce beds at the Alaska Psychiatric Institute (API) under the plan referred to as "API 2000," delivery of mental health commitment services will increasingly be provided at local hospitals. These hospitals may have a financial incentive to maximize use of any mental health unit they operate. The Legislature must be sure that the Department establishes checks and balances in the system, to monitor average lengths of stay (LOS) and overall numbers of commitments, to prevent unnecessary commitments and unsuccessful treatments. Unmonitored commitment practices – fueled by inappropriate profit motives – can reward unsuccessful treatment outcomes by continuing to pay for extended hospitalizations during trials of long lists of ineffective and potentially harmful drug combinations.

I have observed in my work cases of families and patients who firmly felt compelled to go through just such unnecessary drug trials over periods of hospitalization that extended several months.

I think a starting point for a tracking system is knowing the unduplicated numbers of persons involuntarily admitted for evaluation and treatment, their diagnoses, the numbers of persons repeatedly admitted, the number of repeat admits, and the average length of stay. These and other data can be compared with national figures to try to determine whether Alaska's mental health delivery system is in step with national standards – or grossly out of step.

While the hospitals and facilities where evaluations and treatment take place are one potential source for the Department to gather information, it is also true that the Alaska Court System, in the process of issuing commitment orders, could provide information to the Department that would enable tracking of data. Thus I urge you to consider adding language that would specifically require data tracking of involuntary evaluation and treatment.

- **The bill should require Departmental tracking of temporary holds in jails**

Under Alaska's mental health commitment statutes, people who are being detained because of a mental illness are not supposed to be held in jails or other correctional facilities, except when absolutely necessary while awaiting transport, or awaiting an available bed at an evaluation or treatment facility.

It has been a vocal point of criticism of the current and previous administrations that there is no system of tracking the numbers of temporary mental health detentions in jails and other correctional facilities. Data on this use would help in the appropriate allocation of resources to the places of demonstrable need.

LIABILITY FOR MENTAL HEALTH COMMITMENT CHARGES

Involuntary mental health admissions serve an important State public purpose. Persons are hospitalized who are gravely disabled, or who present a danger to themselves or others. Hospitalization provides the opportunity for stabilization, reduction in acuity, and linkage with outpatient services on discharge that will reduce further costs to society. Existing AS 47.30.910 recognizes this state purpose by stating that those who lack the ability to pay for an mental health commitment under AS 47.30.660 – 47.30.910 shall be relieved of liability for costs of evaluation and treatment.

We represent a client who has sued the Department (actually a cross-suit in response to a bill collection action initiated by Bartlett Regional Hospital) for failure to implement existing AS 47.30.910.[1] One of the objectives of that suit is to compel the Department of issue regulations that uniformly and fairly implement AS 47.30.910. We reached a settlement in September 1998 by which the Department pledged to issued the sought-after regulations on March 1, 1999.

[1] ***Bartlett Reg. Hosp. v. C.D. v. State of Alaska, et al.***, No. 1JU 97-2717 CIV (Alaska Sup'r Ct., 1st Jud. Dist.).

♦ **The bill should clarify eligibility for relief to cover "voluntary-in-lieu" admissions**

The need for those regulations could be mooted by S.B. 97, if it passes. S.B. 97 has the potential to resolve several disputes regarding interpretation of AS 47.30.910 that are involved in our lawsuit, including arguments that the current system as implemented by the Department discriminates against those who live outside the Anchorage area, and those whose admission is "voluntary-in-lieu" of an involuntary admission.

