



Rider 37 Newborn Screening Billing

As Required by

**2018-19 General Appropriations Act,
S.B. 1, 85th Legislature, Regular
Session, 2017 (Article II, Department
of State Health Services, Rider 37)**



TEXAS
**Health and Human
Services**

**Texas Department of
State Health Services**

October 2018

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Executive Summary

The [2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 \(Article II, Department of State Health Services, Rider 37\)](#) requires the Department of State Health Services (DSHS) to study the most effective way to bill private insurers for newborn screening (NBS) kits. The study should include the feasibility of requiring DSHS to bill private insurers for the cost of newborn screening and of requiring private insurers to automatically update their payment rates based on panel rates.

DSHS performed a systematic review of billing practices of 53 NBS programs, conducted multiple surveys of private insurers, healthcare providers, and other NBS programs, and met with the Texas Association of Health Plans.

Regarding the feasibility of requiring DSHS to bill private insurers for NBS costs, DSHS found that other states have implemented this model. However, for Texas to follow this model, this change would need to take into consideration challenges with the laboratory budget, upfront and ongoing costs, and various barriers for receiving payment. These factors could require General Revenue, as well as an increase to the NBS fee.

- The DSHS Laboratory's budget stability would need to be addressed before changing the billing model.
- The change would precipitate upfront and ongoing costs for the Laboratory.
- The DSHS Laboratory would have to become an in-network provider with a myriad of insurance companies.
- DSHS would need new capacity to negotiate reimbursement methodologies and amounts for consistency among insurance plans.
- Information collection and information systems would need to be enhanced.

DSHS also studied the possibility of Texas requiring private insurers to automatically update their rates based on updates to the NBS screening fees. Because many insurance companies are not regulated at the state level, it does not

appear to be feasible for Texas to require all private insurers to update their reimbursement rates based on DSHS updates to the newborn screening fee.

DSHS collected information does point to opportunities moving forward:

- More robust technical assistance for providers in billing for newborn screening.
- Possible changes to the timing of billing for NBS kits although this would come with an initial cost.
- Communication with Texas Department of Insurance, Texas Medical Board, and other partners, to ensure full dissemination of upcoming NBS fee changes for both Texas insurers and providers.

1. Introduction

The [2017-18 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 \(Article II, Department of State Health Services, Rider 37\)](#) requires the Department of State Health Services (DSHS) to study the most effective way to bill private insurers for newborn screening (NBS) kits and report the findings by September 1, 2018.¹ DSHS is required to submit the report to the Legislative Budget Board and the permanent standing committees of the Senate and House with primary jurisdiction over appropriations and health and human services. The study is required to include the feasibility of requiring DSHS to bill private insurers for the cost of newborn screening and of requiring private insurers to automatically update their payment rates based on panel rates.

Every year, the DSHS public health laboratory screens 400,000 babies to facilitate early diagnosis of 53 medical conditions. This early diagnosis leads to quick treatment for about 800 to 900 babies a year, and prevents serious complications such as growth problems, developmental delays, deafness, blindness, intellectual disability, seizures, or even early death.

The newborn screening process starts when Texas healthcare providers (e.g., hospitals, pediatricians, midwives) order screening kits from the DSHS Laboratory. The providers use the kits to obtain blood specimens from newborns and submit the specimens to the Laboratory for the screening process. Providers serving insured and self-pay infants pay DSHS \$55.24 per kit, and then seek reimbursement from private insurers or patients.

To conduct the analysis required by Rider 37, DSHS gathered information about common billing models used in other states, the experience of other states with billing private insurers, and the current process and legal parameters for private insurers to update NBS payments.

¹ The due date was extended to October 1, 2018.

2. Background

Texas Newborn Screening Program Overview

The highest volume area of the Department of State Health Services (DSHS) public health laboratory is newborn screening (NBS). This part of the laboratory works in partnership with a DSHS clinical care coordination group to ensure that all newborn babies are screened for 53 genetic disorders or medical conditions and appropriately referred to care as necessary. Early treatment of these disorders can prevent serious complications such as growth problems, developmental delays, deafness, blindness, intellectual disability, seizures, or even early death.

Every year:

- 400,000 infants are laboratory screened – a total of 800,000 blood spot specimens.
- Each child receives an initial screen in the first 48 hours after birth, and a follow up screen between the first and second week of life.
- Roughly 20,000 samples are flagged with abnormal results.
- This leads to the early diagnosis and treatment of disorders for around 800 to 900 infants.

Since its inception in 1965, the Texas NBS program has made leaps in screening care, assisting thousands of Texans in making sometimes life-saving decisions based on information gathered within the first hours of life. As new science and technology emerges, Texas has continuously expanded the number of conditions included in NBS. When the program first started, Texas tested only for Phenylketonuria (PKU). Now, Texas screens for 55 conditions – 53 of which require laboratory-based testing.

The newborn screening program remains one of the state's most successful ongoing public health functions. However, funding continues to be problematic.

- In FY 2017, the costs for newborn screening were \$42.2 Million.
- DSHS received \$35.5 Million in funding for newborn screening.

Texas Newborn Screening Funding Mechanisms

DSHS receives funding for the newborn screening program through two main mechanisms: Medicaid/CHIP-Perinate reimbursements and public health service fees from private pay-supported screenings. DSHS does not receive general revenue for the program.

The cost of each newborn screen is \$48.67 for lab testing, and the allocation for clinical coordination services is \$6.57.

Medicaid and CHIP-Perinate Revenue:

Approximately 57 percent of specimens tested at the DSHS Laboratory are covered by Medicaid. Reimbursement for Medicaid is based on the Medicare allowable rate for each test in the NBS panel, as approved by the Centers for Medicare and Medicaid Services (CMS). The administrator of Texas Medicaid, the Texas Health and Human Services Commission (HHSC), provides DSHS Medicaid reimbursements via an internal voucher process for the Medicaid NBS screening.

- The Medicaid total reimbursement rate per screen for the conditions currently on the NBS panel is \$212.94.
- DSHS receives \$34.50 to partially pay the expense of testing; this amount does not cover clinical coordination services.
- Typically, DSHS receives Medicaid reimbursement about five to eight months after the test is performed.

CHIP-Perinate eligible patients account for approximately 0.02 percent of specimens screened. Reimbursement covers the full cost of performing the laboratory screening and providing clinical coordination services. CHIP-Perinate revenue was just under \$9,000 in fiscal year 2017.

Charity Care:

The DSHS laboratory performs over 40,000 annual NBS screens that have no payor source. These claims are initially submitted to the DSHS laboratory as if they were Medicaid claims but Medicaid cannot pay the claim. This can occur if:

- A patient is not Medicaid eligible
- Patient information does not match with a Medicaid client
- A patient is indigent or otherwise not covered by public or private insurance

The cost of providing charity screens amounts to approximately \$1.8 million annually. DSHS receives no provider payment and General Revenue does not cover this amount.

In 2016, the percentage of screens performed for medically-indigent patients accounted for about five percent of all screens performed by DSHS; however, this volume has increased to about eight percent in 2018.

Private Pay Supported Screening:

For private pay-supported screening, DSHS sends screening kits to providers, with payment due 90 days after the invoice date.

- Providers are charged \$55.24 per kit.
- This covers the most recent cost estimates for both screening and clinical care coordination.
- Typically, DSHS receives payment for the kits about four months after testing has occurred.

