



CONFIDENTIAL + COVERED

Title X Network Perspectives on Confidentiality and Insurance Billing

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JANUARY 2016

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National
Family Planning
& Reproductive Health Association

Funding for this project was provided by the Office of Population Affairs (Grant Number 1 FPRPA006059-01-00). The views expressed by this project do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply official endorsement by the US Government.

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Executive Summary

Confidential & Covered is 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.¹ The project is 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 is to improve service sites' 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 throughout the payment process—in other words, payment that does not breach privacy.

In the first year of the project (2014-2015), the *Confidential & Covered* project team fielded a nationwide environmental scan of Title X family planning providers to identify current practices for protecting patient privacy throughout the payment process. It also conducted policy and legal analyses to understand the environment within which Title X providers operate.

Objectives

The *Confidential & Covered* environmental scan was designed to study the factors that may affect the capacity of the Title X network to bill insurers. The specific objectives of the study were to:

- Describe factors influencing Title X service sites' insurance billing practices when patients request confidential services;
- Identify needs for additional staff training on confidentiality and insurance billing;
- Identify perceptions of revenue unrealized due to avoidance of billing for confidential services; and
- Identify emerging practices to increase patient use of insurance while protecting confidentiality.

To accomplish these objectives, the research team conducted a survey of Title X health center staff (front desk staff, billing/finance staff, managers and clinicians) and program administrators, along with a series of focus group discussions with the National Family

Planning & Reproductive Health Association (NFPFHA) members.

Key Findings

Screening for patients' health insurance coverage and confidentiality needs:

Study findings showed that health centers commonly ask patients about their health insurance coverage and frequently ask patients about their preferences regarding health care-related communications. However, most health centers could improve processes to screen and track patients' insurance coverage and needs for payment privacy.

Protecting patient confidentiality:

Study findings showed that many health centers have well-developed policies and practices for protecting confidentiality of care-related communications, but few specific policies related to insurance billing communications such as explanations of benefits (EOBs).

Working with Medicaid and commercial insurance companies:

Study participants described confusion

about how third-party payers may impact confidentiality of payment, especially in the rapidly changing insurance landscape under the Affordable Care Act. They indicated that Title X health centers have very limited capacity to negotiate confidentiality protections with third-party payers.

Financial impact of current confidentiality and insurance billing practices: Study participants were unsure of the impact of avoiding insurance claims due to confidentiality concerns on revenue. Some expressed concern that patients would seek confidential services for financial reasons rather than safety or other concerns.

Training practices and needs related to confidentiality and insurance billing: Study participants considered providing confidential health care to be important to their patients and to the health center mission. However, the

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

study findings suggest that further training is needed to differentiate between health-care related communications and insurance billing-related communications.

Recommendations

The report presents recommendations that may help Title X health centers to generate more revenue while recognizing that protecting confidentiality and serving patients regardless of their insurance status or payment source is the heart of the Title X program.

Recommendations	Section
Screen for confidentiality at each appointment.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Ask specific questions about billing rather than assuming that patients who express desires regarding health center communications also need payment that does not breach privacy.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Ensure that there is a way to communicate to billing or other staff if a patient discloses information in the exam room or at check out that may indicate a need for increased privacy protection.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Track patients based on their needs for private payment, rather than health center communications, so that if the claim is denied because of other third-party liability, staff know if they can seek reimbursement.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs Working with Third Party Payers Financial Impact
Provide health insurance literacy as part of outreach and enrollment activities, including describing to patients the range of communications they may receive from their insurer.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs Financial Impact
Review organizational policies to clarify that all patients should be assessed for individual privacy needs. For example, do not assume all teens need payment privacy. ²	<ul style="list-style-type: none"> Protecting Patient Confidentiality Financial Impact
Implement income verification for those on the sliding scale. Title X recommends income verification, though specific policies for documentation are determined by grantees. Write income verification policies that have flexibility to ensure that they do not become barriers to service when patients are unable or unwilling to provide documentation for safety or other concerns. ³	<ul style="list-style-type: none"> Protecting Patient Confidentiality
Rather than flagging the entire medical record for confidentiality, if possible do so by visit or by service.	<ul style="list-style-type: none"> Protecting Patient Confidentiality

2 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.

3 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>.

Recommendations	Section
Make efforts to collect outstanding balances at other visits and by using an alternative method of contact to send statements, such as e-mail.	<ul style="list-style-type: none"> • Protecting Patient Confidentiality • Financial Impact
Create a fact sheet or one pager about health care communications - including EOBs, what the health center may send home, and other ways information might be sent to patients.	<ul style="list-style-type: none"> • Protecting Patient Confidentiality
Determine how the Medicaid agency in your state implements the third-party payer liability requirements.	<ul style="list-style-type: none"> • Working with Third Party Payers
Determine the process for sending consumer communications from the largest health insurers your organization has contracts with, including Medicaid and especially Medicaid Managed Care.	<ul style="list-style-type: none"> • Working with Third Party Payers
Clarify eligibility requirements for Medicaid family planning expansion programs in your state — how is inability to use a commercial insurance plan defined?	<ul style="list-style-type: none"> • Working with Third Party Payers
Create training programs to help staff feel comfortable discussing payment options with patients and how those may impact privacy.	<ul style="list-style-type: none"> • Working with Third Party Payers
Remind patients that the Notice of Privacy Practices given to all insurance policyholders will have information about how to redirect private health information.	<ul style="list-style-type: none"> • Working with Third Party Payers
Write policies that clearly differentiate between confidential services and payment privacy.	<ul style="list-style-type: none"> • Training
Messaging about new policies should make clear that confidentiality is still a high priority and available for those who need it.	<ul style="list-style-type: none"> • Training
Create trainings that differentiate between confidential services, payment that does not breach privacy, and requirements of the Health Insurance Portability and Accountability Act.	<ul style="list-style-type: none"> • Training
Foster understanding of the importance of seeking reimbursement from third-party payers to sustain the program.	<ul style="list-style-type: none"> • Training

Conclusion

As Title X providers respond to a growing base of newly insured patients coupled with the strain on grant funding, they will continue to need to modify their business practices by contracting with commercial and public payers. While contracting with third-party payers is an important step toward diversifying program income, the study results seem to show that many providers may also want to consider changes to health center practices and policies to be able to take full advantage of insurance reimbursement. The study found that most participants did not recognize that avoiding billing for services due to patients' confidentiality concerns could lead to revenue losses. Recommendations shared in the report are meant to provide approaches to interacting with patients, health center staff, and insurers to decrease revenue loss due to the provision of health care that does not breach patient privacy.

Overview of the Project

Confidential & Covered is 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.⁴ The project is 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 is to improve service sites' 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 throughout the payment process—in other words, payment that does not breach privacy.

In the first year of the project (2014-2015), the Confidential & Covered project team fielded a nationwide environmental scan of Title X family planning providers to identify current practices for protecting patient privacy throughout the payment process. It also conducted policy and legal analyses to understand the environment within which Title X providers operate.

Background

The Affordable Care Act (ACA) along with longer-term health care delivery trends have changed conditions for safety-net family planning providers, including those funded by Title X. Expansion of health insurance coverage through insurance marketplaces and expanded Medicaid eligibility in some states have increased access to insurance reimbursement for Title X health centers. At the same time, public funding for family planning has been declining due to federal and state budget constraints, a poor economy, and competing priorities. As a result, it is more critical than ever for health centers to use Title X funds strategically and to seek other sources of income.

A growing base of newly insured patients coupled with the strain on grant funding have compelled Title X health centers to modify their business practices by contracting with commercial and public payers. Title X providers view commercial or public insurance reimbursement as a component of overall program income. The extent of the increase in insurance claims revenue reimbursement may depend on many factors, including how the ACA has been implemented in the state, whether Medicaid has been expanded, the number of commercial payers in the state, insurance reimbursement rates, and health center capacity to seek reimbursement from Medicaid and commercial payers.

Providers in the Title X program have a longstanding commitment to providing services regardless of patient circumstance,⁵ and requirements to maintain confidentiality are in statute, guidance and case law. Title X providers, like those in many safety-net health programs, are also required to seek third party reimbursement when possible.⁶ As described above, many patients seen in Title X health centers are newly insured and are likely to be insured as dependents—through a spouse, partner, or parent. This adds complexity to questions such as “Do you need confidential services?” or “How should we contact you?” because information about the care of patients insured as dependents can be shared with policyholders through a variety of channels, including mailings (e.g. explanations of benefits) and electronic communications (e.g. posting on patient portals).

4 The members of the collaborative are Altarum Institute in partnership with the Urban Institute, the Gutmacher 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.

5 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.

6 Program Requirements for Title X Funded Family Planning Projects, Sec. 8. [see note 5, above]

Federal and state requirements for insurance communications to policyholders can also pose a challenge for providers to uphold privacy during the payment process. State policies about consumer communications may vary by plan type (fee for service, managed care, or self-insured plans)⁷ and by payer type (commercial or public), in addition to federal requirements. Finally, Title X family planning providers operate in diverse settings and funding circumstances which may influence the need for additional revenue, comfort with billing, and capacity to make policy changes at a health center level. These considerations make it virtually impossible to arrive at a single policy approach or operational best practice for increasing use of insurance by patients who are concerned about a confidentiality intrusion due to consumer communications.

The Health Insurance Portability and Accountability Act (HIPAA) allows communications for “treatment, payment, or health care operations” without the express authorization of the individual,⁸ and Title X requires efforts to be made to collect reimbursement from other parties when it is available. However, patients and providers may want to keep services private to the extent that no information, including billing or insurer communication, is released to the insurance policyholder or other family members. This is a higher standard of privacy than required by HIPAA, but is explicitly permitted by Title X.

Title X health centers often resolve this conflict by not billing commercial payers, using grant funds to provide services, writing off charges, or where possible, using a Medicaid family planning expansion program that allows confidentiality as an additional reason for eligibility.⁹ The practice of defaulting to public programs or not billing for services may represent revenue loss for Title X health centers. Commercial insurance plans often offer the highest reimbursement rates relative to other payers. Additionally, there may be patients who are unfamiliar with their insurance or the questions being asked of them, who may be able to use their health insurance if their concerns were addressed. Defaulting to public programs or avoiding billing may mean that Title X service sites forgo potential sources of revenue even in cases where insurance billing may be possible—tapping their limited Title X funds to cover patients whose care, in some cases, could be covered by their health insurance. These considerations show the complexity of decisions associated with billing health insurance for services for both health center staff and insured patients. In addition to sharing information or having communications sent to parents, spouses, or partners, patients may also have questions about what costs they will be responsible for, especially under plans with high deductibles and cost-sharing requirements.

In the context of a shifting insurance and health care delivery landscape, uncertainty about the future of Title X funding, and the Title X network’s continued commitment to protecting patients’ confidentiality, this report offers insight into Title X service sites’ billing and operational practices that may help grantees and subrecipients navigate this complex landscape.

Environmental Scan Objectives

Confidential & Covered is designed to study the factors that may affect the capacity of the Title X network to bill insurers. The specific objectives of the study were to:

- Describe factors influencing Title X service sites’ insurance billing practices when patients request confidential services;
- Identify needs for additional staff training on confidentiality and insurance billing;
- Identify perceptions of revenue unrealized due to avoidance of billing for confidential services; and
- Identify emerging practices to increase patient use of insurance while protecting confidentiality.

7 Abigail English, Robin Summers, Julie Lewis, and Clare Coleman, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015).

8 Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub.L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of titles 18, 26, 29, and 42 of the U.S. Code).

9 Jennifer Frost, Rachel Benson Gold F, Lori 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.]

To accomplish these objectives, the research team conducted a national survey of Title X health center staff (front desk staff, billing/finance staff, managers and clinicians) and program administrators. The research team also conducted a series of focus group discussions with NFPRHA members. The research was reviewed by the George Washington University's Institutional Review Board and found to be exempt.¹⁰ The details of the survey and focus group methodology are described in more detail in the Appendix.

Key Findings

This report presents findings from the survey and focus groups according to several key themes identified as most relevant to Title X grantees and subrecipients, including:

- Screening for patients' health insurance coverage and confidentiality needs;
- Protecting patient confidentiality in communications, record keeping and health insurance billing and payment;
- Working with Medicaid and commercial insurance companies;
- Financial impact of current confidentiality and insurance billing practices; and
- Training practices and needs related to confidentiality and insurance billing.

The survey found that avoidance of billing due to patients' confidentiality concerns could lead to revenue losses. However, Title X providers did not have a clear understanding of the impact of this practice. The research team focused on communications that may be generated throughout the insurance claims process and lead to unwanted information being shared with insurance policyholders or other family members, such as an explanation of benefits (EOBs). Therefore, the research does not fully explore the impact on privacy and confidentiality of electronic health records or other communications at the health center level such as test results or appointment reminders. The report presents recommendations that may generate more revenue while recognizing that protecting confidentiality and serving patients regardless of their insurance status or payment source is the heart of the Title X program.

