SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1428

SPONSOR: Health, Aging and Long-Term Care Committee and Senator Dawson

SUBJECT: Newborn Hearing Screening

DATE: April 24, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.	Emrich	Deffenbaugh	BI	Favorable
3.			FP	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 1428 provides requirements and procedures for the universal screening of newborns for hearing impairment. The bill provides for the following:

- legislative intent that the provisions of the act be implemented only to the extent that funds are included in the General Appropriations Act for carrying out the purposes of the act;
- applies to hospitals, birth centers, health care providers attending home births, and home births not attended by a health care provider;
- provides for universal newborn hearing screenings by providers and specifies time frames for the screenings;
- requires education of parents of newborns on the importance of screening and follow-up care;
- mandates Medicaid coverage and specifies payment methodologies for Medicaid, managed care and other insurers for newborn hearing screening; and
- provides for referral for ongoing care under certain conditions.

This bill creates an undesignated section of law.

II. Present Situation:

Background

According to the American Speech-Language Hearing Association, hearing loss is the most common congenital disorder in newborns and 20 times more prevalent than phenlyketonuria (PKU), a condition for which all newborns are currently screened. Less than 20 percent of the babies born in the U.S. are born in hospitals with universal newborn hearing screening programs. Based on national statistics, 3 infants per 1,000 have a hearing impairment. It is estimated that another 3 infants per 1,000 are born with moderate hearing loss which could be identified with the wide use of universal newborn screening and intervention programs. With an approximate annual

birth rate of approximately 190,000 in Florida, 1,140 newborns per year (or 6 percent) would be expected to have a hearing impairment.

A majority of hospitals only test infants considered "at risk for hearing loss," who have conditions such as low birth weight, a family history of hearing problems, or other specific medical conditions. However, research indicates that testing only those babies considered "at risk" results in the identification of only 40-50 percent of children with hearing loss.

The average age that children with hearing loss are identified in the U.S. is 12 to 25 months of age. When hearing loss is detected late, critical time for stimulating the auditory pathways to hearing centers of the brain is lost. Speech and language development is delayed, affecting social and emotional growth and academic achievement.

Infants identified with hearing loss can be fit with amplification by an audiologist at as young as 4 weeks of age. With appropriate early intervention, language, cognitive, and social development for these infants is very likely to develop on par with hearing peers. Children born with a hearing loss who are identified and given appropriate intervention before six months of age had significantly better language skills than those identified after six months of age. Studies have also indicated that detection of hearing loss during infancy followed with appropriate intervention minimizes the need for rehabilitation during the school years.

Methods and Costs for Newborn Hearing Screening

Advances in technology have contained costs for hospital-based newborn hearing screening. Screening costs typically range between $25 and $40. Two types of electrophysiologic procedures are used to screen newborns singly or in combination: a) auditory brainstem response testing (ABR) and b) otoacoustic emissions testing (OAE). Auditory brainstem responses are measured by placing electrodes on the baby's head. Sound is then introduced to the baby's ears through tiny earphones while the child sleeps. The electrodes measure if the brain is detecting the sounds. This test is painless and takes only about 5 minutes. Otoacoustic emissions are faint sounds produced by most normal inner ears. The sounds cannot be heard by people, but can be detected by very sensitive microphones that are placed in the ear canal. During testing, a tiny flexible plug is inserted into the baby's ear and sound is then projected into the ear through the plug. A microphone inside the plug records the otoacoustic emissions that the normal ear produces in response to the incoming sound. The emissions are not detected in an infant who cannot hear. OAE testing is painless and can be done while the baby sleeps.

National Debate on the Effectiveness of Newborn Hearing Screening:

While there appears to be a nationwide move toward universal hearing screening of newborns, some recent studies question the effectiveness of this approach.

In 1998, the American Academy of Pediatrics adopted universal newborn hearing screening as a standard of care. This means that it is accepted practice that all newborn infants should be screened for hearing problems as part of newborn infant care. However, according to a recent article published in the March 1999 issue of *Pediatrics*, the journal of the American Academy of Pediatrics, universal newborn hearing screening is not necessarily the only, best, or most cost-

effective way to achieve the goal of early identification of hearing loss due to the high rate of false-positive results at first-stage screenings.

