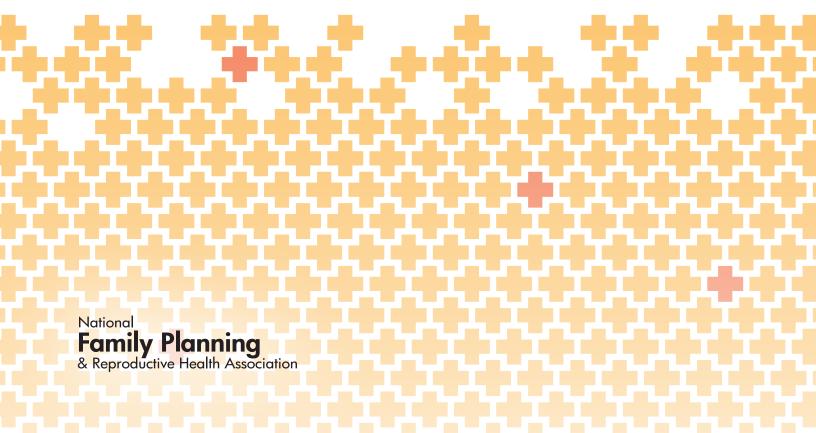
### Impacts of an Intervention to Improve Screening for Patients' Health Insurance and Need for Payment Privacy in the Title X Network

**CONFIDENTIAL** 

Jennifer Yarger, Amanda Mulligan, Leah E. Masselink, Megan Couillard, Susan F. Wood, Claire D. Brindis, and Clare Coleman



# CONFIDENTIAL ♦ COVERED

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### **JUNE 2017**

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### **Executive Summary**

*Confidential & Covered* was a three-year research project funded by the US Department of Health & Human Services' Office of Population Affairs as part of its Affordable Care Act Collaborative.<sup>1</sup> The project was designed to identify policies and practices to mitigate revenue loss at Title X family planning providers due to the provision of confidential health services. The project's purpose was to improve health centers' sustainability and preserve one of Title X's core principles, namely the provision of confidential care for patients served by this essential program. *Confidential & Covered* partnered with the Center for Adolescent Health & the Law, the George Washington University's Milken Institute School of Public Health, and the University of California, San Francisco's Bixby Center for Global Reproductive Health to conduct research on insurance use and confidentiality through the payment process.

In the third year of the project (2016–2017), the *Confidential & Covered* project team fielded a study to examine how an intervention involving health insurance screening processes and staff training impacted staff knowledge and skills related to screening for patients' health insurance coverage and their need for payment privacy. It also investigated whether the intervention increased insurance billing while maintaining client confidentiality at Title X health centers.

### **Objectives**

The *Confidential & Covered* randomized trial was designed to evaluate the impacts of an intervention that modifies how Title X health centers screen for patients' insurance coverage and their need for payment privacy.

The specific objectives of the study were to:

- Evaluate whether the intervention increases staff knowledge and skills related to screening for patients' health insurance coverage and need for payment privacy.
- Identify the extent to which patients opt not to use their insurance because of concerns about potential breaches of confidentiality during the billing process.
- Evaluate whether the intervention leads to an increase in patient use of insurance.

To achieve these objectives, the project team conducted a stepped wedge cluster randomized trial in 17 Title X service sites across the United States. The study involved the sequential rollout of the intervention to the participating sites; by the end of the study, all sites implemented the intervention, although the order in which they did so was determined at random. The study collected surveys of staff who were involved in patient intake before and after the intervention, along with semistructured interviews with intake staff after the intervention. Administrative and claims data were collected throughout the study, as well as patient responses to the questions that sites used to screen for health insurance coverage and the need for payment privacy.

### **Key Findings**

**Impact on staff knowledge and skills** The *Confidential & Covered* training was successful in increasing staff knowledge and skills that are necessary to distinguish between the need for confidential care and payment that does not breach privacy.

#### Staff response to the intervention

Intake staff responded positively to the training, particularly those who were relatively new to their roles in screening for health insurance coverage. Staff believed that the screening processes were helpful, easy to follow, and provided an opportunity to educate patients about their coverage. They indicated that they would want to continue following the insurance screening processes after the end of the study.

### Prevalence of patients opting not to use their insurance

The intervention screening protocol involved screening each patient at each visit for their health insurance coverage and need for payment privacy. During the intervention, sites asked questions to specifically identify patients who had insurance but did not want to use it, and the reasons why they opted not to use insurance for the visit; comparable questions were not asked during the control period. Patients who indicated that they had health insurance yet opted not to use it accounted for 4% of family planning visits. The percentage

i The members of the collaborative are Altarum Institute in partnership with the Urban Institute, the Guttmacher Institute, and NFPRHA. More information about the Affordable Care Act Collaborative can be found at hhs.gov/opa/affordable-care-act/affordable-care-act-collaborative.

of these patients who opted not to use their insurance was higher among female patients than male patients, among patients under age 20 than older patients, and among patients at Planned Parenthood health centers than patients at other types of Title X service sites.

### Reasons patients gave for opting not to use their insurance

The most common reason patients gave for choosing not to use their insurance was concerns about confidentiality. Staff observed that patients who were concerned about the cost of using their insurance were somewhat likely to change their minds and use their insurance after speaking with intake staff. On the other hand, patients with confidentiality concerns were unlikely to change their minds about using their insurance.

#### Impact on rates of billing insurance

Overall, the intervention did not lead to increased rates of billing insurance; encounters during the intervention period were just as likely to be billed to insurance as encounters during the control period. A longer-term evaluation may be necessary to detect an impact of the intervention on billing rates.

### Conclusion

Following recent cuts in federal funding for the Title X program, recipients of the program's funding have felt increasing pressure to identify new revenue streams, including taking advantage of all opportunities for insurance reimbursement. Securing insurance reimbursement is complex and can present multiple challenges for sites, including determining the best strategy to screen for health insurance coverage and identify patients with confidentiality concerns related to billing or insurance. This study found that the *Confidential* & *Covered* training led to improvements in staff knowledge and skills related to screening for health insurance and the need for payment privacy. When sites implemented the intervention screening processes, patients opted not to use their insurance for 4% of family planning visits. The majority of those patients cited concerns about confidentiality as their reason for not using their insurance. Overall, the intervention did not lead to increased rates of billing insurance. However, intake staff responded positively to the intervention and expressed support for continuing the screening protocol after the conclusion of the study.

### Recommendations

The report includes the following recommendations that may help Title X health centers increase revenue while protecting patients who are in need of payment that does not breach privacy:

Educating staff and patients about health insurance coverage and payment privacy

- Provide trainings for staff, such as the *Confidential & Covered* training webinar, that differentiate between confidential care and communication and payment that does not breach privacy.
- Offer trainings to all staff, particularly staff who are new to the role of screening for health insurance coverage.
- Provide patient education to help expand their health insurance literacy, including information about the range of communications they may receive from their insurer, as well as information to help them understand their coverage.

Screening for health insurance coverage and confidentiality needs

- Screen for health insurance coverage at each appointment.
- Screen for the need for payment privacy at each appointment.
- Screen all patients for health insurance coverage and confidentiality needs, regardless of factors such as age or the reason for the visit.
- Ask specific questions about insurance billing rather than assuming that patients who express desires for confidential care and health center communications also need payment that does not breach privacy.
- Ask specific questions to understand why patients choose not to use their insurance.
- Build the capacity to provide the option of splitting health insurance claims, so patients can use their insurance for some services while opting out of using their insurance for other services that require payment privacy.
- Develop a strategy for documenting and tracking when patients choose not to use their insurance coverage.

Materials developed for the intervention, including the training webinar, may be accessed at https://www.confidentialandcovered.com/.

# Introduction

Confidential & Covered was a three-year research project funded by the US Department of Health & Human Services' Office of Population Affairs as part of its Affordable Care Act Collaborative.<sup>1</sup> The project was designed to identify policies and practices to mitigate revenue loss at Title X family planning providers due to the provision of confidential health services. The purpose was to improve health centers' sustainability and preserve one of Title X's core principles, namely the provision of confidential services for patients served by this essential program. *Confidential & Covered* partnered with the Center for Adolescent Health & the Law, the George Washington University's Milken Institute School of Public Health, and the University of California, San Francisco's Bixby Center for Global Reproductive Health to conduct research on insurance use and confidentiality through the payment process.

In the third year of the project (2016–2017), the *Confidential & Covered* project team fielded a cluster randomized trial to investigate how an intervention involving health insurance screening processes and staff training impacted staff knowledge and skills related to screening for patients' health insurance coverage and need for payment privacy. It also examined whether the intervention increased insurance billing while maintaining client confidentiality at Title X health centers.

### Background

The expansion of health insurance coverage under the Affordable Care Act (ACA) has increased access to insurance reimbursement for safety-net family planning providers, including those funded by Title X. The Title X program requirements specify that providers must seek third-party reimbursement for services and supplies provided whenever possible.<sup>2</sup> Given the decline in federal funding for the Title X program in recent years, commercial and public insurance reimbursement have become even more vital for health centers' financial sustainability.