Providers seek reimbursement from responsible parties, including private insurers. DSHS bills providers for the NBS paid kits, with a recovery rate of nearly 100 percent.

Private pay NBS fees are determined by an estimation procedure established in accordance with [Texas Health and Safety Code Chapter 12, Section 12.032, Fees for Public Health Services](#).² The components of the methodology include:

- Direct costs associated with the test
- Clinical care coordination activities, case management activities, and client benefits
- Overhead and contingency costs³

² Per Texas Health and Safety Code Chapter 12, Section 12.032 (c), the fee charged for a public health service may not exceed the cost to the department of providing the service.

³ Overhead and contingency costs include items like: quality assurance and quality control, safety costs, capital equipment, courier services, purchasing, information technology and newborn screening costs for the medically indigent.

3. Data Collection and Analysis

Data Collection Approach and Activities

In order to perform the analysis required by Rider 37, DSHS sought information from health care providers, insurance providers, and other states that directly bill insurance through their NBS programs.

Data collection took place over the course of months, and included an open public meeting, surveys, and stakeholder meetings. DSHS also received written feedback from stakeholder organizations, which is attached in Appendix D of this report. The following sections detail data gathered through these efforts.

Provider Experiences in Billing Private Insurance

In Texas, healthcare providers are responsible for recovering their costs for paid newborn screening kits. To better understand the provider experience and challenges, DSHS developed a survey and distributed it through the Texas NBS Program's ListServ. The ListServ includes approximately 12,000 recipients, including representatives of professional organizations such as the Texas Medical Association, the Texas Pediatric Society, and the Texas Hospital Association. 151 individuals provided responses. The table below provides a breakdown of individuals who responded on behalf of their facility or practice.

Type of Facility	Number of Responses	Collect NBS Specimens	File Insurance Claims for NBS Kits
Hospital	29	96.5%	27.6%
Multiple Physician Office	53	86.8%	41.5%
Single Physician Office	31	83.9%	41.9%
Midwife	16	100%	12.5%
Birth Center	10	100%	70%
Other	12	75%	8.3%

The response rate for the survey was a little over one percent. For hospitals, it appears that 12 percent of approximately 240 potential birthing hospital responders submitted survey answers. While these numbers are small in comparison to the number of facilities, providers, and clinics that send in NBS samples for screening, common themes arose that are illustrative of the diversity of provider experience with the NBS billing process.

Provider Internal Processes:

Survey responses showed that providers and facilities handle their internal NBS processes differently. These differences could impact their ultimate experiences and conclusions related to the NBS billing process.

- Some responders bill insurance for reimbursement; others do not.
- Some responders reported having a billing department for support; others do not have one.
- Some responders reported making efforts to update or negotiate increased reimbursement rates from insurance companies; others did not.
- Some responders reported that insurance contract renegotiations occur annually for them; others reported renegotiations that take place as much as five years apart.
- Some responders report using one Current Procedural Terminology (CPT) code to claim reimbursement; others use multiple CPT codes to make their claims.
- Some respondents choose to refer their patients to another facility for NBS specimen collection; others reported considering the referral option.

Provider Experiences:

- While some responders reported receiving reimbursement for nearly all of their claims, a substantial number reported only a low percent of reimbursement.
- The amount of reimbursement rate varied widely among responders, from \$6.33 per kit to \$110 per kit, with a significant amount being below \$55.24.
- The responders reported a widely varying amount of time to update insurance payment rates for NBS fee increases, from as little as two months up to five years.

Provider Concerns: From the survey responses received, some common themes emerged related to the NBS screening billing process.

- Need for provider education about billing codes or process
- Frustration that there is no mechanism to return unused or damaged screening kits
- Challenges with patient eligibility or insurance coverage, refusal of self-pay patients to pay bills
- Concerns with inadequate reimbursement or lack of billing staff to pursue payment

4. Other States' Experiences with Direct Billing

The 53 newborn screening programs in U.S. states, territories, and the District of Columbia operate according to four basic billing models. Descriptions of these models are found in Appendix A. Differences among the 53 NBS programs are based on several factors:

- Whether a second screen is offered: 14 states are two-screen states, including Texas.
- Whether the state charges a fee: All but five states charge a fee. Texas charges a fee.
- What the level of the fee is: The highest fee in the U.S. is \$163; Texas is the sixth lowest at \$55.24.
- Who gets charged the fee: 48 states charge hospitals or providers.
- When the fee gets charged: 17 states presell the NBS kit, including Texas, while others charge after birth or testing.

Rider 37 requires DSHS to evaluate the feasibility of having the DSHS NBS program charge patients or insurance companies directly. Of the 53 U.S. newborn screening programs, four states have operated according to this model: Arizona, California, Florida, and Washington.

DSHS collected information from these programs to learn more about the successes and challenges experienced with direct billing. More detailed descriptions of these four state programs are found in Appendix B.

Feedback from the Arizona, California, Florida, and Washington NBS programs revealed five factors that should be considered when weighing the feasibility of the DSHS NBS program direct billing insurance and patients for screening.

Volume: DSHS handles substantially more screens annually than the four states. The DSHS laboratory performs about 800,000 screens annually. In comparison:

- **Arizona:** ~ 160,000 screens annually
- **California:** ~ 490,000 screens annually
- **Florida:** ~225,000 screens annually
- **Washington:** ~180,000 screens annually

Budget Stability: Of the four state NBS programs, the more successful implementations of direct billing were out of state programs that had an alternate funding mechanism to ensure budget stability. Texas NBS is currently operating at a shortfall for private, Medicaid, and medically-indigent screens.

- **Florida:** Screening fees are supplemented by a \$15 fee per birth, paid by birthing facilities.
- **Florida:** It appears that Medicaid revenue offsets any losses due to inability to collect from insurance companies or parents.

Responsible Party: The four states also take different approaches as to who must pay the screening fee. The NBS programs that directly bill midwives and parents have more difficulty with recouping payments than those programs that only collect from birthing facilities.

- **Arizona:** Hospitals/birthing facilities/midwives, Medicaid, insurance companies or parents for second screens.
- **California:** Hospital/birthing facilities, parents or insurance for home births.
- **Florida:** Medicaid, insurance companies. No billing for parents without insurance.
- **Washington:** One time billing at hospitals/birthing facilities, Medicaid or insurance companies for out of hospital births.

Billing Mechanism: For the four states, an overhead related to billing is included in the NBS program costs. DSHS does not currently have this type of billing infrastructure in place.

- **Arizona:** Arizona was unsuccessful with in-house billing, and switched to instead contract with a billing company. For a program roughly 20 percent the size of Texas's program, the cost is \$700,000, or nine additional dollars per screen.
- **California:** California uses a dual system, where facility billing is conducted in house, and billing for insurance or parents is conducted by a contractor. The cost for handling these approximately 3,000 non-facility billed births and all prenatal screening is about \$540,000 a year, plus four percent of all collections.
- **Florida:** Florida conducts its billing completely in house, and indicates that this in-house capability requires significant resources due to the need to follow up with companies and parents.

- **Washington:** Per contract, a third party biller charges about 30 percent of collections for non-facility births. The NBS program handles facility billing with dedicated financial and contracts staff.