In particular, S.B. 97 would make plain that a specified class of persons – those with family incomes under 185% of the poverty line – would be eligible to apply for relief from liability for the charges of both involuntary evaluations or treatments, and for so-called "voluntary-in-lieu" evaluation or treatment.[2]

Failure to provide relief to "voluntary-in-lieu" patients will lead to increased involuntary admissions to take advantage of the relief program. Providing relief only to those who are involuntarily admitted ***creates an incentive*** to refuse to seek mental health treatment. Under the existing statute, the determination of ability to pay is to made for all admissions occurring under AS 47.30.660 – 47.30.910 – and this includes both "voluntary-in-lieu" and involuntary admissions.[3] Indeed, for a person who agrees voluntarily to undergo mental health services, under a threat by a treating physician to seek involuntary commitment, we think it would violate the due process and equal protection clauses of the Alaska and the United States Constitutions to decline to provide the same relief for "voluntary-in-lieu" admissions as for involuntary admissions.

However, from the perspective of the mental health disability community, SB 97 presents a trade-off: the current statute, the State argues, does not permit relieving those voluntarily admitted from liability. We disagree with the State's interpretation of current AS 47.30.910 that is in the books, pointing to the text of the statute, the context of other related statutes, and to past practices of the Department in relieving persons from liability for voluntary admissions. However, S.B. 97 would moot this legal dispute, and avoid uncertainty as to the outcome of litigation.

However, S.B. 97 is a retraction from the current level of relief provided by AS 47.30.910. The existing statute requires the Department to relieve a person from liability based on the patient or liable person's ***ability to pay***. Thus persons of modest means, under the existing statute, could obtain relief from mental health commitment bills that exhaust their resources – that is, they should be able to if the statute is administered the way it is worded.

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[2] A "voluntary-in-lieu" admission is one where the treating physician has expressed an intent to seek involuntary commitment if the patient does agree to voluntary commitment, the patient otherwise meets the involuntary commitment criteria, and the patient (or for a minor, the patient's family) does agree to a voluntary commitment.

[3] See AS 47.30.803 (regarding conversion from involuntary to voluntary status); AS 47.30.655 (1)(creating policy goal of encouraging seeking of voluntary treatment).

By endorsing the concept of SB 97, the community of mental health consumers are getting greater certainty about who would be eligible for the relief, and the amount of relief per person is likely to be greater, but the persons who will benefit is reduced.

S.B. 97 limits relief to those whose income is below 185% of the federal poverty line.[4] Thus a significant percentage of the so-called "working poor" – those with incomes under 200% of the poverty line – will lose their ability to obtain relief even if they lack the ability to pay for an outstanding mental health commitment charge. The Center on Budget and Policy Priorities issued a study showing that in the mid-1990s, 34.5% of Alaskans with income under 200% of the federal poverty guidelines went without health insurance – altogether 12,000 out of an estimated 34,000 working poor.[5] As Alaska continues the trend toward growth in visitor and other seasonal, temporary jobs, while losing valuable jobs in the oil and gas, timber and government sectors, these numbers of uninsured working poor will likely increase.

We believe it is penny-wise and pound-foolish not to consider providing relief to the working poor – those most likely to become successfully re-employed and to stay off of public benefits.

- **The bill should be refined to accomplish its purpose:**

There are other parts of the bill that will require revision if the bill is to have its intended effect. These are summarized as follows:

1) revision of the eligibility language, since the current language referring to ability "to contribute" could apply to most if not the entire eligibility population, and then the bill does nothing

2) revision of the appeal procedures; current language allows the Department to suspend an appeal indefinitely, placing an appeal in perpetual limbo, while the Department gleans information that it has asked of itself

3) there should be a clear statement of release from liability upon payment of the charges, similar to Medicaid law (which requires that a provider must accept the Medicaid payment as 100% payment and prohibits billing the patient for uncovered charges)

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[4] Applicable federal poverty guidelines are:

Size of Family	Poverty Level	185% of Poverty Level
1	$10,320	$18,060
2	$13,840	$24,220
3	$17,360	$30,380
4	$20,880	$36,540
each additional member	add $3,520	add $6,160

Source: 64 Fed.Reg. 13,428-430 (Mar. 18, 1999), *reprinted at* http://aspe.os.dhhs.gov/poverty/99poverty.htm.

