Rider 37 Subcommittee Meeting Minutes
July 31, 2018
12:10 p.m. – 1:05 p.m.
Conference Call

Table 1: Rider 37 Subcommittee member attendance at the Tuesday, July 31, 2018 meeting.

MEMBER NAME	YES	NO
Nancy Beck, M.D.	P	
Charleta Guillory, M.D.	P	
Joseph Schneider, M.D.	P	
Elizabeth "Kaili" Stehel, M.D.	P	
Linda Zediana, R.N.		X

Yes: Indicates attended the meeting **No:** Indicates did not attend the meeting **P:** Indicates participated by phone

Table 2: Newborn Screening Unit and other HHS staff attendance at the Tuesday, July 31, 2018 meeting.

HHS STAFF NAME	YES	NO
David Martinez	X	
Patricia Lanfranco	X	
Aimee Millangue	X	
Susan Tanksley, Ph.D.	P	

BACKGROUND OF SUBCOMMITTEE

Rider 37 Subcommittee Formation during the July 16, 2018 Newborn Screening Advisory Committee (NBSAC) Meeting: Committee members and Department of State Health Services (DSHS) Public Health Laboratory staff discussed the status of the *Rider 37 Study Report* and the potential impacts to the newborn screening billing process and laboratory budget.

NBSAC Chair, Dr. Charleta Guillory, recommended calling a special meeting to draft a letter on Rider 37. However, Dr. Grace Kubin, Laboratory Services Section Director, stated the letter from the NBSAC can be included as part of the submission. Dr. Guillory requested a subcommittee to draft a letter for Rider 37 from the Committee.

Subcommittee Members to draft a letter for Rider 37 are as follows:

1. Dr. Joseph Schneider
2. Ms. Linda Zediana
3. Dr. Elizabeth Stehel
4. Dr. Nancy Louise Beck

RIDER 37 SUMMARY, July 16, 2018 NBSAC Meeting: Dr. Rachel Lee, DSHS Laboratory Services Section, presented the PowerPoint and handout, *Rider 37 Study Report Updates.* The 2017-2018 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Department of State Health Services,

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Rider 37) requires DSHS to study the most effective way to bill private insurers for newborn screening kits. The study must include the feasibility of requiring DSHS to bill private insurers for the cost of newborn screening kits and of requiring private insurers to automatically update their payment rates for the cost of the newborn screening kits based on panel changes.

CURRENT NEWBORN SCREENING BILLING PROCESS SUMMARY, July 16, 2018 NBSAC Meeting: Dr. Grace Kubin, Laboratory Services Section Director, reviewed the Newborn Screening Billing Process and Laboratory Budget in the PowerPoint, *Laboratory Services Section Budget Overview.* Texas' current system for generating revenue and covering costs of newborn screening is based on Newborn Screening Kits. Costs are covered by Medicaid/CHIP/Charity or by private pay/self-insurance. Providers must use Medicaid/CHIP/Charity kits only for babies covered by Medicaid or CHIP or those unable to pay. The state does not charge providers for these kits or cards. For babies covered by private pay/self-insurance, the submitter (hospital or medical provider) is invoiced by the state a flat fee. This structure is based off payment per specimen on a blood spot card.

SUBCOMMITTEE MEETING NOTES

This was the first conference call meeting and was called to order at 12:10 p.m. by Subcommittee Chair Dr. Joe Schneider. Dr. Schneider and Patricia Lanfranco, DSHS, Newborn Screening Unit Coordinator, greeted everyone and requested attendees introduce themselves. This meeting was held via conference call and was audio recorded.

Dr. Schneider stated the purpose of the subcommittee meeting is to give the NBSAC input into Rider 37 by drafting a formal response letter to the DSHS Laboratory. The Lab is working on a Rider 37 Study report, which is expected to be completed by August 31, 2018. The Subcommittee discussed a direct response to the issue posed by Rider 37 and considered alternative approaches to generating revenue and folding the costs of the newborn screening program.

The Committee discussed numerous issues, as described below:

- Current billing system of Newborn Screening Kits/two cards is not working.
- Medicaid funding insufficient and separate legislative process from Rider 37.
- Separate Medicaid and private pay cards may result in issue with increasing use of Medicaid/charity cards over private pay cards, possibly due to misuse.
- Problem of Cost vs. Revenue: Price of kits does not include costs for future research and development or addition of new disorders to screening panel.
- State is taking a loss and always behind on funding.
- Two-card system affects costs to hospitals and costs to private physicians differently. Physician billing for second screen often results greater cost burden on small practice physicians than on hospitals for the first screen.

- Bundled costs often results in providers absorbing administrative overhead costs. Costs may be greater than amount billed to and paid by insurers.
- Stakeholders report need for uniform billing codes and alignment of fee updates with Medicare fee schedule.
- An alternative approach would be to bill insurance companies and Medicaid directly. State government would bill by the insurer of baby and include the cost of two screens and follow up.
- Process would be free for physicians and other medical providers administering newborn screening. Money would flow from insurers to the state as opposed to flowing from insurers to providers to the state.
- Four states with this model do not have good reports of this process. How would money get back to the state if hospitals pay insurance companies per child and include all the follow up tests? Potential lag time in billing process may limit ability to standardize costs among insurers.
- New bill collection processing and handling system may cost state government more in time, labor, and administrative costs. Feedback needed from doctors on whether they would be happy to transfer responsibility of collecting payments to state since they would no longer collect fees.
- Could retain current process of charging for two cards for two screens.
- Change statute to allow for automatic increase in fees based on percentage/formula rate instead of a flat fee. Rate would allow for research and development costs be included before new tests are implemented and ensure the Medicaid program is carrying an appropriate load of the costs. Private medical providers would not be forced to cover the costs when there are increases. Mandating reimbursement of a rate and not a specific fee would also help cover administrative overhead costs.
- Communicate to the public that newborn screening is just as important as vaccinations, etc. and rally families to advocate to their representatives.
- Have funding structure account for administrative and further service costs. Recognize additional time and labor costs involved from staff and other specialists. Follow up care, especially for abnormal screens, may involve referrals to medical specialists and additional testing.
- Tie Rider 37 input to previous NBSAC recommendation for looking into mechanism for funding new conditions added to the newborn screening panel made to DSHS Commissioner, Dr. John Hellerstedt. Connecting the complex issues of billing and funding would make letter more effective.

Dr. Schneider will draft a document of thoughts and ideas from the subcommittee meeting to be distributed to and reviewed by the subcommittee members.

Dr. Schneider adjourned the meeting at 1:05 p.m.