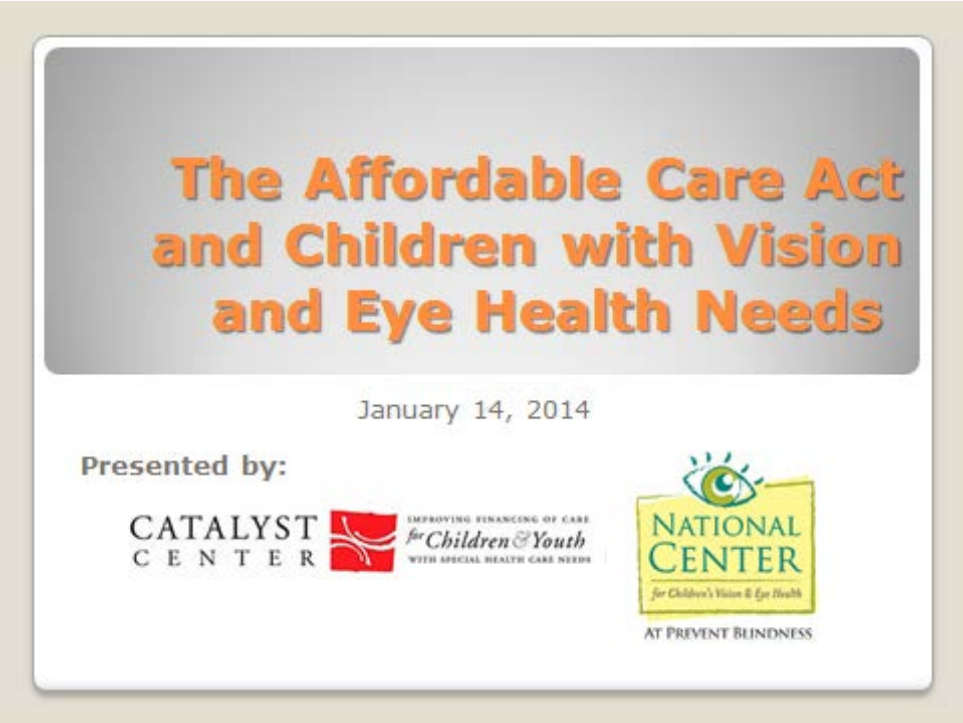
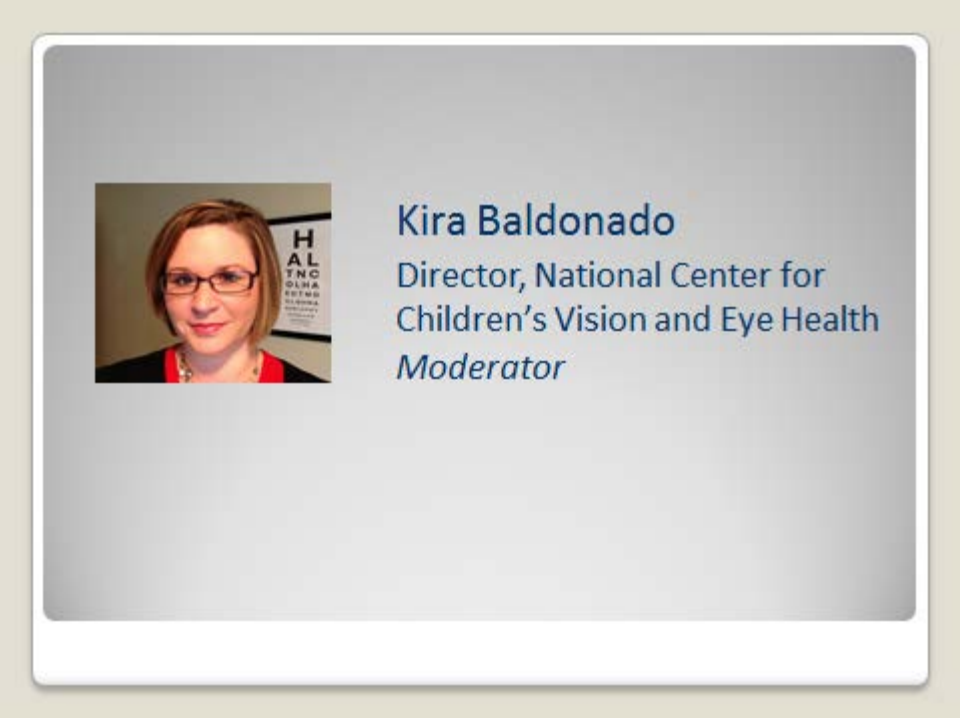
Webinar Transcript: The Affordable Care Act and Children with Vision and Eye Health Needs

