CONFIDENTIAL
+COVERED

Screening for Clients' Health Insurance and Confidentiality Needs Workbook

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National
Family Planning
& Reproductive Health Association

Contents

Introduction

A. Statement of Need for Screening

Confidential & Covered was a three-year research project funded by the US Department of Health & Human Services' Office of Population Affairs designed to identify policies and practices to mitigate revenue loss for Title X family planning providers due to the provision of confidential health services. The objective of the screening intervention, *Screening for Clients' Health Insurance and Confidentiality Needs,* was to improve health centers' sustainability and preserve one of Title X's core principles, the provision of confidential services, by better screening for patients' health insurance and confidentiality needs.

While the commitment to confidentiality is at the core of Title X program,[1] it may present challenges when health centers seek third-party payer reimbursement for services provided to patients seeking payment that does not breach privacy. It is a common practice for health centers to regularly screen patients for health insurance and the need for confidential services and present patients with options for redirecting care-related communication during patient intake. However, it is less common to ask patients about their privacy needs regarding insurance billing or payments. Few health centers have policies to guarantee privacy throughout the third-party reimbursement process which may include deliveries of an explanation of benefits (EOB) or bills to the policyholder.[2] Consequently, if a patient indicates a need for payment privacy, health centers will sometimes forgo billing insurance, and therefore potential reimbursements, in order to maintain the patient's confidentiality.

The *Confidential & Covered* screening intervention was designed to train staff to ask and document patients' insurance coverage and their needs for confidentiality rather than assuming patients who express concerns regarding health center communications also need payment that does not breach privacy. Between January and April 2017, 17 Title X health centers ("pilot sites") implemented the present screening protocol.[3] This workbook was based on the implementation experience of these sites and their lessons learned.

The *Confidential & Covered* screening intervention consisted of a recorded webinar training[4] and 3 screening questions. The training is a 23-minute video that described the intervention in detail and provided the viewer with an overview of the screening questions that comprised the protocol. This workbook provides tools and materials used by pilot sites that may be adapted to support implementation of the health insurance screening questions. Experiences and tips from pilot sites have been highlighted.

B. Screening Intervention Design

The screening intervention requires that staff who do patient intake at their health centers ask patients a series of questions about their insurance coverage and whether they would like to use insurance. Because patients' situations may change over the course of time, a critical element of the intervention is for staff to ask *every* patient the protocol questions at *every* visit, regardless of the patient's age or if the patient is known to the health center.
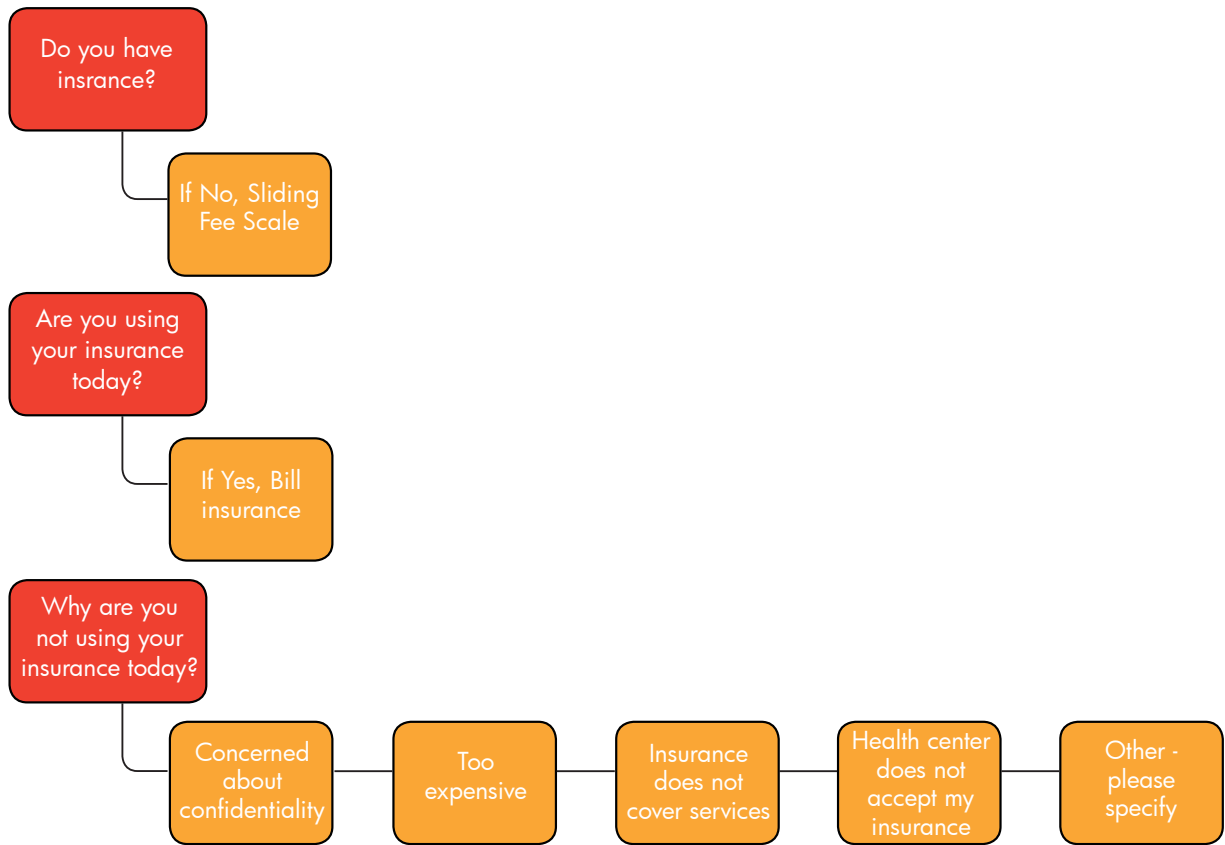
The screening questions are designed to fit seamlessly into a variety of intake processes; they may be asked prior to the visit, when an appointment is made online or on the telephone, or on the day of the appointment during check-in.

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1 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 8. http://www.hhs.gov/opa/pdfs/ ogc–cleared–final–april.pdf. 42 C.F.R. § 59.11.

2 Leah Masselink, Julie Lewis, Monique Morales, Liz Borkowski, Tishra Beeson, Susan F. Wood, and Clare Coleman, Tile X Network Perspectives on Confidentiality and Insurance Billing (Washington, DC: National Family Planning & Reproductive Health Association, 2016).

3 For more details about the study, please see: Jennifer Yarger, Amanda Mulligan, Leah E. Masselink, Megan Couillard, Susan F. Wood, Claire D. Brindis, and Clare Coleman, Impacts of an Intervention to Improve Screening for Patients' Health Insurance and Need for Payment Privacy In the Title X Network (Washington, DC: National Family Planning & Reproductive Health Association, 2017).