The need to maximize reimbursement from third-party payers can pose

challenges to family planning providers seeking to uphold Title X's strong commitment to maintaining patient confidentiality. Title X confidentiality requirements3 have been incorporated into Title X program guidance,<sup>4</sup> and they are one of the reasons individuals choose to seek services at Title X-funded health centers.<sup>5</sup> Many patients seen in Title X health centers are likely to be insured as dependents under a parent's, spouse's, or partner's plan. Communications generated throughout the insurance claims process, such as an explanation of benefits (EOB) or posts to electronic patient portals, may lead to unwanted information being shared with insurance policyholders or other family members.

In addition to screening for whether patients have insurance coverage, modifying screening processes to include specific confidentiality concerns related to billing or insurance is important for protecting patients who are in need of payment that does not breach privacy. A nationwide environmental scan of the Title X network found that most health centers could improve how they screen for patients' concerns about allowing their health insurance to be billed. A majority of the survey participants reported that they asked patients if they had concerns about confidentiality related to phone calls (71%) or mailings (67%) coming from the health center. In comparison, only 52% reported asking whether patients had confidentiality concerns about billing in general, and

<sup>1</sup> The members of the collaborative are Altarum Institute in partnership with the Urban Institute, the Guttmacher Institute, and NFPRHA. More information about the Affordable Care Act Collaborative can be found at hhs.gov/opa/affordable-care-act/affordable-care-act-collaborative.

<sup>2</sup> Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 8. https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf.

<sup>3 42</sup> C.F.R. § 59.11.

<sup>4</sup> Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. https://www.hhs.gov/opa/sites/default/files/ogccleared-final-april.pdf.

<sup>5</sup> Jennifer J. Frost, Rachel Benson Gold, and Amelia Bucek, "Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs," Women's Health Issues 22 (November 2012): e519-e525.

fewer reported asking whether patients had confidentiality concerns for specific visits (40%) or services (26%).<sup>6</sup>

Improving the process for screening and tracking patients' insurance coverage and need for payment privacy can also help to bolster the center's financial sustainability. Health center staff may assume that patients who express concerns regarding their care and health center communications also need payment that does not breach privacy.7 Instead of billing third-party payers, they use grant funds to cover services, write off charges, or, if available, use a Medicaid family planning expansion program.8 Defaulting to public programs or avoiding billing can mean lost revenue in cases when a patient's care could be covered by health insurance. On the other hand, asking more specific screening questions might enable Title X providers to bill patients' insurance by determining their specific needs and addressing their concerns. In addition, there may be some patients who are new to insurance or have low levels of health insurance literacy who would consider using their insurance after speaking with staff about their concerns.

Another benefit of improving the process for screening and tracking patients' insurance coverage and need for payment privacy is gaining a better understanding of the financial impact of current confidentiality and insurance billing practices. Many Title X providers lack a clear understanding of how often they avoid billing due to patients' concerns about confidentiality or the financial impact of this practice on their health centers.<sup>9,10</sup> Understanding the characteristics of the patients who opt not to use their insurance and the specific types of services for which they choose not to use insurance can help sites improve their staff training and screening processes. In the long run, improving screening and tracking related to patients' need for payment privacy may help sites to more precisely anticipate their revenue flow.

### Description of the Intervention

The *Confidential & Covered* project team developed an intervention to improve how Title X health centers screen for patients' health insurance and need for payment privacy. The intervention built on research conducted in the first two years of the project, including a nationwide environmental scan of Title X health centers and legal and policy analysis. A working group of individuals with experience representative of the Title X network also provided invaluable input on the intervention.

The intervention included two components, described below:

- 1. Staff training
- 2. Insurance screening protocol and questions

#### Staff training

As part of the intervention, each staff member who was involved in the patient intake process at the service site received training via a 23-minute webinar. The training included information about Title X program requirements, the importance of insurance reimbursement for sustainability of the health center, and differentiating between confidential care and communication and payment that does not breach privacy. The training also provided a detailed explanation of the intervention screening process.

At the end of the training, the goal was that each staff member would be able to:

- 1. Describe why insurance reimbursement is important for the sustainability of the health center.
- 2. Differentiate between confidential care and communication and payment that does not breach patient privacy.
- 3. Understand how to follow a protocol for screening patients for health insurance and their need for payment that does not breach patient privacy.

### Insurance screening protocol and questions

During the intervention period, intake staff were instructed to ask three specific questions to screen for patients' health insurance coverage and the need for payment privacy (*Table 1*). Versions of the questions were available for sites that

<sup>6</sup> Leah Masselink, Julie Lewis, Monique Morales, Liz Borkowski, Tishra Beeson, Susan F. Wood, and Clare Coleman, Title X Network Perspectives on Confidentiality and Insurance Billing (Washington, DC: National Family Planning & Reproductive Health Association, 2016). https://www.confidentialandcovered.com/file/ ConfidentialandCovered\_ResearchReport.pdf.

<sup>7</sup> Ibid.

<sup>8</sup> Jennifer J. Frost, Rachel Benson Gold, Lori F. Frohwirth, and Nakeisha Blades. Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010. (New York: Guttmacher Institute, 2012). http://www.guttmacher.org/pubs/clinic-survey-2010.pdf [Accessed March 20, 2014.]

<sup>9</sup> Abigail English, Amanda Mulligan, and Clare Coleman, Protecting Patients' Privacy in Health Insurance Billing & Claims: An Oregon Profile (Washington, DC: National Family Planning & Reproductive Health Association, 2017). https://www.confidentialandcovered.com/file/1-research/1.1-research--findings/Oregon\_StateProfile\_ CC.pdf.

<sup>10</sup> Leah Masselink, Julie Lewis, Monique Morales, Liz Borkowski, Tishra Beeson, Susan F. Wood, and Clare Coleman, Title X Network Perspectives on Confidentiality and Insurance Billing (Washington, DC: National Family Planning & Reproductive Health Association, 2016). https://www.confidentialandcovered.com/file/ ConfidentialandCovered\_ResearchReport.pdf.

ask patients about their health insurance coverage at the site during check inverbally or using a paper form-or when patients make an appointment over the phone. The screening questions also were available in Spanish. Staff were instructed to ask all patients the screening questions at each appointment, including new and returning patients. Staff received a decision tree to help guide them through the screening questions. They also received a conversation guide to help navigate discussions about insurance use with patients. During the intervention, staff had access to continuing technical assistance from the Confidential & Covered project team.

Materials developed for the intervention, including the training webinar, may be accessed at https://www. confidentialandcovered.com/.

#### **Control period practices**

During the control period, sites followed their standard processes for screening patients for health insurance coverage and confidentiality needs. All of the sites asked patients about their health insurance coverage using questions such as "Do you have health insurance?" Some of the sites asked questions that specifically referred to using insurance to pay for the visit such as "Will you be using insurance today?" None of the sites asked separate questions to specifically identify patients who had insurance but did not want to use it, and the reasons why they opted not to use insurance for the visit. Sites were also asked to refrain from offering training related to confidentiality, aside from the Confidential & Covered webinar, throughout the course of the study.

### **Objectives**

In this study, the Confidential & Covered project team investigated whether the intervention involving health insurance screening processes and staff training impacted staff knowledge and skills related to screening for patients' health insurance coverage and their need for payment privacy. The study also examined whether the intervention increased insurance billing while maintaining client confidentiality at Title X health centers. In addition, the study examined how often patients choose not to use their insurance because of concerns about potential breaches of confidentiality during the billing process.

Questions for screening on a paper registration/intake form

1. Do you have insurance today?
□ No
2. Are you using your insurance today?
□ No
Not applicable—do not have insurance
3. Why are you not using your insurance today? (Check all that apply.)
Concerned about confidentiality
Too expensive
Insurance does not cover services
Health center does not accept insurance
🖵 Other (please specify)
Not applicable — do not have insurance or using insurance
Questions for screening verbally at the health center during check in
1. Do you have insurance today?
If patient has insurance:
2. Are you using your insurance today?
If patient has insurance but is not using it: 3. Why are you not using your insurance today? I will read several reasons, and please tell me if any of them apply to you. [Read each response option.] Concerned about confidentiality Too expensive Insurance does not cover services Health center does not accept insurance Other reason (please specify)
Questions for screening when patients make an appointment over the phone
1. Do you have insurance?
□ No
If patient has insurance:
2. Will you be using your insurance for this visit?
□ Yes
If patient has insurance but is not using it:
<ol> <li>Why won't you be using your insurance for this visit? I will read several reasons, and please tell me if any of them apply to you.</li> </ol>
[Read each response option.]
Concerned about confidentiality
□ Too expensive
Insurance does not cover services
Health center does not accept insurance
Generation (please specify)

# Methodology

To achieve the study objectives, the project team conducted a stepped wedge cluster randomized trial in 17 Title X service sites from January to April 2017. Participating sites included stand-alone family planning centers, Planned Parenthood health centers, district and county health departments, and Federally Qualified Health Centers (FQHCs) in eight of the ten Health Resources & Services Administration (HRSA) regions. The study involved the sequential rollout of the intervention to the participating sites; all sites implemented the intervention by the end of the study, but the order in which they did so was determined at random.

The study used both qualitative and quantitative data collection methods. The project team conducted baseline and follow-up surveys of staff involved in intake in order to compare staff knowledge and skills related to health insurance screening and confidentiality before and after the intervention. Semi-structured interviews were conducted with intake staff after the intervention to gather their feedback on the training and the insurance screening procedures. Administrative and claims data were collected throughout the study in order to compare rates of billing before and after the intervention. During the intervention period, the project team collected and analyzed responses to the questions that sites used to screen for insurance coverage and the need for payment privacy. Additional information about the study methodology is included in the Appendix.

