Chapter 35
Financing & Sustainability

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Financing and sustainability strategies are critical to all Early Hearing Detection and Intervention (EHDI) programs and must be an integral part of program design. Since EHDI is considered a standard of care, the ability of a program to sustain itself is of vital importance. The average state EHDI budget, as reported by the 2004 EHDI State Survey, was $538,573, with budgets ranging from a low of $77,200 to the highest at $3,460,000. These figures demonstrate that EHDI programs and activities involve a significant financial investment.

Program sustainability is one of the key elements that the Maternal and Child Health Bureau (MCHB) and Centers for Disease Control and Prevention (CDC) require all state grantees to address. Sustainability applies to every facet of an EHDI program—from the administrative home at the state department of health to individual hospital screening departments, diagnostic audiology services, and early intervention providers.

Funding and Sustainability Strategies for the State EHDI Program

Strategy 1. Obtaining and maintaining federal funding and grants. Most state programs are currently funded primarily through grants awarded by the MCHB and CDC. A nationwide survey of states conducted by the National Center for Hearing Assessment and Management (NCHAM) in 2004 indicated that MCHB and/or CDC grant funding comprised an average of 69% of state EHDI program budgets. A large majority of states indicated the loss of federal funding would have a major or catastrophic impact on their EHDI program. In light of this finding, every effort should be made to maintain and maximize federal funding sources while striving to identify state and local sources of continued funding.

Grant availability is announced by requests for proposals (RFPs) on the federal grant website (http://www.grants.gov), news releases, and other sources. Prospective grantees must pay careful attention to RFPs and strictly adhere to

the grant guidance. Project officers have written the guidance specifically for the grant activities and outcomes expected by their respective agencies. It is important to note that almost all primary grant and supplemental funding opportunities are competitive, so applications must clearly reflect compliance to the guidance. Competitive grant applications are initially reviewed to be sure they are in compliance with the guidance; then reviewed and scored by an independent panel of experts. Some applicants have been unpleasantly surprised when they were not among those who were funded.

Important links for MCHB and CDC grants:

- Maternal and Child Health Bureau, http://www.mchb.hrsa.gov/
- Centers for Disease Control and Prevention, http://www.cdc.gov/NCBDDD/ehdi/
- Federal grants website, http://www.grants.gov/

Strategy 2. Establishing, maintaining, and strengthening state legislative mandates. Currently, there are 43 states (plus the District of Columbia and Puerto Rico) that have legislative statutes related to EHDI. Currently, only 28 of 43 state statutes (65%) require screening of all babies, while others require only 85% of newborns to be screened.

States with a legislative mandate should regularly evaluate their current statute and seek opportunities to improve and strengthen it. Those states without a statute may have efforts in progress to successfully pass a mandate. In light of this, the following considerations should be kept in mind:

- Newborn hearing screening is widely accepted as a standard of care. There are potentially serious liability issues associated with not providing screening services.
- Legislation should be consistent with the Joint Committee on Infant Hearing (JCIH) 2007 recommendations.
- An EHDI advisory committee should be charged with annually reviewing your state mandate—or efforts to establish one—and other related matters. This review should ensure that rules are consistent with current standards for EHDI programs and funding is available to carry out all rules and regulations.
- Consider the political climate, constituent support, and other legislative factors for each legislative session and plan appropriately.
- A coalition of speech and hearing, medical, parent, and other interested groups can be a powerful political force in helping to enact or modify legislation.

It is important to note that legislation outlines the minimum expectations of state policy-makers but does not necessarily define all of the activities that state EHDI programs are doing. For example, Rhode Island has one of the nation's best tracking and reporting systems, reports information to the department of health, and has an advisory committee, despite the fact that none of these activities are addressed by the Rhode Island legislation. If enacting a legislative mandate or strengthening an existing mandate is not feasible or politically prudent, programs can still be strengthened and sustained through strong coalitions, partnerships, and agreements.