4 Training can be found at www.confidentialandcovered.com.

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Do you have
insrance?
    └─ If No, Sliding
       Fee Scale

Are you using
your insurance
today?
    └─ If Yes, Bill
       insurance

Why are you
not using your
insurance today?
    └─ Concerned    Too        Insurance    Health center   Other -
       about        expensive  does not     does not        please
       confidentiality         cover services  accept my     specify
                                            insurance
```

For the patients who indicate that they do not wish to use their insurance for the visit, staff are encouraged to engage in follow-up discussions to identify the reasons that they do not want to use their insurance and potential billing options with the patient. For example, if a patient opts not to use insurance because he or she enrolled in a high deductible insurance plan and is worried about cost, staff would explain that billing health insurance reduces the patient's deductible. The staff member would then discuss the sliding fee scale for payment of the services.

Implementation of Screening Intervention

Based on the experiences of the pilot sites, the following figure outlines the five steps for implementation:

Step 1	Prepare the Organization
Step 2	Update Policy and Procedures
Step 3	Train Staff and Distribute Supplemental Materials
Step 4	Implement the Screening Questions
Step 5	Compile Data, Analyze and Evaluate

Step 1 – Prepare the Organization

The first step in the implementation of the screening intervention is to incorporate the screening questions into intake and/or appointment scheduling processes. This step requires health centers to review current intake processes, modify intake forms to include the questions on paper or in an Electronic Health Record (EHR), and redesign the intake/appointment scheduling workflow to accommodate the health insurance screening questions. Additionally, it must be determined how, when, and where it is best for staff to input patient responses to the screening questions so they can be retrieved for analysis. Three versions of the questions (written response, verbal response in person, verbal response over the phone while making an appointment) are available to health centers to allow for better integration of the questions into standing procedures. Spanish translations of the screening questions are also available.

Tool #1 — *The insurance screening questions are presented in both English and Spanish*

Questions for screening on a paper registration/ intake form:	
English	**Spanish**
1. Do you have insurance today? • Yes • No	1. ¿Tiene seguro médico en estos momentos? • Sí • No
2. Are you using your insurance today? • Yes • No • Not applicable—do not have insurance	2. ¿Va a usar su seguro médico hoy? • Sí • No • No aplica- no tengo seguro médico
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	3. ¿Por qué no va a usar su seguro médico hoy? *(Marque todos los que correspondan)* • Preocupado/a por la confidencialidad • Es demasiado caro • El seguro no cubre los servicios • El centro de salud no acepta seguro • Otro (Por favor, especifique_____) • No aplica- no tengo seguro médico o voy a usarlo
Questions for screening verbally at the health center during check in:	
English	**Spanish**
1. Do you have insurance today? • Yes • No	1. ¿Tiene seguro médico en estos momentos? • Sí • No
If patient has insurance: 2. Are you using your insurance today? • Yes • No	*Si tiene seguro:* 2. ¿Va a usar su seguro médico hoy? • Sí • No

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_____)	*Si el paciente tiene seguro, pero no va a usarlo:* 3. ¿Por qué no va a usar su seguro médico para esta cita? Voy a leer varias razones y por favor dígame cuales de ellas corresponden a su situación. *(Lea todas las respuestas disponibles)* • Preocupado/a por la confidencialidad • Es demasiado caro • El seguro no cubre los servicios • El centro de salud no acepta seguro • Otro (Por favor, specifique_____)

Questions for screening when patients make an appointment over the phone:

English	Spanish
1. Do you have insurance? • Yes • No	1. ¿Tiene seguro médico? • Sí • No
If patient has insurance: 2. Will you be using your insurance for this visit? • Yes • No	*Si tiene seguro:* 2. ¿Va a usar su seguro médico para esta cita? • Sí • No
If patient has insurance but is not using it: 3. 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. *(Read each response option)* • Concerned about confidentiality • Too expensive • Insurance does not cover services • Health center does not accept insurance • Other reason (please specify_____)	*Si el paciente tiene seguro, pero no va a usarlo:* 3. ¿Por qué no va a usar su seguro médico para esta cita? Voy a leer varias razones y por favor dígame cuales de ellas corresponden a su situación. *(Lea todas las respuestas disponibles)* • Preocupado/a por la confidencialidad • Es demasiado caro • El seguro no cubre los servicios • El centro de salud no acepta seguro • Otro (Por favor, specifique _____)

A. Intake Process

Based on current procedures and policies, determined when it is best for staff to ask the screening questions. Several options are below:

Option 1: Incorporate the screening questions into existing paper intake forms that patients complete upon arrival (for both walk-in and appointment patients). Attached here are several options:

- Tool #2 Patient information form – A comprehensive patient information form that covers basic demographics and income assessment (English and Spanish translations).
- Tool #3 Insurance verification form – A form used to collect income as well as insurance information.
- Tool #4 Eligibility and registration form.
- Tool #5 Returning client form – A form used to update the patient demographic and insurance information.

Pilot Sites' Experiences:

o   Staff reported that patients were more comfortable responding to health insurance screening questions on paper. Patients have more time to consider the answers when they are sitting in the waiting room than when they are asked verbally at the front desk.

o   Asking patients the screening questions verbally was more difficult or not always as well-received in health centers that had more open front desk areas with less privacy.

o   Sometimes patients asked why staff were asking these questions, stating that the health center should already have their information or commenting that they had never been asked these questions before.

Tool #2 (A) — *The following tool is a sample of an intake form with the screening questions*

Last name: _____ First name: _____ Middle initial: _____

Name used *(if different from legal name above)*: _____

Pronouns: ☐ He/him/his   ☐ She/her/hers   ☐ They/them/theirs   ☐ Other _____/_____/_____

Date of birth: [___][___]-[___][___]-[___][___][___][___]
                Month   Day   Year

Age:[___][___]

What sex were you assigned at birth *(meaning on your <u>original</u> birth certificate)*? ☐Female ☐Male ☐Intersex

What is your gender identity?