# Staff Knowledge and Skills to Screen for Insurance and Confidentiality Needs

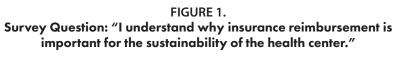
This section summarizes findings from the baseline and follow-up surveys on the impact of the intervention on staff members' knowledge and ability to screen for health insurance coverage and the need for payment privacy.

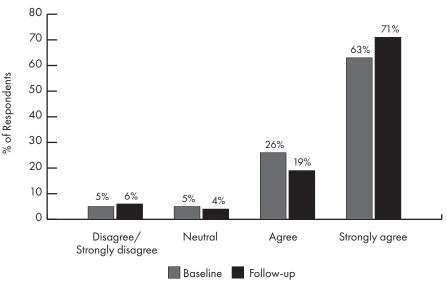
The surveys included measures in five domains:

- 1. Knowledge about why insurance reimbursement is important for the sustainability of the health center
- 2. Knowledge about the differences between confidential care and payment that does not breach privacy
- 3. Confidence in performing screening for health insurance coverage and the need for payment privacy
- 4. Confidence in performing activities associated with screening for insurance and the need for payment privacy
- 5. Learning needs related to screening for insurance and the need for payment privacy

### Knowledge about Why Insurance Reimbursement is Important for the Sustainability of the Health Center

The training included information aimed at fostering staff understanding of the importance of seeking reimbursement from third-party payers to improve the financial sustainability of the Title X service sites. The majority of survey respondents reported high levels of understanding of the importance of insurance reimbursement to sustain their health centers (indicated by "strongly agree" responses) at both the baseline (63%) and follow-up survey (71%) (*Figure 1*); however, the increase from baseline to follow-up was not statistically significant.





Note: N = 93 at baseline and 80 at follow-up.

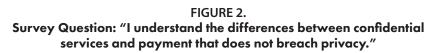
### Knowledge about the Differences between Confidential Care and Payment that Does Not Breach Privacy

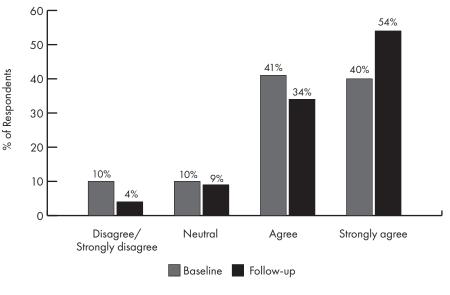
The training aimed to help staff differentiate between confidential care and communication and payment that does not breach privacy. There was a statistically significant increase in the percentage of survey respondents who strongly agreed that they understood the differences between confidential services and payment that does breach privacy from baseline (40%) to follow-up (54%) (Figure 2). Ten percent of respondents were not confident in their understanding of these differences (as indicated by "strongly disagree" or "disagree" responses) at baseline, which declined to 4% of respondents at follow-up.

### Confidence in Screening for Health Insurance and the Need for Payment Privacy

The project team asked intake staff about their level of confidence in their ability to screen for patients' health insurance coverage and need for payment privacy. At baseline and follow-up, 59% of survey respondents reported confidence in their ability to screen for patients' health insurance coverage (indicated by "extremely confident" responses) (Figure 3). There was a statistically significant increase in the percentage of respondents who reported confidence in their ability to screen for patients' payment privacy needs from baseline (45%) to follow-up (59%). There was also a small but not statistically significant increase in the percentage of respondents who reported confidence in their ability to screen for patients' communication preferences from baseline (58%) to follow-up (66%).

The training and supporting materials aimed to help staff develop skills for effective communication with patients regarding their insurance coverage and concerns about using their insurance for

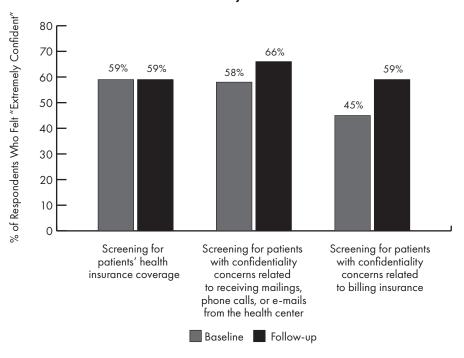




Note: N = 93 at baseline and 80 at follow-up

#### FIGURE 3.

Survey Question: "Below are some questions about your level of confidence in your ability to perform various activities at the health center. By confidence, we mean your belief or feeling that you can do the activity well."

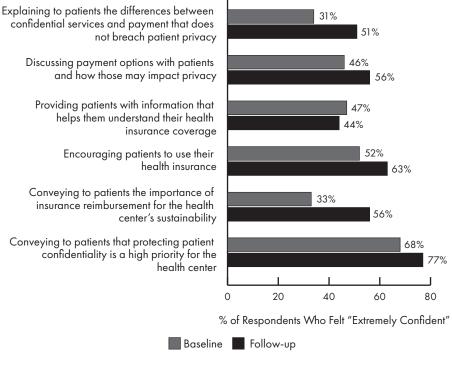


Note: N ranged from 92–93 at baseline and 75–78 at follow-up due to missing data on some measures.

family planning services. At baseline, the largest group of respondents (68%) reported confidence in their ability to convey to patients that protecting patient confidentiality is a high priority for the health center (as indicated by "extremely confident" responses) (Figure 4). In comparison, 31% of respondents reported confidence in their ability to explain to patients the differences between confidential services and payment that does not breach privacy. Similarly, 33% of respondents reported confidence in their ability to convey to patients the importance of insurance reimbursement for the health center's sustainability.

A larger percentage of respondents reported confidence in their ability to perform the various activities at followup compared to baseline. The increase in staff confidence from baseline to follow-up was statistically significant for two activities: conveying to patients that protecting patient confidentiality is a high priority for the health center (68% to 77%), and discussing payment options with patients and how those may impact privacy (46% to 56%). At follow-up, only 44% of respondents reported confidence in their ability to provide patients with information that helps them understand their health insurance coverage, which suggests the need for more staff training and support in this area.

### FIGURE 4. Survey Question: "Below are some questions about your level of confidence in your ability to perform various activities at the health center. By confidence, we mean your belief or feeling that you can do the activity well."

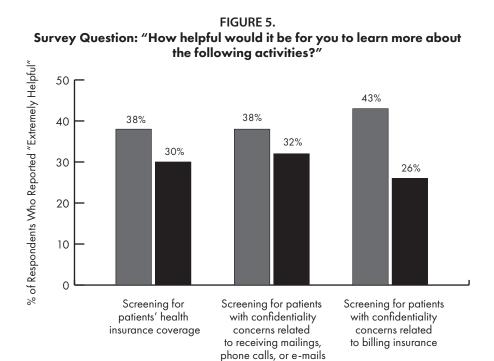


Note: N ranged from 85–92 at baseline and 75–78 at follow-up due to missing data on some measures.

### Learning Needs Related to Screening for Health Insurance and the Need for Payment Privacy

The surveys also assessed how helpful it would be for intake staff to learn more about screening for health insurance coverage and the need for payment privacy, along with a range of related activities. At baseline, more than one third of survey respondents reported that it would be helpful to learn more about each of the activities presented (as indicated by "extremely helpful" responses) (Figures 5 and 6). The largest percentage of respondents reported that it would be helpful to learn more about screening for patients with confidentiality concerns related to billing insurance (43%) and explaining to patients the differences between confidential services and payment that does not breach patient privacy (41%).

For each of the activities, the percentage of survey respondents who reported that it would be helpful to learn more about them declined from baseline to follow-up. There was a statistically significant decline in the percentage of respondents who reported that it would be helpful to learn more about screening for patients with confidentiality concerns related to billing insurance (43% to 26%), explaining to patients the differences between confidential services and payment that does not breach patient privacy (41% to 21%), and discussing payment options with patients and how those may impact privacy (37% to 21%).

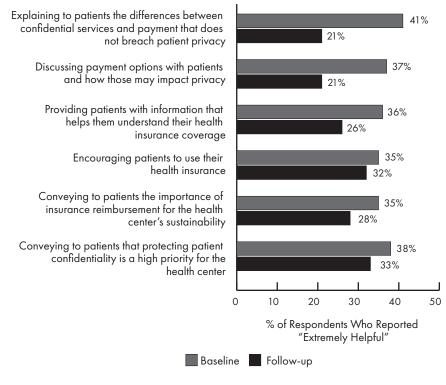


Note: N ranged from 91–93 at baseline and 75–78 at follow-up due to missing data on some measures.

from the health center

Baseline Follow-up

#### FIGURE 6. Survey Question: "How helpful would it be for you to learn more about the following activities?"



Note: N ranged from 87–92 at baseline and 72–77 at follow-up due to missing data on some measures.

### Staff Response to the Training and Insurance Screening Protocol

This section summarizes staff perceptions of the training and intervention screening protocol, along with their views on the challenges to implementing the screening protocol and desire to continue following the screening protocol after the conclusion of the study.