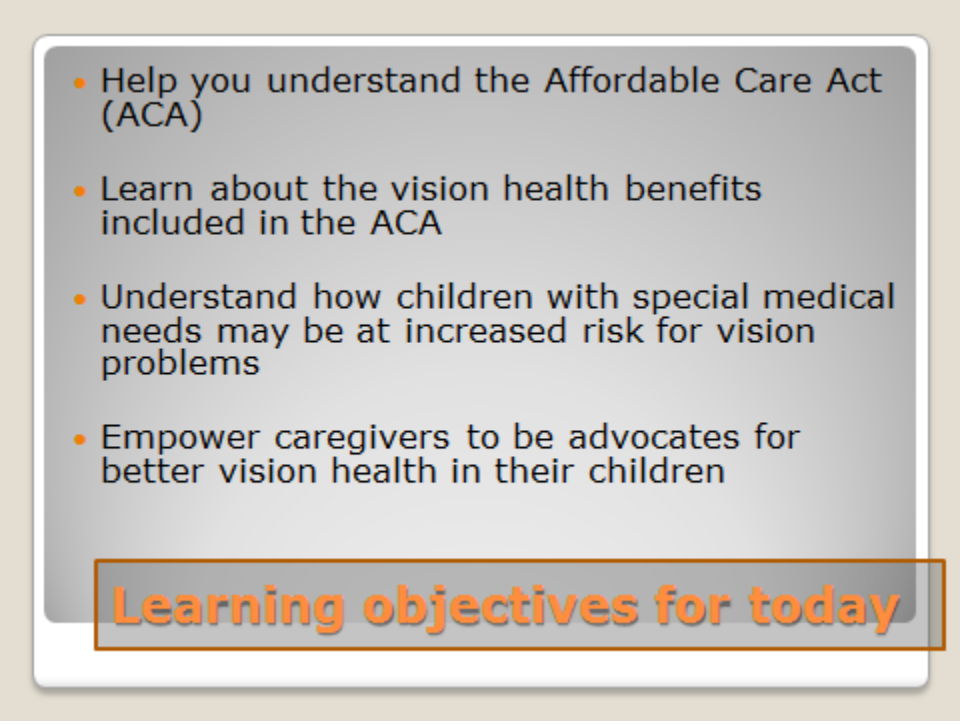


Kira Baldonado: Welcome to today's webinar- The Affordable Care Act and Children with Vision and Eye Health Needs

The webinar is brought to you today through the collaborative efforts of the Catalyst Center: Improving Financing of Care for Children and Youth with Special Health Care Needs and the National Center for Children's Vision and Eye Health.



My name is Kira Baldonado, I'm director of the National Center for Children's Vision and Eye Health, and I'll be your moderator for today. On behalf of the National Center for Children's Vision and Eye Health, we are pleased to be able to partner with the Catalyst Center to help families and caregivers better understand the Affordable Care Act and the vision essential health benefit as well as how they can serve as better advocates for their child's vision health.



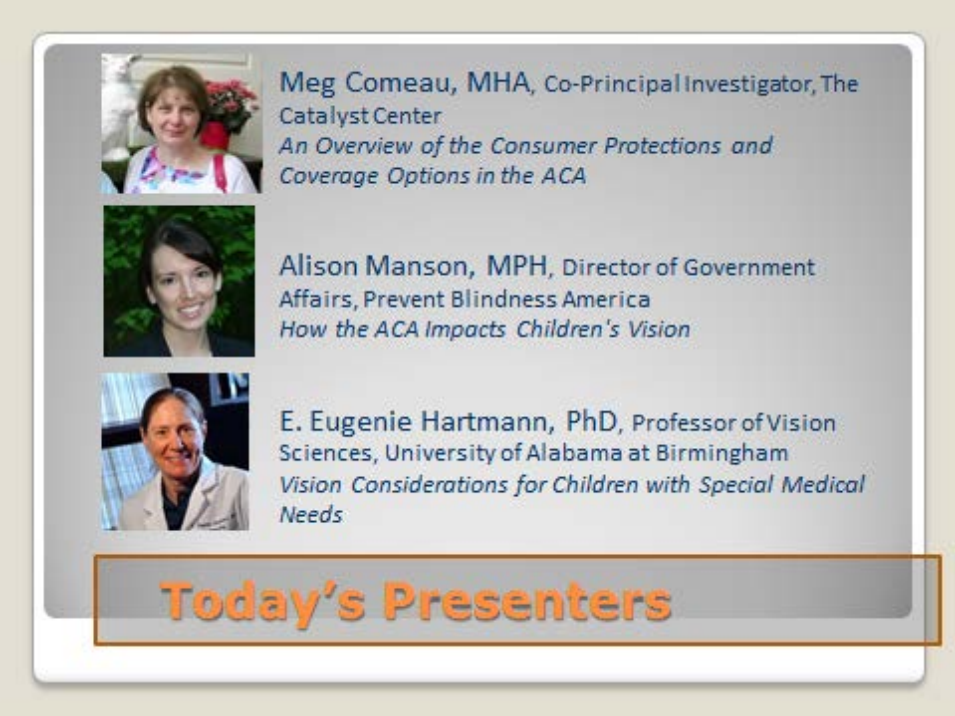
Today's webinar will:

- Help you understand the Affordable Care Act
- Learn how the vision health benefits included in the Affordable Care Act will benefit children
- Understand how children with special medical needs may be at increased risk for vision problems
- Empower caregivers to be advocates for better vision health in their children

Today's webinar is being recorded and a link to the webinar will be provided to all registrants as well as made available on the websites for the Catalyst Center and the National Center for Children's Vision and Eye Health. The link will be available in about one week. We will be taking questions at the end of the last presentation. Due to the large number of participants we will take questions via the chat feature on GoToWebinar, otherwise all phone lines will remain muted. Please type in your question at any time into the chat feature and we will address as many as possible during the Q & A portion of today's program. If your question is for a specific presenter please indicate your preference.

At this time, Kathy Watters, HRSA/MCHB project officer for the Catalyst Center would like to say a few words of welcome to all. Kathy?

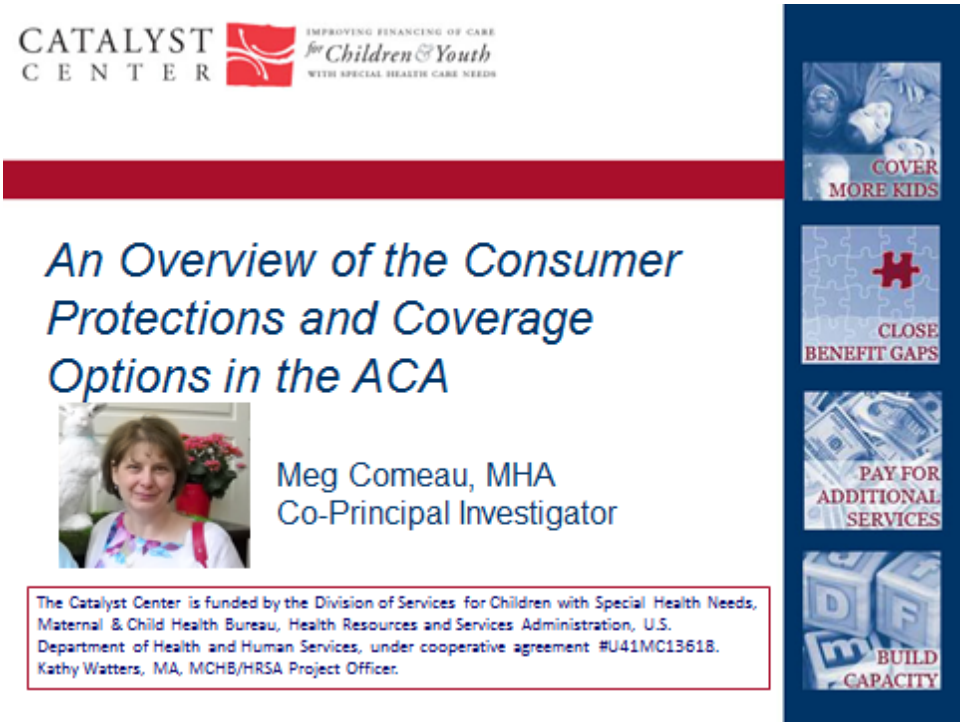
Kathy Watters: On Behalf of the Health, Resources and Services Administration and the Maternal and Child Health Bureau (MCHB), I am pleased to welcome all of you to this very exciting and timely webinar. As you may know the MCHB is undergoing new developments under the Direction of our Associate Administrator, Dr. Michael Lu. He emphasizes the Bureau's unique role is to develop the public health system for the maternal and child health populations, including children with special health care needs. Through Cooperative Agreements and grantees, such as the Catalyst Center and the National Center for Children's Vision and Eye Health, the Bureau is investing in helping families, states and communities to better understand the healthcare system, including financing issues, in order for families to thrive in their communities. Again, welcome and thank you so much for your participation.