[5] J. Guyer and C. Mann, *Employed But Not Insured: a State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance*, CENTER FOR BUDGET AND POLICY PRIORITIES, at page 5, Table 1 (Feb. 9, 1999), *reprinted at* http://www.cbpp.org/2-9-99mcaid.htm.

4) to avoid any equal protection claims, language should be adopted that makes the program available to all persons seen for evaluation or treatment under AS 47.30.670 – 47.30.910, not just at those facilities "designated" by the Department. Otherwise, a person who happens to receive service at an "undesignated" facility will not be eligible for the relief program, despite being in all other ways similar to someone evaluated or treated at a "designated" facility

5) in determining eligibility, household income should be refined to include only family income of a person residing with the applicant. The income of a person not owing a duty of support cannot lawfully be counted in determining a person's eligibility for a program based on financial need.

I will be happy to continue to work with Sen. Kelly's staff and other interested parties to arrive at language that addresses the concerns raised in these comments.

From Doug Bonnemeyer

From: Audit Report on DHSS - DMA and DMHDD Program Selected Issues by Division of Legislative Audit, 9/1/97

Recommendation No. 4

DMHDD should obtain client service data to enable effective management of the State's community mental health programs.

Currently, the lack of client service data renders DMHDD unable to determine if community mental health funding is appropriate. No reliable data currently exists which accurately reflects the total number of clients annually receiving publicly funded community mental health services. While the Medicaid payment system does collect the number of clients served through Medicaid, major deficiencies exist in DMHDD's data collection concerning clients served by state grant funds.

DMHDD has collected selective mental health client data from providers for many years using a management information system (MIS). However, the type of information collected is not adequate to measure the number of clients served by the state grant system. Inherent system inadequacies such as no mandatory provider participation requirements, no data verification process, and a varying definition between providers of who qualifies as a "client" makes the reliability of the data suspect. Some providers we interviewed expressed frustration that while they spend the time to submit data reports to DMHDD, nothing of value seems to result.

Furthermore, current data collection methods do not allow unduplication[27] between the number of clients served as reported by DMHDD's MIS and the number of clients served as reported by the Medicaid MIS. Without this ability, DHSS cannot identify the total population of mental health clients served nor detect if Medicaid payments are being made for clients also funded through state grants.

DMHDD is currently implementing a new MIS in an attempt to address some of the data collection problems that currently exist. All providers will be required to report data as of July 1, 1997. However, due to provider concerns about confidentiality and beliefs that client consent is necessary to report this information to the State, we believe the effectiveness of the new MIS system could be jeopardized. We did not ascertain whether these provider concerns

[27] Unduplication refers to the process of eliminating duplicate counts of the same client that results due to a client receiving services through both programs.

are valid. However, in order for DMHDD to implement an effective data collection system they must be addressed. If data is reported as currently envisioned by the MIS, DMHDD will only be able to compute an unduplicated count of clients if providers appropriately report the Medicaid clients. Since client names will not be reported, DMHDD will not be able to independently verify whether clients reported by community mental health centers are also Medicaid eligible.

While the number of clients served does not reflect the amount of service delivered, we believe that a significant element of grant funding decisions should be based on the historical number of clients served in an area. Currently, it appears DMHDD bases its grant funding allocations primarily on how much a provider was granted in prior years. As revealed in the table to the right, per capita grant funding has not been equal across selected population areas. DMHDD personnel note that it does not zero base budget[28] when awarding state grants. Instead, there is the concept of a base budget for grantees. Some of the providers we interviewed did not understand how grant allocation decisions were made nor did they perceive the process as fact-based or scientific.

FY 97 Per Capita Community Mental Health Grant Funds for Selected Population Areas

Kenai - $16
Anchorage - $33
Fairbanks - $44
Matanuska-Susitna - $44
Juneau - $69

Based upon DMHDD listings of FY 97 grant awards and Department of Labor July 1996 population totals.