### Attitudes toward the Training

The follow-up survey assessed respondent's perceptions of the Confidential & Covered training webinar. Most respondents agreed or strongly agreed that the training helped them to feel more confident in their ability to screen for patients who need payment privacy (66%) and helped them to understand the importance of thirdparty reimbursement for the health center's sustainability (62%) (Figure 7). The majority of respondents agreed or strongly agreed that the training was worth their time (69%) and that it was a valuable experience (70%). One survey respondent shared that the training raised her awareness of the importance of screening patients:

"At first I thought this was a meaningless endeavor (meaning a waste of time), however, I find it has made me more cognizant of my screening of patients while talking to them on the phone about services and insurance, and when setting up basic appointments. I'm still working on how to talk to clients about their insurance because insurances seem so erratic (unwilling and inconsistent) about coverage."

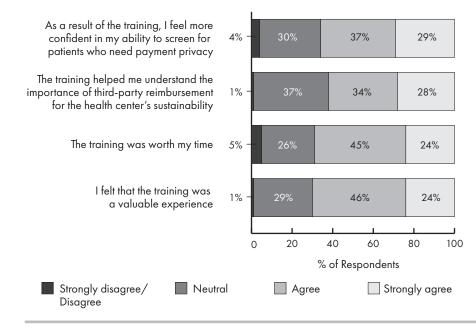
–Intake staff at a county health department

One respondent who was neutral about the value of the training pointed to the importance of hands-on training: "Practicing, hands on, will make the screening process easier until it becomes a norm."

In the interviews, most participants reported that the training was helpful, with some noting that it was a "nice introduction" and others a "good review." Staff who had held their professional roles for less time tended to view the webinar as more useful than those with more experience. Interview participants who had a longer tenure in their position were more likely to report that the webinar presented little new information. One participant noted, "It backed up what I already knew."

#### FIGURE 7.

Survey Question: "Below are some questions about the Confidential & Covered online training you received. Please answer if you strongly disagree, disagree, agree, or strongly agree with the following statements." (N=76)



Staff viewed the conversation guide and decision tree mostly as useful supplements to the training webinar. One interview participant reported that the language in the documents helped her to encourage patients to share their concerns about using their health insurance: "People were willing to share if we approached it the correct way." Other participant reactions included:

- "It gave me more explanatory tools to use with the patient."
- "It really helps to have the little guideline we can go over in our spare time, just in case these questions do come up."
- "Having the language to explain [insurance options] is really valuable."

During several interviews, participants stated that the training introduced them to the idea of splitting health insurance claims, which was new to them or their Title X service site. For example, a contraceptive service could be billed to insurance, while a sexually transmitted disease (STD) screening at the same visit could be a confidential, self-pay item. All participants who noted this piece of the webinar during the interviews said their sites had the ability to split the claims of the visit to allow for different payment types.

### Attitudes toward the Screening Protocol

Overall, interview participants believed that the screening processes were helpful and straightforward. One interview participant stated, "The questions you set out for us to use have actually helped us a great deal. I don't see anything negative about them, or anything that could be improved. It's pretty straightforward." Interview participants reported that the response options for the question regarding reasons for not using insurance options were reflective of their patients' experiences. Some indicated that the new questions were useful because of their simplicity: "It helps approach it in the right way, so they can understand what

we can do for them." Another interview participant reported that the questions were useful because "sometimes [patients] don't know we take insurance."

Interview participants from service sites that already asked similar insurance screening questions were split in how useful they rated the questions. Some noted that the training and new questions were not useful because of the similarity to old methods and previous knowledge: "I felt that a lot of the information in the training didn't pertain to where we work... And a lot of the information about asking about insurance we already do, so I didn't get a lot out of it."

Interview participants also observed that another positive outcome of the screening process is that patients' records were updated more regularly. Several participants noted that their sites did not ask patients about insurance at every patient visit prior to the intervention. Once a patient was marked as "uninsured" in his or her file, it would only be updated if the patient initiated conversation around insurance. In this case, a patient may have insurance and health centers may not bill it for months or years. Interview participants did not seem to think this was malicious or intentional, but ordinary patient forgetfulness or a patient's lack of awareness that they needed to notify the health center of changes in coverage. With the intervention in place, sites could more easily identify and update patient insurance records.

Documenting patients' responses to the screening questions can help health centers gain a better understanding of concerns about using health insurance in their patient population. In addition, one interview participant noted that the action of reporting the answers could be a useful training tool for new staff: "If we were to train someone new, I really like that we have to log [the patients' answers to the screening questions]. That way, at least for me, it's a way I remember to [ask the questions] if I know I have to log it down somewhere. I would train them the same way, at least until they're comfortable enough to remember."

Regarding the burden of implementing the screening protocol, the screening questions were generally not seen as requiring much extra effort by the participants. A few stated that the small amount of extra time with a patient is typically acceptable, but can be detrimental when there are multiple people waiting to be checked in. Overall, the screening questions were wellreceived. One participant noted that it was "probably the least amount of change to the work flow that anyone's asked us to do; it fit in really well with what we were already doing." Other participants echoed this sentiment as well.

### Challenges to Implementing the Screening Protocol

All of the interview participants reported high rates of adherence to the screening protocol. Some reported that they might not ask the screening questions if there was a backlog of patients waiting to check in or if there was more activity at the front desk, causing them to overlook the questions. Several staff members explained that they might not ask the screening questions if a patient had recently visited the health center, such as if they came back for a prescription or for a follow-up appointment.

Sites varied by whether they asked the questions verbally and/or put them on a paper form. Several interview participants reported that verbal answers made it easier to initiate a conversation around payment. One participant made this point regarding paper forms: "People might have more time to consider their answer if they're sitting in the waiting room with the form in front of them versus a verbal response."

Several interview participants noted that the openness of their front-desk area could affect how likely patients were to disclose confidentiality concerns and the reasons behind them. One participant thought that even with an open front desk, the screening questions helped enable patients to be "more willing to admit they do have insurance." Two interview participants who worked in centers with open front desk spaces stated that a patient may be more likely to disclose their situation to a nurse or other medical professional with whom they have built a relationship.

"I'm not sure why, but [this patient] was very adamant about not using his insurance, and [confidentiality] was why [he] didn't want to use it. He might've said more to the nurse while he was back there, but as far as up front here, I don't ask a lot about the personal stuff. It's pretty open up front here. But I do know he came back again, same thing, didn't want to use his insurance."

–Billing clerk at a county health department

"It's just hard, like I said, when you're face to face, checking them in at that window. They're not readily jumping up to give you the information. Lots of times it's not until they go back in the room and they've kind of formed a bond with somebody that they're saying 'I'm in this situation and I don't want anything [shared],' so then maybe the nurse or the provider comes up then to talk to the front desk person to explain why we need to find a different way for this patient to have the appointment paid for."

–Front desk staff at a county health department

Only one interview participant reported that they had a patient who chose not to answer the screening questions. According to the participant, this patient wanted to maintain a high level of confidentiality during the visit, and wanted only to receive services and leave.

### Desire to Continue Following the Screening Protocol

Most interview participants thought the intervention as a whole was useful and they would like to continue using the screening questions after the completion of the study. One interview participant noted that the intervention in general raised awareness of the need to help protect patient privacy in the billing process, and said, "For our agency, it's opened their eyes, like 'how can we better this [process] for our patients, for our clients?'" Interview participants who already had similar screening questions in place seemed to feel that the continuation of the screening questions was a given:

- "We'll still definitely be screening our patients for the reasons behind why they do not want to use their insurance or what is keeping them from using their insurance. Like I said, that is a regular, everyday practice for us, so that will continue."
- –Front desk manager at a Planned Parenthood health center

However, interview participants had a more mixed response when asked if they would continue tracking responses of the screening questions. While there was general agreement about the usefulness of the questions themselves, tracking the overall trends in insurance use or nonuse did not seem to be helpful to every center. One interview participant noted that the overall summary report was useful, but not necessarily because of the screening questions: "It was kind of eyeopening to see what procedures we did do over and over and over again."

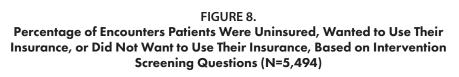
# Health Insurance Billing

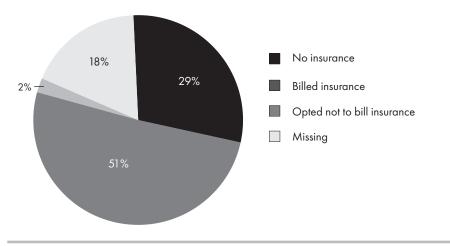
As part of the intervention, participating sites were instructed to screen patients at each visit for whether they had insurance, whether they intended to use their insurance, and the reasons why they opted not to use their insurance for the visit. This section summarizes patients' responses to the intervention screening questions; comparable data were not collected during the control period. It also summarizes interview participants' views regarding why patients chose not to use their insurance and their willingness to change their minds about using their insurance after speaking with the intake staff. Finally, this section presents findings regarding the difference in the insurance billing rate between the intervention and control period.

### Prevalence of Patients Choosing Not to Use Their Insurance

Patients who chose to use their insurance accounted for just over half (51%) of family planning encounters at the study sites during the intervention period (*Figure 8*). Uninsured patients accounted for nearly one-third (29%) of encounters. Patients who indicated that they had health insurance yet opted not to use it accounted for 4% of encounters. The responses to the intervention screening questions were missing for 18% of encounters, primarily from three of the participating sites.