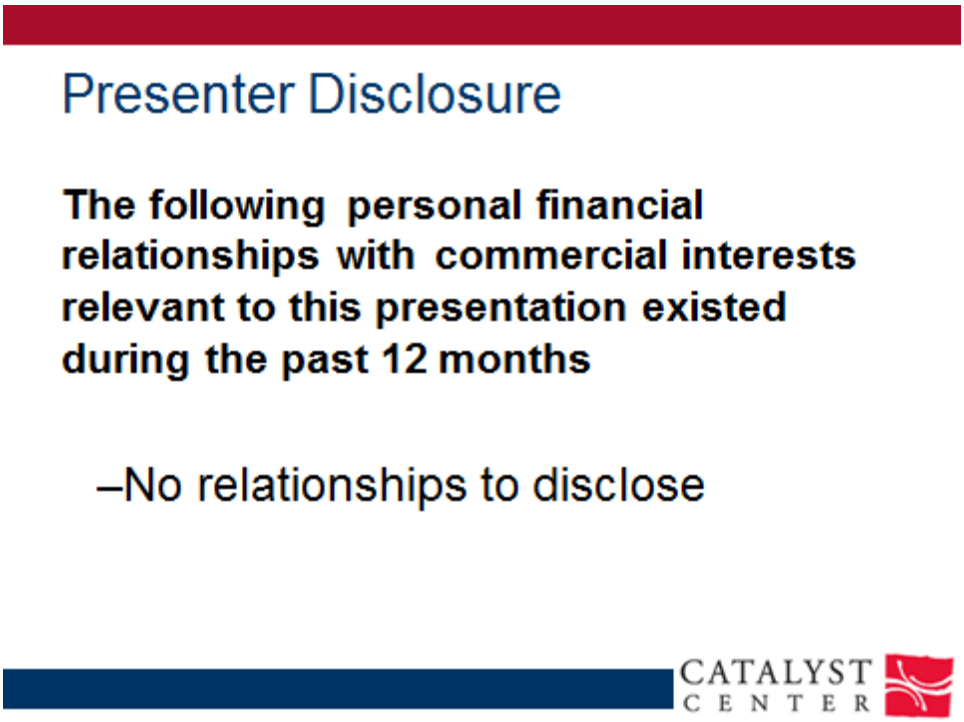
Kira Baldonado: Thank you, Kathy. We have three wonderful presenters with us today:

- Meg Comeau, MHA, Co-Principal Investigator, The Catalyst Center
  An Overview of the Consumer Protections and Coverage Options in the ACA
- Alison Manson, MPH, Director of Government Affairs, Prevent Blindness America
  How the ACA Impacts Children's Vision
- E. Eugenie Hartmann, PhD, Professor of Vision Sciences, University of Alabama at Birmingham
  Vision Considerations for Children with Special Medical Needs

I will now turn control of the webinar over to our first presenter- Meg Comeau of the Catalyst Center. Meg?



Meg Comeau: Thanks, Kira – it's been a real pleasure working with you, Alison and Dr. Hartmann in preparation for today's webinar and I've appreciated the opportunity to learn more about children's vision and eye health needs. My name is Meg Comeau and I'm the co-principal investigator for the Catalyst Center.



Before we get going with the content of the presentation, I must mention I have no financial relationships or conflicts of interest to disclose.

For those of you who are not familiar with the Catalyst Center, I wanted to take a minute to start with just a quick overview of who we are and what we do....

- Funded by the Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau (MCHB); the same division that funds the Nat'l Center for Children's Vision and Eye Health. We're all part of the same big happy funding family.
- The Catalyst Center is a project of the Health and Disability Working Group, based at the Boston University School of Public Health
- The Maternal and Child Health Bureau funds several topic and diagnosis specific national centers, like the National Center for Children's Vision and Eye Health. In addition, the Bureau has six core outcome measures focused on the system of services for children with special health care needs, and there is a national technical assistance center dedicated to each of them. We are the center dedicated to working with States and stakeholder groups on achieving the outcome measure that: "…all children and youth with special health care needs have access to adequate health insurance coverage and financing."

Insurance coverage, whether public, private or a combination of both, that meets the needs of children with special health care needs (CSHCN), including those with vision and eye health needs, must be:

- Universal and continuous so everyone who needs coverage can get it and they can stay on it
- Affordable, not just the premiums for the coverage but also the co-insurance and deductibles and copays associated with it
- Adequate—it needs to cover through benefits what children need.