¹⁰ Institutional Review Board #111404

Screening for Patients' Health Insurance Coverage and Confidentiality Needs

As patients seeking health care at Title X health centers are increasingly insured, modifying screening processes to not only include income, insurer type/company/plan, but also specific confidentiality concerns related to billing or insurance are critically important to improve program revenue, leverage grant dollars, and most importantly, protect patients who are in need of payment that does not breach privacy. Throughout the research process, *Confidential & Covered* was particularly interested in learning about Title X health centers' strategies to screen patients for insurance coverage that assume the use of insurance as a payer and take into account the needs of those who may have concerns about using their insurance.

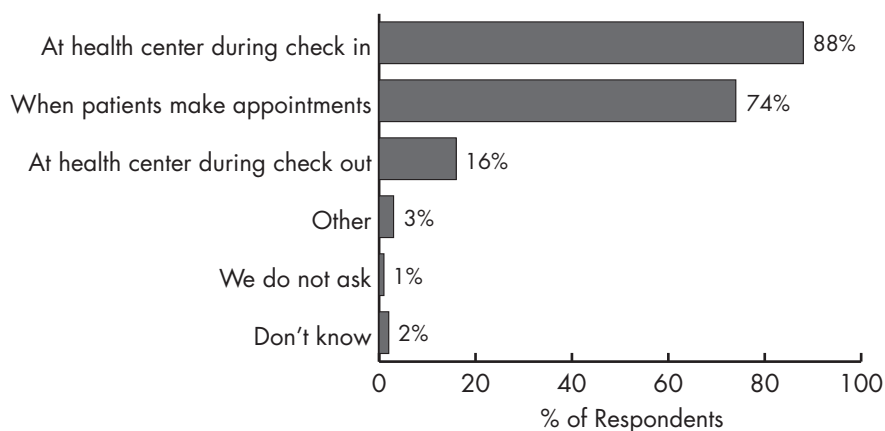
Health Insurance Coverage

Title X health centers are required to screen for and report on payer type for all of their patients.¹¹ As a result, it is not surprising that most Title X health center staff members reported that they ask patients about their health insurance coverage at the health center during check in (88%) and/or when patients make appointments over the phone or electronically (74%) (*Figure 1*). Fewer participants said that they asked during check out (16%) or at other times (3%).

Staff members were most likely to report asking patients about their health insurance using general questions such as "Do you have health insurance?" (86%) or "What is your health insurance coverage?" (50%) (*Figure 2*). They were less likely to report asking with questions that specifically refer to using insurance to pay for services such as "How will you be paying for your visit today?" (40%) or "Will you be using health insurance for this visit?" (38%). These specific

FIGURE 1. Survey Question: "When does your organization ask patients about their health insurance coverage?"*

(Check all that apply)



*Question was asked of: Billing/finance, clinical, front desk, and management staff

questions clarify expectations for patients and staff members that using insurance is an option, and potentially serve as a conversation opener about

using health insurance to pay for services rather than simply as a checkbox for reporting.

11 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. <http://www.hhs.gov/opa/pdfs/fpar-reissued-oct13.pdf>

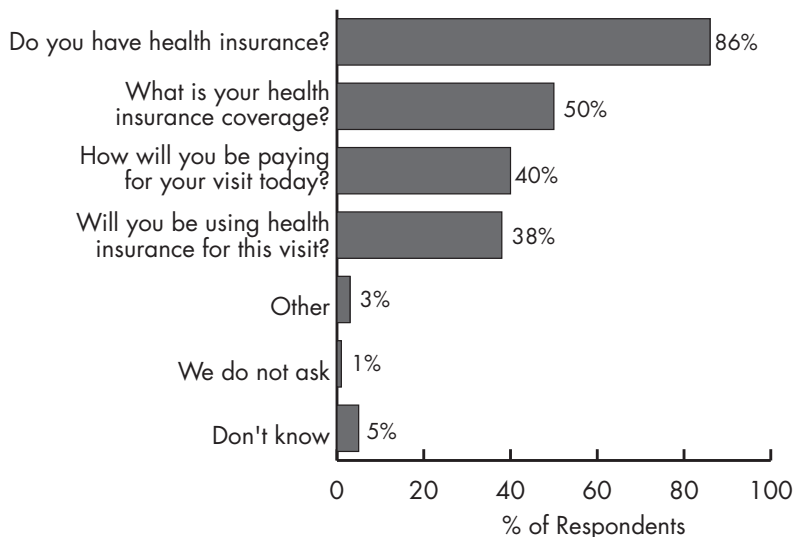
Confidentiality Needs

Family planning and reproductive health services may be considered sensitive for some individuals for various reasons and at different times during their lives. Unlike other providers, Title X health centers and other safety-net family planning providers often ask about confidentiality and communications preferences in the course of patient registration. Front desk and billing/finance staff members who responded to the survey were most likely to report asking new patients about their need for confidential services when they check in for the first time (57%) (*Figure 3*). A smaller percentage of front desk and billing/finance staff respondents also said that they asked all patients about their confidentiality needs, either when they arrive for each visit (50%), call to schedule appointments (43%), or check out (8%). Asking at only the first visit rather than at each returning visit may be a missed opportunity to identify patients whose circumstances have changed. Additionally, not asking at check out may be a missed opportunity to discuss the potential impact of insurance communications, particularly if additional services were provided during the visit that may have triggered unanticipated confidentiality concerns.

Staff members were more likely to ask patients about whether they have confidentiality concerns in the context of communications than about insurance billing (*Figure 4*). A majority reported that they asked patients if they had concerns about confidentiality related to phone calls (71%) and mailings (67%) coming directly from the health center. Fewer respondents (34%) indicated that they asked about confidentiality concerns related to e-mails. This concern about communications is often considered tantamount to a concern about billing insurance, and tracked as “do not contact” within the medical record at a health center. This practice can make it difficult to later discern if the patient was willing to allow their insurance to be billed.

FIGURE 2. Survey Question: “What question(s) does your organization use to ask about health insurance coverage?”*

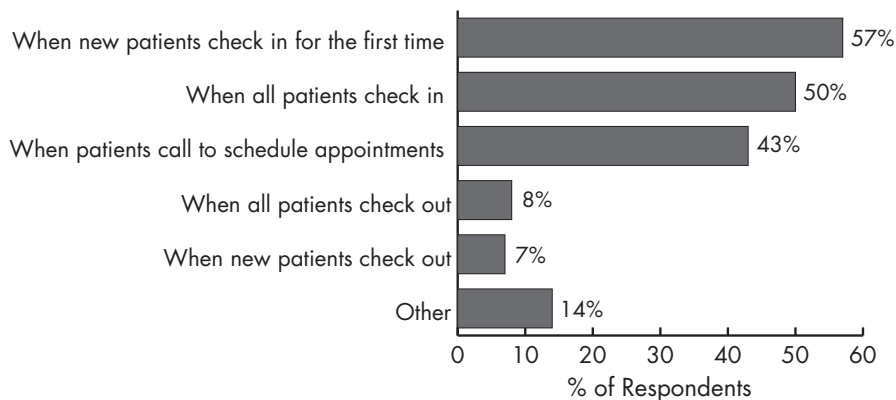
(Check all that apply)



*Question was asked of: Billing/finance, clinical, front desk, and management staff

FIGURE 3. Survey Question: “In your organization, when is it determined that patients need confidential services?”*

(Check all that apply)



*Question was asked of: Billing/finance and front desk staff

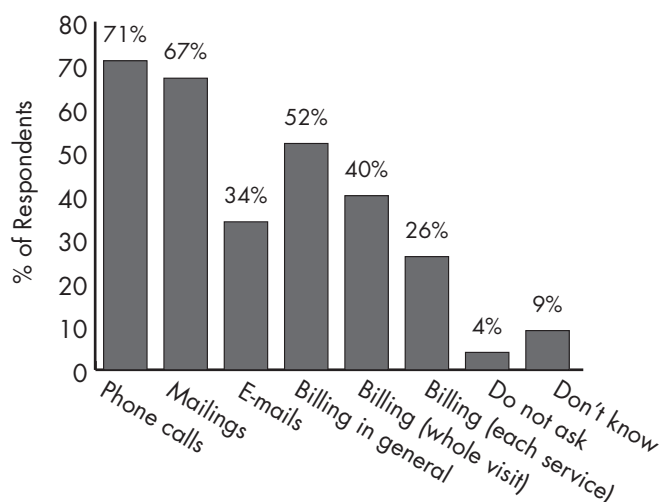
Staff members were less likely to report that they asked patients if they had confidentiality concerns specific to insurance billing. Those who said they asked were most likely to report asking whether patients had confidentiality concerns about billing in general (52%) than for specific visits (40%) or services (26%).

Since Title X health center clinicians may learn about patients' confidentiality concerns even when other staff members do not, the survey also asked them to report on the circumstances that would cause them to reassess a patient's need for confidential payment (*Figure 5*). Among the clinicians who answered the question, a large majority said they would reassess if the patient requests that information about a specific service does not get sent home (88%), if a patient divulges a sensitive home situation (81%), or if a patient is a minor (81%).

A smaller group of clinicians (43%) also said they would reassess the need for confidential payment for patients who present with symptoms or diagnoses incongruent with their health and social history.

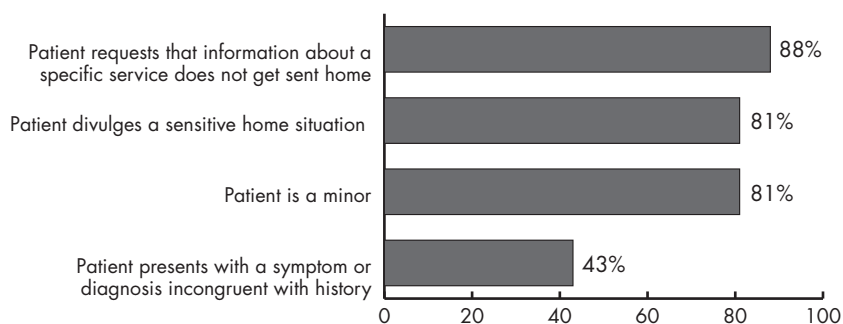
When front desk staff were asked about the specific questions they asked to determine patient confidentiality needs, 80% said that they asked patients whether they had concerns about receiving mail or phone calls from the health center at their homes (*Figure 6*). Fewer front desk staff said that they asked whether patients had concerns about billing their health insurance (52%) or whether they planned to use insurance to pay for services (39%). Front desk staff members were least likely to say that they used questions about confidentiality that did not specifically mention communications or health insurance: "Do you need confidential services?" (36%) or "Do you need confidential services today?" (25%).

FIGURE 4. Survey Question:
"How does your organization screen for the need for confidentiality?
We ask if patients have concerns about confidentiality related to..."*
(Check all that apply)



*Question was asked of: Billing/finance, clinical, front desk, and management staff

FIGURE 5. Survey Question:
"Under what circumstances would you reassess a patient's need for confidentiality through the payment process?"*
(Check all that apply)



*Question was asked of: Clinical staff

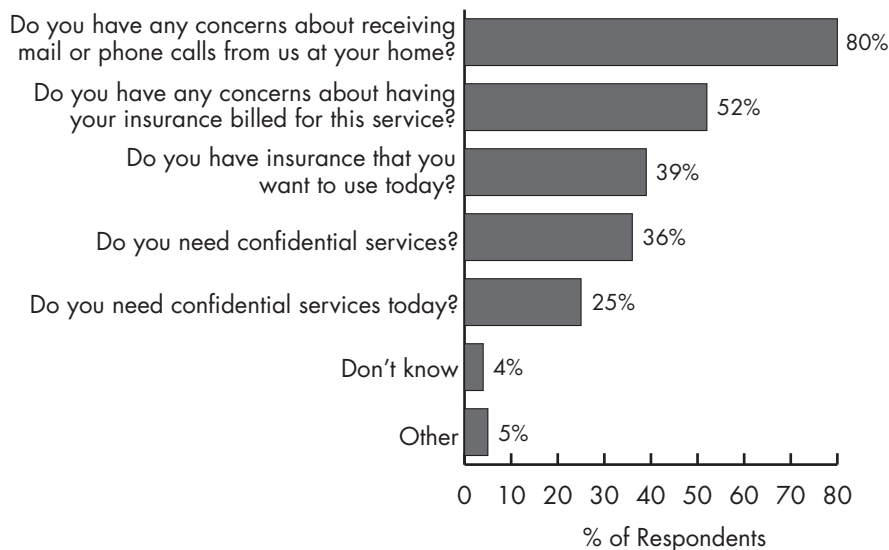
One survey participant noted that using more generally worded questions like “do you need confidential services?” might make it difficult for patients to understand why they were being asked, especially because Title X health centers already emphasize that all services are confidential:

“Linking the content and purpose of the confidentiality questions we ask our clients are important. There seems to be a huge disconnect between the ways some sites are asking the client if they want confidential care—everyone says yes, who doesn’t want confidential reproductive health care?—which is then recorded but isn’t always effectively used as a screening question for how to bill for services, especially if the client has another source of payment on file.”