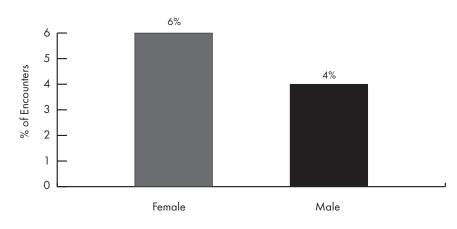
Responses to the health insurance screening questions varied by characteristics of the Title X service sites and the patients. Patients who chose not to use their insurance accounted for 6% of the encounters with female patients, compared to 4% of the encounters with male patients (Figure 9). Patients under age 20 years were more likely to choose not to use their insurance than older patients; patients who chose not to use their insurance accounted for 10% of the encounters with patients aged 15-17 and 6% of the encounters with patients aged 18-19 (Figure 10). In addition, the percentage of encounters in which patients opted not to use their insurance was higher at Planned Parenthood health centers (8%) than stand-alone family planning centers (2%), health departments (3%), and FQHCs (less than 1%) (Figure 11).





#### FIGURE 9.

Percentage of Encounters in which Patients Opted Not to Use Their Insurance, by Sex of the Patient, Based on Intervention Screening Questions



Note: N = 4,996 for females and 497 for males.

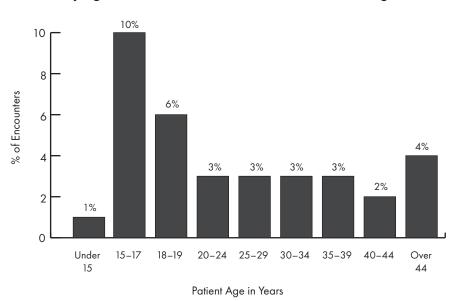
### Patients Choosing Not to Use Their Insurance Due to Confidentiality Concerns

Among the patients who did not want to use their insurance, the most common reason given was concerns about confidentiality. According to patient responses to the intervention screening questions, 44% of the patients who did not want to use their insurance for the visit cited confidentiality concerns (Figure 12). This finding aligned with the perceptions expressed by interview participants; each intake staff interviewed noted that the most common reason patients gave for not wanting to use their insurance was concerns about potential breaches of privacy in the billing process, such as a family member learning about their visit through an EOB sent to their home. One interview participant explained that confidentiality concerns could outweigh cost concerns, stating, "They'll pay cash, the whole bill, whatever it is."

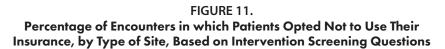
Patients who chose not to use insurance for confidentiality reasons were disproportionately adolescents and young adults. More than one-third (39%) of patients who avoided billing because of confidentiality concerns were under 18 years old, compared to 10% of all patients (*Figure 13*). Almost half (45%) of the patients requiring payment privacy were aged 18–24, compared to 36% of all patients. Only 17% of patients requiring payment privacy were aged 25 years and older, compared to more than half (54%) of all patients seeking family planning services.

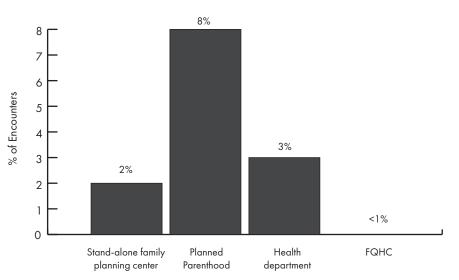
Interview participants observed that the overwhelming majority of patients with confidentiality concerns were young people on their parents' insurance plan. While most participants noted that minors and teens were the primary age group affected by confidentiality concerns, several noted that they saw these cases in patients up to age 25, given that children can stay on their parents' insurance until age 26 under the ACA. Participants generally indicated that asking all three screening questions is

#### FIGURE 10. Percentage of Encounters in which Patients Opted Not to Use Their Insurance, by Age of the Patient, Based on Intervention Screening Questions



Note: N = 153 for under age 15 years, 461 for ages 15–17, 519 for ages 18–19, 1,345 for ages 20–24, 1,170 for ages 25–29, 769 for ages 30–34, 465 for ages 35–39, 308 for ages 40–44, and 304 for ages 45 years and older.





Note: N = 1,361 for stand-alone family planning centers, 2,131 for Planned Parenthood health centers, 847 for district and county health departments, and 1,155 for FQHCs.

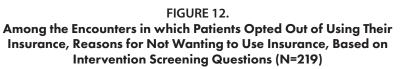
important with younger patients, with one remarking that, "Particularly with minor clients, the confidentiality piece should be vocalized."

Interview participants commented that most of the older patients with concerns about payment privacy were covered by a spouse's or partner's insurance, particularly wives covered under their husbands' insurance. One participant spoke of her experience: "If they say, 'I really don't want to use this insurance, it's held by my husband or my wife, I don't feel comfortable with them knowing that I'm here. They wouldn't be comfortable that I'm here.' Then we can definitely assess the situation, but most of the time where it's a confidentiality issue, it is a minor. A lot of non-minors are not falling into that bracket. It would pretty much just be someone who has insurance through their spouse."

The majority (88%) of patients who did not want to use their insurance due to confidentiality concerns were female, which interview participants also observed. However, clients who avoided using their insurance because of confidentiality concerns were disproportionately male; although males comprised 9% of all encounters, they accounted for 13% of the encounters in which patients did not want to use their insurance due to confidentiality concerns.

Nearly half (49%) of the visits in which patients did not want to use their insurance due to privacy concerns included a contraceptive service, compared to 37% of all encounters (*Figure 14*). Interview participants noted that female patients typically requested payment privacy for contraceptive services or STD screenings and male patients mostly requested payment privacy for STD screenings.

Encounters for which patients did not want to use their insurance occurred disproportionately at Planned Parenthood health centers. Three-quarters (75%) of encounters in which patients did not want to use their insurance due to



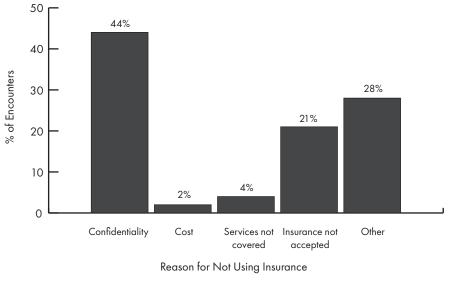
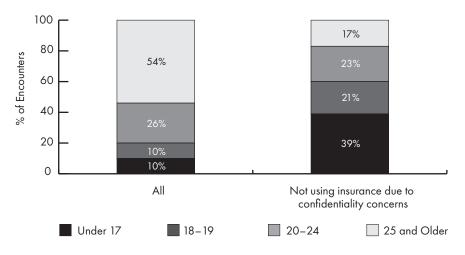


FIGURE 13.

Percentage of Encounters by Patient Age Group among All Encounters and Encounters in which Patients Chose Not to Use Insurance Due to Confidentiality Concerns



Note: N = 5,494 for all encounters and 96 for encounters in which patients opted not to use their insurance due to confidentiality concerns.

confidentiality concerns were patients from Planned Parenthood health centers, even though Planned Parenthood health centers accounted for 39% of all encounters (*Figure 15*). This finding is not surprising given differences in the provision of contraceptive services by provider type. According to the claims data, Planned Parenthood health centers provided contraceptive services in 43% of encounters, compared to 13% of encounters at the other types of health centers.

Based on the staff interviews conducted for the study, Planned Parenthood health centers may receive more requests for payment privacy regardless of the type of services patients are receiving. One interview participant from a Planned Parenthood site noted that some patients requested payment privacy irrespective of the type of services they received because of the negative associations some people have with Planned Parenthood. In contrast, staff from other types of sites reported that patients had concerns about payment privacy when they were receiving particularly sensitive services, such as contraceptive services and STD screening.

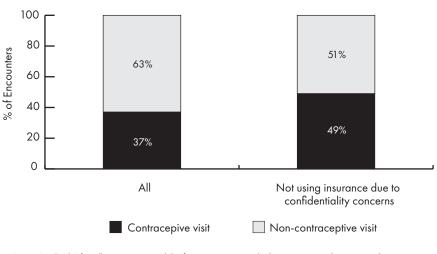
Patients who had concerns about confidentiality and needed payment that does not breach privacy also seemed to request confidential communications. One interview participant said of her patients seeking complete confidentiality: "They don't even want to give us an address; they'll use a friend's address, a friend's phone number, ... [a fake name, a fake birthday]." Another interview participant described a common workaround at her site: "If they want to be confidential we put the [center's] address."

### Other Reasons for Not Using Insurance

Aside from confidentiality concerns, the intervention screening questions allowed patients to check other reasons for not using their insurance. One in five patients who did not want to use their insurance checked that "health center does not accept insurance" and 4% checked that "insurance does not cover services."

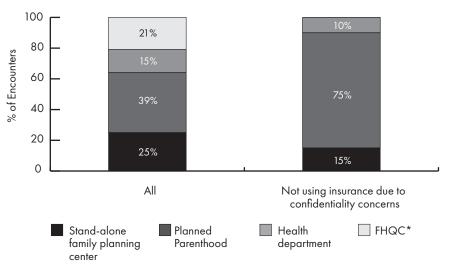
According to the intervention screening questions, patients cited cost concerns — "too expensive" — in 2% of the encounters. In contrast, interview

#### FIGURE 14. Percentage of Encounters that Included a Contraceptive Service among All Encounters and Encounters in which Patients Chose Not to Use Insurance Due to Confidentiality Concerns



Note: N = 5,494 for all encounters and 96 for encounters in which patients opted not to use their insurance due to confidentiality concerns.