A study published in the August 1999 issue of *The American Journal of Otology* suggests that universal hearing screening is neither economical nor the best method to insure that infants with hearing problems receive the appropriate care. The authors of this 10-year study suggested that hospitals should focus their resources on newborns with known risks due to factors such as family history, low birth weight, and herpes infection. They also urged that primary care physicians and other people who have contact with children receive additional training to detect the signs of deafness.

Florida's Infant Hearing Screening Efforts:

Since 1985, Florida has required all newborns with any risk factors for hearing loss to be screened. Such risk factors include a family history of hearing loss and low birth weight. In 1998, the Legislature approved, in the General Appropriations Act, universal newborn hearing screening pilot programs at the University of Florida and University of Miami in hospitals in their respective areas. In FY 1999, the Department of Health, Children's Medical Services (CMS) created a grant program for universal newborn hearing screening. Under this program CMS has given grants to 48 hospitals to perform newborn hearing screenings.

Insurance Mandates

Pursuant to s. 624.215, F.S., every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, must submit to the Agency for Health Care Administration and the legislative committee having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.

III. Effect of Proposed Changes:

The bill establishes a statewide program of universal hearing impairment screening, identification, and follow-up care for newborns and infants. The bill requires licensed hospitals or other state-licensed birthing facilities to provide for universal hearing screening for all newborns, prior to discharge from the facility. In the instance of a home birth, the health care provider in attendance is responsible for referral for the hearing screening. The bill requires the initial screening procedure and any medically necessary follow-up reevaluations leading to diagnosis to be a covered benefit under Medicaid. Health insurance policies and health maintenance organizations are required to compensate providers for "the covered benefit at the contracted rate." The bill requires that non-insured persons who cannot afford the testing must be given a list of newborn hearing screening providers who will provide the testing free of charge.

Section 1. The bill creates an undesignated section of law relating to newborn hearing screening which:

- provides legislative intent that the provisions of the act be implemented only to the extent that funds are provided in the general appropriations act and legislative intent as to the scope and nature of the program, as well as the program goal;

- defines the terms "agency" (the Agency for Health Care Administration), "department" (the Department of Health), "hearing impairment," "infant," "licensed health care provider," "management," "newborn," and "screening" (defined as a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation);

- requires each licensed hospital or other state-licensed birthing facility that provides maternity and newborn care services to screen all newborns for the detection of hearing loss and requires the screening to occur prior to discharge, to prevent the consequences of unidentified disorders;

- requires licensed birth centers that provide maternity and newborn care services to refer all newborns, prior to discharge, to a licensed audiologist, or to a hospital or other newborn hearing screening provider for screening; the referral for appointment must be made within 30 days after discharge; and written documentation of the referral must be placed in the newborn's medical chart;

- requires that, in the event the parents or legal guardians of the newborn object to the screening, the screening must not be completed, and a record must be maintained of the lack of performance of the screening, signed by the parent or guardian;

- requires that, in the instance of home births, the health care provider in attendance is responsible for coordination and referral to a licensed audiologist, hospital, or other newborn hearing screening provider within 30 days and that when the home birth is not attended by a primary health care provider the referral must be made by the health care provider within the first 3 months after the child's birth;

- requires all newborn and infant hearing screenings to be conducted by a licensed audiologist, licensed medical or osteopathic physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening and that every licensed hospital must obtain the services of a licensed audiologist or other newborn hearing screening provider, through employment or contract or written memorandum of understanding to provide staff training, screening program supervision, monitoring of the scoring and interpretation of test results, rendering of appropriate recommendations, and coordination of appropriate follow-up services;

- requires that appropriate documentation of the screening completion, results, interpretation, and recommendations must be placed in the medical records within 24 hours after completion of the screening procedure;

- provides that the screening of a newborn's hearing should be completed before the newborn is discharged from the hospital; provides that if screening is not completed prior to discharge due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after discharge; and requires that screenings performed after discharge or due to

initial screening failure must be completed by an audiologist licensed in the state, or by a hospital or other newborn hearing screening provider;

- requires each hospital to formally designate a lead physician responsible for programmatic oversight for newborn hearing screening; and requires each birth center to designate a licensed health care provider to provide programmatic oversight and to ensure that the appropriate referrals are being completed;