To identify mental health needs in Alaska, the Alaska Mental Health Board (AMHB) relies to some degree, on national prevalence[29] rates to develop funding recommendations to the Alaska Mental Health Trust Authority (AMHTA) which in turn makes funding recommendations to the legislature. In its September 1996 annual report, AMHTA indicated that various boards[30] use a combination of national prevalence data compared with the use of services to forecast the number of persons requiring services. AMHTA notes that:

> *Prevalence data is not necessarily an indicator of service need, however. Some individuals do not need publicly funded services because they have private supports. Conversely, some require assistance but do not seek out help from which they could benefit.*

In its July 1997 report to the AMHTA, AMHB also notes that national prevalence estimates likely distort the actual state-level prevalence due to Alaska's increasing urbanization. The prevalence rates used are based upon national studies which do not address the unique geographic, social, and economic conditions that exist in Alaska.

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[28] Zero base budget refers to the process of having each expenditure or item justified as to its need or cost.

[29] Prevalence is the total number of estimated cases in a given population at a specific time.

[30] The planning boards referred to are: the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, and AMHB.

The AMHTA has identified the lack of adequate client data as one of the hurdles to effective implementation of the State's comprehensive integrated mental health program. We recommend that DMHDD work with providers, AMHB, and AMHTA to develop a solution to what we consider a major deficiency in the State's mental health program by implementing a system to collect complete, accurate, and unduplicated client data. Changes in the funding and delivery of mental health services, in response to Recommendation Nos. 1 and 2, may change current data needs.

From: DHSS Response to Legislative Audit - 9/1997

Recommendation #4: DMHDD should obtain client service data to enable effective management of the State's community mental health programs.

DMHDD agrees with the importance of collecting outcome data for the purpose of determining the effectiveness of mental health services. The division is currently implementing a new data collection system that provides more complete information about the clients who

[1] Rates for group treatment are clarified and for intensive rehabilitation services are made all inconclusive.

receive services from the community mental health providers. This system called ARORA is designed to measure the following:

- Service utilization;
- Under- and over-utilization per agency by target population(s);
- Patterns of service per demographics, region, and identified needs;
- Basic service outcomes;
- Service history per individual;
- Service/funding relationship and history per grantee;
- Comparison of utilization with outcomes; and
- Consumer involvement in service planning

ARORA MIS Timeline	
July 92	Include MH Data in ADA MIS
July 93	Develop MIS Design
July 94	System & Design Analysis
Dec 95	Build ARORA MIS
June 96	Enhance grantees' data processing
Sept 96	MIS Regs draft
July 97	ARORA Implementation Starts
Dec 97	Regulations Effective

As a result of these measurements, we will know *how grant and Medicaid funds are utilized*, whether consumers are included in treatment planning, the amount and type of services delivered, and whether those services are achieving desired outcomes. The new MIS has the capacity to unduplicate clients and services across both grant funding and Medicaid funding. This will allow for the integration of information about services provided through these two sources. These efforts will create a more complete picture of the services delivered to consumers. DMHDD will use this objective information to plan and develop annual budgets. As a result, these budgets will more accurately reflect service needs throughout the state.

Revised regulations will address agencies' concerns about confidentiality and clearly define the legal authority of the Department to collect and protect client information that is sent to the State by providers. These new regulations are in the final stage of adoption. Providers are required by existing statute and these new regulations to submit MIS information to the Department.

Recommendation #5: DMHDD should develop meaningful outcome measures and collect meaningful outcome data to determine effectiveness of services provided by public community mental health funding.