#### FIGURE 15. Percentage of Encounters by Type of Site among All Encounters and Encounters in which Patients Chose Not to Use Insurance Due to Confidentiality Concerns



\*Less than 1% of the encounters in which patients opted out of billing insurance due to confidentiality concerns were at FQHCs.

Note: N = 5,494 for all encounters and 96 for encounters in which patients opted not to use their insurance due to confidentiality concerns.

participants stated that concern about cost, including having a high copay, was the second most common reason for not using insurance after confidentiality concerns. Several of the interview participants mentioned that their center offered payment plans for those who either could not afford the copay or did not have the funds at the time of service. One participant said that people may report that they do not have insurance if they are unable to pay: "I think they have a misunderstanding about what if they don't have the actual copay amount to pay, so they'll tell us they don't have insurance because they don't want to pay the copay. But we do offer ways where they can just pay it later." Another participant noted that copayments were more of an issue for younger patients who tend to be less knowledgeable about costsharing and the availability of services regardless of their ability to pay.

In addition to copayments, high deductibles also presented a barrier to using insurance. One participant summarized:

> "We've had patients who come in who have very high deductibles on their insurance, so they can't afford to go through their insurance, because their insurance just isn't going to pay anything for them because they have, you know, five thousand dollar deductibles. Their copays are very high on office visits for them. The ones who are accessing confidential services that still don't want to use their insurance, the majority of that seems to be because of their deductibles on their insurance."

-Frontline worker at a standalone family planning center

Another interview participant stated, "The two reasons [to not use insurance] that I would say are most common are confidentiality and cost. If you have a very high deductible, sometimes it can be less expensive to pay out of pocket than to pay the deductible cost." There is a notable disconnect between this comment and the ACA's contraceptive coverage mandate, which requires most health plans to provide contraceptive methods to women without cost sharing. Several participants noted that where confidentiality concerns were the most common reason for not using insurance among younger people, cost concerns (specifically regarding the deductible) were the most common reason among older patients.

In addition, more than one-fourth (28%) of patients who did not want to use their insurance cited "other" reasons for this decision. Although the intervention screening question provided the option for patients to explain the "other" reasons for not using their insurance, Confidential & Covered did not collect these responses. Based on insights gleaned from the staff interviews, some patients chose this "other" category because of concerns about the burden or hassle involved in using their insurance. For example, one participant believed that young males were choosing not to use insurance based more on simplicity than an actual confidentiality concern:

"Whereas it seems like with males, they come in, and our [out of pocket] STD testing is only twelve dollars, so they mark, 'Yes, I have insurance.' And then I say 'Do you have your insurance card?' and their reply will be 'Well it's only twelve dollars; I'll go ahead and pay for it.' And then you can get into the 'Yes, it is, but if we choose to go through your insurance then it also goes toward your deductible, and the insurance billing for us really does help to sustain our clinic,' as opposed to - and I don't say this — a measly twelve dollars.

-Receptionist at a stand-alone family planning center

Other patients did not feel comfortable disclosing their reason for not wanting to use their insurance.

Interview participants suggested that in some states, policies set by Medicaid and commercial insurance companies, including policies related to the insurance reimbursement process and insurance billing communications, can influence patients' decisions around using their health insurance. Some state Medicaid plans assign patients to a primary care provider (PCP). Participants reported that there were occasional problems billing patients if they were trying to receive services from a provider other than their PCP. Participants noted that getting the issue resolved could involve calling the PCP for a referral or changing the patient's PCP entirely. Many participants noted that their patient populations have limited understanding of how insurance works, and these intricacies make the process more difficult for the patient. In these cases, patients may decide to present as uninsured and be treated as a self-pay client in order to avoid the hassle of using their insurance.

### Patients Changing Their Minds about Using Their Insurance

*Confidential & Covered* asked the intake staff who participated in interviews how often patients changed their minds about not using their insurance after speaking with them. Some interview participants could recall a small number of patients who used their insurance but likely would not have done so prior to implementing the intervention screening processes. Avoiding billing due to patient concerns can lead to revenue loss, so interview participants noted that even a small increase in billing contributes to the financial sustainability of the health center. One participant said:

"I feel like [the screening questions] are really easy questions to answer. I don't feel like it's a burden for our clients to answer a couple more questions on the forms. Even if only in a month we get three more clients who end up using their coverage than they would've before, I feel like that's huge — not just for us, but for educating our clients about how their insurance works. I'm all about it. I think it's great."

–Front desk staff at a stand-alone family planning center

In general, interview participants noted that young people with confidentiality concerns were very unlikely to change their minds about not using insurance. One participant stated, "If a patient has already decided that there's no way in hell their mom and dad can find out they got birth control, I don't think any amount of conversation can really change that." Participants were largely empathetic to adolescents and young adults concerned with confidentiality. One front desk worker stated in regard to patients concerned about potential breaches of confidentiality, "With that, I'm apt to not push the issue, because I really respect that."

One participant shared that even when she knows a plan does not send EOBs, she would still forego insurance reimbursement for minors for their peace of mind. She stated, "They're already stressed out and freaked out and nervous and scared and filled with all kinds of dread and worry and anxiety, so anything we can do to help ease that we're happy to do."

On the other hand, participants noted that adult patients were more likely to change their minds about not using insurance if their main concern was cost. Several interview participants noted that if patients do not have the money for the copay at the visit, the patients might falsely report that they do not have insurance. Several participants explained that their sites had payment options in place for these situations, such as sliding fee scale options or payment plans. One participant explained that when proof of income is not required, the center might not receive accurate information when patients are filling out eligibility forms:

> "I've had people literally just say, 'Should I lie?' and I'm [thinking] *Why?* 'No.' I had told someone the other day, 'I'm kind of uncomfortable with that question, so I'm going to give you this form, and you do what you feel is right.""

–Front desk staff at a Planned Parenthood health center

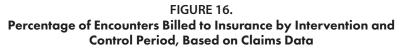
Many interview participants stated that their patients often have a low level of health insurance literacy, and the screening questions provided an opportunity to educate their patients about health insurance. One participant expressed a sentiment shared in most of the interviews: "[Young people] have no idea how insurance works or how things get paid. They just go to the doctor and don't worry about it." During their conversations with patients, participants explained that they provided more information and education about the insurance process. Regardless of whether the interaction resulted in the patient choosing to use their insurance, interview participants viewed the opportunity to

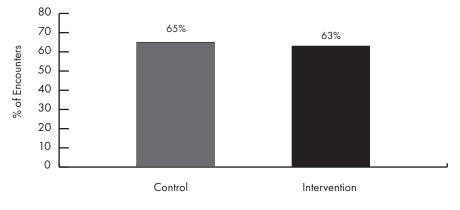
educate patients about health insurance as a positive outcome.

Although some acknowledged that it would be beneficial for the health center if more patients used insurance, there was a conscious effort by many of the interview participants to keep the conversations educational and non-coercive. One participant noted the reality of the situation by saying, "I wouldn't tell patients, but it does behoove us for them to have insurance. If they have insurance, we're thrilled to have them use it."

### Change in the Rate of Billing Insurance

Analyses of claims data indicated that the rate of insurance billing did not change significantly after the study sites implemented the training and insurance screening processes. During the control period, 65% of family planning encounters were billed to insurance, compared to 63% of family planning encounters billed to insurance during the intervention period (*Figure 16*). The slight difference in billing between the intervention and control periods was not statistically significant.





Note: N = 13,836 for the control period and 5,493 for the intervention period.

# **Discussion and Conclusion**

The Confidential & Covered project team conducted a cluster randomized trial at 17 Title X service sites across the United States in order to provide insights into changes health centers may incorporate to maximize insurance reimbursement while maintaining protections to patient privacy. The study found that the Confidential & Covered training was successful in increasing staff knowledge and skills that are necessary to screen patients for health insurance and the need for payment privacy. Staff reported a statistically significant increase in their knowledge of the differences between confidential services and payment that does not breach privacy, as well as their confidence in their ability to explain those differences to patients. Most of the staff who received the training believed that it was a valuable and worthwhile use of their time. Title X health centers may want to focus their training on staff who are new to screening for health insurance coverage, as staff new to their role in patient intake found the training to be particularly helpful.

Patients' responses to the intervention screening questions offer a better understanding of patients' insurance coverage and their need for payment privacy. During the intervention period, patients who indicated that they had health insurance yet opted not to use it accounted for 4% of family planning visits. Intake staff interviewed for the study shared that patients who do not want to use their insurance may present as uninsured, so this figure likely underestimates the extent to which individuals do not use their insurance when receiving care at Title X health centers. The majority of patients who opted not to use insurance cited concerns about confidentiality as their reason for not billing insurance. The intervention did not lead to increased rates of billing; encounters during the

intervention period were just as likely to be billed to insurance as the encounters during the control period. However, staff reported that they would want to continue to implement the screening processes after the conclusion of the study.

There are several possible reasons why the study did not find evidence of an increase in billing following the intervention. First, it is possible that the participating sites were already billing insurance in most cases when patients had coverage prior to the intervention. Sixty-five percent of encounters were already billed to insurance prior to the intervention, and data from the intervention period indicate that roughly one-third of patients were uninsured. This leaves a relatively small number of patients who may have had insurance but opted not to use it. Given the high rate of billing at the onset of the intervention, it may take longer for the intervention training and screening processes to make a detectable, statistically significant impact on the rate of billing.