The American Speech-Language-Hearing Association (ASHA) has recognized that even those states that have EHDI legislation may not have adequately addressed issues beyond newborn hearing screening, such as follow-up and intervention services for deaf or hard-of-hearing infants. Mandating a strong newborn hearing screening program is futile without the strong intervention policies required to provide the maximum benefits from early identification of hearing loss. Sustainability of entire EHDI programs could be in jeopardy without a

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comprehensive state mandate. ASHA has drafted model legislation and provided a list of talking points for states that wish to strengthen their legislative mandate and ensure adequate funding is available. The model legislation is comprehensive and can be tailored to meet the needs of an individual state. Areas addressed in the model legislation include:

- Improving tracking and surveillance to reduce the number of cases lost to follow-up.
- Privacy concerns associated with the exchange of health-related information.
- Providing comprehensive coverage of early intervention and amplification devices.
- Promoting an unbiased, family-centered approach to early intervention opportunities to help parents make the best choice for their child.

These documents entitled, "EHDI Phase II Model Legislation and Talking Points," are available on the AHSA website: http://www.asha.org/News/Advocacy/2009/EHDIPhaseIILegislationandTalkPoints.htm

The following link on the NCHAM website provides summary information and links to current state statutes: http://www.infanthearing.org/legislative/index.html

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Strategy 3. Obtaining recognition as a state public health program. Universal recognition of EHDI as a public health program is a critical step toward achieving sustainable program funding. Mandatory information collection and reporting to the state department of health from screening, diagnostic, and intervention facilities is an important step toward recognition of EHDI as a public health program. Currently, 29 of 43 state statutes (67%) require hospitals to report information from newborn hearing screening to the state department of health. Without adequate information management, EHDI programs are unable to report to their legislature or advisory boards the status of the program. For state EHDI programs to continue to receive funding, they must justify expenditures and provide objective information that the program is functioning as intended. If your state does not require such reporting, this would be an important issue to be addressed by the EHDI advisory committee.

Strategy 4. Supporting reimbursement to hospitals for newborn hearing screening. Reimbursement is a critical issue for screening hospitals. Currently, 19 of 43 state statutes (44%) include a provision mandating that newborn hearing screening will be a covered benefit of health insurance policies issued in their state. Due to loopholes in how insurance reimbursement occurs, hospitals in most of these states have been unable to successfully collect reimbursement for newborn hearing screening procedures. A common dilemma is when the entire birthing event is included in one capitated charge called a *diagnosis related group* (DRG). This means that all hospital services provided to mother and child in the birth-associated hospital stay are bundled together into one charge. The insurance benefit (both public and private) capitates the payment for the entire stay or DRG regardless of the services provided. The bottom line for hospitals is that any services provided beyond those included in the DRG are not reimbursed.

Some hospitals and birthing facilities contract with an outside agency to provide newborn hearing screening services. In such cases, the outside agency provides staff and equipment to conduct the screening program in the hospital. Outside agencies are finding it increasingly difficult to be reimbursed for their services without employing extra support staff to resolve billing and paperwork issues.

Strategy 5. Supporting reimbursement for diagnostic and habilitation service providers. Payment for outpatient

screening and/or diagnostic services is in peril in many states due to budgetary pressure and cuts. In the past 2 years, several states have cut funding for all hearing services from Medicaid coverage (e.g., Utah). Early diagnosis and intervention is critical for deaf or hard-of-hearing infants to have positive outcomes for speech, language, emotional, and educational development. Budget cuts and poor reimbursement for diagnostic and intervention services have caused many professionals to decline to serve this time-intensive population. This is particularly true for those families receiving Medicaid services. Recent rounds of budget cuts and projected state deficits reinforce the need for EHDI programs to be constantly vigilant and able to justify budget items.

Strategy 6. Standardize best practices across state programs to reduce variability and cost. Well-recognized professional groups, such as the JCIH, have published carefully considered and researched recommendations for EHDI program practices. Many state EHDI programs list their policies and procedures on their website. Other information, such as minimum standards of practice for pediatric audiology and standards for newborn hearing screening, may be readily obtained from these websites.

Further information may be obtained on the NCHAM website: www.infanthearing.org/stateguidelines/index.html

Funding and Sustainability Strategies at the Hospital/Individual Screening Program Level

Strategy 1. Maintaining stakeholder support. Screening programs should have relevant statistics available for use in education of administrators and providers. Positive identification of hearing loss and the associated human impact stories need to be presented, making the impact of the screening program real for all stakeholders.

The American Academy of Pediatrics has identified an EHDI "chapter champion" in each state. This pediatrician can be a valuable ally for providing support and education to fellow physicians and other healthcare providers. Many chapter champions serve on state EHDI advisory committees and volunteer their time in countless other ways to assist EHDI program effectiveness.