Potential for Revenue Loss: Each state indicated some margin of loss or inability to collect from certain payers. It is unknown whether, for Texas, this revenue loss would be greater under a direct billing system in comparison to the current NBS fee process.

- **Arizona:** As an example, has \$1.15 Million in unpaid fees for bills sent to parents.
- **California:** 40 percent of home birth fees are being reimbursed.
- **Florida:** About 15 percent of all specimens cannot be billed due to insufficient billing information.
- **Washington:** Although Washington did not provide specific metrics, the NBS program there indicated major challenges in collecting from insurance companies.

5. Feasibility of DSHS Directly Billing Insurance

To examine the feasibility of DSHS directly billing insurance for newborn screening, DSHS evaluated the billing models utilized in other states that directly bill insurance, developed a private insurer survey and a provider survey, and met with representatives from the Texas Association of Health Plans (TAHP) to learn more about insurance coverage and reimbursement for newborn screening. Review of the information points to three important feasibility considerations:

The DSHS Laboratory's budget stability would need to be addressed before changing the billing model.

The ability of the four states to continue direct billing, without reducing services or running on a shortfall, hinges on the stability of the program's budget through General Revenue and Medicaid funding mechanisms.

Currently, the NBS program at DSHS is not fully funded, and the entire DSHS state public health laboratory is running at a perpetual shortfall. In the next biennium, if this shortfall is not addressed, programmatic reductions may be the only option to allow the DSHS laboratory to continue operations within available funding.

While it is possible for DSHS to change the billing model of the Texas NBS program, this is only true if the current newborn screening and laboratory shortfall is addressed, and the laboratory budget reaches a predictable and stable position with its funding.

The change would precipitate upfront and ongoing costs for the Laboratory.

DSHS currently has a billing group of six staff who coordinate laboratory billing for newborn screening, drinking water and other environmental testing, and microbiology and clinical chemistry testing. These staff bill private insurance for certain clinical chemistry and microbiology test procedures using insurance information received on the test requisition form.

Responses from states that bill private insurance indicate that either increased staffing would be required to research outstanding claims filed directly with insurance companies and to pursue collection activities; or increased resources

would be needed to set up, maintain, and monitor contracts with a third-party billing vendor.

Based on this information, in order to implement direct billing, upfront and ongoing costs would need to be included for three areas:

- Additional funding to cover the time from when the billing of providers for NBS kits stopped and the flow of revenue from billing insurance begins.
- Funding to cover anticipated revenue loss due to lowered collections by DSHS. The current DSHS recovery rate from private insurance is seven percent.
- Funds for staff to either augment current billing staff, or for staff to support contract management of a third party vendor who would administer direct billing for DSHS.

Due to numerous variables that would need to be addressed to develop a cost estimate for billing private insurers, a specific estimate is not presented. However, based on information from other states, costs *for these pieces alone* could range from \$6.3 million to \$9.8 million per year. The additional costs could result in a higher fee.

The DSHS Laboratory would have to become an in-network provider with a myriad of insurance companies.

For current DSHS billing of private insurers, about 93 percent of the time, DSHS had to write off the cost without payment. 35 percent of these write-offs are contractual write-offs, where usually DSHS is not an enrolled provider with the insurance company or the laboratory fee exceeds the insurance allowable amount. The DSHS Laboratory is currently not an in-network laboratory for any third-party private insurance carriers.

The agency would need to go through individual credentialing/provider enrollment with each third-party insurance carrier doing business in Texas to ensure in-network status. The cost of this piece would depend on several factors, and cannot be estimated without further details.

DSHS would need new capacity to negotiate reimbursement methodologies and amounts for consistency among insurance plans.

Data from the insurance company survey results indicate the current payment rates vary and are based on CPT codes, contracts, or usual and customary (U&C) rates for non-contracted providers. The acceptable CPT codes vary as well: one company accepts only one specific code, another accepts a list of nine codes, and the other accepts all valid CPT codes. None of the respondents indicated that they update their payment rates based on the DSHS fee schedule price for NBS.

A switch to direct billing by DSHS would require DSHS to attempt negotiations to ensure that insurance company rates cover the cost of screening. If DSHS was unable to negotiate adequate reimbursement, the Department would not be able to cover its cost. Florida, a program about 28 percent the size of the Texas program, indicated an annual loss of approximately \$8.4 million on 15 percent of tests they were unable to bill. The annual loss to Texas cannot be determined without further information.

Information collection and information systems would need to be enhanced.

The Texas NBS kit currently does not contain fields for collection of information necessary to submit a successful third-party claim (e.g., ordering physician, diagnosis code, insurance information). The DSHS Laboratory does not have face-to-face contact with the newborn's family and must rely on the submitter to obtain all information required to bill private insurance. Without widespread adoption of electronic transmission of data from the submitter to DSHS, additional DSHS staff would be needed to receive and enter insurance information into the database to use for submitting claims.

Based on this, funds would need to be allocated for DSHS to stand up capacity and logistical infrastructure to collect and receive insurance information via the healthcare provider, and to bill insurance companies:

- An updated NBS kit to include insurance collection information.
- Materials and training to ensure adequate data collection by the healthcare provider.

- An update to the Laboratory's electronic ordering system, an information technology project that has been roughly estimated at \$7.8 Million for a two-year implementation period.
- An upgrade to the Laboratory Information Management System to capture additional data fields.

With further information or direction from the Legislature, DSHS could fully project the cost of needed IT system enhancements or additions.

6. Feasibility of Requiring Insurers to Update NBS Rates

Currently, DSHS has no statutory authority to require insurers to update their reimbursement rates to match DSHS fees. The Texas Department of Insurance (TDI) only regulates any insurance plans that are headquartered within Texas. Also, TDI only regulates fully-insured companies, not those categorized as self-funded plans. For this reason, at this time, no state agency could fully accomplish the goal of requiring insurers to automatically update their NBS rates, and even a change in state law or regulation may not fully address this. Possibly federal changes would be able to address reimbursement issues.

The information collected through surveys did point to particular success in reimbursement among some providers who bill using multiple CPT codes. While requiring a specific level of reimbursement may not be feasible, it may instead be possible to provide technical assistance to providers around what elements they might include in billing to improve their reimbursement. For instance, DSHS can encourage submitters to use multiple CPT codes instead of a single CPT code to file insurance claims. The survey results indicate higher payment rates when using multiple CPT codes. In addition, DSHS can work with TDI and the Texas Medical Board (TMB), and other partners, to ensure timely information is provided to insurance companies and providers about upcoming changes to the NBS rate.

Also, insurance providers and some health care providers indicated that reimbursement rates tie to Medicare allowable rates. Current payment rates are based on CPT codes, contracts, or U&C rates for non-contracted providers. Therefore, matching the timing of any DSHS NBS fee increase to coincide with the January 1 annual updates of Medicare allowable rates, could potentially ease the process for updating private insurer payment rates based on DSHS NBS rates. DSHS could also inform all insurers and healthcare providers of the new fees at least 60 days to six months in advance so they can include in their contract renegotiations.

7. Conclusions

The information gathered by DSHS during the Rider 37 analysis process indicate, that while it is feasible for the state program to directly bill insurance and parents for newborn screening, this change would need to take into consideration challenges with the laboratory budget, upfront and ongoing costs, and various barriers for receiving payment. These factors could require General Revenue, as well as an increase to the NBS fee. At the same time, it does not appear to be feasible for Texas to require all private insurers to update their reimbursement rates based on DSHS updates to the newborn screening fee.