☐Female
☐Male
☐ Genderqueer / gender non-conforming

☐Trans female / woman
☐Trans male / man
☐Different identity (please state):_____

PATIENT INFORMATION

Social Security # [___][___][___]-[___][___]-[___][___][___][___]

Years of education completed: [__][__]

Preferred language: ☐ English   ☐ Español ☐ Other _____

Marital status: ☐Single   ☐Married   ☐Partnered   ☐Divorced   ☐Other: _____

REQUIRED CONTACT INFORMATION AND INSTRUCTIONS
(In order to provide you with high quality health services with respect for your privacy, we ask that you instruct us on how to get in touch with you to discuss matters such as important lab results and medical follow up, appointment scheduling, billing issues, pharmacy refill orders or potential drug recall)

Please provide an address where you can <u>receive mail</u>:

Street address: _____ Apartment: _____
City: _____ State: ____ Zip Code: [___][___][___][___][___]   County: _____

Which type of envelope do you prefer we use? ☐Health center's ☐Plain *(only clinic mailing address)*

If we call, what should we say? ☐Health center ☐ Doctor's office ☐ Other *(please specify):* _____

Preferred phone: [__][__][__]-[__][__][__]-[__][__][__][__]

Alternate phone (if applicable): [__][__][__]-[__][__][__]-[__][__][__][__]

Can we leave a detailed message on your voicemail?   ☐Yes   ☐ No

EMERGENCY CONTACT

Name: _____

Telephone #   [__][__][__]-[__][__][__]-[__][__][__][__]

Relationship: _____

Do they know you are a patient at this health center? ☐ Yes   ☐ No

INSURANCE INFORMATION *(Please give your card to the front desk staff if you will be using insurance)*

Do you have health insurance today? ☐Yes ☐No

Are you using your insurance today? ☐Yes ☐ No

If no, why are you not using your insurance today? *(Please check all that apply)*

☐Concerned about confidentiality   ☐Too expensive   ☐Insurance does not cover services

☐ Health center does not accept insurance ☐ Other ☐ Not applicable

If yes, who is your insurance provider? _____

What sex is listed with your insurance: ☐Female ☐Male *(Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence, so will show up on your encounter form/fee ticket today.)*
Are you the primary subscriber to your insurance?   ☐Yes ☐ No
If no, what is your relationship to primary subscriber? ☐ Parent ☐ Spouse ☐ Other_____
What is their date of birth? [_][_]-[_][_]-[_][_][_][_]   Month   Day   Year

FINANCIAL INFORMATION *(This helps us determine if you qualify for discounted or free services and for statistical reporting to help us maintain our financial discounts program)*

Household Income: $_____ ☐Weekly ☐Monthly ☐Yearly *(including your salary, partner salary, unemployment or social security, public assistance, alimony or child support, etc.)*
Family Size:_____ *(the number of people that live with you and/or others that you support financially)*

DEMOGRAPHIC INFORMATION *(For statistical reporting or verification purposes only)*

Race (you may select more than one): ☐African American or Black ☐ Asian ☐White ☐Native American or Alaska Native ☐Pacific Islander or Native Hawaiian			
Ethnicity:	☐Hispanic	☐Non-Hispanic	
Employment Status:	☐Full-time	☐ Part-time	☐Unemployed
Student Status:	☐ Full-time	☐ Part-time	☐ Not a student

FAMILY PLANNING INFORMATION *(For statistical reporting)*

What is your <u>primary</u> method of preventing pregnancy? *(Please select only one)*			
Not Applicable – ☐Pregnant OR seeking pregnancy	☐In a same-sex relationship	☐Menopause	☐Abstinence
☐Condom - Male ☐Condom – Female ☐Natural Family Planning ☐Implant (Nexplanon) ☐Injection			
☐ Intrauterine Device - *Please circle:* Mirena / Liletta / Skyla / ParaGard ☐Patch ☐ Pills ☐ Female Sterilization			
☐Male Sterilization ☐Partner Sterilization ☐ Vaginal Ring ☐Withdrawal			
Other *(please specify):* _____(e.g., spermicide-only, rely on female method, diaphragm, cervical cap, sponge)			

HOW DID YOU HEAR ABOUT US?

☐I am a previous patient	☐Friend/family	☐Internet search
☐Other health provider	☐Health center session or program	☐Other (please specify):_____

By signing I certify that the above information is accurate and I agree to the terms stipulated in this form:

          Client Signature: _____

Tool #2 (B) — *The following tool is a sample of an intake form with the screening questions in Spanish*

Apellidos: _____ Nombre: _____
Nombre que prefiere usar (si es diferente al nombre legal): _____
Pronombres: ☐Él ☐Ella ☐Ellos/ellas ☐Otro_____/_____/_____

Fecha de nacimiento: [__][__]-[__][__]-[__][__][__][__] Mes Día Año	Edad:[___][___]

Sexo asignado al nacer *(en el certificado de nacimiento <u>original</u>)* ☐Femenino ☐Masculino ☐Intersexual

¿Cuál es su identidad de género? ☐Femenino ☐Masculino ☐Queergénero / género variante	☐ Mujer trans / mujer ☐Hombre trans / hombre ☐Otra identidad (especifique):_____

INFORMATION DEL PACIENTE

Número de Seguro Social [___][___][___]-[___][___]-[___][___][___][___]	
Años completados de educación: [_][_]	Idioma preferencial: ☐Inglés ☐Español ☐Otro _____
Estado marital: ☐Soltero/a ☐Casado/a ☐ Emparejado/a ☐Divorciado/a ☐Otro: _____	

INFORMACIÓN DE CONTACTO E INSTRUCCIONES *(Para proveer atención de alta calidad en cuanto a su privacidad, necesitamos instrucciones para contactarle para discutir asuntos importantes, tales como resultados de laboratorio y seguimiento médico, citas, asuntos de facturación, renovaciones de recetas o potenciales retiradas de medicamentos del mercado)*

Proporcione una dirección donde prefiere recibir correo: Calle: _____ Apartamento: _____
Ciudad: _____ Estado: ___ Código Postal: [_][_][_][_][_] Condado: _____
¿Qué tipo de sobre prefiere que usemos? ☐Centro de Salud ☐Regular *(solo con dirección postal de la clínica)*
Si llamamos, ¿cómo debemos identificarnos? ☐Centro de Salud ☐Oficina del doctor ☐Otro *(especifique):* _____
Teléfono preferencial: [__][__][__]-[__][__][__]-[__][__][__][__]
Teléfono alternativo (si corresponde): [__][__][__]-[__][__][__]-[__][__][__][__]
¿Podemos dejar un mensaje detallado en su buzón de voz? ☐Sí ☐No

CONTACTO EN CASO DE EMERGENCIA

Nombre: _____	Número de teléfono [_][_][_]-[_][_][_]-[_][_][_][_]
Relación: _____	¿Sabe esta persona que Ud. es un paciente de este centro de salud? ☐Sí ☐ No

DATOS DE SU SEGURO MÉDICO *(Entregue su tarjeta al personal de recepción, en caso de usar seguro médico)*

¿Tiene seguro médico en estos momentos? ☐ Sí ☐No
En caso de que sí, ¿usará su seguro hoy? ☐ Sí ☐No
En caso de que no, ¿Por qué no va a usar su seguro médico hoy? *(Marque todos los que correspondan)*
☐Preocupado/a por la confidencialidad ☐Es demasiado caro ☐El seguro no cubre los servicio
☐El centro de salud no acepta seguro ☐Otro ☐No aplica- no tengo seguro médico o voy a usarlo
En caso de que sí, ¿cuál es su proveedor de seguro médico? _____
¿Cuál es el sexo mencionado en su seguro?: Femenino Masculino *(El nombre y el sexo registrados por su seguro médico deben usarse en documentos relacionados con el seguro, la facturación y correspondencia. Por eso, hoy los usaremos en su ficha médica donde se listan los códigos de diagnóstico y de los procedimientos para efectos de facturación).*