The Department agrees with the importance of collecting meaningful data for purposes of determining the effectiveness of mental health services. The Department is participating with the planning boards and the AMHTA in a planning process for the next Comprehensive Integrated Mental Health Plan (CIMHP). The next CIMHP will identify common methods to measure the impacts of our services on Alaskans who need mental health services. This approach to planning is called Results-Based Planning and starts with developing a common

Fairbanks Community Mental Health Center

ARORA Consent Form

Client #: _____ Client Name: _____

PURPOSE: The Division of Mental Health and Developmental Disabilities (DMH/DD) has asked the Fairbanks Community Mental Health Center (FCMHC) to submit certain additional data on each of FCMHC's clients. The purpose of this form is to ask you whether you authorize FCMHC to submit personal identifying information about you.

ARORA PROJECT: The DMH/DD has developed a management information system called the Alaska Recipient Outcomes Research Application (ARORA). The DMH/DD wants FCMHC and other community mental health agencies throughout the state to submit certain personal identifying data on each client.

NON-IDENTIFYING INFORMATION: The data which FCMHC will submit for the ARORA project includes non-identifying information about you, such as race, sex, marital status, income, date of birth, and diagnosis. Historically FCMHC has routinely furnished this kind of non-identifying information about FCMHC's clients to various state and federal agencies and other authorized persons for statistical analysis and other legitimate uses.

PERSONAL IDENTIFYING INFORMATION: The additional data which the DMH/DD requests for the ARORA project includes the following personal identifying information about you:

1: The first two letters of your last name.
2: The first two letters of your first name.
3: The last four digits of your Social Security Number.

Please Check One of the Following:

_____ YES, I authorize FCMHC to provide personal identifying information about me to the Division of Mental Health and Developmental Disabilities.

_____ NO, I do not authorize FCMHC to provide personal identifying information about me to the Division of Mental Health and Devlopmental Disabilities.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Relationship Date

_____ _____
Witness Date

NAVIGATION MENU

ARORA MENTAL HEALTH DATABASE LAWSUIT INFORMATION PAGE

This web page contains information about a lawsuit challenging the legality of the State of Alaska's ARORA mental health reporting requirements. The site is maintained by Fairbanks attorney Gail Ballou as a service to persons who are interested in learning about the ARORA database, the state's reporting requirements, the ARORA lawsuit, and related issues. The author represents plaintiff Fairbanks Community Mental Health Center in the ARORA lawsuit, but nothing at this web site is an official statement on behalf of Fairbanks Community Mental Health Center.

What is ARORA?:

ARORA is a computerized government data collection system which compiles information about mental health care consumers in Alaska. The term "ARORA" is an abbreviation for the name of the system, *"Alaska Recipient Outcome Research Application."*

Through the ARORA system, the state's Division of Mental Health and Developmental Disabilities seeks to collect detailed information about every consumer who obtains services from a mental health care provider who receives state funding through Alaska's community mental health services program. The information which the Division gathers includes a wealth of personal information as well as each consumer's specific diagnosis(es) from a checklist of mental health disorders known as the DSM-IV. In November of 1997, the state adopted administrative regulations which formally authorize the ARORA system and which require all mental health care providers who receive state grant funds to report information about their clients to the Division.

The Division intends to keep ARORA information indefinitely and to use the information for "program planning, program evaluation, and research," including cross-referencing information with other state databases. According to a recent newspaper article, the ARORA database already contains information on 9,000 people.

What's the problem with ARORA?

Many mental health care consumers and professionals have serious misgivings about ARORA. One concern is that the ARORA regulations and reporting requirements may violate consumers' rights and providers' duties under various provisions of state and federal law, such as Alaska statutes protecting the confidentiality of therapist-patient communications and federal law governing the use of Social Security numbers. Some providers are not complying fully with the ARORA reporting

requirements because of this concern about the legal status of ARORA. Another concern is that the ARORA reporting requirements, even if legal, interfere with mental health therapy because consumers understandably do not want to divulge intimate details of their lives to therapists who must forward those details to a government computer database.

One concerned provider, Fairbanks Community Mental Health Center, recently filed a lawsuit to resolve doubts about the legality of the ARORA system. In response to the lawsuit, Senator Pete Kelly (R-Fairbanks) has introduced legislation to address some of the legal issues raised in the ARORA lawsuit.