The survey data from the newborn screening providers, the experiences from states that bill private insurance for some aspect of newborn screening, and the billing models that represent the majority of how other NBS programs bill for testing do not produce any one model without challenges to either the NBS programs or the healthcare providers. Changing the current model comes with costs and many considerations, likewise the current model creates challenges for health care providers.

At the same time, DSHS collected information that points to some possible opportunities moving forward:

- More robust technical assistance for providers in billing for newborn screening, through DSHS and other partner organizations.
- Possible changes to the timing of billing for NBS kits although this would come with an initial cost.
- DSHS communication with TDI and TMB, and other partners, to ensure full dissemination of upcoming NBS fee changes for both Texas insurers and providers.

List of Acronyms

Acronym	Full Name
CADPH	California Department of Public Health
CCC	Clinical Care Coordination
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
D.C.	District of Columbia
DSHS	Department of State Health Services
HHS	Health and Human Services
LIMS	Laboratory Information Management System
MMA	Managed Medical Assistance
NBS	Newborn Screening
TACHP	Texas Association of Community Health Plans
TAHP	Texas Association of Health Plans
TDI	Texas Department of Insurance
TMB	Texas Medical Board
U&C	Usual and Customary

Appendix A. Four Common U.S. Newborn Screening Billing Models

Currently, there are 53 Newborn Screening (NBS) programs in the United States, including 50 states, the District of Columbia (D.C.), and two U.S. Territories (Guam and Puerto Rico). These NBS programs are funded in a variety of ways, including state funds, Medicaid, Title V (federal Maternal and Child Health Services Block Grant), provider fees, and in limited cases, insurance reimbursements. NBS programs also differ in other ways such as whether one or two screenings are performed per infant, which types of disorders are included in the screening panels, types of follow-up services provided, and the amount of fees charged for this service.

Forty-eight states (including Texas) charge a fee for NBS laboratory services. Of these, fees range from \$30 in Louisiana and Arizona to \$162.98 in Rhode Island. Of states that charge a fee, Texas currently has the sixth lowest fee in the country.

The 48 states that charge fees generally operate according to four models, as summarized below.

Model #1: Free Kits, Submitters are Billed Once after Testing

This model is currently used by 22 programs, six of which perform two screens per birth.

- NBS kits are sent to the submitter free of charge.
- The submitter collects the specimen and submits it to the testing laboratory.
- After testing is completed, the submitter of the initial screen is billed the total cost of newborn screening, which means that in two-screen states, this submitter is billed for both screens.
- Submitters seek reimbursement from third party payors, usually as part of the birthing package.

This model has advantages and disadvantages as described below by the NBS programs that use this model:

Advantages:

- Removes the need to track which specific NBS kits were shipped to each submitter through an inventory system.

- Reduces billing performed by the states since there is only one bill sent, even for two-screen states:
 - No upfront payments are required.
 - Submitters only have to perform billing or seek reimbursement from insurance one time.
- When NBS fees increase due to program costs or expansion, the new fee can be put in place at the same time as the expansion and all affected specimens will be billed using the new fee.

Disadvantages:

- It is difficult to bill if the initial screen is not collected by the birthing facility or is lost in transit. Programs deal with this issue in different ways.
- It is difficult to bill midwives since the births do not occur in a birthing facility.
- Birthing facilities are billed to cover costs of all screens. Reimbursement rates from insurance for the birthing package may not be increased accordingly. Some birthing facilities obtain reimbursement from third-party payors for each screen separately.

Model #2 Pre-sold Kits, Only Birthing Facilities Billed

This model is currently used by 11 programs, of which four perform two screens per birth.

- NBS kits are pre-sold to submitters and either the order for the kits is accompanied by payment or the submitter is billed after the order is fulfilled.
 - For states performing two screens, NBS kits with double collection cards, one for first screen and the other for second screen, are generally used.
- Only the first-screen submitters are responsible for payments and they seek reimbursement from third-party payors, usually as a part of the birthing package.
 - Second-screen submitters can use the second-screen portion of a double kit or order supplemental NBS kits free of charge.
- Specimens are collected and submitted to the laboratory for testing.

This model has advantages and disadvantages as described below by the NBS programs that use this model:

Advantages:

- No billing is needed if the payment is submitted with NBS kit order.
- Less billing is required in two-screen states as billing invoices are only sent to the entity that submits the first screen.
- Better recovery rate because no new kits can be ordered if previous bill is not paid.
- Second-screen submitters do not have to seek reimbursement.

Disadvantages:

- The NBS program must track which specific NBS kits were shipped to each submitter through an inventory system and establish a process to exchange or credit ruined and defective kits, which requires time and resources.
- Birthing facilities are billed to cover costs of all screens. Reimbursement rates from insurance for the birthing package may not be increased accordingly. Some birthing facilities obtain reimbursement from third-party payors for each screen separately.
- It is difficult to bill if the initial screen is not collected by the birthing facility or is lost in transit.
- When NBS fees increase due to program costs or expansion, any kits sold prior to the fee increase can be used for future, costlier screening.

Model #3 Free Kits, Submitters Billed after each Specimen Tested

This model is currently used by seven programs, of which one, Arizona, performs two screens per birth.

- NBS kits are provided to the submitter free of charge.
- The specimen is collected and submitted to the testing laboratory.
- The submitter is billed for each specimen submitted to the testing laboratory after testing is completed and seeks reimbursement from third-party payors.

This model has advantages and disadvantages as described below by the NBS programs that use this model:

Advantages:

- There is no need to track which specific NBS kits were shipped to each submitter through an inventory system, which saves time and resources.

- Unsatisfactory specimens are not billed or are billed at a lower rate.
- Submitters are not billed until testing is completed, so there are no upfront payments.

Disadvantages:

- Some submitters may be confused about the billing process, specifically physicians collecting the second screen.
- Second-screen submitters may experience difficulties in receiving adequate reimbursement from private insurers.

Model #4 Pre-sold Kits, Submitter Billed for each Specimen

This model is currently used by six programs, of which two (including Texas) perform two screens per birth.

- NBS kits are pre-sold to submitters and either the order for the kits is accompanied by payment or the submitter is billed later.
 - For states performing two screens, each submitter is billed regardless of whether the entity is submitting the first or second screen.

This model has advantages and disadvantages as described below by the NBS programs that use this model:

Advantages:

- No billing is performed if the payment is submitted with the NBS kit order.
- Trends in the number of specimens submitted per year allow for an estimation of potential funding generated by NBS testing.
- A better recovery rate because no kits can be ordered if no payment is received.

Disadvantages:

- More billing activity for the states performing two screens as billing invoices are sent to all submitting facilities.
- Tracking must occur on which specific NBS kits were shipped to each submitter through an inventory system.

- Healthcare providers need to provide upfront payments and maintain an inventory of NBS kits.

Submitters may experience difficulties in receiving adequate reimbursement from private insurers, which impacts their ability to recover NBS program costs.

- When NBS fees increase due to program costs or expansion, any kits sold prior to the fee increase can be used for future, costlier screening.

Appendix B. Experience of other States with Billing

The four states that perform direct billing, as contemplated by Rider 37, include: Arizona, California, Florida, and Washington. DSHS interviewed each state program and gathered the following details related to those states' experiences with direct billing.