As this participant pointed out, patients might think that “yes” is the only obvious answer when health center staff ask whether they need confidential services, even if they might not have concerns about receiving communications or having their health insurance billed. A set of questions asking about specific concerns related to communication, including mailings, phone calls or e-mails, versus insurance billing (overall or for specific visits or services) might give staff members a clearer understanding of patients’ needs. In some cases, asking more specific questions might enable Title X providers to bill patients’ health insurance after ascertaining the exact nature of patients’ confidentiality concerns.

Confidential & Covered asked participants to suggest questions to help staff explain the consequences of billing health insurance to patients and determine whether billing might pose a threat to patients’ specific confidentiality needs (*Table 1*).

FIGURE 6. Survey Question:
“In your organization, what questions are asked verbally to determine whether patients need confidential services?”*
(Check all that apply)



*Question was asked of: Front desk staff

Each of these questions places the issue of confidentiality in a more specific context—the possibility that information about the services a patient obtains may be seen by their insurance policyholder or other family members if s/he is covered as a dependent under their insurance plan. This prevents confusion that is

possible when using some of the more general questions that do not expressly tie confidentiality to the billing process.

In addition to identifying patients in need of payment that does not breach privacy, participants stressed the importance of educating patients about

Table 1. Suggested questions for staff to use with patients

Can we send a bill home that would say what services you got today?
Do we need to keep your family planning services confidential from your partner, spouse, or parent?
If we use your insurance, your parents might be able to see which clinic you used and what you were seen for. Do you want to use your insurance or not? Either way is fine.
It looks like you have _____ insurance, with _____ as a policyholder. Would you feel comfortable billing this insurance for your visit today and in the future?

the billing process. In one of the focus group discussions, a billing/finance staff member noted that Title X health center staff members often need to explain the implications of insurance billing procedures and communications to patients who may have limited experience with health insurance:

“We say to them things like, ‘Can we send a bill home that would say what services you got today?’ You have to be very directive with a lot of our folks, who often this might be the first time they’ve ever had insurance. We’re their only provider, so they don’t know how that all works, and we’re walking them through that in conversation rather than gathering it on paper. I don’t know that we always get what we need from [them]... Then again, there are people that argue it’s easier for them to put something on paper than to say it face to face. We have to struggle with that and find a balance.”

Recommendations

Health centers commonly ask about health insurance coverage and frequently ask patients about their preferences regarding health care-related communications. However, the survey findings show that most health centers could improve processes to screen and track patients’ insurance coverage and the need for payment that does not breach privacy.

- Screen for confidentiality at each appointment.
- Ask specific questions about billing rather than assuming that patients who express desires regarding health center communications also need payment that does not breach privacy.
- Ensure that there is a way to communicate to billing or other staff if a patient discloses information in the exam room or at check out that may indicate a need for increased privacy protection.
- Track patients based on their needs for private payment, rather than health center communications, so that if the claim is denied because of other third-party liability, staff know if they can seek reimbursement.
- Provide health insurance literacy as part of outreach and enrollment activities, including describing to patients the range of communications they may receive from their insurer.

Protecting Patient Confidentiality

This section discusses findings related to the operational practices that health centers may employ once it is determined that a patient requires confidentiality protections. Health centers may use a variety of practices to maintain patient confidentiality throughout the care delivery and payment processes. However, their practices for protecting confidentiality of care-related communications (e.g., test results, prescription renewals, and appointment reminders) were significantly more developed than their practices for protecting confidentiality of insurance billing-related communications. Instead, most respondents reported that their health centers employed strategies designed to avoid billing for patients requiring confidential services rather than to protect confidentiality while billing insurance as the research team had anticipated.

For example, the vast majority of respondents reported that they check if a patient has requested confidentiality protections before calling or sending communications by mail (90%). Over half (62%) also reported that their health centers do not send bills at all for patients who have requested confidentiality, and another 15% reported having a modified billing process for patients who need confidentiality. Respondents described an impressive array of strategies to protect patients receiving services at their health centers, including by directing lab results or bills back to the health center, mailing special postcards, or using patient passwords to verify callers.

These findings underscore the degree to which confidentiality is embedded in the program. However, they also suggest that while many organizations are committed to confidentiality, they have not yet grappled with how to address confidentiality in the insurance billing process. Practices to protect confidentiality in the insurance billing process were far more limited in comparison to the variation of practices identified that were designed to establish alternative plans for communicating with patients needing confidential care. While assuring patient preferences regarding sending or sharing information is an important aspect of maintaining patient privacy, organizations might be using patients' communications preferences as a proxy for whether they want their insurance billed without specifically

ascertaining whether insurance billing is possible or developing strategies to protect patients' privacy while billing insurance.

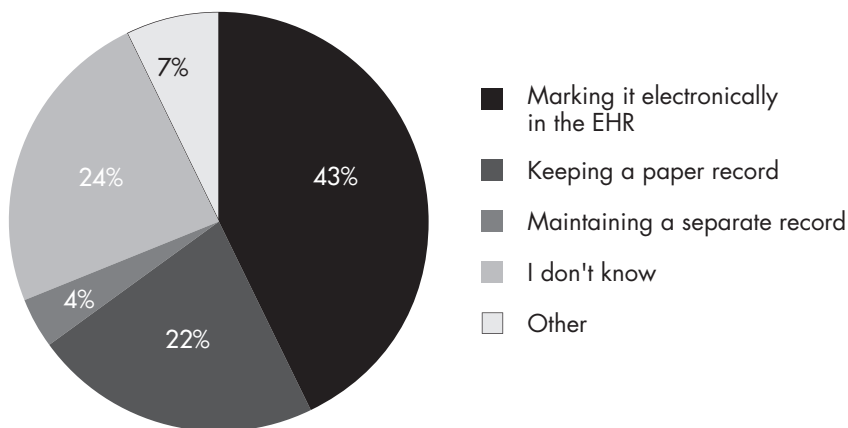
Tracking Patients' Confidentiality Requests

After establishing that a patient requires confidential services, organizations adopt a variety of strategies for documenting and tracking that information. When asked how a patient's requests for

payment that does not breach privacy were documented, the majority of respondents indicated that they marked such requests either in the patient's electronic medical record (43%) or in the paper record (22%) (*Figure 7*). Fewer respondents (4%) indicated that their organizations maintained separate records for patients requesting confidential services.

Survey responses demonstrated that in organizations where this information could be documented both electronically

FIGURE 7. Survey Question:
"How is a patient's desire for payment that does not breach their confidentiality recorded?"*



*Question was asked of: Billing/finance, clinical, front desk, and management staff

and on paper, awareness and consistency is crucial both for ensuring confidentiality and minimizing revenue loss. For example, according to one survey respondent,

“All clients have a paper superbill generated for all public health services. When [the patient requests] special confidentiality, the paper superbill¹² is prominently marked as such. The EHR, where the electronic billing information is processed, is also ‘flagged’ as special confidentiality. If either of these are marked special confidentiality (and hopefully both) the claim (if any) is processed separately. If only one method (EHR or paper superbill) is marked, special confidentiality further investigation is warranted and done.”

Insurance Billing & Payment

A key objective of the *Confidential & Covered* project was to identify organizational policies for protecting patient confidentiality when billing insurance. Given the challenges, health centers had fewer well-developed policies in this area than the research team anticipated. For example, when front desk and billing/finance staff were asked about their organizations’ protocols when a patient needs confidential payment, only a quarter (25%) of respondents reported that their organization had a separate billing process. The vast majority (74%) reported that their organizations put patients with confidentiality concerns on the sliding fee scale.

Though placing confidential patients on the sliding fee scale was the most frequently reported policy, a few respondents (17%) indicated that their organizations had adopted a modified policy for income verification when working with a patient who has requested confidential services. Fifty-six percent reported that their income verification process was the same regardless of confidentiality needs. However, 19% reported that they did not conduct income verification at all in such instances.

While there may be cases in which a patient is unable to provide income documentation because of confidentiality needs or is unable to pay because a partner or parent monitors their expenses, such a policy may lead to revenue loss in the case of defaulting to a zero slide or to overcharging patients in the case of defaulting to full fee if no income verification is provided.

A survey participant offered one example of a modified policy for income verification pertaining to adolescents:

“Our intake form asks for types of payment options along with insurance and Medicaid billing information. We have patients acknowledge HIPAA by signing [and dating the] form along with a sticker that is placed in the chart that is reviewed for privacy prior to signing. We also post income and sliding fee and contact information in our software that we use. This alert type information is available for staff to see on the computer without having the chart in front of them. We also have teens take a form home if they want to use their parents’ insurance so that the parent can sign and provide

income so we know how to offer a sliding fee scale as well should the parent want to support the teen’s services. There is also an alert for this.”

Given that utilization of the sliding fee scale for patients identified as in need of additional confidentiality protections is the most common practice, how it is operationalized greatly impacts an organization’s revenue cycle. Front desk and billing/finance staff were asked how their organizations ensure confidentiality for these patients. About half (50%) reported that the patient’s complete record is flagged, which indicates that half of the organizations will put all services the patient receives onto the sliding fee scale. A smaller group reported that either the superbill for that particular visit does not proceed to the claims process (23%) or less frequently that the superbill follows a separate process (13%). A notable 29% reported that they did not know.

A focus group participant described an example of an operational strategy to avoid billing for patients who did not want their insurance billed due to confidentiality concerns:

“Then in terms of the confidential billing, the way our system works is even if they say that they don’t want to use their insurance, we still have to find a way to prevent our billing company that we pay from going back. They double check everybody and make sure that they didn’t have insurance that they didn’t tell us about. Even if we don’t put it in there, it could still get billed later on. We use, I don’t know what to call this, fake codes. A code that is not billable, so that we’re documenting the

¹² A superbill is a form used by medical practitioners and clinicians so they can quickly complete and submit the procedure(s) and diagnosis(s) for a patient visit for reimbursement. It is generally customized for a provider office and contains patient information, the most common CPT (procedure) and ICD (diagnostic) codes used by that office, and a section for items such as follow-up appointments, copays, and the provider’s signature. Definition from the American Academy of Professional Coders

encounter and what happened, but it's not possible for it to be billed. I don't know enough about that side of things. It's got like a CONF at the beginning or end, or something like that... that will bounce back to our billing company contractor people and show up as an error, or it doesn't work, then they'll see what code it is they know they're not supposed to be billing for that person."

A promising finding was that a majority (86%) of clinicians reported that they have *not* avoided coding for confidential services provided during a visit, which is a key step in minimizing revenue loss. Coding for confidential services could reflect clinicians' confidence in the organization's policies to document patients' willingness to use their health insurance or be placed on the sliding fee scale.

Specific Scenarios

The research team was interested in identifying some of the scenarios that may be more complex for health center staff to address in terms of need for payment that does not infringe on patient privacy. In particular, the team was interested in knowing how front desk, billing/finance, management, and clinical staff would address issues of confidentiality for patients insured as dependents. Survey respondents were asked to relay their organizational billing practices in the following scenarios described in the survey: minors insured under a parent's plan, young adults insured as dependents on a parent's plan, and adults insured as dependents on a spouse's plan.

Minors on Parents' Insurance Policies

In the first scenario, respondents were asked if their organization would bill insurance if a minor insured under a parent's plan expressed hesitancy, saying, "I am not sure what my parents will do if they find out." A majority of respondents (83%) reported that their organization would not bill, while only 15% reported that billing would depend on the patient's specific circumstances. Respondents described a variety of factors they would

consider in determining whether to bill a teen patient's insurance, but many of those respondents proceeded to describe follow-up discussions with the patient in order to pointedly determine whether or not to bill (*Table 2*). For example, according to a survey respondent,

"We would have a further discussion regarding the patient's need for confidentiality. We would make it clear to the patient that we respect and understand their need for confidentiality

Table 2. Themes Across Cited Factors that Influence Decision to Bill Insurance

Minors

- Parents' awareness that the minor is receiving services
 - ▶ Does the patient feel unsafe if parents find out?
 - ▶ Is patient concerned about parents knowing about any services or only specific services?
 - ▶ Some parents accompany minors to the health center, so may be OK to bill insurance in those cases
- Eligibility for other sources of payment (e.g. Medicaid family planning expansion)
- Some health centers include a conversation with social workers and/or nurses in case patients change their minds about billing insurance mid-visit

Young Adults

- Specific nature of concerns or fears—many would consider same questions about parents' awareness as for minors
- Eligibility for other sources of payment (e.g. Medicaid family planning expansion)
- Financial concerns
 - ▶ Is the patient concerned that spouse or other policyholder will know about services, or is the concern related just to the cost of services billed to insurance?
 - ▶ Can payment arrangements be made if patients do not want to bill insurance but cannot pay full amount owed out of pocket?