Parent education materials presented in prenatal classes or on the education channel of the birthing facility provide an excellent means of obtaining stakeholder support and should be utilized whenever possible. Excellent educational materials may be obtained on the NCHAM website: www.infanthearing.org/screening/nhsresources.html

Strategy 2. Long-range planning. Programs should have a 5-year budget plan for equipment upgrade, replacement, maintenance, and repair. While individual hospital guidelines and definitions for capital items and minor equipment vary, equipment needs should be planned within organizational parameters well ahead of the expected time of use.

Screening program managers should work with hospital planners and department heads to anticipate changes in birth rates, changes to NICU levels, etc. to appropriately project equipment and staffing needs.

Strategy 3. Equipment financing. Ideally, equipment should be included in hospital or birthing facility operating budgets. In many cases, especially small rural facilities, procuring funds for equipment is challenging. Sources of funds that may be considered include:

- ***Hospital foundation, auxiliary, or other volunteer groups.*** Most hospitals have one or more organizations that exist to raise funds for facility needs, including equipment. Many hospitals have received needed equipment funds through the efforts of one or more of their associated groups.

Healthcare reform and its implications and impact on EHDI reimbursement is unknown. The Affordable Care Act (ACA) includes a preventative services mandate, which requires insurers to cover without cost-sharing the preventative services recommended by HRSA. ACA coverage includes hearing screening and assessment for newborns and children. Plans may not charge for any co-pays, deductibles, or co-insurance to patients receiving these services. While plans in existence prior to March 2010 are exempt, they will relinquish exempt status if they make significant changes to their coverage (e.g., cost sharing, cutting benefits, or reducing employer contributions). Most plans have yearly changes that will remove this exemption.

Positive identification of hearing loss and the associated human impact stories need to be presented, making the impact of the screening program real for all stakeholders.

- ***Service clubs.*** Service organizations, such as the Lion's Club, Sertoma, or the Quota Club, often provide funds for equipment. You can identify these groups through your state nonprofit association or from local directories. The state nonprofit association often has a directory that provides information on groups in the state, including foundations, clubs, and associations, as well as the types of projects they typically support.

Strategy 4. Accurate determination of EHDI program costs. Each program must know their actual cost per infant. This is crucial for overall program planning, accurate screening-to-pay off calculations on equipment purchases, evaluation of program efficiency, and addressing full-time equivalents (FTE) staffing needs. Items that ***must be considered when determining program costs include:***

- Cost of equipment based on the estimated number of infants that can be screened over the projected life of the equipment, usually assumed to be 5 years.

Photo courtesy of NCHAM

- Annual maintenance and disposable costs, including calibration, repair, probe replacement, office supplies, etc.

- Salaries for EHDI staff activities, including screening and follow-up, information management, reporting, and administration.

- Information management system (IMS) costs for hardware, software, and support (e.g., tracking software, such as HI*TRACK, OZ, etc.).

Strategy 5. Maximize reimbursement opportunities and accurately track the value of services provided. Hospital screening and diagnostic audiology programs must ensure they are billing and coding correctly for every service provided. Accurate coding is essential for claims submitted to third-party payers. Following is a brief summary of the key components of the complex system of coding for reimbursement:

Reimbursement for healthcare services is dependent upon the consistent and accurate use of codes to identify:

- Procedures performed (CPT codes)
- Diagnosis or diagnoses [ICD (International Classification of Diseases) codes]
- Devices, supplies, and equipment acquired for the client (HCPCS codes)

The Current Procedural Terminology (CPT) coding system describes how to report procedures or services performed, such as a hearing screening test. The CPT system is maintained and copyrighted by the American Medical Association. Each CPT code has five digits.

The ICD coding system describes how to report diagnoses and disorders. The ICD code version in current use is the ICD-9-CM (ICD, 9th revision, Clinical Modification). The ICD-9-CM is maintained by the National Center for Health Statistics of the U.S. Public Health Service. Each ICD-9 code has three numeric digits followed by a decimal point. Proper coding is essential to maximizing reimbursement.