Arizona Experience in Insurance and Patient Billing

- Arizona performs two screens as part of their NBS program and uses double kits (i.e., contains kits for collection of both the first and second screens). Arizona has approximately 85,000 births a year and approximately 75,000 second screens per year. The hospital collects the first screen, detaches the second screen card and gives it to the parents to take to their physician for the first well-child check-up. If the parent forgets to bring the card or the card is damaged, a supplemental card may be used.
- Arizona provides the NBS cards for free to healthcare providers and bills for the screening after testing is completed.
- The first screen is billed to the hospital or birthing facility (\$30 per screen, which is typically reimbursed as part of the birthing package) and payment is usually received 30 days later.
- The second screen (\$65 per screen) is billed to the responsible party, which is typically the child's health insurance provider (i.e., private insurers, Medicaid programs, or other third party payors). Healthcare providers send in a separate sheet containing insurance information when they submit the specimen for testing.
 - If the parents are uninsured, then they are directly billed for the fee.
 - If complete insurance information is provided to submit a claim successfully, Arizona may receive payment, but the amounts vary; it usually takes one week to one month to receive payments.
- When billing was performed directly by the health department, five to six full-time staff were needed to manage the billing process, which consisted of monthly invoices using a single CPT code S3620 (newborn metabolic screening panel) for claims.

- Due to hiring restrictions, software breakdowns, and lack of medical billing expertise, collections started to significantly decrease in recent years, and the decision was made to outsource the billing process.
- Arizona executed an approximately \$700,000 a year (about \$9 per screen) contract with a third-party to process its NBS billing. The contractor has 12 full-time staff for managing the billing and collection processes.
- The billing contractor started in April 2016, and by the end of 2016, at least \$500,000 in unpaid invoices had accumulated due to unpaid bills sent to parents of uninsured infants.
 - As of April 2018, of the \$1.8 million billed to parents, \$1.15 million was overdue by more than 125 days.
- Arizona indicated that some of their major challenges for low collections were due to:
 - Unsuccessful use of CPT S3620 code; different insurance companies have different reimbursement rates based on the code.
 - Difficulty in setting up a separate contract with each insurance company. These contracts require frequent renegotiation, with rates between \$2 and \$65.
 - Different insurance companies have different required information for billing.
 - Incomplete or incorrect patient information results in frequent denials and multiple resubmissions.
 - Difficulty in contacting parents to obtain missing information.
 - Low success rate (26 percent) of payment receipts from billed parents.
 - Issues related to midwife births, due to difficulties both with insurance payments and patient inability to pay.
- The Arizona Department of Health is planning to switch to selling specimen kits in advance, and is currently investigating billing hospitals and birthing facilities only for both screens at the same time.

Florida Experience in Insurance Billing

- Florida performs one screen as part of their NBS program.
- Newborn screening services in Florida are jointly-funded through a \$15 fee paid by birthing facilities for each live birth and the billing of the newborn screening tests performed by the Florida State Public Health Laboratory using CPT codes specific for tests performed on each specimen.
- Medicaid and private insurance companies are billed after newborn screening testing is completed; however, Florida does not bill families without insurance coverage.
- The Florida Newborn Screening Laboratory has contracts with 13 Florida Managed Medical Assistance (MMA) Plans (Medicaid) and one with a private insurer, Florida Blue.
- The claims are sent to the insurance company electronically through a clearinghouse or as paper claims three times a day.
- Medicaid usually remits payment the week following claims submission and the other insurers usually pay within two to three weeks. Florida will only receive what the insurance pays and does not bill clients for any co-pay.
- The billing is based on the Medicaid fee schedule for Medicaid or for MMA managed care insurance and on the Medicare fee schedule for third party insurance.
- Currently, the total amount for the test is billed at more than \$250 per sample. When a new test is added to the screening panel, the relevant CPT code is added to the billing process.
- Submitters provide the insurance information on the NBS specimen demographic sheet or send a separate sheet containing a copy of the insurance card.
- Florida indicated that some of their major challenges are:
 - Many resources are needed to bill and follow up with insurance company claim denials or to obtain correct insurance information.

- About 15 percent of the specimens cannot be billed due to insufficient billing information.
- Although reimbursement from private insurance does not match the level of services provided, Florida receives sufficient remittance from Medicaid to fully support the NBS Program.
- Florida identified that a major benefit of their billing process is that it provides excess revenue and a stable funding source for the NBS program.
 - The amount Florida bills insurance is based on the individual tests performed on each specimen, which exceeds the cost of performing newborn screening.
 - All revenue received is deposited in an account specific for newborn screening and public health laboratory use only.

California Experience in Insurance Billing

- California performs one screen as part of their NBS program.
- The current NBS fee is \$141.25, which is a one-time charge for each baby, and does not take into account how many specimens may be submitted for that baby.
- Billing occurs after testing of the initial screen is completed.
- The California Department of Public Health (CADPH) NBS program bills hospitals and birthing centers directly for 99.4 percent of the initial screen on a monthly basis for tests submitted for a particular month.
- Approximately 0.63 percent of California babies (approximately 3,000 newborns each year) are born at home.
 - For these homebirths, CADPH bills insurance and patients directly using an existing billing process established for prenatal screening tests and a third-party biller, Sutherland.
 - Sutherland bills the following responsible payers for prenatal screening and homebirth newborn screening based on information available from the CADPH computer system or after Sutherland conducts skip tracing and eligibility verifications.

- Insurance information is obtained from the test forms or from a copy of the patient's insurance card.
- Sutherland is a national company, with many resources and access to a large database with previous claim data. Sutherland also provides a call center in English and Spanish to answer questions from patients and others.
- Sutherland is paid a set rate for customer service (seven staff, \$45,500 per month) and set rates for printing and mailing of the patient bills. In addition, Sutherland receives four percent of what it collects through the billing process.
- California's contract with Sutherland includes third-party billing for prenatal screening in addition to NBS screening.
 - The cost is about \$3 million per year for both services.
 - Revenue generated by Sutherland's third-party billing for NBS is around \$300,000.
- The NBS Program sends Sutherland monthly electronic billing files. If claims are not paid, the amount owed can be deducted from the patient's state tax refund.
- Billing for NBS from homebirths was recently added and the current reimbursement rate for these is about 40 percent.
 - Prior to Sutherland's services, remittance was received in about six months, but now payments are received within 60 days due to electronic remittances.
 - The CADPH call center was able to handle only 56 percent of customer service calls, but Sutherland addresses 98 percent of calls.
- California indicated that a major challenge was that it required working with a consultant with expertise in healthcare revenue management and specializing in medical billing to help develop the contract.
 - Initially, there were some significant up-front programming changes to the CADPH database and associated costs.
- California identified the following benefits:

- Revenues for screening exceed the cost of the Sutherland contract.
- Improvements in insurance billing and customer service have improved the public's perception of the CADPH NBS program, leading to reduced negative publicity about the program.