Adult Dependents

- Specific nature of concerns or fears—history of abuse?
- Eligibility for other sources of payment (e.g. Medicaid family planning expansion)
- Financial concerns
 - ▶ Is the patient concerned that spouse or other policyholder will know about services, or is the concern related just to the cost of services billed to insurance?
 - ▶ Can payment arrangements be made if patients do not want to bill insurance but cannot pay full amount owed out of pocket?

and can provide services without billing private insurance. Asking more specific questions such as ‘Do you feel you might be in danger?’ etc. This also gives opportunity to discuss/ encourage family involvement if appropriate. If the client is still ‘unsure’ about parent reaction, we would not bill PI [private insurance].”

In comparison, the second scenario referenced a minor insured under a parent’s policy who is *not* concerned about her parents knowing about a pregnancy test. Only 59% of respondents reported that their organization would bill the patient’s insurance, while 17% said it would depend on similar factors as the scenario with a minor patient who had clearly expressed confidentiality concerns. Nearly a quarter (24%) of respondents reported that their organization would not bill the patient’s insurance for this scenario, which could reflect organization-wide policies to not bill insurance for minors.

Young Adult Dependents on Parents’ Insurance Policies

In the third scenario, researchers described a young adult, 22 years of age, on a parent’s insurance policy who is not sure whether she wants her parents knowing (an ambiguous response of, “I’ll probably have to tell my parents if the [pregnancy] test is positive”). In this scenario, slightly more than half of the respondents (54%) reported that their organization would not bill insurance and only 10% reported that they would. Among the 37% who reported that their decision would depend on the patient’s circumstances, many cited anecdotes that reflected a need for further discussion. For example,

“I would give her the same options as the 17 year old. It depends on the circumstances of the patient to their parents. Ask what the patient’s fears and concerns are with respect to their

parents. Let them know if the parents are the subscriber of their insurance, there is the possibility they will see the services that were performed. Ask if they can make payments without submission of an insurance claim. Let them know payment agreement can be made if they cannot pay in full at the time of service. Ultimately, the patient would make the choice whether to bill the insurance or pay out of pocket.”

Adult Dependents on Spouses’ Insurance Policies

In the fourth and final scenario the research team described a situation in which a 36-year-old on a spouse’s policy states, “My husband will be really mad if he finds out I spent money on this.” The largest group of respondents reported that their organization would not bill (45%). A large group (40%) said their decision would depend on the patient’s specific circumstances, and 15% reported that their organization would bill. Respondents said that differentiating between financial and other confidentiality concerns was a key factor in their decisions to bill insurance for adult dependent patients:

“If the patient requests confidential services initially they would be placed under the [Family Planning] Grant. However, this patient may not be seeking confidential services so much as she is unsure of her financial responsibility based on her health care. If the patient is more concerned about her husband finding out about money she has spent, we would offer to call her insurance and find out what the coverage for services is and if her portion is acceptable or not. This is a different situation than her feeling threatened that his knowledge of her choices regarding her body would affect their relationship/ he would try

to prevent her from accessing services.”

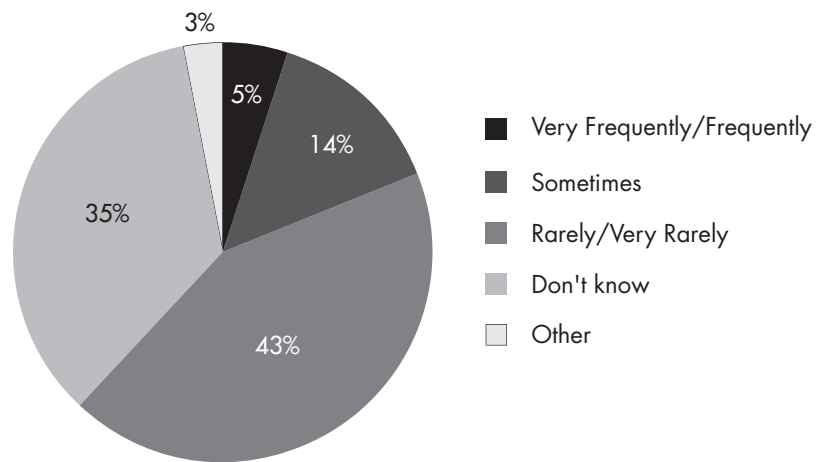
“We would ask her to clarify if she thinks her insurance would not cover the services, thus resulting in a later bill that her husband would be upset about if he found [out]. Depending on her family size and income level—we will explain that she might have to pay more out of pocket if she’s not using her insurance, but it’s possible we can offer a price reduction through our Title X sliding scale for her—so even if she bills her insurance and it doesn’t cover it, or it only covers part of it, then the visit will help out her family by going to their insurance deductible and then we can take care of some or all of the charges through our sliding scale. Sometimes this ends up changing the patient’s mind.”

Across the scenarios, it was clear that reported organizational billing practices considered patients’ age as well as their circumstances. For patients with potential confidentiality concerns, respondents were more likely to say billing insurance was dependent on additional factors if that patient was a young adult (37%) or an adult dependent (40%) as opposed to if the patient was a minor (15%), for whom they were more likely to simply avoid billing regardless of other factors. These scenarios highlight the complexity of decisions associated with billing health insurance for services for both health center staff and insured patients. In addition to sharing information or having communications sent to parents, spouses, or partners, patients may also have questions about what costs they will be responsible for, especially under plans with high deductibles and copayment costs.

Billing Processes & Disclosures of Information

Overall, survey participants were relatively confident that their organizations' insurance billing processes provided adequate protection for patients' confidential information (*Figure 8*). Nearly half (43%) said that their organizations' insurance billing practices rarely or very rarely resulted in unwanted disclosures of confidential information and only 5% reported that unwanted disclosures happened frequently or very frequently. Another 14% said unwanted disclosures happened sometimes. More than one third of participants (35%) said they did not know how often unwanted disclosures happened due to their organizations' insurance billing practices. However, because many Title X-funded organizations default to not billing insurance, it is unclear whether this finding is related to not billing insurance or protections put into place by the health center while billing insurance.

FIGURE 8. Survey Question: "How frequently do you think insurance billing processes result in unwanted disclosures of information about your center's patients to unintended recipients?"*



*Question was asked of: Billing/finance, clinical, front desk, and management staff

Recommendations

Survey findings show that many health centers have well-developed policies and practices for protecting confidentiality of care-related communications but few specific policies related to insurance billing communications.

- Review organizational policies to clarify that all patients should be assessed for individual privacy needs. For example, do not assume all teens need payment privacy.¹³
- Implement income verification for those on the sliding scale. Title X recommends income verification, though specific policies for documentation are determined by grantees. Write income verification policies that have flexibility to ensure that they do not become barriers to service when patients are unable or unwilling to provide documentation for safety or other concerns.¹⁴
- Rather than flagging the entire medical record for confidentiality, if possible do so by visit or by service.
- Make efforts to collect outstanding balances at other visits and by using an alternative method of contact to send statements, such as e-mail.
- Create a fact sheet or one pager about health care communications — including EOBs, what the health center may send home, and other ways information might be sent to patients.

¹³ Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.

¹⁴ 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>.

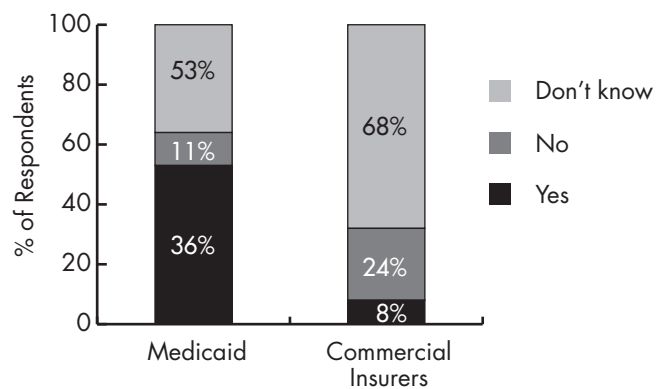
Working with Third-Party Payers

This section summarizes findings from the survey and focus groups on Title X health center staff members' experiences and organizational practice for working with third-party payers, specifically Medicaid and commercial insurance companies, to protect patients' confidentiality while seeking reimbursement from third-party payers.

Patients who need payment that does not breach privacy have always sought services at Title X health centers; however, in the past, many health centers did not regularly seek reimbursement from insurers.¹⁵ This may have been because patients did not have an insurer or because the health center did not bill insurance. Furthermore, as noted by the survey and focus group participants, the population seen at Title X health centers often experience changes in their health insurance plans or they may not know whether they have coverage. As insurance enrollment and contracting has expanded, Title X providers have become increasingly concerned about how to maintain this level of protection while billing insurance when possible.

Many Title X health center staff members expressed uncertainty about third-party payer practices to protect confidentiality throughout reimbursement for services. For example, more than half of program administrators and health center managers said they did not know if Medicaid (53%) or commercial insurance companies (68%) in their states had confidentiality policies (Figure 9). Among those who said they knew, managers and program

FIGURE 9. Survey Question:
“Do Medicaid and/or commercial insurers in your state have policies in place to protect enrollee confidentiality?”*



*Question was asked of: Management staff and program administrators

administrators were much more likely to report that Medicaid programs in their states had confidentiality policies (36%) than commercial insurers (8%). But the fact that the majority of managers were unsure of the confidentiality policies of third-party payers in their states demonstrates a significant lack of information about working with insurers among Title X health center staff.

15 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. <http://www.hhs.gov/opa/pdfs/fpar-reissued-oct13.pdf>

Medicaid

Survey and focus group participants described different experiences working with several different types of Medicaid coverage, including:

- Fee-for-service Medicaid;
- Medicaid managed care (sometimes referred to as MCOs)¹⁶; and
- Medicaid family planning expansions.¹⁷

Participants highlighted different confidentiality protection issues for each type of Medicaid coverage, but they also reported significant uncertainty about how coverage types (fee-for-service, Medicaid managed care, or family planning expansions) addressed confidentiality related to communicating with enrollees. Participants noted that many Medicaid programs' practice of seeking reimbursement from other potentially liable third parties (such as a patient's commercial insurer) as a reason they sometimes avoided billing for sensitive services. This has become increasingly difficult to manage at the health center level because of two emerging policies. First, the ACA requires a system for health insurance enrollment referred to as "no wrong door," meaning that regardless of how an individual applies for coverage, either through a Medicaid program or a marketplace website, they are supposed to be assessed for eligibility for all potentially available coverage programs, including full-benefit Medicaid and commercial insurance through the marketplace with a financial subsidy.¹⁸ This has created the possibility that an individual's enrollment in a family planning-only or other limited-benefit Medicaid coverage could be disclosed to a family member when that family member

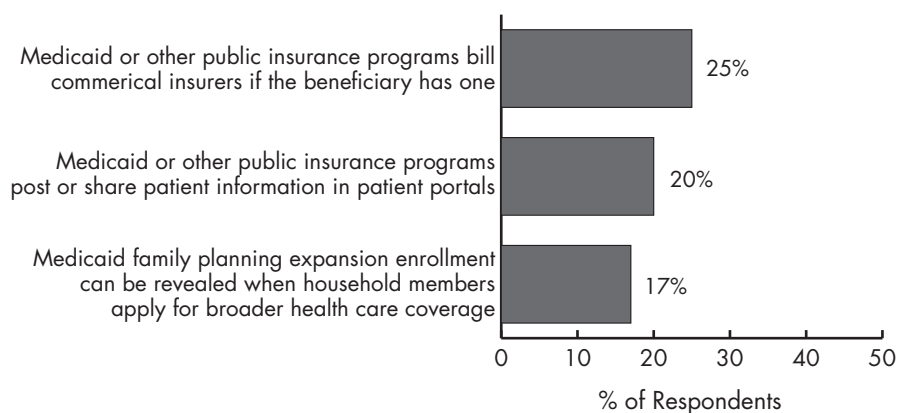
seeks full-benefit Medicaid or commercial coverage for their family, even though there are supposed to be safeguards in place to prevent these disclosures.

Secondly, Medicaid was designed as a payer of last resort, both to conserve financial resources and to ensure that payers that should be responsible (like commercial payers that have collected premiums) pay claims for which they are liable. In addition to collecting information from Medicaid enrollees about potential sources of payment, states have begun combining previously disparate systems into third-party payer databases to be used to verify claims and ascertain whether there may be another responsible party in order to directly seek reimbursement from the other payer or return the claim to the provider. These processes are nearly impossible for health centers or individual patients to

manage, making it even more important to screen individuals for billing-specific confidentiality concerns.

Survey and focus group participants reported they were more confident that patients will not receive EOBs or other communications from fee-for-service Medicaid programs than from any other program. Less than a quarter of survey respondents reported that communications, such as posting information to patient portals, was a major barrier to protecting patient confidentiality in the Medicaid claims process (*Figure 10*). They noted that since many Medicaid programs treat each beneficiary as his or her own policyholder and already limit EOBs to certain circumstances rather than sending them nearly universally, as with commercial insurance, protecting patient confidentiality while billing fee-for-

FIGURE 10. Survey Question:
"Which of the following are barriers (within Medicaid) to protecting patient confidentiality during the billing process at your organization?"*
(Check all that apply)



*Question was asked of: Billing/finance, clinical, front desk, and management staff

¹⁶ Medicaid coverage administered through an agreement between a state Medicaid agency and a managed care organization (MCO)

¹⁷ Medicaid family planning expansions cover family planning-related services for patients who would not otherwise qualify for Medicaid coverage through Medicaid state plan amendments or section 1115 waivers. This paper refers to family planning waivers and state plan amendments as family planning expansions.