The hearing screening/testing CPT codes have been updated for 2012 implementation. The codes are listed in the 2012 CPT Codebook in sequence and include the Medicare physician fee schedule national payment rates. The actual payments received are adjusted by the relevant geographic index. There are several codes that are used to describe early hearing detection testing to a payer. The procedure codes are divided into screening and evaluation codes (see *Table 1*).

While it is not the intent of this chapter to be a comprehensive review of billing and reimbursement, the following links will provide in-depth information on this complex issue:

- Billing & Reimbursement (ASHA)
- 2012 ICD-9-CM Diagnosis Codes Related to Speech and Hearing Disorders (ASHA)
- Classification of Diseases, Functioning, and Disability provided by the CDC

Table 1
CPT Procedure Codes

CPT Code	Description	When to use . . .
92558 (OAE Screening Code)	Evoked otoacoustic emissions screening (DPOAE or TEOAE) automated analysis.	When performing an automated pass/fail screen with a fixed or limited number of frequencies at a single intensity level. Most OAE newborn screenings will fall in this category.
*92587 (OAE Limited Diagnostic Code)	Distortion product-evoked otoacoustic emissions limited evaluation (to confirm the presence or absence of a hearing disorder, 3-6 frequencies) or transient-evoked otoacoustic emissions with interpretation and report.	When 3-6 frequencies are tested bilaterally and include the interpretation of the test with reporting of the results in the patient's medical record. Audiologists performing both tests (DPOAEs & TEOAEs) may seek additional reimbursement by using the -22 modifier in conjunction with CPT 92587.
*92588 (OAE Comprehensive Diagnostic Code)	Comprehensive diagnostic evaluation (quantitative analysis of outer-hair cell function by cochlear mapping, minimum of 12 frequencies) with interpretation and report.	When at least 12 frequencies are tested bilaterally. If fewer than 12 are performed, the appropriate code is 92587 (see above). A report is required to document the test results.
92586 (ABR Screening Code)	Auditory-evoked potentials for evoked-response audiometry and/or testing of the central nervous system—limited.	When performing an automated pass/fail screen, use this code for screening.
92585 (ABR Diagnostic Code)	Auditory-evoked potentials for evoked-response audiometry and/or testing of the central nervous system—comprehensive.	When performing a diagnostic ABR, use this code for diagnostic testing.

*These codes are typically used by audiologists as part of a diagnostic evaluation and are not appropriate for hospital newborn hearing screening programs.

IMPORTANT NOTE: According to the National Center for Health Statistics (the federal agency responsible for use of the International Statistical Classification of Diseases and Related Health Problems), the 10th revision (ICD-10-CM) is now available for public viewing. Please note that the codes in ICD-10-CM are not currently valid for any purpose or use. The effective implementation date for ICD-10-CM (and ICD-10-PCS) is October 1, 2013.

- Model Superbill for Audiology provided by ASHA
- Changing Healthcare Financing for EHDI Programs: The Essential Elements of Reimbursement (Bob Fifer, Ph.D., University of Miami, Fall 2011)

Funding and Sustainability Strategies That Apply at All Levels of EHDI Programs

Stategy 1. Be concerned with funding at every level of the EHDI program. State financing and sustainability strategies must address reimbursement concerns at all levels of the EHDI program. Screening is the necessary first step in the EHDI process and must be adequately funded in order to continue. Some states (i.e., Arizona) bundle the entire cost of the EHDI program into the screening fee collected by the hospitals, making this reimbursement vital for program sustainability. It is important that each state's EHDI advisory committee have a working subcommittee dedicated to reimbursement and program funding issues.

Strategy 2. Anticipate questions. A good sustainability plan includes anticipating questions from key stakeholders and supporters. Program personnel should have responses thoughtfully prepared in anticipation of frequently asked questions. It is important to provide emphasis on key points and themes that you want to convey. It is vital to have completed a thorough program evaluation, so responses can be based on solid supportive data, including epidemiology, incidence, and outcomes.

Photo courtesy of NCHAM

Strategy 3. Establishing strong relationships with key partners is vital to ensuring program sustainability. Three specific examples of key partnerships are:

1. ***State legislators and political decision-makers.*** Programs should have information prepared in anticipation of legislative activities before, during, and after legislative sessions. It is critical to track proposed legislation and/or budget hearings that could affect EHDI program funding. Key partners can help compile a pre-session legislative report, provide ongoing updates during the session, assist preparations to testify, and arrange for post-legislative session follow-up.