Second, the intervention may have influenced the rate of billing insurance positively and negatively at the same time. According to interview participants, a small number of patients changed their minds about using their insurance, most often after talking with front desk staff about their concerns about the cost of using insurance. However, by ensuring that staff screen for concerns about payment privacy at each visit, the intervention may have increased the number of patients who chose not to bill due to confidentiality concerns related to the billing process. The positive and negative impacts may cancel one another out, leaving a null effect on the overall rate of billing.

A third possible reason why the rate of billing insurance did not change is that interview participants at some sites reported that the intervention was not substantially different than their service sites' previous practices. When recruiting sites to participate in the study, the project team interviewed site administrators to ensure that the study only included sites whose training and screening practices were significantly different from the intervention. However, some intake staff stated in interviews that they had received similar training in the past, or the insurance screening processes were similar to their experiences screening patients at their health centers.

Finally, these findings may reflect inconsistent implementation of the insurance screening processes. Nearly all intake staff were successful in completing the training webinar, and the study found significant impacts of the intervention on staff knowledge and skills. However, some of the staff interviewed reported situations when they did not ask the insurance screening questions, and the extent to which they modified the questions in practice is not known.

Additionally, the duration of the intervention period may have been insufficient for sites to fully incorporate changes in habits and practices. Staff at safety-net sites often have many responsibilities and roles to fulfill; with many competing priorities and demands for staff attention, staff may require additional time and practice to fully acclimate to and implement a change in screening protocol. Ongoing support and training so that these practices are maintained with fidelity over time is key for ongoing efforts to increase revenue while protecting patient confidentiality. Finally, the results can be viewed more broadly as reflecting the many challenges facing Title X health centers as they respond to a growing base of newly insured patients coupled with a strain on grant funding. In addition to improving the process of screening for health insurance and coverage needs, the study pointed to the importance of educating patients about insurance. This effort should take place prior to screening patients for their insurance coverage so patients with concerns about using their insurance feel comfortable reporting that they have coverage. While improving staff training and screening practices is an important first step, providers may want to consider additional changes to health center practices and policies to be able to take full advantage of insurance reimbursement while protecting patient privacy.11

#### Recommendations

Based on the study findings, *Confidential & Covered* offers the following recommendations to help Title X health centers increase revenue while protecting patients who are in need of payment that does not breach privacy:

Educating staff and patients about health insurance coverage and payment privacy

- Provide trainings for staff, such as the Confidential & Covered training webinar, that differentiate between confidential care and communication and payment that does not breach privacy.
- Offer trainings to all staff, particularly staff who are new to the role of screening for health insurance coverage.
- Provide patient education to help expand their health insurance literacy, including information about the range of communications they may receive from their insurer, as well as information to help them understand their coverage.

Screening for health insurance coverage and confidentiality needs

- Screen for health insurance coverage at each appointment.
- Screen for the need for payment privacy at each appointment.
- Screen all patients for health insurance coverage and confidentiality needs, regardless of factors such as age or the reason for the visit.
- Ask specific questions about insurance billing rather than assuming that patients who express desires for confidential care and health center communications also need payment that does not breach privacy.
- Ask specific questions to understand why patients choose not to use their insurance.
- Build the capacity to provide the option of splitting health insurance claims, so patients can use their insurance for some services while opting out of using their insurance for other services that require payment privacy.
- Develop a strategy for documenting and tracking when patients choose not to use their insurance coverage.

<sup>11</sup> Leah Masselink, Julie Lewis, Monique Morales, Liz Borkowski, Tishra Beeson, Susan F. Wood, and Clare Coleman, Title X Network Perspectives on Confidentiality and Insurance Billing (Washington, DC: National Family Planning & Reproductive Health Association, 2016). https://www.confidentialandcovered.com/file/ ConfidentialandCovered\_ResearchReport.pdf.

# Appendix

### Study Design

The Confidential & Covered project team conducted a stepped wedge cluster randomized control trial in 17 Title X service sites across the United States. A cluster design was necessary because of the nature of the intervention; insurance screening practices are generally set at the site level, as compared to the individual patient or encounter level. At the beginning of the study period, all sites followed their standard training program and insurance screening processes. Subsequently, each site was randomized to cross from the control to the intervention on a specific day such that all sites were exposed to the intervention by the end of the study. Data were collected throughout the study, so each site contributed data under the control and intervention conditions.

The University of California, San Francisco Committee on Human Research reviewed the study and considered it to be exempt from ethical approval (CHR #16-20224). Funding for this project was provided by the Office of Population Affairs (Grant Number 1 FPRPA006059-01-00).

### Site Recruitment

The project team recruited Title X services sites for participation in the study through three primary channels:

- 1. Announcements in the electronic newsletters of NFPRHA and the Office of Population Affairs (OPA).
- 2. Recruitment emails issued to Title X grantees and members of the Family Planning Councils of America (FPCA), the State Family Planning Administrators (SFPA), and NFPRHA.

3. Flyers distributed at the NFPRHA 2017 National Conference.

The project team requested that interested sites complete a brief online survey that gathered information about the site characteristics and current health insurance screening practices. Eligible sites received Title X funding, provided direct clinical services, had at least 100 family planning encounters per month, and at least 15% of family planning encounters billed to insurance. If sites were potentially eligible based on their survey responses, the project team conducted a minimum of two phone calls to ensure that the site's training program and its processes for screening for patients' health insurance and need for payment privacy were substantially different than the intervention. The project team also confirmed that sites had the capacity to implement its intervention and meet the study's data collection requirements. Using this recruitment process, the project team initially identified and enrolled 12 sites in the study in January 2017, with an additional six sites added between February and March 2017. After one site was lost due to unexpected staff turnover that limited their capacity to participate in the study, the final sample included 17 Title X service sites. Participating sites were compensated for their time.

### **Site Characteristics**

The study included sites in eight out of ten Health Resources & Services Administration (HRSA) regions (*Table* 2). Sites included a mix of stand-alone family planning centers, Planned Parenthood heath centers, district and county health departments, and Federally Qualified Health Centers (FQHCs), reflecting the diversity in the Title X network.

### Randomization

An independent statistician at the University of California, San Francisco Clinical and Translational Science Institute completed the randomization according to a computer-generated schedule. The randomization determined when sites transitioned from the control to intervention. The twelve sites enrolled in the study at the end of January 2017 were included in the randomization; six of the sites were assigned to begin the intervention in March, and the other six were assigned to begin the intervention in April. One site assigned to begin the intervention in March dropped out of the study. A second site postponed implementation until April because of delays in their ability to collect the administrative and claims data for the study. The six sites that were added in February and March were not randomized; all were assigned to an April intervention start date to allow sufficient time to prepare to implement the intervention. In total, four sites began the intervention in March and thirteen began the intervention in April.

### Baseline and Follow-up Surveys

The Confidential & Covered project team collected data on how the intervention impacted staff knowledge and skills through electronic baseline and follow-up surveys. Site coordinators submitted a staff roster with the contact information for all staff who were involved in patient intake at their sites. The project team sent the staff a link to the baseline survey on the first day of the intervention; the link to the training webinar was placed at the end of the survey to ensure that staff completed the baseline survey before the training. In the fourth week of the intervention period, the project team sent the same intake staff members

a link to the follow-up survey. Up to three reminders were sent by email to encourage staff to complete the surveys, and site coordinators provided staff additional reminders to complete the surveys.

Based on a literature review, the project team developed the surveys to ask staff to self-assess their ability to screen for health insurance coverage and the need for patient privacy. The surveys included items in the following domains:

- Knowledge about why insurance reimbursement is important for the sustainability of the health center
- Knowledge about the difference between confidential care and payment that does not breach privacy
- Confidence in performing screening for health insurance coverage and the need for patient privacy
- Learning needs related to screening
- Staff attitudes toward the training (follow-up survey only)

The project team used Stata 13 to conduct descriptive analyses of the survey responses. Logistic regression with generalized estimated equations (GEE) were used to model the relationship between the intervention and staff knowledge and skills.

### Semi-structured Interviews

In addition to the surveys, the project team conducted semi-structured telephone interviews with intake staff about their experiences with the intervention.

By reviewing staff responses to the baseline survey, the project team identified at least one intake staff member at each site who reported that patient intake is one of his or her primary responsibilities. When multiple staff from a site reported that they were primarily dedicated to patient intake, the project team selected staff based on their number

### Table 2. Number and Percentage of Sites Participating in the Confidential & Covered Study, by Selected Characteristics (N=17)

	Number (%)
Region	
Region 1 (CT, ME, MA, NH, RI, VT)	2 (11.7%)
Region 2 (NJ, NY, Puerto Rico, Virgin Islands)	5 (29.4%)
Region 3 (DE, DC, MD, PA, VA, WV)	1 (5.9%)
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)	1 (5.9%)
Region 5 (IL, IN, MI, MN, OH, WI)	1 (5.9%)
Region 6 (AR, LA, NM, OK, TX)	1 (5.9%)
Region 7 (IA, KS, MO, NE)	0 (0%)
Region 8 (CO, MT, ND, SD, UT, WY)	1 (5.9%)
Region 9 (AZ, CA, HI, NV, American Samoa, Mariana Islands, Micronesia, Guam, Marshall Islands, Republic of Palau)	0 (0%)
Region 10 (AK, ID, OR, WA)	5 (29.4%)
Type of Site	
Stand-alone family planning center	5 (29.4%)
Planned Parenthood health center	5 (29.4%)
Health department	4 (23.5%)
Federally Qualified Health Center (FQHC)	3 (17.6%)

of years of experience working at the site; researchers intentionally interviewed staff with varying levels of experience working at Title X health centers. The project team consulted the site coordinators to ensure that the identified staff had experiences that might be considered representative of the rest of the staff at their site; in some cases the site coordinator recommended a different staff member because of scheduling conflicts. Research staff then contacted the staff members inviting them to participate in a telephone interview. The consent and information sheet were shared with staff before the day of the interview.