¹⁸ Patient Protection and Affordable Care Act (H.R. 3590), Pub. L. No. 111-148, 124 Stat. 119 (signed into law March 23, 2010), and amended by the Health Care and Education Affordability Reconciliation Act of 2010 (H.R.4872), Pub. L. No. 111-1522 (signed into law March 30, 2010).

service Medicaid may be less fraught than with any other payer.

However, participants noted that billing fee-for-service Medicaid did not guarantee confidentiality for patients. One survey participant noted that data sharing between fee-for-service Medicaid and other public benefit programs could make it easier for confidentiality breaches to happen well outside the control of the health center:

“There have been breaches on other parts of the Medicaid system. For instance, last year they sent out reminders to people that they might be eligible for federal free lunch plans because they had someone in their household on Medicaid. When parents don’t know someone in the household is on Medicaid, it could lead to questions. That’s the sort of breaches that are happening. They’re really indirect, and would be hard to figure out.”

Medicaid Family Planning Expansions

Participants recognized Medicaid family planning expansions as critical to their health centers’ fiscal health and a key source of coverage for their patients, especially those who needed family planning services outside their full benefit insurance coverage. However, they also noted that seeking reimbursement from these programs could lead to challenges to protecting confidentiality as with full-benefit Medicaid or commercial insurance. For example, 25% of survey participants who identified insurance-related barriers to confidentiality protection reported that Medicaid family planning expansion programs sometimes sought payment from other sources of coverage (for example, commercial insurers) after reimbursing the health center.

One focus group participant noted that the individuals with both commercial and public coverage can be a particular problem, as it can be unclear which insurer is responsible for payment—leaving it to the health center staff to untangle.

Participants reported that some Medicaid family planning expansion programs utilize Medicaid’s good-cause exception to better protect the confidentiality of patients. The good-cause exception should be available across Medicaid, though respondents primarily referred to it within family planning expansions. Federal law requires Medicaid enrollees to provide insurance information during initial Medicaid application and redetermination processes in order to assist in identifying and pursuing third parties that may be liable to pay for services and care under Medicaid.¹⁹ The good-cause exception allows individuals not to provide such information if cooperation could lead the patient or another person being subjected to physical or emotional harm. The good-cause exception can be used by individuals eligible for either full-benefit Medicaid or family planning expansions; it allows patients to withhold information about their third party-payers from the Medicaid agency, with the intent being that the Medicaid agency will not seek reimbursement from the other payer. Most participants reported based on experience with their Medicaid programs that good-cause exceptions were effective in ensuring that no information was shared with commercial insurance companies of patients covered under Medicaid family planning waivers, ensuring that their care could remain confidential from family members.

Some survey participants (17%) also reported that patients enrolled in Medicaid family planning expansions could have their coverage revealed to family members when a parent or

spouse attempts to sign up for other coverage—through the health insurance marketplaces for example. A focus group participant described how some health insurance enrollment portals could inadvertently reveal this information to parents or other family members:

“A minor comes and enrolls in our family planning [expansion]. The family member, let’s just say it is [the] mother, father, doesn’t matter, doesn’t know for confidential reasons that their minor son or daughter has enrolled. They then go on their own to enroll right on the portal, and although it was not intended to happen, it inadvertently shows up, ‘Oh, but your daughter already has Medicaid family planning program.’ Again, this was not a malicious intent, but it is the complex nature of what’s happening with just all the enrollment in our crazy health care system.”

Another focus group participant pointed out that sometimes EHRs or pharmacy records could also cause breaches of confidentiality for patients covered under Medicaid family planning expansions. Prescriptions filled outside the health center can be tracked within EHRs or pharmacy systems in ways that can be accidentally revealed to patients’ family members when they seek care or fill prescriptions outside the Title X health center.

Several participants noted that Medicaid family planning expansion policies have changed in their states since the implementation of the ACA. A few said their states had not extended their family planning waivers, while others reported that their states had cut family planning expansion funding to a minimal level under the assumption that patients no

19 Abigail English, Robin Summers, Julie Lewis, and Clare Coleman, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015).

longer need family planning expansions as they have other sources of coverage under the ACA. In a focus group, one manager expressed skepticism at the assumption that patients had other sources of coverage and worried that it would eliminate one of the main sources of non-Title X revenue for her health center:

“More and more people [for which] we’re unable to bill that insurance for confidential services puts more and more people into the Title X pool, where we’re out of Title X dollars. We eat that cost. Just trying to stay afloat by being able to provide those services is our main struggle, especially with our [Medicaid] waiver program ending. We are so worried now about what’s going to happen, because over 60% of our patients were either covered under full Medicaid or our waiver program. Now that that program is gone, how many people have actually gotten into the exchange?”

Medicaid Managed Care

Survey and focus group participants reported that protecting confidentiality for patients covered by Medicaid managed care was more difficult than for fee-for-service Medicaid or family planning expansions. They were not confident that Medicaid managed care organizations (MCOs) would apply the same confidentiality protections as fee-for-service Medicaid. In their experience, Medicaid MCOs could not guarantee that they would suppress EOBs for sensitive services. In some cases Title X health center staff members were not comfortable billing the managed care organizations at all, while others used alternative workflows to ensure that patients did not receive EOBs or other communications from MCOs at their homes.

A few participants noted that their states had worked with managed care organizations on their full-benefit Medicaid expansions, which created extra

complexity and uncertainty for health centers and patients, especially in states where the expansion managed care was implemented alongside fee-for-service Medicaid:

“The patient education piece has been really daunting as well because lots of [patients are] newly insured or differently insured or just off their parents’ insurance, or even Medicaid expansion. People [don’t] understand that Medicaid has certain managed care groups that they can’t come here. We’re getting all these denials of ‘Well, they have this Medicaid, they have this Medicaid.’ The patients are [saying], ‘I don’t even know what I have’. You check eligibility and it’s like the tiniest, finest print at the bottom of page six of the eligibility of Medicaid... It’s the education piece and that’s really impacted our ability to create a refined effective revenue cycle process. No one knows what we’re doing.”

In a focus group discussion, a nurse administrator described the dilemma Title X health centers face when determining whether or how to bill when patients are covered by Medicaid managed care plans:

“Where people that used to be on Medicaid (Medicaid never sent EOBs), you were safe to just bill Medicaid when they came in, and nobody ever knew, and it was fine. But now we’re not sure... right now it’s a big fat question mark, really. What we ended up talking about in the training with the staff was just that if there’s a question about somebody’s coverage, you’re going to have to do them as self-pay right now and put them on the sliding scale. Which is kind of a double edged sword. We’re letting them in and we’re giving them services, but then we could potentially be getting more, but until we

know for sure that it’s really protected, then how can we in good conscience do this without breaking our own policies? It’s a big question mark right now.”

Most Title X health center staff noted that many of the same commercial insurance companies are involved in Medicaid managed care and employer-sponsored or individual commercial insurance, so the companies tend to use the same strategies for any patients requesting confidentiality. Many participants said they do not bill Medicaid managed care because they cannot be sure no communications will be sent home, unlike fee-for-service Medicaid and some Medicaid family planning expansions. A focus group participant reported that her center did not bill Medicaid because MCOs “don’t care” about patient confidentiality, and they could not keep information from being shared with MCOs if they entered it into their billing systems:

“These MCOs...they’re commercial. They started out as commercial, and now they’re moving into the state Medicaid plans. They only have one mindset — for profit, commercial, my way, no way at all. They don’t get the confidential side of it. They don’t care about the confidential side of it. It’s their way or no way. In Texas, we don’t get the option of excluding the MCO. Ours is a portal system, so if we bill it to Medicaid, Medicaid is going to kick it to the MCO automatically. In that case, we have to know we’re not going to be able to...bill the Medicaid. We have to bill a sliding fee scale or something...to make sure the patient gets confidential services.”

Participants noted that working with Medicaid MCOs can also cause unexpected threats to confidentiality. One billing/finance staff member reported in a focus group that her center had

encountered challenges working with an outside lab. Because the labs were required to bill MCOs but likely did not know that family planning patients may have confidentiality concerns, she worried that the lab could send communications to patients even when the health center had taken the appropriate steps to protect confidentiality while billing Medicaid:

“The labs we’re ordering are family planning related labs, but they’re not seen as family planning if the outside lab bills. The outside lab is required to bill the MCO, so they’re required to have contracts with the MCOs. That’s where things get really crappy because once it’s out of our hands, it’s out of our hands. We do fee-for-service, so we’re good. The labs we send out, not so much. I’m feeling a little sick to my stomach thinking about contracting these MCOs to get paid because if they can’t guarantee confidentiality, we don’t want anything to do with that. We just won’t send over the insurance information to collect.”

Commercial Insurance

Survey and focus group participants expressed even greater uncertainty about protecting confidentiality while billing commercial insurance companies. They described negotiating agreements to suppress EOBs or limit communications with commercial insurance companies as nearly impossible—*“like trying to talk to the wall”*—because of the volume and complexity of their insurance contracts and insurance companies’ unwillingness to negotiate with small providers such as many Title X health centers.

Survey respondents were much more likely to report that EOBs or other communications could breach patient confidentiality with commercial insurance companies than Medicaid: 44% said that communications from commercial insurance companies were barriers to protecting patient confidentiality, and

22% reported that commercial insurance companies could breach confidentiality by posting information to patient portals (*Figure 11*).

Focus group participants described several other challenges and opportunities in working with commercial insurance companies. A few mentioned that their health centers’ grants and arrangements with insurance companies required them to collect copayments, even for patients who might qualify to pay \$0 on the sliding fee scale:

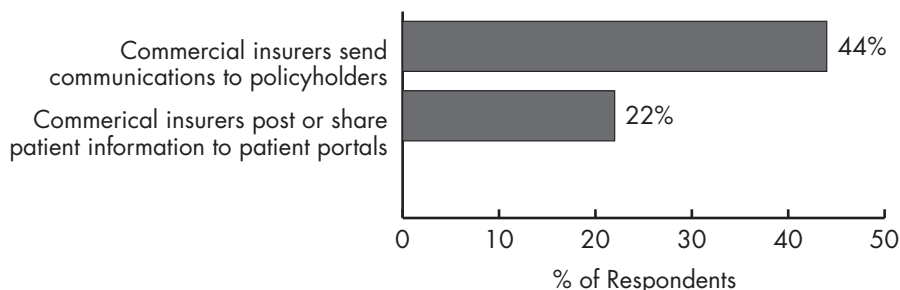
“...We’re even having arguments with our commercial payers over...There’s a stipulation with our 330 grant and there’s also one with Title X that states that an individual can only be charged as much as they would pay on a sliding fee scale. So if you have a teenager that comes in and they’re wanting confidential services or if they’re just wanting to use their insurance anyway, you run through the insurance. They have a \$20 copay, but since they don’t have a job, they should only pay zero because they’re at 100 percent of the federal poverty level. So then you wouldn’t be collecting that \$20,

and the insurance companies are saying, ‘No, you have to collect that \$20, that’s a requirement.’”

Others reported that some patients were hesitant to bill visits to their insurance not because of confidentiality concerns, but because they did not want non-preventive visits counted toward their deductibles. Some newly offered plans under the ACA have very high deductibles, so patients may perceive this as prohibitive even if they have coverage and have no other concerns about using it. Some thought they could increase patients’ use of commercial insurance in these cases by educating their front desk staff about how to help patients use their insurance, drawing on Title X funds if necessary to cover services outside of those offered without cost-sharing.

One participant also suggested that the new rules for coverage of preventive visits under the ACA could present an opportunity to reduce consumer communications by not sending EOBs or other communications for those services covered without cost-sharing. This policy change may require changes to state law. However, further policy and legal research makes this option less appealing because some services would likely fall outside of the list of preventive services eligible for EOB suppression, such as treatment for

FIGURE 11. Survey Question:
“Which of the following are barriers (within commercial insurance) to protecting patient confidentiality during the billing process at your organization?”*
(Check all that apply)



*Question was asked of: Billing/finance, clinical, front desk, and management staff

sexually transmitted diseases and follow-up contraceptive visits.

Several survey and focus group participants noted that some commercial insurance companies have mechanisms to modify or suppress EOBs and other communications for patients with confidentiality concerns.²⁰ However, in most cases these require patients to make the requests themselves; providers cannot request the protections on their behalf. Most participants reported that this mechanism is likely underutilized because patients may not feel empowered to contact their insurance companies with confidentiality requests, but it could be an option for some patients. Survey and focus group participants said that the administrative burden, such as staff time and creation of resources, to investigate confidentiality protections for the commercial insurance companies they work with and educating patients to request them may not be worth the ability to bill insurance for many Title X health centers.