- Universal and continuous, affordable health insurance **coverage** is a critical first step to accessing health care services and reducing financial risk based on health care needs
- Robust **benefits** under insurance coverage support access to the many essential and specific health care services children with special health care needs require to learn, grow and thrive.

The Affordable Care Act

- The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148)
  signed into law March 23, 2010
- The Health Care and Education Reconciliation Act (Pub. L.111-152)
  signed into law March 30, 2010

Together, they're known as the Affordable Care Act, or ACA

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The Affordable Care Act (ACA), federal legislation passed by Congress in 2010 and fully implemented just this month, is a major initiative that offers opportunities to improve health insurance. I'm going to spend the next few minutes briefly discussing some of the opportunities – and some of the risks – from a broad CSHCN standpoint; our next speaker, Alison Manson, will discuss more specifics of the ACA related to children's vision and eye health.

Major Areas of Focus in the ACA

- Insurance reforms ("Patient's Bill of Rights" - consumer protections)
- New or expanded pathways to coverage (Medicaid expansion, MOE, Marketplaces), paired with Individual Mandate (everyone has to have coverage)
- Cost and Quality Provisions

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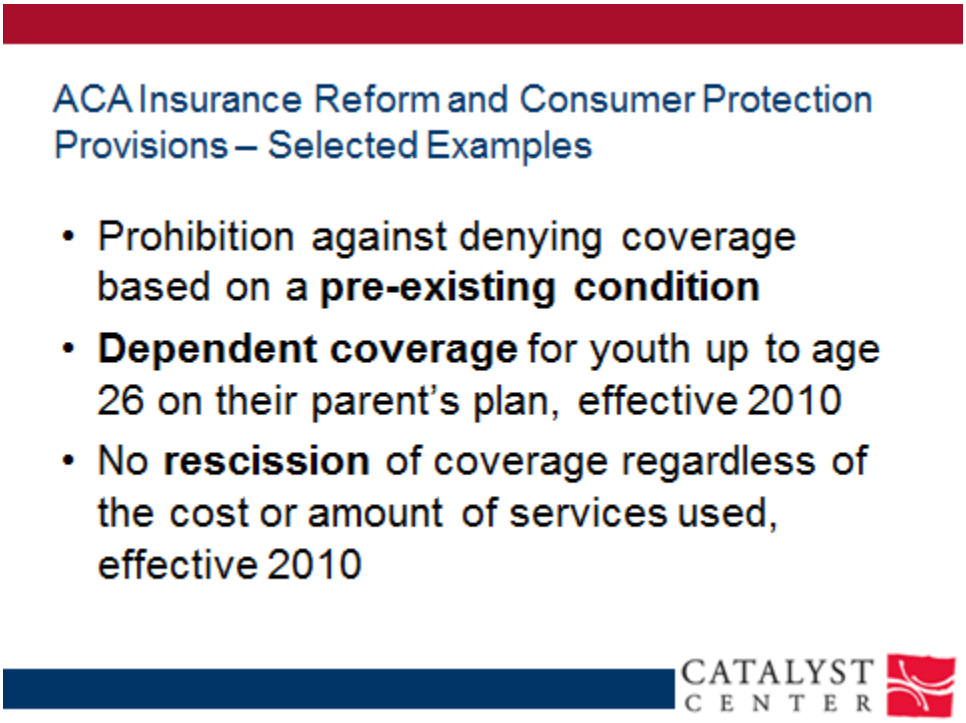
The ACA is not just the Marketplace plans, what some folks call "Obamacare." The ACA, as published by the US Government Printing Office, is 906 pages long and there are actually three major areas of focus in it:

- Insurance reforms (also known as the "Patient's Bill of Rights" or the consumer protections)
- New or expanded pathways to coverage (Medicaid expansion, the maintenance of effort provision, the Marketplace plan), paired with an Individual Mandate (everyone who can afford it has to have coverage)
- Cost and Quality Provisions

Because our time is limited, I'm going to concentrate my remarks on the first two of these areas of focus.



