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 (DSHS) 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 payer 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" 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 (Chair)
Alice Gong, MD (Vice Chair)