About the ARORA lawsuit:

Case name: *Fairbanks Community Mental Health Center, Inc. v. State of Alaska*
File no.: 4FA-98-3530 Civil
Court: Superior Court for the State of Alaska, at Fairbanks
604 Barnette Street, Room 342
Fairbanks, Alaska 99701

Selected court filings as of March 15, 1999 (click on link to view document):

- Complaint for Declaratory and Injunctive Relief filed December 31, 1998
- State's Answer (on-line copy not yet available)
- State's Motion for Judgment on the Pleadings filed March 15, 1999 (on-line copy not yet available)

Senate Bill 97

Senator Pete Kelly (R-Fairbanks) has introduced legislation which proposes to solve some of the legal problems identified in the ARORA lawsuit by partially repealing existing laws which require mental health care professionals to protect consumers' privacy. The bill, known as SB 97, is currently in the senate Health, Education and Social Services Committee, of which Senator Kelly is vice chair.

To read the full text of SB 97 or to find information about the bill, visit the SB 97 Information Page.

Have an opinion about ARORA or SB 97? Use these links to contact Alaska government officials:

- Division of Mental Health and Developmental Disabilities
- Governor Tony Knowles
- Senator Pete Kelly (sponsor of SB 97 and Vice Chair, senate HES Committee)
- Other members of the senate Health, Education and Social Services Committee, which is considering SB 97:
    - Senator Mike Miller (R-North Pole) (Chair)
    - Senator Drue Pearce (R-Anchorage)

- Senator Gary Wilken (R-Fairbanks)
- Senator Kim Elton (D-Juneau)

- Other Alaska state senators
- Alaska state representatives

Updated: March 16, 1999

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From the **Fairbanks Daily News-Miner**
January 18, 1999, at B-1
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Lawsuit filed over mental health reporting requirement

By Al Slavin, Staff Writer

After two years of talk, concern over a state database that contains profiles of mental health patients has escalated into a legal battle.

A local organization has filed a court challenge against a state-mandated reporting requirement because it believes the system jeopardizes patient confidentiality.

"For two years we've been trying to get this thing squared away and express our concerns and here's where we are," said Doug Pomeroy, executive director of the Fairbanks Community Mental Health Center.

State officials disagree with Pomeroy's claims regarding confidentiality and think the management information system, known as ARORA, serves a valuable purpose in formulating departmental policy and strategy.

"We have an obligation to collect data so we can do effective planning," said Karl Brimner, director of the state's Division of Mental Health and Developmental Disabilities.

The colleagues now find themselves at the opposite end of a philosophical rift. The Fairbanks Community Mental Health Center recently filed a lawsuit against the division in Fairbanks Superior Court. They have requested a court injunction that would prohibit the division from gathering or disclosing any of the data.

Pomeroy's organization had always shared case information with the state in the past. The details are used in the planning and budgetary process. The division's new management information system, called the Alaska Recipient Outcomes Research Application, reached beyond the traditional, more generic reporting requirements.

ARORA requires precise patient information to establish an algorithm, which then serves as a patient's identity. The first two letters of a patient's first and last name are designated as a label, along with the patient's date of birth and last four digits of his or her social security number.

This permits the division to determine whether services are being duplicated and gauge the effectiveness of treatment in individual cases. Pomeroy believes an individual can be identified if the labeling information is cross-referenced with other public records that are more readily available to the public.

His agency's attorney, Gail Ballou, conducted an experiment to that effect. Pomeroy gave Ballou 23 algorithms established under the ARORA guidelines. They were referenced against public records. Pomeroy said Ballou was able to identify 16 of those individuals [see sidebar].

Pomeroy is worried that patients will hold back on

Decoding ARORA algorithms

(this sidebar is not part of the original News-Miner article)

In the ARORA database, individual mental health care consumers are not identified by name. Instead, each consumer is assigned a fourteen-digit code which is called

disclosing information in light of the mandatory reporting requirements and it will undermine the trust relationship.