¿Es Ud. el asegurado titular de su seguro médico? ☐Sí ☐ No
En caso de que no, ¿cuál es su relación con el asegurado titular? ☐Padre/Madre ☐Esposo/a ☐Otra_____
¿Cuál es la fecha de nacimiento del titular? [__][__]-[__][__]-[__][__][__][__] 　　　　　　　　　　　　　　　　　　　　Mes　　Día　　Año

INFORMACIÓN FINANCIERA *(Esto nos ayuda a determinar si Ud. califica para obtener descuentos o servicios gratis y para recolectar información estadística que nos permita mantener nuestros programas de descuentos financieros)*

Ingreso del Hogar: $_____ ☐Semanal ☐Mensual ☐Anual *(incluya su salario, el de su pareja, desempleo o seguro social, asistencia pública, pensión conyugal o manutención para los niños, etc.)*
Tamaño de la familia:_____ *(número de personas que viven con Ud. y/u otros que Ud. mantiene financieramente)*

INFORMACIÓN DEMOGRÁFICA *(Para informes estadísticos o solo para propósitos de verificación)*

Raza (puede seleccionar más de una): ☐Afroamericana o Negra　　☐Asiática　　☐Blanca ☐Nativo americana o nativo de Alaska　☐Nativo de Hawái u otras islas del Pacífico
Origen étnico:　　☐ Hispano　　☐No-Hispano
Empleo:　　☐Tiempo completo　　☐ Tiempo parcial　　☐Desempleado/a

INFORMACIÓN DE PLANIFICACIÓN FAMILIAR *(Para informes estadísticos)*

¿Cuál es su método *principal* para evitar embarazos? *(Seleccione solo uno)*
No corresponde - ☐Embarazada O intentando quedar embarazada ☐Pareja del mismo sexo ☐Menopáusica ☐Abstinencia
☐Condón: *Hombre* ☐Condón: *Mujer* ☐Planificación Familiar Natural ☐Implante (Nexplanon)
☐Píldoras　☐Esterilización femenina ☐Esterilización masculina ☐Esterilización de la pareja
☐Anillo vaginal ☐Eyaculación fuera de la vagina ☐Confiar en el método usado por la mujer
☐ Otro *(especifique):* _____(ej., solo espermicida, diafragma, capuchón cervical, esponja)

¿CÓMO SE ENTERÓ DE NUESTROS SERVICIOS?

☐ Soy un/a paciente previo/a	☐Amigo/familia	☐Búsqueda en Internet
☐Profesional médico	☐Cartel del edificio	☐Cartel público
☐Sesión o programa educativo del Centro de Salud	☐Otro (especifique):_____	

Con mi firma certifico que la información anterior es cierta y concuerdo con los términos estipulados en este formulario:

Firma del Cliente: _____

Tool #3 — *The following tool is a sample of an income verification form with the screening questions*

Reproductive Health Assessment Income Sheet

Name _____Birthdate _____

Phone Number _____

Address_____Apt_____   Zip Code_____

Emergency Contact_____Emergency Contact Phone Number_____Relationship_____

May we contact you by phone or mail at your home?   Yes ☐   No ☐

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1. What is your **hourly pay**? $__On average, how many hours do you work **per week**? _____

2. What is your live-in partner's **hourly pay**? $ _____On average, how many hours does your partner, living with you, work **per week**?_____

3. Do you or your live-in partner receive **tips**?   Yes ☐ No ☐   If yes, how much **per week**? $_____

4. Do you or your live-in partner get paid by **salary or commission**? Yes☐ No☐ If yes, how much? $_____

5. Do you or your live-in partner receive income from **SSI, disability, unemployment, family aid, or alimony**? Yes☐ No☐   If yes, **how much**? $_____   **How often**?   Weekly ☐   Monthly ☐   Annually☐

6. Do you have other household income? If yes, **how much**? $_____
How often? Weekly ☐ Monthly ☐   Annually ☐

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7. Please indicate the number of people living in the household **supported** by this income: _____

8. Mark the **Race/Races** that identify you:
   White ☐   Black/African American ☐   American Indian/Alaskan Native ☐   Asian☐
   Hawaiian/Pacific Islander ☐   Other ☐   Not Reported/Refused ☐

9. Do you consider yourself **Hispanic or Latino**?   Yes ☐   No ☐

10. Do you have insurance today?
    ☐ Yes
    ☐ No

11. Are you using your insurance today?
    ☐ Yes
    ☐ No
    ☐ Not applicable—do not have insurance

12. 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 my insurance
    ☐ Other (please specify_____)
    ☐ Not applicable—do not have insurance or using insurance

Consent

- Since some medical conditions may affect my care, it is my responsibility to give as complete and accurate a medical history as possible. If new problems that may be related to my condition or care arise, I understand I should inform the clinic. I understand that it is my responsibility to seek care elsewhere for any other medical problems beyond what is provided by the clinic.
- I understand that I have a right to refuse any procedures or services including Rapid HIV testing, that are recommended. Refusing some types of care will not jeopardize my receiving appropriate care for other problems or concerns.
- I know that all services provided by the clinic are confidential. I understand that the results of some tests for sexually transmitted infections and other diseases must be reported to the Health Department in a confidential manner, as required by law.
- Our services are confidential; however, if you are under the age of 18 and share with us a history of sexual or physical abuse or neglect, we are required by law to report this to the Department of Health & Welfare. Please ask us if you have any questions about these laws.

The undersigned has read, fully understands, and agrees to all of the above provisions and information in this document.

Signature_____   Date _____

Official Use Only

Verified Proof of Income: Pay Stubs ☐   Taxes ☐   Bank Statement ☐   Letter of Benefits ☐

Comments: _____
_____
_____--

Tool #4 — *The following tool is a sample of an eligbility and registration form with the screening questions*

Eligibility and Registration Form

Please Write Clearly! *This form, and all health center documents, are private and confidential.*
Please ask if you would like more information about confidentiality and how it applies to your records and your visit here.

Name *(First, Middle Initial, Last)*		Date of Birth *(mm/dd/yyyy)*		*Best way to reach me is...(X)*	*Do **NOT** contact me at ... (X)*
Mailing Address	Street/PO Box City ZIP Code				
Main Phone					
Back up Phone					
Email Address					
Employer Name & Phone					

Race (check all that apply): ❑ White   ❑ Alaska Native/American Indian   ❑ Black/African American
❑ Native Hawaiian/Other Pacific Islander   ❑ Asian
Hispanic or Latino: ❑ Yes   ❑ No
Number of Household Members: _____
Includes all people who share your living expenses, including you, your spouse/partner, parents, children, and/or relatives living in your household. Non-family roommates are not included if you pay separate bills. If you are under 18 and are paying for your own services today, you may indicate a household of one person.
Household Income: Each Month $_____ OR Each Year: $_____
*Includes all money made by all household members, before taxes are taken out, from jobs, tips, student loans for general living expenses, alimony, public assistance, disability or worker's compensation, social security or retirement, military or veteran's benefits, and unemployment. Use adjusted income if self-employed. **If you have zero income, please explain how you pay your living expenses:**_____*