Washington Experience in Insurance Billing:

- Washington performs two screens as part of their NBS program and uses a single kit.
- Washington charges \$92.60 per baby, of which \$84.40 is for the NBS program and \$8.20 is for clinical/diagnostic care.
- A one-time charge for the NBS test is charged per baby, no matter how many specimens are submitted for that that baby.
- Billing occurs after testing of first screens is completed, and the second screen is performed for no additional charge.
- Overall, 96.25 percent of births occur at hospitals. Out-of-hospital births are billed differently than hospitals/clinics/laboratories.
- The NBS fee is billed to the submitting facility directly, and the facility in turn bills the insurance company (including Medicaid).
- The NBS Program has a dedicated financial and contracts specialist to handle all facility billing, which takes about eight to ten hours per month to complete.
- 3.75 percent of specimens (approximately 3,400 newborns) are categorized as out-of-hospital births and private insurance or Medicaid are billed.
 - The midwives send either an insurance form or a check from the family (out-of-pocket) with the NBS specimen.
 - The NBS Program enters the data from the forms, which is used by the medical biller to make claims to insurance companies.
 - A third-party biller is used to submit claims because the expertise for this process is not available in-house.

- In addition, 16-20 hours per month are required for the financial and contracts specialist to generate the billing list and ensure appropriate insurance information was received.
- The third-party biller charges about 30 percent of what is collected.
- The Washington NBS Program indicated that some of their challenges are:
 - Often do not receive full reimbursement from the insurance companies when billed directly
 - Achieving in-network status with all insurance companies is a difficult process.

Appendix C. Survey of Insurance Providers and Interview with Texas Association of Health Plans

The survey was distributed through the Texas Department of Insurance (TDI), the TAHP, and the Texas Association of Community Health Plans (TACHP). Only three survey responses were received. Based on the survey results, the DSHS Laboratory would need to negotiate a separate contract with each private insurer to become an in-network laboratory. Two of the insurers indicated multiple contracts may be required and one of the private insurers requires a “bricks-and-mortar” presence in its headquarter state of Arkansas. All insurers indicated that contracts could be set up as evergreen (automatically renewing) with negotiation available upon request.

TAHP indicated that currently 25 percent of Texans are covered by commercial health insurance plans and over 40 percent of them are covered by “self-funded” plans. Self-funded plans, which provide employee benefit coverage typically funded by the employer, are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) and are not governed by state insurance laws or regulators. Another 20 percent of Texans have no health insurance. TAHP works with insurance companies providing coverage in Texas and commented that DSHS directly billing private insurers would not be an efficient use of state resources due to the small percentage (approximately 25 percent) of births that would be covered by these private insurers.

Appendix D. Stakeholder Written Comments

Texas Pediatric Society

August 2, 2018

Rachel Lee, Ph. D.
Biochemistry & Genetics Branch Manager
Texas Department of State Health Services
Newborn Screening Laboratory, MC 1947
PO Box 149347
Austin TX 78714-9347

Dear Dr. Lee,

On behalf of the Texas Pediatric Society (TPS), the Texas Chapter of the American Academy of Pediatrics, representing over 4,200 pediatricians across the state, we want to thank the Department of State Health Services (DSHS) Newborn Screening Program for inviting us to provide comment on the Rider 37 slides presented at the July 12, 2018 stakeholder meeting.

We share the Department's belief that newborn screening is essential to the health of Texas children and appreciate the ongoing collaboration to improve our newborn screening program for the betterment of all those involved. While we value the expertise of DSHS and the research presented on July 12th, TPS continues to have serious concerns regarding the potential recommendations of the Rider 37 report.

As required by S.B. 1, 85th Legislature, Regular Session, Article II, Department of State Health Services, Rider 37, DSHS was directed to study the most effective way to bill private insurers for newborn screening kits. This study should include two specific components:

1. The feasibility of requiring DSHS to bill private insurers for the costs of newborn screening
2. The ability of DSHS to require private insurers to update payment rates for newborn screening

By the end of the final Rider 37 report, TPS hopes that the Department will have made two distinct recommendations to the Legislature on these two components based on the research presented at the July 12th stakeholder meeting. Additionally, regardless of the agency's recommendations, we urge you to make the Legislature aware of the associated costs so that the Department's critical lab funding is not diluted.

Below, we will provide additional analysis on the research provided by DSHS.

Feasibility of DSHS Billing Private Insurance for Costs of Newborn Screening

The research did not provide feasibility of implementing a system in which DSHS would bill private insurers for the entire costs of newborn screening. While slides 45-51 did provide insight into the mechanics and challenges of other states who follow this model, they did not overlay what the impact on Texas' program would be and the administrative and financial feasibility of such a change. Additionally, the final section of the slide deck includes several examples of common newborn screening billing models in the United States, but did not include the model in which the state directly billed insurance. We are concerned this infers a direct state billing model is not under consideration for final recommendation.

We do appreciate the survey information on the impact of such a change on healthcare providers. From the data provided it seems to be an overall perceived improvement to their practice flow and a reduction in the administrative and financial burden. In fact, the challenges associated with states who directly bill private insurance are the exact same burdens that private practices are experiencing currently in Texas including, but not limited to:

- following up on denials,
- wrong or insufficient insurance information,
- insufficient reimbursement,
- confusing and varied coding requirements,
- frequent renegotiation regarding payment and in-network status

While we recognize that a model where the state bills commercial insurance directly is simply a shift of these burdens onto DSHS, physicians feel the Department is better equipped to manage these burdens and find efficiencies that small physician practices would not be able to. Centralizing these burdens is more beneficial to the

system as a whole then spreading them across the state's pediatric outpatient clinics.

The Ability of DSHS to Require Private Insurance to Update Payments Rates for Newborn Screening

We appreciate the research and survey information regarding approaches to update private insurers' payment rates for newborn screening. Based on the limited information provided from health plans, it is clear reimbursement for newborn screening kits are based on contracts with individual physician practices and not the actual flat cost of the newborn screening kit (slide 13 & 16). This is inherently problematic as the reimbursement rates can fall well below those found in the fee schedule in the Texas Administrative Code (25 TAC §73.54), which is based on the price of the actual newborn screening kit. It does not allow variance based on individual contract negotiations. Additionally, health plans survey data show they are not utilizing the DSHS published rate to determine updates in newborn screening kit reimbursement (slide 14). Unfortunately, the research provided does not highlight why this discrepancy exists between the reimbursement practices of commercial insurance and DSHS rule.

We continue to recommend requiring health plans to automatically update their payment rates for the cost of newborn screening kits as updated in the Texas Administrative Code. To ensure this happens appropriately and without delay, we would also recommend that DSHS create a specific timeline for this process in rule. This process could look like the following:

1. DSHS Newborn Screening Program determines fee increase is needed.
2. The final increased fee amount, reason for fee increase and start date for 90-day implementation window is provided to external stakeholders.
3. 90-day implementation period begins, and health plans make system changes.
4. Newborn screening kit fee increase in effect and all physicians receive increased reimbursement for newborn screening kit by end of 90-day implementation period.

We look forward to seeing the draft DSHS Rider 37 legislative report with two distinct recommendations and identified barriers on the feasibility of directly billing insurance in Texas and requiring health plans to automatically update payment

rates for the cost of newborn screening kits based on panel changes. Thank you again for the opportunity to comment on the research provided at the July 12, 2018 stakeholder meeting. We appreciate your dedication to the health and wellbeing of Texas children.