"This relationship is what mental health work is built on," Pomeroy said. "If it's a poor one, mental health work cannot occur. That's why our concerns about the management information system known as ARORA are so acute."

The lawsuit identifies a perceived conflict between the confidentiality laws that regulate such professions as psychologists, therapists and others involved in social work. At odds is an administrative regulation adopted by the division. It requires all mental health organizations to comply with the mandatory reporting requirements or they risk losing state funding. In the case of the Fairbanks Community Mental Health Center, that would translate into a $3 million loss.

"I suppose that's a possible consequence somewhere in the future," Brimner said.

Each year, the division doles out $32 million in grants to 45 mental health organizations across the state. Brimner estimated that about 20,000 individuals received services. The ARORA database was created in November 1997 and that database now includes case information on 9,000 individuals.

Brimner is not alarmed by the privacy concerns raised by Pomeroy because he believes proper safeguards are in place.

"The algorithm protects the ability to solicit that information," Brimner said. "Within my division, there are only a limited amount of people that have access to that information and they know they can be subject to prosecution or penalties."

Brimner said the information enables the division to not only ascertain the effectiveness of treatment, but locate specific areas where additional services may be required.

"The division thinks those are the links that are important to us so that we can do the best planning," Brimner said. "It tells us not only how many being served but how they are being served."

The Washington State Supreme Court had a similar opinion in a decision handed down in 1986.

an algorithm. This code, or algorithm, is supposed to protect the identity and privacy of mental health care consumers, but it does not.

The fourteen-digit ARORA algorithm consists of the first two letters of the consumer's first and last names, the consumer's date of birth, and the la four digits of the consumer's Social Security number. For example, the ARORA algorithm for a person named Jane Smith who was born on November 4, 1955 and whose Social Security number is 123-45-6789 is JASM1104556789.

Such a mixture of letters and numbers may seem impenetrable at first glance, but in fact it is easy to decode an ARORA algorithm and to determine a mental health care consumer's identity.

The fastest way to decode an ARORA algorithm is to use elementary computer search-and-sort techniques to compare an algorithm to information contained in one or more government or private computer databases which contain most Alaskans' names, birth dates, and Social Security numbers. Examples of such databases include the Permanent Fund Dividend file, law enforcement's Alaska Public Safety Information Network (APSIN), and credit reporting companies' records. By using simple search-and-sort methods, it is easy to identify every person in a database whose whose name, birth date, and Social Security number match the information contained in an ARORA algorithm. For nearly all ARORA algorithms, there will be only one match.

Since there ordinarily will be just one match, an ARORA algorithm is a highly reliable device for identifying and tracking mental health care consumers. Indeed, an ARORA algorithm is often a better identifier than is a consumer's name alone, since an algorithm contains information (birth date and part of Social Security number) which makes it possible to distinguish among people who have the same name, to track consumers whose names change (for example, women who change their names upon marriage or divorce), and to target consumers who try to protect their privacy by giving a fictitious name, incorrect birth date, or made-up Social Security number.

Of course, most people who might want to decode an ARORA algorithm do not have access to huge government or corporate databases which make it easy to decode an algorithm quickly, but access to these databases is not necessary. An average person who wants to decode an ARORA algorithm can ordinarily do so just by comparing the algorithm to information which is readily available in public records, libraries, and now on the Internet.

In the experiment mentioned in the accompanying News-Miner article, 16 of 23 algorithms were decoded in only 24 hours by one person who researched information which is available to anyone at no cost. Decoding was

A hospital and two patients challenged the legality of reporting requirements. The court ruled in favor of the state in a split decision. The decision permitted the state to gather the data, provided it was "carefully tailored to meet valid governmental interest."

stopped after 24 hours because, by then, the experiment had already demonstrated that ARORA algorithms do not protect the identity or privacy of mental health care consumers.

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