Do you have insurance today?   ❑ Yes   ❑ No
Are you using your insurance today?   ❑ Yes   ❑ No   ❑ Not applicable—do not have insurance
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 my insurance
　　　　　❑ Other (please specify_____)
　　　　　❑ Not applicable—do not have insurance **or** using insurance

Please circle any insurance you (not your children) are enrolled in, eligible for, or have applied for:

Medicaid or Denali Kid Care	❑ Enrolled	❑ Eligible	❑ Applied	❑ No	❑ Don't know
Private Health Insurance	❑ Enrolled	❑ Eligible	❑ Applied	❑ No	❑ Don't know
Medicare	❑ Enrolled	❑ Eligible	❑ Applied	❑ No	❑ Don't know

By signing below, I certify that the information I have provided above is true and correct to the best of my knowledge

Participant Signature:_____**Date:**_____

Program Staff Signature:_____**Date:**_____

For office use only: **C. Minor visit** ❑   **LEP interpreter requested** ❑   **Group #** ____ **Discount** ____%

Tool #5 — *The following tool is a sample of a returning patient form with the screening questions*

Returning Client Information

Please Write Clearly! *This form, and all health center documents, are private and confidential.*
Please ask if you would like more information about confidentiality and how it applies to your records and your visit here.

Name	
Date of Birth	
Phone	

Has your address changed since we last saw you? <u>If yes</u>, please update below	Ok to send mail? (Yes/No)
Mailing Address Street/PO Box City ZIP Code	

Do you have insurance today? ☐ Yes ☐ No

Are you using your insurance today? ☐ Yes ☐ No ☐ Not applicable—do not have insurance

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 my insurance
    ☐ Other (please specify_____)
    ☐ Not applicable—do not have insurance <u>or</u> using insurance

		New? (Y/N)
If insured, list name of coverage:		
If you recently <u>applied</u> for coverage, list name:		

By signing below, I certify that the information I have provided above is true and correct to the best of my knowledge

Signature:_____Date:_____

Staff Signature:_____Date:_____

Option 2: Ask patients to complete a separate paper form with the screening questions. These separate forms may be collected during the check-in process.

Tool #6 — *The following tool contains a half-page form with questions*

Do you have insurance today?
☐ Yes   ☐ No

Are you using your insurance today?
☐ Yes   ☐ No   ☐ Not applicable—do not have insurance

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 my insurance
☐ Other (please specify_____)
☐ Not applicable—do not have insurance or using insurance

Option 3: Ask the screening questions during the scheduling process. Staff enter patient's responses in the Patient Management System (PMS) or EHR when the patient arrives for the appointment. Please note that patients may need to complete the screening questions on site if they arrive for services without scheduling an appointment. Thus, a secondary method for collecting patient responses will be necessary.

B.   Data Elements

Because where and how data are stored varies within and across health centers, the data elements to be collected and analyzed during implementation must first be identified before workflows and processes can be fully refined. To analyze the effects of the implementation of the screening questions, it is important to identify first which patient visits will be tracked. An overview of the data elements is provided below, and more detail can be found online.[5] Pilot sites were required to include only family planning encounters as defined by the Family Planning Annual Report.[6] To ensure health centers are able to conduct meaningful analyses, collect and compile the following data elements at the encounter level:

- *Encounter number*: Create or provide a unique number for each encounter.
- *Patient information:* Include basic demographic information such as age, sex, and patient ID number.
- *Services provided:* Include CPT, HCPCS, and E&M codes for all family planning services provided at the visit.
- *Billing information:* Indicate whether services provided during the visit are billed to the patient's public or private health insurance.
- *Patient responses:* Include patient responses to the screening questions.

By ensuring all these data elements are collected at the encounter level, health centers can later identify patterns in insurance billing such as by service type or patient characteristic.

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5 All materials developed for this intervention may be accessed at www.confidentialandcovered.com
6 Title X Family Planning Annual Report: Forms and Instructions (Reissued October 2013), pp. 7–10.

C.   Workflow

To accommodate the screening protocol and data collection, the intake workflow may need to be modified to include the screening questions and response documentation. Designing a concise workflow with clearly delineated roles and responsibilities is especially important to maintain implementation integrity at health centers without or with limited use of EHR and PMS.

Tool #7 — *The following tool details a pilot site's workflow and provides an example of implementation using an excel worksheet*

1) Staff will be educated on the screening process before the implementation and will complete the required study training.

2) All clients checking into the Reproductive Health Center will be asked the screening questions by the intake staff at every visit.

3) The screening questions will be placed into the PatTrac system under "Documents" in the "Reproductive Health Center" section. The form will be called "CCS."

EHR Screenshot

Documents	Reports	Forms	Exports	
Category	**Select Document**			
RH NEW	FP CONSENT FOR REMOVAL OF SUBDERMAL CONTRACEPTIVE IMPLANT			
	FP EDUCATION FLOW SHEET			
	FP IMPLANON CARE			
	FP SUBDERMAL CONTRACEPTIVE IMPLANT REMOVAL RECORD			
	FP_CONSENT_FP_SERVICES (1216)			
	FP_FLOW_RECORD (4399)			
	FP_INITIAL_RECORD (4398)			
	HIPAA PRIVACY FORM (4617)			
RH PDF	Billing Policy 4-13-16			
	Bridge to Health HBCP 11-2-2015			
	CCS			
	Consent for Depot Medroxy Progesterone Acetate			
	Consent for Oral Contraceptives_v2012 (PDF)			

CCS Form

1. Do you have insurance today?
   ☐ Yes
   ☐ No

2. Are you using your insurance today?
   ☐ Yes
   ☐ 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 my insurance
   ☐ Other (please specify_____)
   ☐ Not applicable—do not have insurance or using insurance

4) After the patient responds and the response is logged, a copy of the CCS form will be printed off and placed in Staff Member A's mailbox.

5) Intake staff will log month, day, PatTrac Number, and patient response into the Excel Tracking Form immediately, before another patient is processed to reduce the chance a patient's repsonse is missed.

Excel Tracking Form

Tracking Form Tracking Form								