Recommendations

Health center staff responding to the survey described confusion about how third-party payers may impact confidentiality.

- Determine how the Medicaid agency in your state implements the third-party payer liability requirements.
- Determine the process for sending consumer communications from the largest health insurers your organization has contracts with, including Medicaid and especially Medicaid Managed Care.
- Track patients based on their needs for private payment, rather than health center communications, so that if the claim is denied because of other third-party liability, staff know if they can seek reimbursement.
- Clarify eligibility requirements for Medicaid family planning expansion programs in your state — how is inability to use a commercial insurance plan defined?
- Create training programs to help staff feel comfortable discussing payment options with patients and how those may impact privacy.
- Remind patients that the Notice of Privacy Practices given to all insurance policyholders will have information about how to redirect private health information.

20 Insurers are required to disclose their privacy practices in communications to the policyholder. These are commonly called Notice of Privacy Practices.

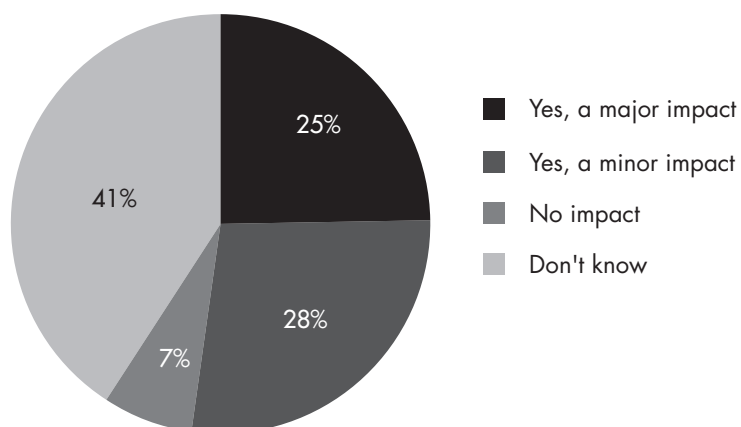
Financial Impact of Confidentiality & Billing Practices

This section summarizes survey and focus group participants' views of the financial impact of their health centers' current practices to protect patient confidentiality in the insurance billing process.

Many participants said their organizations have traditionally defaulted to using Title X in combination with other funds rather than attempting to bill insurance at all in order to preserve patient confidentiality, which may lead to substantial losses of revenue for a health center. As noted above, the research team found some exceptions for fee-for-service Medicaid and Medicaid family planning expansions, but in general very few respondents reported that their health centers billed commercial insurance companies when patients express concerns about confidentiality. Clarifying patients' specific needs and concerns as described earlier could prevent revenue loss.

When survey participants were asked to assess the impact of avoiding billing for confidential visits in their health centers, about half (53%) reported seeing an impact; 25% said it was a major impact, and 28% said it was a minor impact (*Figure 12*). A small percentage (7%) said they saw no financial impact of avoiding billing in their health centers. A large group (41%) said they did not know the impact of avoiding billing at their centers, which suggests that many centers may not consider the financial implications of their billing practices to protect confidentiality.

FIGURE 12. Survey Question:
"Are you aware of a financial impact on your center because you cannot or do not always bill insurance for confidential services?"*



*Question was asked of: Billing/finance, clinical, and front desk staff

Most participants thought that revenue losses from inability to bill payers for insured patients due to confidentiality concerns represented less than 25% of total revenue (37% said less than 10%; 21% said 10-24%) (*Figure 13*). A smaller percentage (12%) thought their centers lost more than 25% of their total revenue due to forgoing insurance billing for confidential services. Nearly one third (30%) of respondents were unable to estimate this revenue loss, which may suggest that the potential for revenue loss is not regularly considered or that information about revenue loss at the health center is not available to staff.

Some participants expressed concern that patients may request confidentiality not because of worries about disclosure, but in order to avoid paying for services. Some gave examples of patients saying that they were requesting confidentiality so that they would not have to pay for services. One respondent feared that word would spread in the community that asking to avoid insurance billing would result in a copay-free visit, and that the organization would eventually be unable to provide clinical services due to loss of payments from people ineligible for subsidized care.

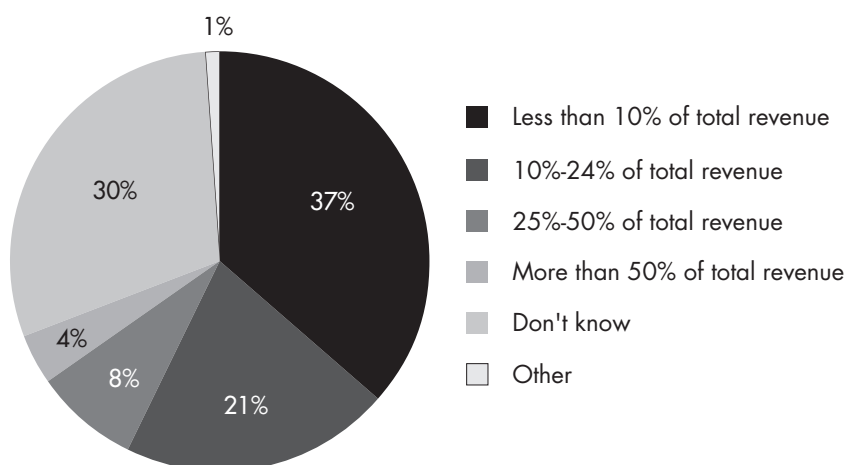
Multiple focus group participants highlighted the importance of educating both patients and staff about instances in which patients concerned about deductibles, but not confidentiality, could have their insurance billed without

incurring high costs. These include visits for preventive services that insurers must cover under the ACA without cost-sharing. A few participants also noted that payments for which patients are responsible can be put on the sliding scale, so co-payments or payments toward the deductible may not be as large as patients might fear.

Some focus group participants also considered it necessary to communicate

about the importance of billing when it would not compromise confidentiality. One participant stressed the importance of ensuring that staff understand the importance of financial sustainability, so that they will assess situations carefully for ability to bill. Another explained that their organization found it important to have patients pay even a small amount as a sign that they recognized the value of the services they received.

FIGURE 13. Survey Question:
“What do you estimate to be the revenue losses from not being able to bill payers for those who are insured and cannot use their insurance due to confidentiality concerns?”*



*Question was asked of: Billing/finance, clinical, and front desk staff

Recommendations

Survey respondents were unsure of the impact that avoiding insurance claims due to confidentiality concerns had on revenue.

- Track patients based on their needs for private payment, rather than health center communications, so that if the claim is denied because of other third-party liability, staff know if they can seek reimbursement.
- Provide health insurance literacy as part of outreach and enrollment activities, including describing to patients the range of communications they may receive from their insurer.
- Review organizational policies to clarify that all patients need to be assessed for need for payment that does not breach privacy. For example, do not assume that all teens need payment privacy.²¹
- Make efforts to collect outstanding balances at other visits and by using an alternative method of contact to send statements, such as e-mail.

21 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.

Training

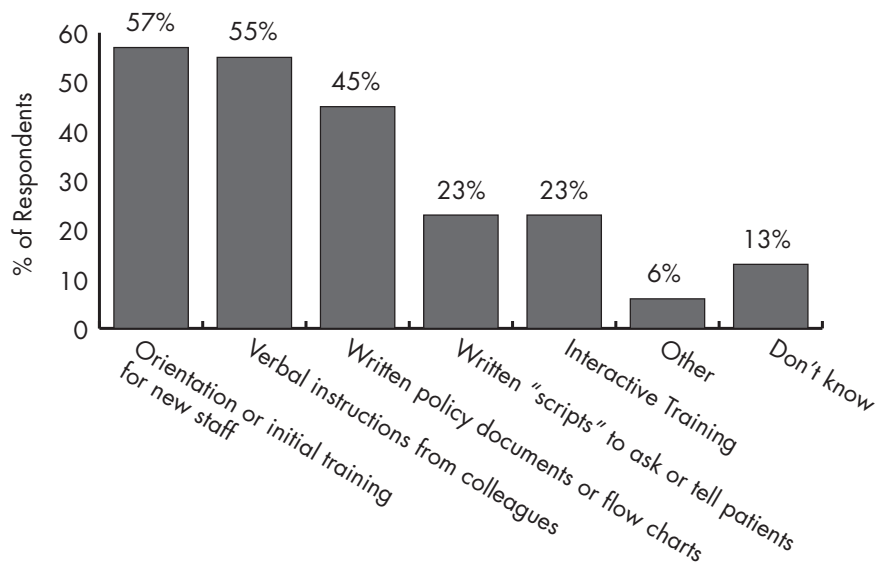
This section summarizes survey and focus group participants' experiences with training about confidentiality and insurance billing in their health centers.

Respondents were asked to indicate whether or not their organization provided training on confidentiality and insurance billing and whether they felt they had received sufficient information and were confident in their skills to navigate patient confidentiality throughout insurance and billing processes.

Among respondents who answered the question, the largest group (57%) indicated that they had received initial training or orientation about providing confidential services for patients using health insurance within their organizations (*Figure 14*). Verbal instructions from colleagues (55%) and written policy documents or flow charts (45%) were the next most commonly reported methods. Participants were less likely to report receiving written scripts (23%) or interactive training (23%) about confidentiality and insurance billing in their organizations. Compared to front desk and billing/finance staff, clinicians were least likely to indicate that they had received all these types of training, and most likely to say they didn't know what type of training they have received about confidentiality and insurance billing (*Figure 15*). Some participants listed other types of training they had received, including webinars, e-mail updates, and discussions in staff meetings.

FIGURE 14. Survey Question:
"What materials or training have you received on confidentiality for patients using their health insurance?"*

(Check all that apply)



*Question was asked of: Billing/finance, clinical, and front desk staff

The research team also asked Title X program administrators what types of confidentiality training they provided to their subrecipients (*Figure 16*). Among administrators who answered the question, the largest proportion (83%) reported that they administer training about providing confidential services to teens. Slightly smaller proportions reported that they administered training about providing confidential services for adults (72%) and about billing procedures to assure confidentiality throughout the billing process (65%). A few program administrators also indicated that they included information about protecting confidentiality in program manuals, trainings and other meetings.

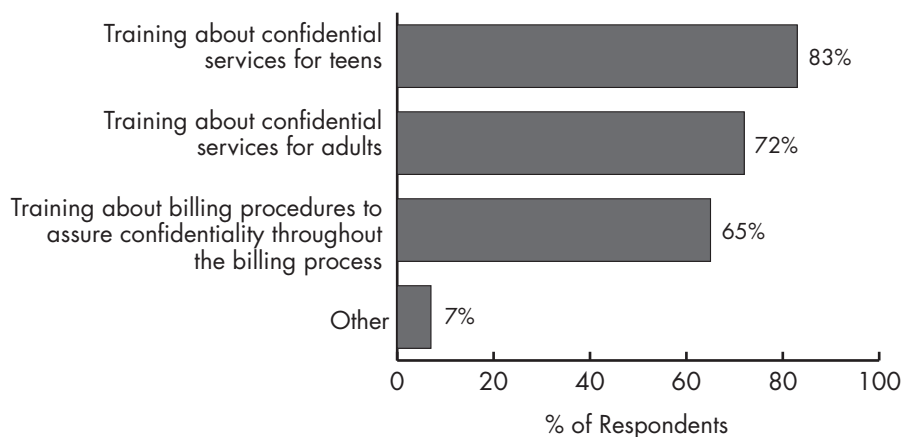
Slightly less than half (46%) of front desk, billing/finance staff, and clinicians indicated that they had received sufficient information about protecting patient confidentiality in the billing and claims process (*Figure 17*). The responses of the three groups were significantly different; however, billing/finance staff were most likely to say they had received sufficient information (64%), and clinicians were least likely to say they had received sufficient information (34%), with front desk staff in the middle (49%).

FIGURE 15. Survey Question:
"What materials or training have you received on confidentiality for patients using their health insurance?"*
(Check all that apply)



*Question was asked of: Billing/finance, clinical, and front desk staff

FIGURE 16. Survey Question:
"Does your organization provide training to subrecipients specifically regarding confidentiality?"*
(Check all that apply)



*Question was asked of: Program administrators

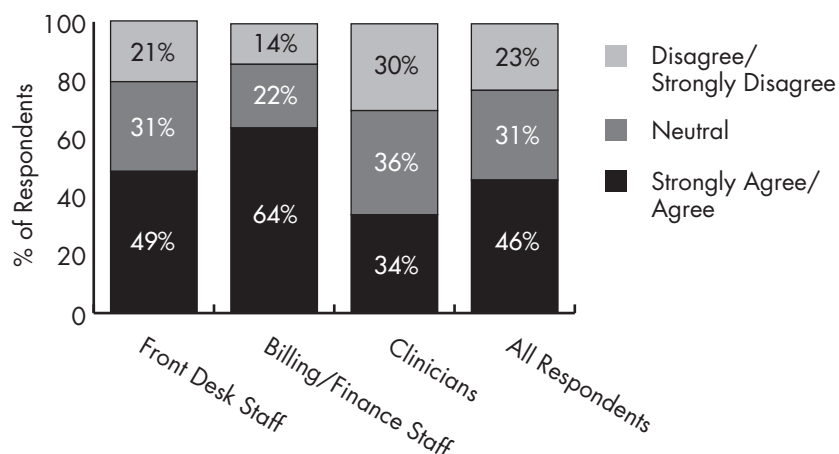
Despite considerable differences in the receipt of training and information, the majority of respondents (59%) reported confidence in protecting patients during billing and payment processes (indicated by “strongly agree” or “agree” responses) (*Figure 18*). Again, billing/finance staff were most likely to report feeling confident (79%), clinicians were least likely (43%), and front desk staff (65%) were between the other two groups.