Two members of the project team conducted the interviews via telephone, which lasted 33 minutes on average. The semi-structured interview guide included questions about staff experiences with the intervention, perceptions of the intervention's effect on use of insurance, and suggestions for improving the intervention. All the interviews were recorded and detailed notes were taken. The notes were analyzed to identify the key themes that emerged from the interviews; direct quotes were identified that illustrate the key themes.

### **Participant Characteristics**

In total, 93 staff who were involved in intake at the participating study sites completed the baseline survey. Of the baseline respondents, 74 (80%) completed the follow-up survey. Another six respondents completed the followup survey but not the baseline survey. A summary of the characteristics for the baseline survey participants can be found in Table 3. The project team interviewed one staff member from all but one of the participating sites, for a total of 16 interviews.

### Administrative and Claims Data

To gather information about health insurance billing, the project team collected administrative and claims data from each of the participating Title X service sites for all family planning encounters from January through April 2017. The study used the Family Planning Annual Report (FPAR) definition of a family planning encounter.<sup>12</sup>

Several data elements were collected at the encounter level: date of encounter: de-identified patient identification number and encounter number; age and sex of the patient; procedure codes of the services provided during the encounter; and whether or not any of the services from the encounter were billed to a patient's public or private health insurance plan. For the purposes of the study, services paid by a state's Medicaid family planning expansion program (i.e., waiver demonstration project or State Plan Amendment [SPA]) were not considered as billed to private or public insurance plans. In addition, sites recorded and submitted patient responses to the screening questions at each encounter throughout the intervention period. The project team provided sites a detailed administrative and claims data collection protocol and Excel template to ensure the comparability of the data across sites and over time. Sites uploaded all administrative and claims data to a secure website.

The project team merged the data that individual sites submitted into a single dataset, which included a total of 19,330 family planning encounters. Table 4 includes a summary of characteristics of the family planning encounters analyzed for the study. The project team used Stata 13 to conduct descriptive analyses of the administrative and claims data. To estimate the intervention effect on

### Table 3. Number and Percentage of Survey Respondents in theConfidential & Covered Study at Baseline, by Selected Characteristics(N=93)

	Number (%)
Primary responsibility is intake	
Yes	47 (51.1%)
No	45 (48.9%)
Years worked at the health center	
Less than 1 year	17 (18.5%)
1–2 years	17 (18.5%)
2–5 years	25 (27.2%)
More than 5 years	33 (35.9%)
Region	
Region 1 (CT, ME, MA, NH, RI, VT)	13 (14.0%)
Region 2 (NJ, NY, Puerto Rico, Virgin Islands)	35 (37.6%)
Region 3 (DE, DC, MD, PA, VA, WV)	4 (4.3%)
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)	3 (3.2%)
Region 5 (IL, IN, MI, MN, OH, WI)	3 (3.2%)
Region 6 (AR, LA, NM, OK, TX)	4 (4.3%)
Region 7 (IA, KS, MO, NE)	0 (0%)
Region 8 (CO, MT, ND, SD, UT, WY)	2 (2.2%)
Region 9 (AZ, CA, HI, NV, American Samoa, Mariana Islands, Micronesia, Guam, Marshall Islands, Republic of Palau)	0 (0%)
Region 10 (AK, ID, OR, WA)	29 (31.2%)
Type of Site	
Stand-alone family planning center	29 (31.2%)
Planned Parenthood health center	23 (24.7%)
Health department	25 (26.9%)
Federally Qualified Health Center (FQHC)	16 (17.2%)

health insurance billing, the project team used bivariate logistic regression with generalized estimated equations to account for clustering, with robust standard error.

### Limitations

Several limitations of this study should be noted. First, the study did not include a process or implementation evaluation to determine the extent to which the intervention was implemented as intended. The project team relied on the site coordinators to ensure that all intake staff completed the intervention training and followed the intervention screening protocol. A limited amount of information about fidelity to the intervention was collected in the semi-structured interviews with staff members involved in intake, which suggested that overall adherence to the intervention was high. In addition, some interview participants indicated that the intervention screening practices were not substantially different than

<sup>12</sup> Office of Family Planning, Office of Population Affairs, Office of the Assistant Secretary for Health, US Department of Health and Human Services. Title X Family Planning Annual Report: Forms and Instructions. Oct 2013. https://www.hhs.gov/opa/sites/default/files/fpar-forms-instructions-reissued-oct-2016.pdf.

their sites' practices during the control period. The project team had interviewed site administrators prior to enrolling them in the study to avoid overlap between existing screening practices and the intervention. However, the site administrators may not have had complete information about the sites' screening practices. Also, although the study sites were diverse in terms of geography and provider type, the findings cannot be considered representative of the entire Title X network. Sites had to have at least 100 family planning encounters per month and at least 15% of family planning encounters billed to insurance. The impact of the intervention may have been different at sites with fewer family planning encounters or sites with a lower percentage of family planning encounters billed to insurance. The study was in the field for four months, with sites implementing the intervention for between one and two months, which is also a limitation. A longer-term evaluation may be necessary to detect an impact of the intervention on billing rates.

Despite these limitations, the study used rigorous research methods to evaluate whether a new intervention involving health insurance screening processes and staff training impacted staff knowledge and skills and increased insurance billing while maintaining client confidentiality at Title X service sites. The study used a mixed methods approach to data collection, and the findings were consistent across the surveys, semistructured interviews, and administrative and claims data. In addition, to the knowledge of the project team, this is the only study to quantify the extent to which patients opt not to use their insurance for family planning services and their specific concerns about using their insurance.

### Table 4. Number and Percentage of Family Planning Encounters in the Confidential & Covered Study, by Selected Characteristics

	Control	Intervention	
	Number (%)	Number (%)	
Billed to Insurance			
Yes	9,001 (65.1%)	3,442 (62.7%)	
No	4,835 (34.9%)	2,051 (37.3%)	
Type of Site			
Stand-alone family planning center	3,626 (26.2%)	1,361 (24.8%)	
Planned Parenthood health center	5,442 (39.3%)	2,131 (38.8%)	
Health department	1,651 (11.9%)	847 (15.4%)	
Federally Qualified Health Center (FQHC)	3,117 (22.5%)	1,155 (21.0%)	
Patient Sex			
Female	12,559 (90.8%)	4,996 (90.9%)	
Male	1,277 (9.2%)	497 (9.0%)	
Patient Age in Years			
Under 15	306 (2.2%)	153 (2.8%)	
15–17	1,061 (7.7%)	461 (8.4%)	
18–19	1,444 (10.4%)	519 (9.5%)	
20-24	3,675 (26.6%)	1,345 (24.5%)	
25–29	2,810 (20.3%)	1,170 (21.3%)	
30-34	1,869 (13.5%)	769 (14.0%)	
35–39	1,202 (8.7%)	465 (8.5%)	
40-44	735 (5.3%)	308 (5.6%)	
45 and older	733 (5.3%)	304 (5.5%)	
Contraceptive Service Provided			
Yes	8,672 (62.7%)	2,008 (36.5%)	
No	5,164 (37.3%)	3,486 (63.5%)	

Note: N was 13,836 for the control period and 5,494 for the intervention period.

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### **About Confidential & Covered**

Confidential & Covered was a multi-year research project designed to understand the factors that may make it difficult for Title X-funded family planning providers to seek reimbursement due to patient privacy concerns. Learn more at www.confidentialandcovered.com.

### **About NFPRHA**

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501 (c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

### **NFPRHA's Membership**

NFPRHA's core members are publicly funded family planning organizations serving those who might otherwise lack access to care. Today, NFPRHA represents more than 800 organizational members that operate or fund a network of nearly 5,000 safety-net health centers and service sites in 50 states and the District of Columbia. Specifically, these members include: service and training grantees of Title X, the nation's only federally funded family planning program; administrators of family planning programs housed in state, county, and local health departments; administrators of Medicaid family planning expansion programs, which extend family planning coverage to millions of women and men; Family Planning Councils; Planned Parenthood affiliates; federally qualified health centers; and other family planning organizations working in communities across the country.

### **Mission Statement & Work**

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive family planning and sexual health care services and supplies for all.

To that end, NFPRHA seeks to maximize the opportunities for protecting and expanding access to family planning services for vulnerable populations by advocating for programs and resources that enhance both the medical services provided through and infrastructure of the publicly funded family planning safety net. Furthermore, NFPRHA prepares its membership for changes in the health care economy by providing policy and operational analyses to help its members consider and execute strategies for adapting to evolving economic and policy climates, and by convening administrators and clinicians to share experiences and best practices that help enhance quality and service delivery.

National **Family Planning** & Reproductive Health Association

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