Sincerely,

Dennis A. Conrad, MD

Dennis Conrad, MD

President, Texas Pediatric Society

CC: Dr. John Hellerstedt, Commissioner, Texas Department of State Health Services

Dr. Douglas Curran, President, Texas Medical Association

Texas Association of Health Plans

July 26, 2018

RE: Newborn Screening Study

Via email: NewbornScreeningLab@dshs.texas.gov

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related healthcare entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

Thank you for reaching out to us and allowing us the opportunity to provide feedback for your study of the feasibility of requiring DSHS to bill private health insurers for the cost of newborn screening kits and of requiring private insurers to automatically update their payment rates for the cost of newborn screening kits based on panel changes. These comments will supplement the survey responses submitted by health plans. TAHP recommends that DSHS continue with the current system or consider alternatives that better address the needs of health care providers without adding the additional complexities and costs that would be required for DSHS to begin billing commercial health plans.

Texas Commercial Insurance Market: The study required by the General Appropriations Act (S.B. 1, 85th R.S, 2017, Article II, DSHS, Rider 37) directs DSHS to focus its study regarding reimbursements for the newborn screening kits on “private insurers.” Private (“commercial”) insurance covers only about 25 percent of Texans. Over twenty percent of Texans have no health coverage. Of those with health benefit coverage, over 40 percent are covered by “self-funded” plans in which plan sponsors (usually employers) fund the employee benefit plans and bear the risk of loss. Administered by insurance companies or other third-party administrators (TPAs), these self-funded plans are primarily regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) and not governed by state insurance laws or regulators. Roughly one-third of Texans with health benefits are covered by public health coverage plans, including Medicaid and CHIP, Medicare, and military plans. Well over half of the births in Texas are covered by Medicaid.

Because commercial insurance covers such a small portion of the newborn children in the state, requiring DSHS to directly bill and collect from private insurers for the screenings for such a small portion of the screened population would not be an efficient

use of limited state resources and would not have a materially beneficial impact on health care providers.

Benefits for Newborn Screening: Virtually all commercial health benefit plans in Texas provide coverage for the newborn screenings. While not a “mandated benefit” under Texas law, the newborn screenings are an Essential Health Benefit included in the Texas “benchmark” plan under the Affordable Care Act⁴. Therefore, lack of benefits coverage for the newborn screenings under commercial coverage is not an issue. Additionally, as preventive care, commercial benefit plans (except with the possible exception of those plans that maintain “grandfathered” status⁵) do not require any enrollee cost sharing (deductible, copayment or coinsurance) for newborn screenings if they are correctly billed as preventive care.

Claims for Newborn Screening: Texas is a “two-screen” state, with a newborn screening initially provided within 24-48 hours after birth, generally in a hospital or birthing center where the newborn was delivered, and a second screening provided one-two weeks after birth, more often collected by pediatricians (or other physicians or health care practitioners).

Most newborn screenings for patients with commercial coverage (both first and second screens) are collected by health care providers that have a privately negotiated contract to be in the health plan’s network. As a part of this negotiated contract, in-network physicians and providers agree to accept certain rates for specific services from the health plan and agree not to “balance bill” the patient/enrollee for any amounts in excess of the contract rate. Payments to network providers are based on the terms of the negotiated provider contract and the payment methodology in effect on the date of service (Payment methodologies under contracts may include diagnosis-related groups, fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies).

⁴ The benchmark plan provides as a covered benefit “evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for [infants, children, and adolescents](#).” These recommendations in turn reference the [Recommended Uniform Newborn Screening Panel](#) as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, which includes a list of core and secondary conditions for screening that encompasses all of the 31 core conditions and 24 secondary conditions included in the Texas screening.

⁵ In order to be classified as “grandfathered,” plans must have been in existence prior to March 23, 2010, and cannot have made significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions). In 2014, 26% of workers covered in employer sponsored plans were still in grandfathered plans,⁴ but it is estimated that the percentage is much lower now and that over time almost all plans will lose their grandfathered status.

As noted on the DSHS website FAQs, "DSHS does not control how insurance companies operate or the reimbursement rates that are set, therefore each individual facility's billing office will need to update their facility's agreements with each insurance carrier." Most provider agreements that base reimbursement rates upon an external source, such as the CMS Medicare fee schedule, require that the rates be updated as the external source is updated (generally no more than six months after the external update). Commercial health plans need time to program their claims systems, but rates can be updated in accordance with the terms of provider contracts with sufficient notice.

Commercial health plan network provider agreements with hospitals and birthing centers often include "global" reimbursement rates (or "case rates") for newborn care that would include the initial screening as well as other (non-physician) health care services provided to the newborn in the facility.

The second screening collection is more often performed in a physician office setting and may or may not be separately billed to commercial health plans. Physician and laboratory/pathology services are generally billed using Current Procedural Terminology (CPT) codes (maintained by the American Medical Association). Health care providers determine which codes to use on claims that they submit to health plans for reimbursement.

Provider network agreements are heavily regulated by the Department of Insurance (TDI). See 28 Tex. Admin. Code sections 3.3703 and 11.901. TDI rules require all network provider contracts to include provisions that will entitle the provider, upon request, to all information necessary to determine that the provider is being compensated in accordance with the contract. "The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds."

TAHP would encourage network physicians and providers to reach out to the network staff of the commercial health plans with which they contract if they believe they are not being paid correctly or adequately for newborn screenings under the terms of their respective agreements. TAHP would be happy to facilitate any such discussions.

Feasibility of DSHS Directly Billing Commercial Health Plans: DSHS currently bills submitting providers for the costs of newborn screening kits and allows those providers to submit claims to commercial health plans. Because DSHS does not provide any services directly to insured enrollees, billing commercial health plans directly is not the best approach to any perceived issues with the current system. In order for DSHS to bill commercial insurers, it would have to set up its own claims submission system (often an expensive and complex process) or pay a third party

to create and submit claims, adding a large amount of unnecessary costs to the system, to be borne either by the State of Texas through DSHS or by Texas consumers of commercial health plans through increased premiums. Health care providers already have systems in place and submit claims to commercial health plans (and generally also Medicaid and/or Medicare) on a daily basis; it is not feasible for DSHS to create a claims system only for these specific claims.

If DSHS were to bill directly, it would likely want to enter into provider contracts with each of the 25+ commercial health plans in the state, which could be an extensive process, again creating unnecessary costs.

Because DSHS does not provide services directly to patients or otherwise engage directly with enrollees, all enrollee and commercial health plan information would need to be transferred from the submitting health care providers to DSHS, likely creating manual errors and adding further unnecessary costs to the process. The health care providers would still be required to be involved in the billing process. If the information is not transferred accurately, DSHS would not be able to submit accurate claims to commercial health plans and would not be reimbursed for those screenings.

In closing, TAHP recommends that DSHS continue with the current system or consider other options that will not add the high level of additional complexities and costs that would be required for DSHS to begin billing commercial health plans.

On behalf of TAHP and our members, we thank you for this opportunity to comment on the proposed rule amendments. If you have any questions, please do not hesitate to contact me at jdudensing@tahp.org or 512-476-2091.

Sincerely,



Jamie Dudensing
CEO
Texas Association of Health Plans

cc: Melissa Eason
TAHP Regulatory Counsel

Jason Baxter
TAHP Director of Government Relations

Texas Hospital Association

July 25, 2018

Via electronic submission

PUBLIC COMMENT LETTER

Susan M. Tanksley, PhD
Biochemistry and Genetics Branch Manager
Laboratory Services Section MC 1947
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Re: Rider 37 Report – Proposed Models

Dear Susan,

On behalf of our more than 465 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced matter. THA has long been an active supporter of ensuring all newborns are timely screened for the life-threatening and life-altering conditions that comprise the uniform screening panel.