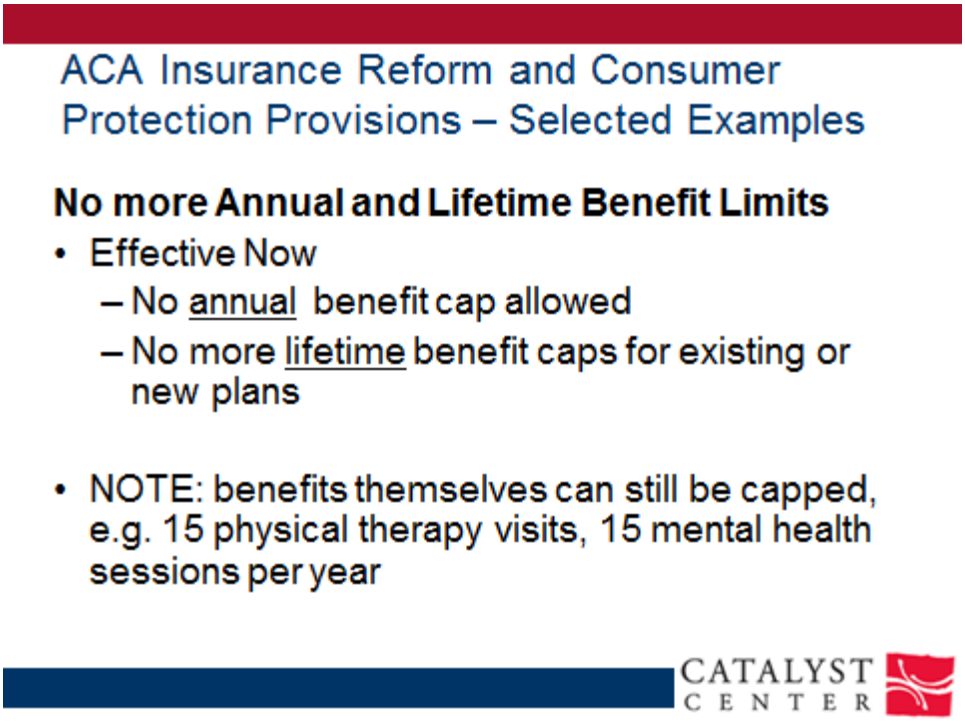
These are some examples of selected insurance reform and consumer protection provisions in the ACA that have specific relevance to CSHCN. I'm going to use the term "provision" a lot – it means a part of the ACA that "provides for" a certain thing either being required that it be done or prohibited from being done, and it sometimes also includes funding – it can also be known as a "Section" along with the relevant number from the final legislation. For example, the first provision on the bulleted list that you see here on the slide is also known as Section 2701.

The three provisions on this slide are some examples that have special meaning for kids with special health care needs:

- Prohibition in the ACA against denying coverage based on a **pre-existing condition – no more job lock** So families of kids who have private insurance who previously may have been unable to change their jobs, take a promotion, move their families to take advantage

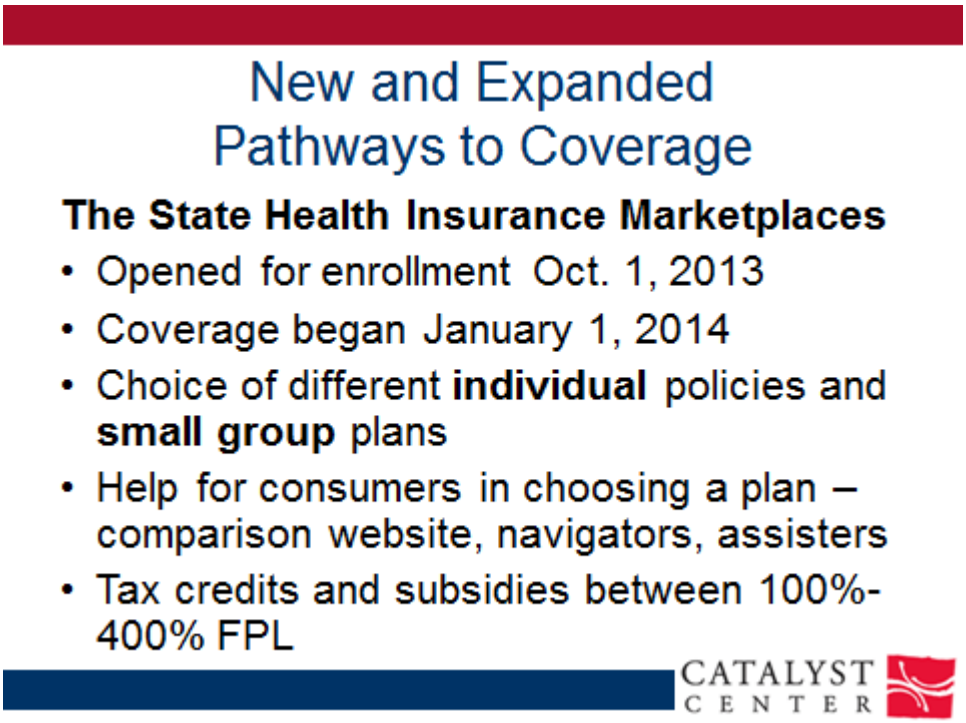
of other opportunities because they were afraid of losing their employer-sponsored coverage, they were afraid that their child's pre-existing condition wouldn't allow them to re-enroll in different kinds of insurance—that will no longer happen to them. They'll have more flexibility in being able to make different kinds of choices for their family, based on this prohibition.