					Reason #1	Reason #2, if applicable	Reason #3, if applicable	If other, list reason
Month	Day	PAT Trac Number	Have Insurance?	Using Insurance?	Why are you not using insurance today?	Why are you not using insurance today?	Why are you not using insurance today?	

6) Every Friday, Staff Member A will match the CCS forms to the patient clinic schedule in PatTrac and the Excel Tracking Form to ensure all patients were asked the screening questions. Staff Member A will convert the patient responses using the following set of codes:

CPT Code	CPT Description	Corresponding responses to intervention screening questions on the intake form		
		Q1: Do you have insurance today?	Q2: Are you using your insurance today?	Q3: Why are you not using your insurance today
CAT	No Insurance	No	N/A – does not have insurance	N/A – does not have insurance or using insurance
DOG	Billing Insurance	Yes	Yes	Not applicable – do not have insurance or using insurance
BIRD	Not Billing – Confidential	Yes	No	Concerned about confidentiality
RAT	Not billing – Cost	Yes	No	Too expensive
FROG	Not Billing – Services covered	Yes	No	Insurance does not cover services
BEAR	Not billing – Insurance not accepted	Yes	No	Health Center does not accept my insurance
SNAKE	Not billing – other	Yes	No	Other (please specify)

7) The "Visit ID" will be entered as the next sequential number (i.e. 1000, 1001, 1002, 1003).

8) CCS forms will then be placed in Staff Member B's mailbox where Staff Member B will scan for record retention.

9) Each week, Staff Member C [health center biller or collector] will input the service codes and billing information on the excel spreadsheet.

10) Data will be collected and submitted.

11) Staff Member A will upload the completed document monthly.
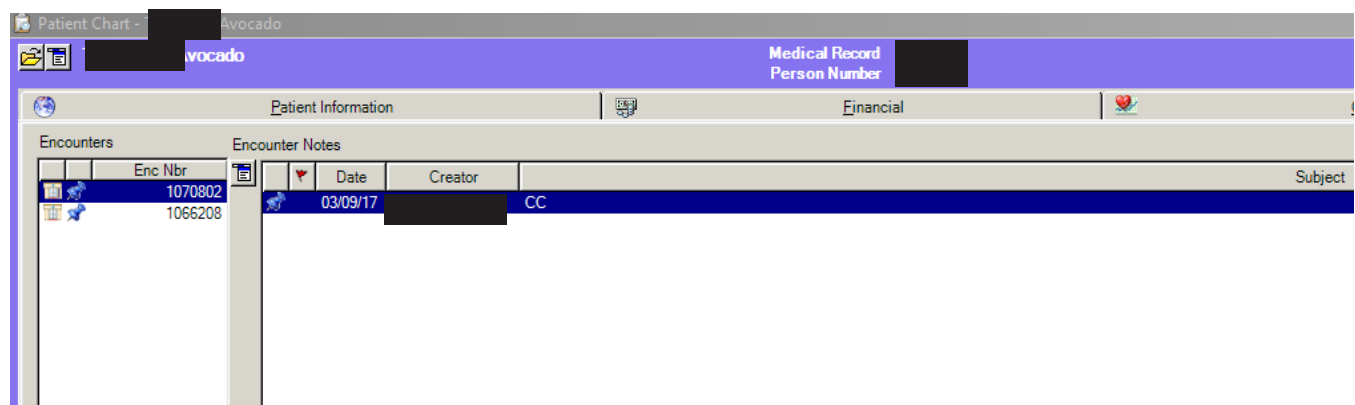
D.   Electronic Health Record Updates

It is important to insert additional fields or expand current fields in EHR or PMS to document and store patient responses. By collecting and housing these data electronically, pilot sites were able to readily review patients' responses and synthesize and extract the data more efficiently. If the EHR or PMS cannot be sufficiently adapted at health centers, ensure that data are collected reliably and validly by designating a clear workflow including a data validation process.

For health centers in which it is feasible to use the EHR/PMS to collect patient responses, identify who will need to be involved to adapt electronic systems. Additionally, establish which staff will enter the data and when they will do so. To minimize error, test the systems in place.

Tool #8 — *The following tool displays the codes a pilot site assigned to each of patient responses options*

Patient Response Option	Code
No Insurance	CC1
Billing Insurance	CC2
Not-Billing—confidentiality	CC3
Not Billing—cost	CC4
Not Billing-services not covered	CC5
Not Billing-insurance not accepted	CC6
Not billing-other	CC7

At patient registration, staff designated the appropriate code to each individual encounter and documented the code in the "encounter note," a field in the EHR system with which staff were already familiar.

Subject

Patient Notes

Subject

CC

User Note Description

Note Entry

CC1

To use the user note descriptions, first pick the text you wish to use from the User Note Description drop down list. Next click the arrow next to the area you wish to place the text.

Created

By:

Date: 03/09/2017

Time: 2:49 P

Modified

By:

Date: 03/09/2017

Time: 2:49 P

☐ Seal Note

Step 2 – Update Policy and Procedures

Policies and procedures may need to be updated to include the screening questions.

Tool #9 — *The following tool is a sample policy and procedure document*

Policies and Procedures		
Policy Number	Policy Name: **Confidential Billing of Third-Party Payers**	Original Effective Date:
Department:		Distribution:
Last Reviewed by:		Committee Approval Date:
Last Reviewed Date:		Last Revised Date:

I. **DEFINITIONS**

Patient: Any individual seeking services at <Organization Name> operated health care delivery sites.

Protected Health Information: According to Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, protected health information is individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral.

Special Confidentiality: The special confidentiality option is available to any family planning user who believes she or he would be at risk of physical or emotional harm if a parent/partner or other household member learned the patient was seeking reproductive health services, including through communications from third-party insurance companies. This option is not limited to teens, nor should it be used for every teen client.

II. **POLICY**

Unless a patient with third-party health insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that Title X is the payer of last resort. When billing third-party insurance companies, all patient individually identifiable information and protected health information (PHI) will be managed according to HIPAA Privacy and Security Rules and other privacy requirements.

In instances where patients request special confidentiality, all personnel at <Organization Name> operated health care delivery sites shall take measures to prevent the disclosure of confidential information via billing and health insurance claims. This also includes confidential communications related to any and all services provided and not billed to third-party payers. Accordingly, patient service information and PHI only will be shared with third-party payers when the patient provides specific documented consent of what specific information may be released, the timeframe for such release, and the entity/ies with which information may be shared.

III. **PROCEDURES**
1. During check-in for every patient visit, the <Job Title(s)> [or individual(s) working in her/his stead] will provide the patient with a copy of the Consent for Use of Personal Health Information Form. This form describes the following:
    ▪ Obligation of <Organization Name> to protect the confidentiality of patient individually identifiable information and PHI
    ▪ Summary of permitted disclosures of patient individually identifiable information and PHI
    ▪ Restrictions on the use and disclosure of patient individually identifiable information and PHI

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2. The <Job Title(s)> [or individual(s) working in her/his stead] will review the Consent for Use of Personal Health Information Form with the patient and complete the form by asking the patient the following questions:

    i.   Would you like us to release any information regarding the services you receive at <Organization Name> to anyone other than yourself, such as another health care provider?

    ii. May we leave a phone message concerning the services you receive at the phone number you provided? If not, is there an alternative phone number where you feel comfortable having us contact you?

    iii. Can we mail you information concerning the services you receive at <Organization Name>?