THA is grateful to have participated in the ongoing stakeholder meetings, and for the opportunity to comment on the materials you presented at the July 12, 2018 Rider 37 Stakeholder Meeting. Those materials were distributed to THA's membership for review. We appreciate all the work you undertook to study current requirements and processes to establish and update newborn screening payment rates, gain an understanding of potential billing issues faced by Texas providers and facilities, compare similar programs in other states, and identify approaches to update reimbursement rates.

We support DSHS's efforts to ensure that newborn screening kits are fully reimbursed by insurers, thus alleviating that burden on providers and facilities. Standardizing billing codes would be very helpful in that regard, as would ensuring that reimbursements accurately reflect the cost involved with administering newborn screenings. These efforts should help the goal of screening every newborn in Texas. We respectfully oppose payment models that shift additional cost burdens to hospitals. We also understand that the cost of newborn screening kits is slated for an increase, but believe that any increase should not be pursued until

reimbursement rates can be synchronized to adequately prevent a payment shortfall for providers and facilities.

THA is committed to continuing our work with you to screen all newborns, and we thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact me at clopez@tha.org or 512-465-1027.

Respectfully submitted,



Cesar J. Lopez
Associate General Counsel
Texas Hospital Association

TEXAS NEWBORN SCREENING ADVISORY COMMITTEE

August 27, 2018

Dr. John Hellerstedt
Commissioner, Texas Department of State Health Services
1100 W. 49th Street
PO Box 149347, MC 1920
Austin, TX 78714-9347

Re: Rider 37 and Newborn Screening Program Funding

Dear Dr. Hellerstedt:

In February, 2018, you wrote to the Texas Newborn Screening Advisory Committee regarding funding mechanisms for the Texas Newborn Screening (NBS) Program. In subsequent meetings, we have received the reports from the laboratory and others that you recommended. In addition, the Committee has reviewed materials regarding Rider 37 plus associated stakeholder comments. This letter provides our conclusions regarding Rider 37 and advice on how to ensure that the Texas NBS Program is adequately funded in the future.

As you know, the Committee was mandated by [House Bill \(HB\) 1795](#) ("Greyson's Law"), 81st Texas Legislature, in 2009 to advise the Department of State Health Services on strategic planning, policy, rules and services related to the NBS Program. Each year, the Program saves an enormous number of dollars and lives. HB 1795 brought the NBS Program closer to national standards, but Texas has since fallen behind again, with four NBS tests approved nationally that are not included in the Texas NBS panel. Worse, after reviewing the evidence, the Committee has concluded that the current funding approaches cannot support the future needs of the NBS Program. The following are some of the facts that led to this conclusion:

- The current funding system saddles physicians, hospitals, and others with significant administrative costs and burdens. Frequently physicians and hospitals find it very difficult to pass on these costs to insurers and other payers such as Medicaid (collectively "payers"). While physician practices regularly bill payers for patient care and potentially could recover NBS costs,

there often are obstacles such as:

- insurer delays in changing reimbursement rates to reflect increases in Program charges;
 - a lack of agreement on billing codes;
 - failure to cover the costs of doing the tests and follow-up of positive results; and
 - reimbursement at rates lower than the costs charged by the state for NBS blood spot cards.
- The accounting for separate Medicaid and private cards creates additional administrative headaches and costs.
 - As the cost of NBS cards increases, there are worrisome declines in the number of private clinics providing newborn screening and increases in the use of "charity" cards.
 - The current approach does not provide a mechanism for the state to obtain or recoup funds needed to develop screenings that are added to the NBS Program, each of which would bring a positive return on investment to society.

The Committee has adopted guiding principles regarding the funding of the NBS Program, as follows:

- The financial benefits of newborn screening accrue to payers, so they should bear the full costs of the NBS Program for their members.
 - Costs recovered by the NBS Program should include the direct and indirect costs of 1) testing and reporting for currently-approved conditions; 2) development and implementation of testing and reporting for newly-approved approved conditions; and 3) follow-up of positive and false negative results for all tested conditions. This is consistent with the Texas Health and Safety Code Sec. 12.032 (c), which states that "The amount of a fee collected for a public health service may not exceed the cost to the department of providing the service".
 - Costs recovered by physicians, hospitals and others should include the direct and indirect costs of: 1) NBS cards; 2) test administration (i.e., a "lab draw" fee); 3) specimen shipment; 4) positive results follow-up; and 5) electronic tracking of these tasks.
- The ideal funding approach should have minimal administrative costs and burden on all parties.

It is with this background that we provide our advice regarding Rider 37 and how to ensure that the NBS Programs are adequately funded in the future.

The Committee concludes the following regarding the Rider 37 question of direct billing of insurers and payers for each individual NBS “kit” rather than the current practice of billing physician practices and hospitals:

- The state would have a significant increase in costs as it, or a third party contractor, would need to track payer information and handle denials for each infant plus enter into contracts and manage billings and receivable with each insurer;
- The state would have a significant cash-flow problem as physician practices and hospitals would stop paying for cards but payments from insurers would not have been received;
- Physician practices likely would be the largest source of insurance information for the second screen. They currently do not provide this to the state. As a result, they would have increased costs from communicating this to the state and handling inquiries where the information is rejected by a payer.

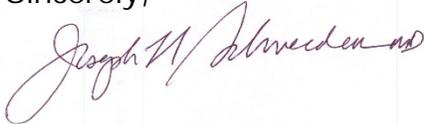
It is because of the above that we offer the following alternative approach for funding the NBS Program:

- Payer information for each infant should be collected by the state from the hospital or birthing center electronically at or around the time of the first screen. Given the current state of EMRs and interfaces (e.g., hearing screening results are reported for each tested infant), this should be achievable with limited one-time additional effort;
- By assuming that the same insurance covers the second screen, physician practices would not be required to report payer information;
- The state should bill payers for the NBS Program costs, as described above, based on their TOTAL number of covered infants born in the state each month as reported by hospitals and birthing centers, rather than each individual child. This would significantly reduce transaction costs and eliminate the cost of individual denials and reconciliations;
- While contracts with insurers would be necessary for such a state-run billing mechanism, this is a one-time cost that could be amortized by adding it into the cost of the NBS Program that is billed. Standardized language referring to “the prevailing NBS Program charge/cost” would be a way to eliminate the need for future contract negotiations;
- Costs for development of new tests should be amortized so that they are recovered from insurers and payers in a way that provides sufficient funding

for keeping Texas up to date with national recommendations. To achieve this, the NBS Program likely would need a special account to retain funds across biennial periods.

We offer the above with the intention of starting the discussion and analysis to replace the current NBS Program billing and funding system, which is not working well for anyone. We appreciate the opportunity to discuss this further in the future.

Sincerely,



Joseph H Schneider, MD (Subcommittee Chair)



Charleta Guillory, MD, MPH (Chair)



Alice Gong, MD (Vice Chair)

Cc:

Janna Zumbrun, MSSW, Associate Commissioner
Grace Kubin, Ph.D., Director, Laboratory Services Section
Susan M. Tanksley, Ph.D., Laboratory Operations Unit Manager
Laboratory and Infectious Disease Services
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