2. ***Federal agencies, such as MCHB and CDC, who currently provide EHDI funding for states.*** The Office of Performance Review conducts rigorous reviews of programs receiving federal funds. A review of any EHDI program that receives MCHB funding can occur at any time.

3. ***Foundations, service clubs, and other potential sources of funds.*** State EHDI programs and individual hospitals should have a "mini grant" template prepared with statistics, needs, and successes. This template should be readily available and easily customized to meet the requirements of specific potential funding sources. Service clubs are often looking for worthwhile projects to fund and may respond favorably to presentations by EHDI program staff or parents of deaf or hard-of-hearing children. The EHDI program advisory subcommittee on finances should be charged with locating potential sources of funds.

There is no doubt that EHDI programs have made a significant difference in the lives of many deaf or hard-of-hearing children and their families.

Strategy 4, Identify program support needs. Every program must have a method of determining the types of support and technical assistance it requires and from whom these services can be obtained. Personnel should be ready to respond quickly when questions arise about support and needs from partnering organizations and/or potential funding sources. Program needs may be determined, and those with the expertise and experience to help may be identified by addressing the following questions:

1. What specific assistance is needed?

2. Who can best provide the assistance?

    - State department of health or other agency staff
    - Federal agencies, such as MCHB or CDC
    - EHDI grantee network (other state EHDI programs)
    - NCHAM Technical Assistance Network
    - A volunteer, such as the AAP chapter champion
    - Contracted consultants

3. When would you like to obtain technical assistance?

4. Where is assistance available? Do you need to travel, bring someone to your site, or could assistance be provided by telephone, Internet, etc.?

Strategy 5. Analyze program outcomes, indicators, and strategies with respect to the overall EHDI picture. Ask hard questions, such as what could be changed about the current EHDI reporting system to better capture the results you feel your program has achieved? How do you measure the impact of culturally sensitive programs? Does your evaluation move beyond simple pre- and posttest comparison? What are the measurable outcomes of your efforts?

Strategy 6. Tell your story. Seeing the difference newborn hearing screening, early identification, and appropriate intervention makes for each individual deaf or hard-of-hearing child and family makes it real and reinforces the value of the EHDI program. Telling individual success stories is a vital part of keeping your program alive and relevant to both the public and program personnel. Identify the appropriate venue and media for telling your story, such as:

- Newsletters
- Websites, print media, radio, television, etc.
- Presentations at professional conferences, grand rounds, political venues, etc.
- Social networking sites
- Programs for social and service organizations

Strategy 7. Develop a sustainability "toolkit." A sustainability toolkit is a complete plan that addresses a host of EHDI program issues, including financing and sustainability. The toolkit should contain:

- An implementation and succession plan for visionary leadership.
- Summary reports of key program indicators and success.
- Best practice documentation and resources.
- A specific plan that addresses funding and fundraising opportunities.
- Material for submission to professional journals and conferences.
- Marketing and communication materials, press releases, etc.
- A leadership networking plan.

Financing and sustainability are issues that require careful planning during the initial phases of an EHDI program and continuous review thereafter. Every EHDI program must have a long-term strategy that addresses the issues listed in *Table 2*.

There is no doubt that EHDI programs have made a significant difference in the lives of many deaf or hard-of-hearing children and their families. Numerous studies have documented the benefits of early identification and intervention. However, no matter how well documented and valuable an EHDI program may be, it simply cannot exist without sufficient funding.

Table 2
EHDI Long-Term Strategy Issues

1	State and federal funding challenges and opportunities
2	Reimbursement and third-party payer issues
3	Alternative sustainability plans in the event state or federal funding is not available
4	Partnership opportunities for all stakeholders
5	Administrative requirements
6	Equipment issues
7	IMSs
8	Evidence-based practice
9	Legislative and regulatory issues

EHDI programs must make every effort to remain financially viable and continue to be the lifeline for families of deaf or hard-of-hearing children.

The financial burden of the EHDI system must be balanced against the significant savings in special education and increased productivity of those who are permitted to reach their full potential. The concept of spending money now to save it later may not register with legislators faced with tight budgets or third-party payers concerned with the bottom line. EHDI programs must make every effort to remain financially viable and continue to be the lifeline for families of deaf or hard-of-hearing children.

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