Half of front desk, billing/finance staff, and clinicians responded that they needed additional training on providing confidential services when patients use their health insurance (*Figure 19*). The need for training varied by type of respondent, with 66% of clinicians but only 34% of billing/finance staff reporting a need for additional training.

Survey write-in responses and focus group discussions provided examples of the content and format of training that participants would like to see. One survey front desk respondent expressed a desire to learn more about the complexities of how certain types of insurance may have relevance for confidentiality, stating:

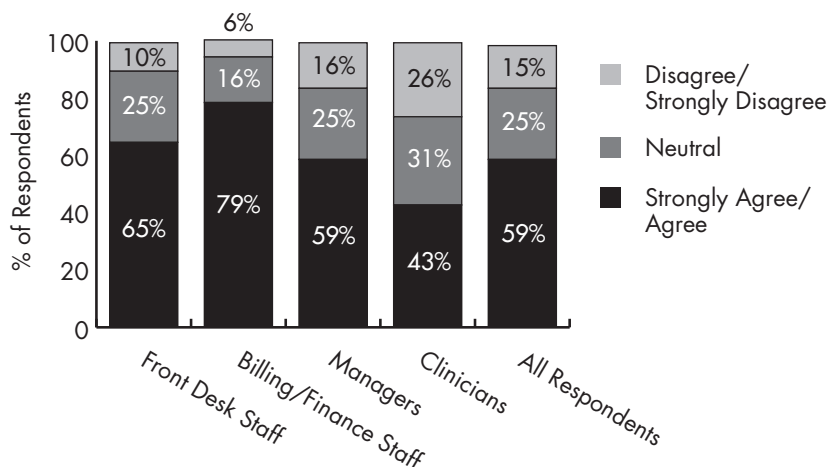
“I feel as though I am well trained on how to keep patient confidentiality when it comes to contacting patients, sending results, communicating via phone or e-mail. ... However, I would like to know more about the billing process, and what happens if we bill Medicaid for a service, and the patient also has a policy under a private insurance—does that show up on the private insurance for parents or spouses to see?”

FIGURE 17. Survey Question:
“I received sufficient information regarding confidentiality and insurance billing policies and procedures in trainings at my organization.”*



* Question was asked of: Billing/finance, clinical, and front desk staff

FIGURE 18. Survey Question:
“I am confident I have the skills I need to protect patient confidentiality in the insurance billing process.”*



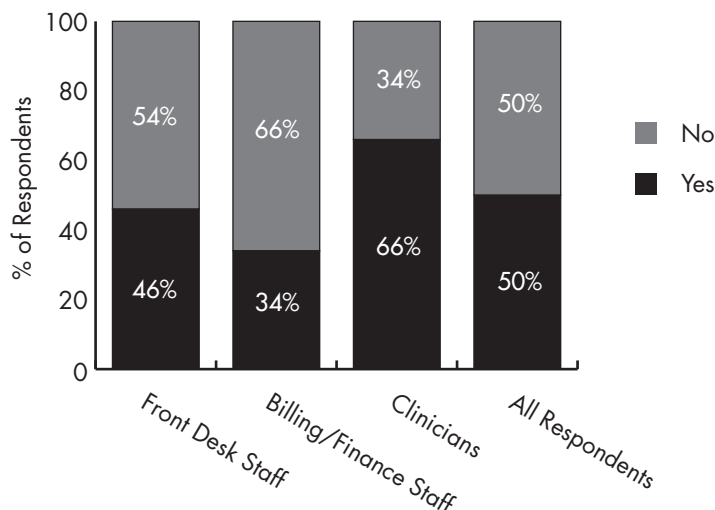
* Question was asked of: Billing/finance, clinical, front desk, and management staff

Some focus group participants described challenges associated with habits and attitudes of staff members, particularly when staff members had been working at a health center for years and were not accustomed to navigating the complexities associated with different types of coverage. One focus group participant described a common staff response as “I check people in. I don’t want to know this.” Another explained, “Everything with billing is complicated because of people’s desire to provide public health and services and [being] very uncomfortable with thinking that we should be able to get revenue for the services that we’ve provided.”

Another aspect that emerged was the need for ongoing training. As one focus group participant explained, “It can’t just be one time and that’s it. It has to be ongoing, and agencies need to view training as an investment.” Another described using monthly small workgroup meetings to troubleshoot issues that arise.

Some focus group participants stressed the importance of interactive training. One noted that staff members are more likely to speak up in smaller groups than in large ones. Another emphasized the effectiveness of scripts and role-playing trainings, stating: “People want to do a good job. They want to be able to do the right thing and be in compliance, but sometimes they just don’t know what they’re supposed to be saying or doing. You have to give the scripts, examples, and case scenarios.”

FIGURE 19. Survey Question:
“Do you believe that you need additional education or training on providing confidential services?”*



*Question was asked of: Billing/finance, clinical, and front desk staff

Recommendations

Respondents considered providing confidential health care to be important to their patients and to the health center mission. However, the survey found that training is needed to differentiate between health-care related communications and insurance/billing-related communications.

- Write policies that clearly differentiate between confidential services and payment privacy.
- Messaging about new policies should make clear that confidentiality is still a high priority and available for those who need it.
- Create trainings that differentiate between confidential services, payment that does not breach privacy, and requirements of the Health Insurance Portability and Accountability Act.
- Foster understanding of the importance of seeking reimbursement from third-party payers to sustain the program.

Recommendations

The report recommendations have been combined here for ease.

Recommendations	Section
Screen for confidentiality at each appointment.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Ask specific questions about billing rather than assuming that patients who express desires regarding health center communications also need payment that does not breach privacy.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Ensure that there is a way to communicate to billing or other staff if a patient discloses information in the exam room or at check out that may indicate a need for increased privacy protection.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs
Track patients based on their needs for private payment, rather than health center communications, so that if the claim is denied because of other third-party liability, staff know if they can seek reimbursement.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs Working with Third Party Payers Financial Impact
Provide health insurance literacy as part of outreach and enrollment activities, including describing to patients the range of communications they may receive from their insurer.	<ul style="list-style-type: none"> Screening for Patients' Health Insurance Coverage and Confidentiality Needs Financial Impact
Review organizational policies to clarify that all patients should be assessed for individual privacy needs. For example, do not assume all teens need payment privacy. ²²	<ul style="list-style-type: none"> Protecting Patient Confidentiality Financial Impact
Implement income verification for those on the sliding scale. Title X recommends income verification, though specific policies for documentation are determined by grantees. Write income verification policies that have flexibility to ensure that they do not become barriers to service when patients are unable or unwilling to provide documentation for safety or other concerns. ²³	<ul style="list-style-type: none"> Protecting Patient Confidentiality
Rather than flagging the entire medical record for confidentiality, if possible do so by visit or by service.	<ul style="list-style-type: none"> Protecting Patient Confidentiality

22 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects, (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.

23 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>.

Recommendations	Section
Make efforts to collect outstanding balances at other visits and by using an alternative method of contact to send statements, such as e-mail.	<ul style="list-style-type: none"> • Protecting Patient Confidentiality • Financial Impact
Create a fact sheet or one pager about health care communications - including EOBs, what the health center may send home, and other ways information might be sent to patients.	<ul style="list-style-type: none"> • Protecting Patient Confidentiality
Determine how the Medicaid agency in your state implements the third-party payer liability requirements.	<ul style="list-style-type: none"> • Working with Third Party Payers
Determine the process for sending consumer communications from the largest health insurers your organization has contracts with, including Medicaid and especially Medicaid Managed Care.	<ul style="list-style-type: none"> • Working with Third Party Payers
Clarify eligibility requirements for Medicaid family planning expansion programs in your state — how is inability to use a commercial insurance plan defined?	<ul style="list-style-type: none"> • Working with Third Party Payers
Create training programs to help staff feel comfortable discussing payment options with patients and how those may impact privacy.	<ul style="list-style-type: none"> • Working with Third Party Payers
Remind patients that the Notice of Privacy Practices given to all insurance policyholders will have information about how to redirect private health information.	<ul style="list-style-type: none"> • Working with Third Party Payers
Write policies that clearly differentiate between confidential services and payment privacy.	<ul style="list-style-type: none"> • Training
Messaging about new policies should make clear that confidentiality is still a high priority and available for those who need it.	<ul style="list-style-type: none"> • Training
Create trainings that differentiate between confidential services, payment that does not breach privacy, and requirements of the Health Insurance Portability and Accountability Act.	<ul style="list-style-type: none"> • Training
Foster understanding of the importance of seeking reimbursement from third-party payers to sustain the program.	<ul style="list-style-type: none"> • Training

Conclusion

As Title X providers respond to a growing base of newly insured patients coupled with the strain on grant funding, they will continue to need to modify their business practices by contracting with commercial and public payers. While contracting with third-party payers is an important step toward diversifying program income, the study results seem to show that many providers may also want to consider changes to health center practices and policies to be able to take full advantage of insurance reimbursement. The study found that most participants did not recognize that avoiding billing for services due to patients' confidentiality concerns could lead to revenue losses. Recommendations shared in the report are meant to provide approaches to interacting with patients, health center staff, and insurers to decrease revenue loss due to the provision of health care that does not breach patient privacy.

Appendix

Methodology

This study used a mixed methods design. The research team gathered data on how Title X health centers approach confidentiality and insurance billing through an electronic survey of Title X health center managers, front desk staff, billing/finance staff and clinicians, as well as a series of focus groups. The focus groups were selected from a convenience sample of NFPRHA members.²⁴ The electronic survey was sent to the full Title X grantee network using e-mail addresses provided by OPA.

Survey Development and Administration

Based on a comprehensive literature review, the research team developed an original survey instrument to gather information from the following groups of Title X providers and staff, including:

- Executive or management staff;
- Front desk, reception, intake or counseling staff;
- Billing, finance, or revenue cycle management;
- Clinical staff; and
- Title X program administrators (at the state family planning administrator or family planning council level).

The survey included items on the following domains:

- Organization characteristics
- Organization confidentiality and payment practices

- ▶ Screening for patients' health insurance coverage and confidentiality needs
- ▶ Protecting patient confidentiality
- ▶ Arrangements with third-party payers to protect patient confidentiality
- Confidentiality and payment training and skills

Survey instruments were tailored to each job role. Only respondents who indicated one of the five job roles being surveyed were included in the study sample.

The survey was administered electronically between December 2014 and February 2015. Representatives of all Title X grantee organizations were invited to participate via e-mail. Each organizational contact was asked to complete the survey themselves and to distribute the survey to each of their Title X service sites. Four respondents from each site were asked to complete the survey, one from each staff position identified in the survey instrument (executive management, front desk staff, billing/finance staff and clinicians) in addition to program administration staff. Among the 2,150 unique e-mail addresses that received original contact, approximately 250 bounced back, contained errors or were outdated. Reminders were sent via e-mail and phone targeting grantees in states and regions with low response rates.

The research team used Stata 13 to conduct descriptive analyses, as well as bivariate analyses (chi-square and Fisher's exact tests) to identify statistically significant differences between responses by participants' job roles.

Focus Groups

To gather additional information and context around the subjects addressed in the survey, the research team conducted a series of eight focus groups with Title X grantee and subrecipient staff members in the following roles: (1) operational staff, (2) revenue cycle staff, and (3) grantee administrators. Recruitment for focus group participants was initiated through an e-mail announcement to all registrants for NFPRHA meetings in January and April 2015. Participants were recruited from a variety of organizational types and states into each focus group. Participants enrolled in groups of up to 12 individuals that most closely matched their staff role in their organization. So that participants could speak freely about their experiences and perceptions, the team avoided assigning an administrator from a grantee and a service site or subrecipient of that grantee to the same focus group.

A team of two trained facilitators conducted one-hour focus group discussions at the two NFPRHA meetings. Topics included the following:

- Organization confidentiality and payment practices
 - ▶ Screening for patients' health insurance coverage and confidentiality needs
 - ▶ Protecting patient confidentiality
 - ▶ Arrangements with third-party payers to protect patient confidentiality
- Confidentiality and payment training and skills

24 NFPRHA represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured women and men. NFPRHA's core members are federally funded family planning organizations.