- **Dependent coverage** for youth up to age 26. They can stay on their parent's plan, that became effective in 2010. A recent report by the CDC showed the rate of uninsurance among young adults has dropped significantly since this provision began; it's especially important for youth with special health care needs who may have become uninsured when they were no longer eligible for coverage under their parents plans previously and who were not eligible for Medicaid for a variety of reasons.
- No **rescission** of coverage regardless of the cost or amount of services allowed in private insurance; that became effective in 2010. So there's no more getting kicked off coverage when you need it, when you start using services.



Here's another example of a consumer provision that's important in the ACA: there are now no more lifetime and annual benefits limits permitted. Originally there were no lifetime benefit limits allowed in the ACA and the amount of money that a private insurance company could limit coverage for gradually increased over time, but now there is no annual benefit cap allowed either. So this is another example with particular relevance for kids with special health care needs. Previously we had situations where babies would be discharged with private insurance from the newborn intensive care unit (NICU) and they would have already reached their lifetime benefit cap. That will no longer happen.

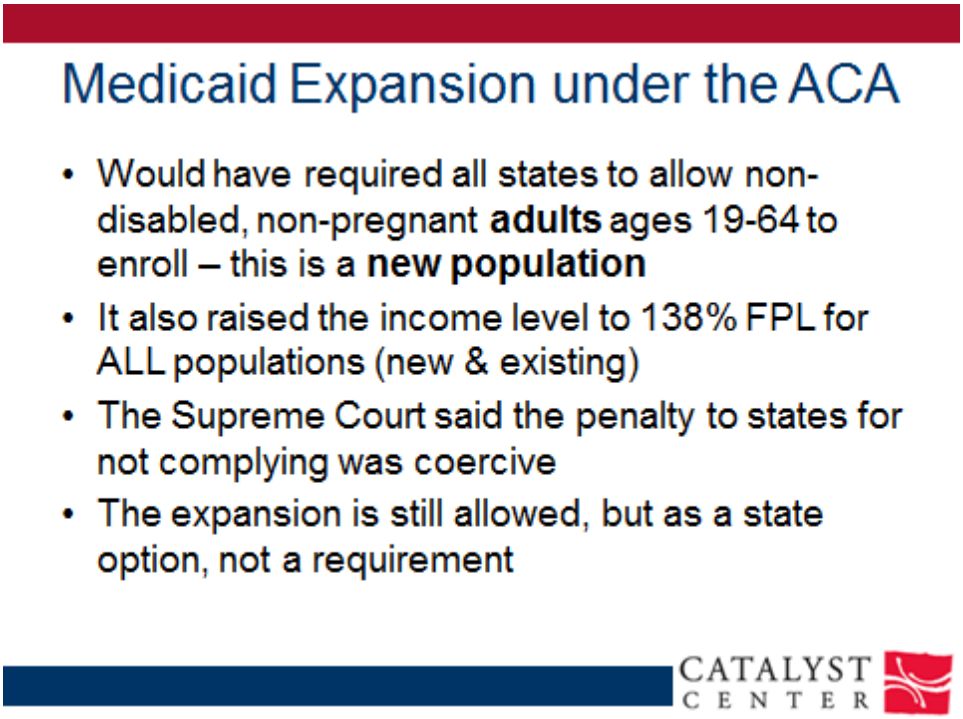
NOTE: There is a caveat associated with this provision that I think is important to mention. Benefits themselves can still be capped, so when we talk about no annual or lifetime benefit limits, we're talking about *dollar* amounts. *Specific benefits themselves* can still be capped. So a private insurance company can't say you have $5,000 of mental health services available to you, but they can say you have 15 mental health sessions per year available to you.



I'd like to turn our attention now to the new and expanded pathways to coverage; I'll talk about these in a bit of detail. The first is the State Health Insurance Marketplaces. I'm sure you've all heard about this in the public media as well as in your own personal lives. Primary among the new and expanded pathways to coverage are the State Marketplaces. I use the term state because they ARE state-specific, however, in approximately half of them, they are being run by the federal government or in partnership with it. They opened for enrollment on Oct 1st –a day that will live in infamy in health technology–and began covering enrollees on January 1st. The Marketplaces offer a choice between different individual policies and small group plans.