- requires each screening to include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration;

- requires that, by October 1, 2000, newborn hearing screening must be conducted on all newborns in hospitals in the state on birth admission and that when a newborn is delivered in a facility other than a hospital, the parents must be instructed on the importance of having the hearing screening performed and must be given information to assist them in having the screening performed within 3 months after the child's birth;

- requires that the initial screening is to be reimbursed for Medicaid patients supplemental to the per diem rate for Medicaid patients not in HMOs, and, when a Medicaid recipient is enrolled in an HMO, the provider is to be paid directly by the Medicaid program at the Medicaid rate. This service is not to be considered a covered service for the purpose of establishing Medicaid HMO payment rates. In the instance of other HMO or insurance policies, the contracted benefit is to be paid at the contracted rate. Non-hospital providers are eligible to bill Medicaid for the professional and technical component of each procedure code. (See *Note below.)

- requires that any child who is diagnosed as having a permanent hearing impairment must be referred to the primary care physician for medical management, treatment, and follow-up services;

- requires that in accordance with Pub. L. No. 105-17, The Infants and Toddlers Program and Individuals with Disabilities Education Act, any child, from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program serving the geographical area in which the child resides; and

- requires that any person who is not covered through insurance and cannot afford the costs for testing be given a list of newborn hearing screening providers who provide the necessary testing free of charge.

*Note: It is unclear whether the above provision mandates a new benefit under health insurance policies and health maintenance organization contracts or whether the bill is augmenting a current mandate. Sections 627.6416, 627.6579 and 641.31, F.S., require individual, group and HMO policies which cover family members to cover child health supervision services which are in accordance with prevailing medical standards consistent with the "Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics." In 1998, the Academy

of Pediatrics adopted universal newborn hearing screening as a standard of care. In 1999, the Academy endorsed the implementation of universal newborn hearing screening, but deferred recommendation of a preferred screening method. The bill requires insurers to compensate *for the covered benefit* at the contracted rate. The covered benefit will be that which is contained in the subscriber's contract, or, absent specific screening coverage, the unspecified screening in the Academy of Pediatrics guidelines.

This provision does clarify on page 5, lines 13-20, that all health insurance policies and health maintenance organization contracts, except for supplemental policies covering specific diseases, hospital indemnity, Medicare supplement, or supplemental policies, shall compensate providers for the covered benefit at the contracted rate, and not provide for supplemental payment.

Section 2. The effective date of the bill is July 1, 2000.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18, Florida Constitution, requires that no county or municipality shall be bound by any general law requiring such local government to spend funds or to take action requiring the expenditure of funds unless the Legislature has formally determined in the committee substitute that such law fulfills an important state interest and the committee substitute must pass by at least a 2/3 vote of the membership of each house of the Legislature.

To the extent that the bill mandates third party payers to cover the cost of such screenings, the bill may represent a mandate to counties and municipalities.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will require additional record keeping for hospitals, birthing centers and health care providers attending at home births. The bill may increase costs to insurers and HMOs.

C. Government Sector Impact:

The estimated Medicaid impact for the bill is $1,371,415 ($596,291 General Revenue). A Governor's Legislative Budget Request for Medicaid contains this amount of funding. However, both the current Senate and House budgets recommend funding for $2, 806,557. The fiscal impact of requiring that hearing screenings be paid supplemental to the inpatient per diem has been informally estimated to be an additional $2,000,000. The estimated impact on hospitals for newborns not covered by health insurance or Medicaid (based in 1998 Hospital Discharge Data) is $181,451. The Department of Health estimates that it will require $440,870 for first year implementation of the bill, and $817,678 in the second year of the bill.

VI. Technical Deficiencies:

On page 2, lines 24-31, there appears to be inconsistent language regarding when the referral for screening must be made. On line 26, the referral must be made prior to discharge. On lines 30 and 31, the referral must be within 30 days after discharge. However, the proper interpretation may be that the "referral appointment" must be made prior to discharge and such appointment must be within 30 days after discharge.

On page 5, line 14, the word "health maintenance organizations" should be interpreted to mean "health maintenance organization contracts."

VII. Related Issues:

None.

VIII. Amendments:

None.