The focus group discussions were recorded and transcribed. Two members of the research team conducted thematic analysis of the transcripts until they reached a consensus on key themes.

Both the survey and focus group protocols were reviewed and approved by the Office of Human Research at the George Washington University. Funding for this project was provided by the Office of Population Affairs (Grant Number 1 FPRPA006059-01-00).

Participant Characteristics

Among the respondents who consented to take the survey, 1967 respondents provided complete enough responses to be included in the analysis. In addition, a total of 54 NFPRHA members participated in one of the eight focus group discussions. A summary of sample characteristics for the survey (*Table 3*) and the focus groups (*Table 4*) can be found below.

Limitations

This study has several limitations. Although the size of the survey sample was robust, the findings cannot be considered representative of all Title X grantees and services sites, nor all site staff because of the way the survey invitation was disseminated. Also, health centers whose staff members were willing to participate in the study may be different from those whose staff members did not participate. In addition, research team analysis did not account for the variation that may be present between staff members in different roles within health centers. Because participants could indicate more than one organization type (and some indicated three or more organization types), the research team was not able to link responses within the same organization based on zip code and organization type. Instead, analysis is limited to overall comparisons by job role— concordance or discordance between responses from participants in the same organizations was not analyzed. The focus group participants were selected using a convenience sample of NFPRHA meeting attendees, which is also a limitation.

Table 3. Confidential & Covered Survey Respondent Descriptive Statistics (N = 1967)

	Number (%)
Job Role	
Management	612 (31.1%)
Front desk staff	541 (27.5%)
Billing/finance staff	254 (12.9%)
Clinicians	441 (22.4%)
State program administrators	119 (6.1%)
Length of Employment	
Less than 1 year	162 (8.3%)
1 to 2 years	149 (7.6%)
2 to 5 years	329 (16.9%)
More than 5 years	1309 (67.2%)
Organization Type*	
Community development/community action program	84 (4.3%)
Family planning council	114 (5.8%)
Federally qualified health center	281 (14.3%)
Hospital-based program	66 (3.4%)
Local/county health department	1001 (51.0%)
School-based health center	47 (2.4%)
State family planning program	48 (2.4%)
Affiliated nonprofit health center	232 (11.8%)
Unaffiliated nonprofit health center	71 (3.6%)
University or college health center	23 (1.2%)
Other	37 (1.9%)
HHS Region	
Region 1 (CT, ME, MA, NH, RI, VT)	86 (4.4%)
Region 2 (NJ, NY, Puerto Rico, Virgin Islands)	133 (6.9%)
Region 3 (DE, DC, MD, PA, VA, WV)	274 (14.1%)
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)	392 (20.2%)
Region 5 (IL, IN, MI, MN, OH, WI)	194 (10.0%)
Region 6 (AR, LA, NM, OK, TX)	180 (9.3%)
Region 7 (IA, KS, MO, NE)	257 (13.3%)
Region 8 (CO, MT, ND, SD, UT, WY)	114 (5.9%)
Region 9 (AZ, CA, HI, NV, American Samoa, Mariana Islands, Micronesia, Guam, Marshall Islands, Republic of Palau)	199 (10.3%)
Region 10 (AK, ID, OR, WA)	111 (5.7%)

*Respondents could indicate more than one organization type

Despite these limitations, the study offers an in-depth look at Title X health centers' health insurance billing and confidentiality practices by using the mixed methods approach. The findings were also

consistent across the survey and focus groups. Finally, there are few studies that are able to assess the real time challenges of safety-net family planning providers.

Table 4. Confidential & Covered Focus Group Participant Descriptive Statistics (N = 54)

	Number (%)
Job Role*	
Management	38 (70.4%)
Front desk staff	2 (3.7%)
Billing/finance staff	8 (14.8%)
Clinicians	7 (13.0%)
State program administrators	11 (20.4%)
Other	5 (9.3%)
Length of Employment	
Less than 1 year	5 (9.3%)
1 to 2 years	12 (22.2%)
2 to 5 years	4 (7.4%)
More than 5 years	33 (61.1%)
Organization Type*	
Community development/community action program	3 (5.6%)
Family planning council	14 (25.9%)
Federally qualified health center	3 (5.6%)
Hospital-based program	1 (1.9%)
Local/county health department	6 (11.1%)
School-based health center	2 (3.7%)
State family planning program	10 (18.5%)
Affiliated nonprofit health center	10 (18.5%)
Unaffiliated nonprofit health center	11 (13.0%)
University or college health center	0 (0%)
HHS Region	
Region 1 (CT, ME, MA, NH, RI, VT)	3 (5.6%)
Region 2 (NJ, NY, Puerto Rico, Virgin Islands)	4 (7.4%)
Region 3 (DE, DC, MD, PA, VA, WV)	9 (16.7%)
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)	3 (5.6%)
Region 5 (IL, IN, MI, MN, OH, WI)	12 (22.2%)
Region 6 (AR, LA, NM, OK, TX)	4 (7.4%)
Region 7 (IA, KS, MO, NE)	6 (11.1%)
Region 8 (CO, MT, ND, SD, UT, WY)	5 (9.3%)
Region 9 (AZ, CA, HI, NV, American Samoa, Mariana Islands, Micronesia, Guam, Marshall Islands, Republic of Palau)	6 (11.1%)
Region 10 (AK, ID, OR, WA)	2 (3.7%)

*Respondents could indicate more than one job role and organization type

Acknowledgements

The authors wish to thank Daryn Eikner, Audrey Sandusky, and Robin Summers of NFPRHA, in addition to Allie Rabinowitz, Kyrstin Racine, and Deepika Srivastava. The authors also wish to thank Claire Brindis and Jennifer Yarger of the University of California San Francisco's Bixby Center for Global Reproductive Health, Holly Mead of The George Washington University's Milken Institute School of Public Health and Tasmeen Weik of the Office of Population Affairs. Finally, *Confidential & Covered* is indebted to the staff of Title X programs for their time and insight.

Funding for this project was provided by the Office of Population Affairs (Grant Number 1 FPRPA006059-01-00). The views expressed by this project do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply official endorsement by the US Government.

About *Confidential & Covered*

Confidential & Covered is 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.

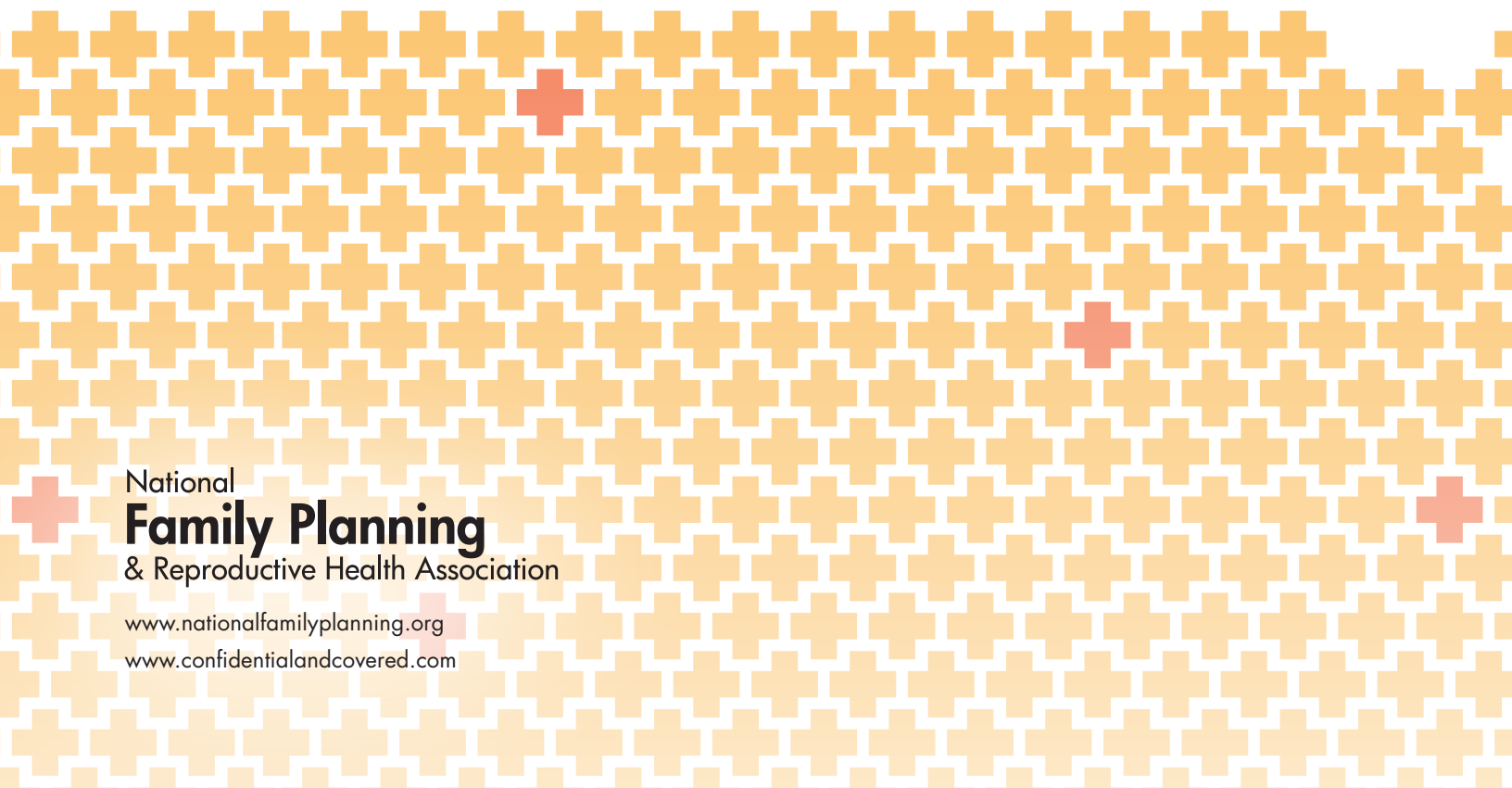
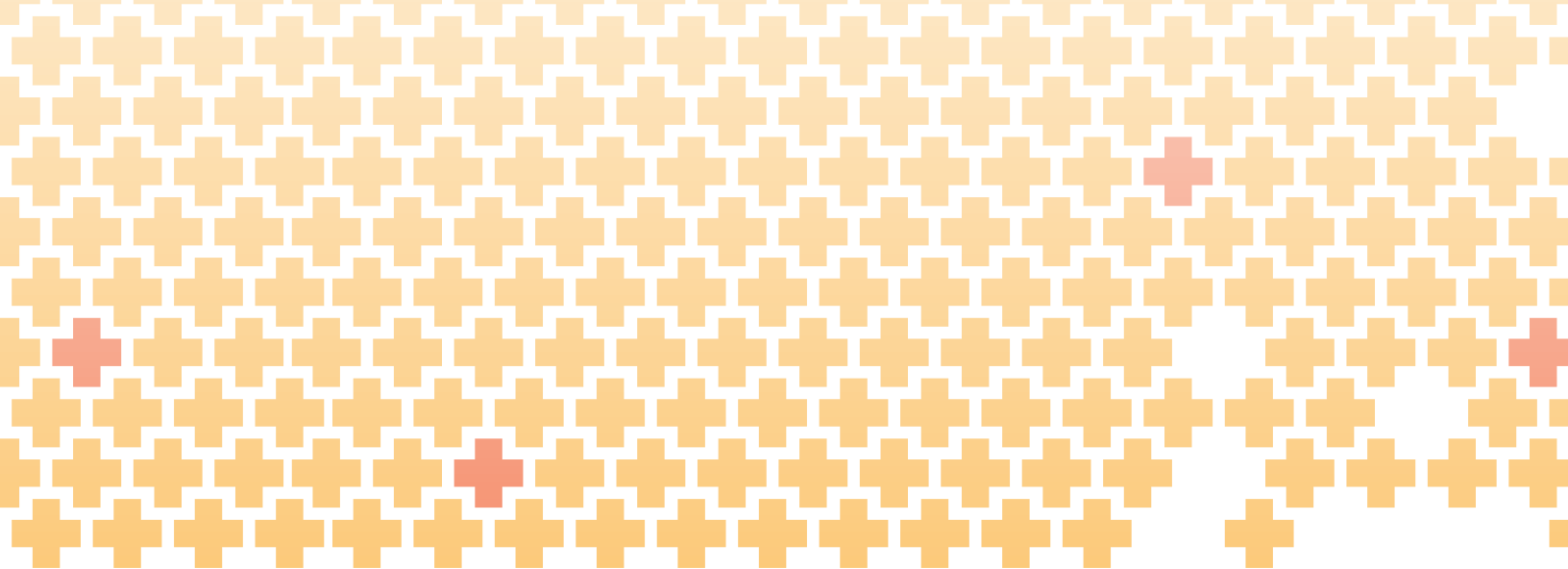
NFPRHA's Membership

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

www.nationalfamilyplanning.org
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