3. The <Job Title(s)> [or individual(s) working in her/his stead] will review the completed form with the patient, after which the patient will sign the completed form. Should the client answered "no" to any of the above questions, staff will confirm the patient's confidentiality requirements and document them in <Organization Name>'s practice management system (PMS) / electronic health record (EHR).

4. At each visit, patients also will be asked to complete the Patient Information or Income Verification Form with the <Job Title(s)> [or individual(s) working in her/his stead], which includes the following questions:

    i.   Do you have health insurance coverage?

    ii. Are you using your health insurance today? This may result in your insurance company sending an Explanation of Benefits (EOB) that summarizes the services you receive to the primary policyholder or posting information about the services you receive online within their portal.

    iii. If you do not wish to use your health insurance today, is it because of any of the following reasons:

    - Concerned about confidentiality
    - Too expensive
    - Health insurance plan does not cover services
    - Health center does not accept the patient's health insurance
    - Other reason (please specify: _____)
    - Not applicable

5. The <Job Title(s)> [or individual(s) working in her/his stead] will review the patient's responses. If the patient identifies any special confidentiality needs, staff will confirm the patient's confidentiality requirements and document them in <Organization Name>'s practice management system (PMS) / electronic health record (EHR).

6. Patients who do not wish to have their health insurance billed will be informed that they will be responsible for payment. Low-income patients may qualify for a reduced fee for certain services, as determined by <Organization Name>'s Family Planning Sliding Fee Scale.

    Per sliding fee scale policies and procedures, the <Job Title(s)> will use the patient's income and household size information to determine whether the patient qualifies for a reduced fee on the Family Planning Sliding Fee Scale.

7. Bills with outstanding patient balances will never be sent to the home of a patient who requests special confidentiality. Any collection of payment is to be made at the health center.

8. Outstanding balances for patients who request special confidentiality will never be sent to a collection agency.

Step 3 – Train Staff and Distribute Supplemental Materials

A. Staff Training

It is likely that the screening questions will trigger conversations between intake staff and patients that may be new to staff. Therefore, staff should be well acquainted with the screening questions and the health centers' policies and procedures before initiating the screening protocol. Additionally, staff should understand when they will ask the screening questions, how they will document responses, and who to go to should they experience any technical difficulties. Prepare materials and reserve time during a staff meeting to address these points.

Tool #10 — The following tool is a sample training webinar. Microsoft PowerPoint slides contained information about Title X program requirements, the importance of insurance reimbursement for sustainability of the health center, and differentiating between payment that does not breach privacy and confidential services. The presentation also included a detailed explanation of the intervention screening process. These slides were the basis of the training webinar distributed to pilot sites and may be accessed online.[7] Health centers may wish to customize the training deck with their own workflow, forms, and processes.

> *Learning objectives:* After viewing the training webinar, the goal was that each staff would be able to:
> 1. Describe why insurance reimbursement is important for the sustainability of the health center.
> 2. Differentiate between payment that does not breach patient privacy and confidential services.
> 3. Understand how to follow a protocol for screening patients for health insurance and their need for payment that does not breach patient privacy.

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7 Materials developed for the intervention may be accessed at www.confidentialandcovered.com
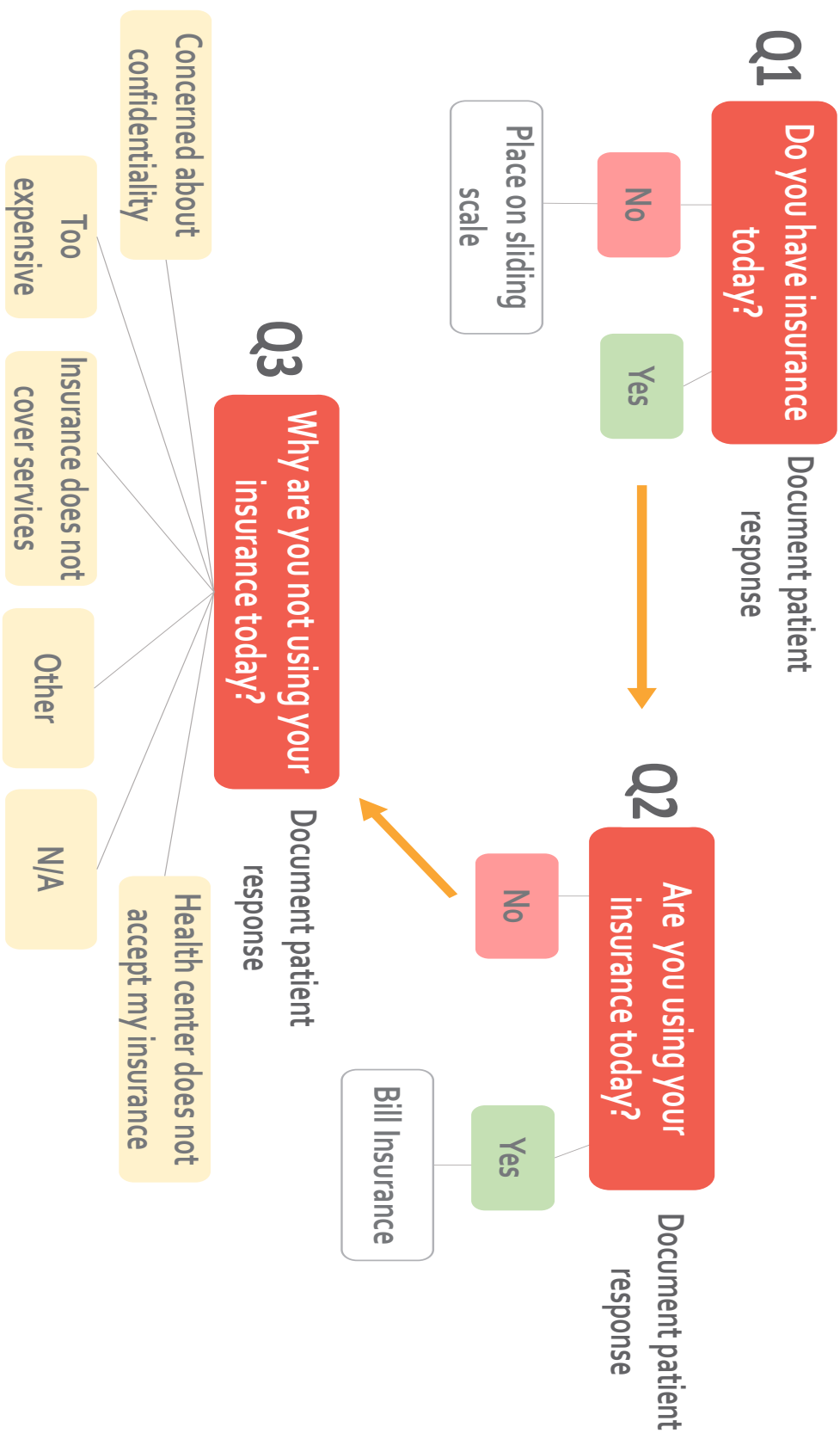
Pilot Experiences

o   *"The training gave me an appreciation for the work the front staff does and that makes my job much easier. I'm more confident billing patients when I know that the front desk is asking the right questions and noting it on their screen. When I prepare claims, things pop up for confidentiality and I'm not fumbling through things, trying to figure out if a 15 or 16 years old came in and needs to be confidential or if a parent came with them." -A biller at a stand-alone Title X health center.*

o   *"This training was extremely helpful on getting us on the path to the correct questions to ask our patients about insurance and confidentiality- to be able to put that into our system from the start. In the past, we hadn't done training on that aside from center-specific practices, on how to talk to a patient." -A staff member at a Title X health center*

o   *"I think the webinar is a nice introduction. A little bit of the webinar was review, but we have a new hire and it was helpful. I like the webinar in conjunction with the other documentation to really solidify why it's important and why we should ask these questions." - A clinic assistant at a stand-alone Title X health center.*

B. Supplemental Materials

The following are supplemental materials designed to support staff during implementation of the screening questions:

Tool #11— *The following decision tree was developed to support staff in navigating the insurance screening questions and corresponding actions.*

Decision Tree

Q1 Do you have insurance today?

Document patient response

- No → Place on sliding scale
- Yes

Q2 Are you using your insurance today?

Document patient response

- No → Why are you not using your insurance today?
- Yes → Bill Insurance

Q3 Why are you not using your insurance today?

Document patient response

- Concerned about confidentiality
- Too expensive
- Insurance does not cover services
- Other
- N/A
- Health center does not accept my insurance

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Tool #12—*The following conversation guide provides sample language for staff to initiate conversations with patients about their concerns and confidentiality needs*

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Screening for Patients' Health Insurance and Confidentiality Needs Conversation Guide

Confidentiality

Patients have many different reasons for wanting to protect their confidentiality. Reasons that they give may involve:

- Not wanting family members or a partner to know that they are accessing services. They may be concerned about an explanation of benefits (EOB) or other billing statements.
- Concerns that their employer may review the claim and it may impact their employment.

> **SAY**: *I understand that your privacy is important to you. All of your services here are confidential. Do you have specific concerns about billing your insurance? Are you worried about all parts of your visit, or are there some parts that are ok to bill?*

> For patients who indicate that their reason for not using insurance is something other than confidentiality and payment privacy, it is important to encourage them to use the insurance coverage that they have whenever possible.
>
> > **SAY**: *Using your insurance allows us to continue providing services to everyone. When we bill your insurance, it means that the funding that we have can be used for other patients who don't have access to insurance.*

Confusion

Patients that have only used the sliding scale for services may not understand how to use their insurance. They may assume that because they have only used the sliding scale for services at your health center, your center does not accept insurance. Additionally, patients may not understand how to use their insurance benefit to get care. Patients may say:

- I thought you didn't take insurance.
- Can I still come here if I use my insurance?

Discuss if your center is contracted with their insurance company and work with the patient to educate them about how they can use their insurance to cover their care.

> **SAY**: *We accept insurance and we are contracted with the following companies. Let's see if we are an in-network provider so that you can use the coverage that you have.*

CONFIDENTIAL
+COVERED

Coverage

With many plans moving to a HMO or EPO model, patients may have insurance that significantly limits which providers they can go to for covered services. This can be confusing for patients that have a long history with your center. They may say:

- o   I'd rather just see who I already know.
- o   I don't know how to find a provider with this insurance.

Encourage the patient to see an in-network provider for their services. You can offer them copies of their records to take with them and the assurance that they are always welcome to come back if their insurance situation changes.

> **SAY**: *Are you willing to go to a provider that is in network for your plan instead? The cost for your visit will be much lower if you use a provider in your network.*

Financial

Billing insurance adds a level of uncertainty about how much will be covered and what charges may be billed to the patient later. Patients may say:

- o   My insurance doesn't cover *anything*.
- o   It's more expensive to use my insurance, I'd rather use the sliding scale.

For Title X services, centers aren't allowed to bill patients for more than they would have paid if they were on the sliding scale. Your center may provide a broader range of services than just the covered Title X services. You will need to discuss your facility's policies regarding billing patients for non-Title X services.

> **SAY**: Billing your insurance for services that we provide doesn't mean that you'll pay more. If you are responsible for a copay or deductible, we'll only charge you what you would have paid if you hadn't used insurance at all. Are you willing to have us bill for today's services?

Other

Patients have many reasons for not using their insurance and not all will fit under these broad categories. Please record these reasons for not using insurance so that your health center can track the responses. As these situations arise, seek out guidance from your supervisor on how to handle the situation in accordance to your internal policies.

Tool #13 - *The following tool is a sample phone script from a pilot site that presented the screening questions to patients when they called to schedule an appointment.*

Phone Script

NO ← Do you have insurance? → **YES** · · · Will you be using your insurance for this visit? → **YES**

YES → Can you please provide me with your insurance carrier and/or ID number? Also, please remember to bring your insurance card to your visit on {DATE}.

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. ← **NO**

Too expensive ← Health center does not accept insurance → Although we don't accept that insurance, you may be eligible for our sliding fee scale and if there is a cost to you we can set up a fair payment plan. Could you please tell me your current household size and weekly or monthly income?

Concerned about confidentiality ← Insurance does not cover services

Can you tell me more about your concerns? → Other reason (please specify) → Many of the services we provide are considered preventative and may be covered under your current health insurance policy. Have you contacted your insurer about coverage of these services?

If you have health insurance, we can bill your insurer. If there is a cost to you, we will set up a fair payment plan. We will work with you, whatever your situation may be. → Please know that you will receive professional and confidential care, no matter what your income or insurance status.

No Insurance

Would you like to meet with our Certified Application Specialist? He can help determine your eligibility for healthcare insurance. ← We offer a sliding price scale based on your income that can significantly reduce what you might have to pay. If there is a cost to you, we will set up a fair payment plan.

Please know that you will receive professional and confidential care, no matter what your income or insurance status. Our screenings, exams, birth control and consultations are very affordable, and in some cases free of charge. ← We do not want concerns about cost to ever prevent a patient from making an appointment. We will work with you- whatever your situation may be. We will never turn anyone away for inability to pay.

Pilot Experiences
o   Staff kept the decision tree and/or the conversation guide on their desk and referenced them when having a discussion with patients regarding their insurance.
o   *"It really helps to have the little guideline we can go over in our spare time, just in case these questions do come up."* – A staff member at a Title X health center

Step 4: Implement Screening Questions

Initiate the collection of patient responses to the screening questions with revised forms and workflows. Leadership may wish to hold additional meetings to check in on implementation and troubleshoot.

Step 5: Compile Data, Analyze and Evaluate

Compile patient demographic and response data, codes for services rendered, and billing information for analysis.

By collecting and analyzing data on health insurance coverage and insurance use, health centers may learn more about their patient population and adapt to patient needs. Health centers may improve staff training and screening processes if they understand the characteristics of the patients who opt not to use their insurance and the situations in which patients choose not to use insurance. Therefore, look for patterns by service code, patient age, patient sex, and patient response to the screening protocols.

Acknowledgements

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.