If you don't have access to large-group insurance, you are eligible for coverage through your state Marketplace and if your family income is between 100-400% of the federal poverty level, you may also qualify for tax credits and subsidies. If you're eligible for large-group insurance, you can consider switching to a Marketplace plan. But you won't qualify for the tax credits and subsidies unless the job-based insurance you're eligible for is unaffordable or doesn't meet other minimum requirements.

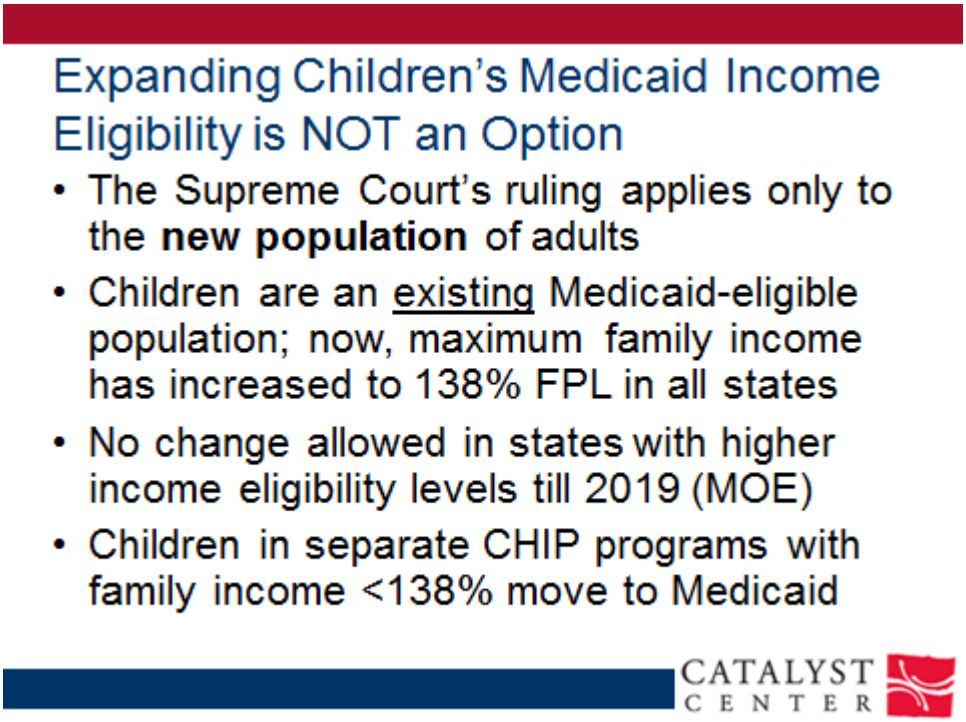
Health insurance is a big decision. There is help for consumers in making choices about what plan or policy might be best for them and their families on the Healthcare.gov website, the individual state-run Marketplace websites, through consumer navigators, assisters and brokers.



Another pathway to coverage through the ACA is the Medicaid expansion; I'm sure many of you have heard about this.

- The Medicaid expansion as it was originally written in the ACA would have required all states to allow non-disabled, non-pregnant **adults** ages 19-64 to enroll in Medicaid – this is a **new mandatory population** – a tiny handful of states had optional waivers to allow coverage of this group before the ACA, but not many.
- The Medicaid expansion part of the ACA also raised the income level to 138% of the poverty level for ALL populations, both new and existing
- The Supreme Court in its decision on the constitutionality of the ACA said the penalty to states—if they didn't expand their Medicaid eligibility, they would lose all their federal funding for their entire Medicaid program—they said that penalty for not complying with this new rule was coercive, not fair, and unconstitutional
- So the expansion is still allowed under the court's decision, but as a state option, not a requirement

For youth and young adults with special health care needs, especially those who do not have access to affordable, employer-sponsored insurance and who do not meet the strict standard of disability for Medicaid coverage, the Medicaid expansion will open up a pathway to coverage that has much lower cost sharing than private insurance. For states that do not take up the expansion, uninsurance among non-disabled, non-pregnant adults will continue to be a problem.



We've just been discussing the Medicaid expansion for adults. The Supreme Court's ruling applies only to the *new mandatory population* of adults

- Children are an *existing* mandatory Medicaid-eligible population; now, minimum family income has increased to 138% of the federal poverty level in all states for their Medicaid eligibility

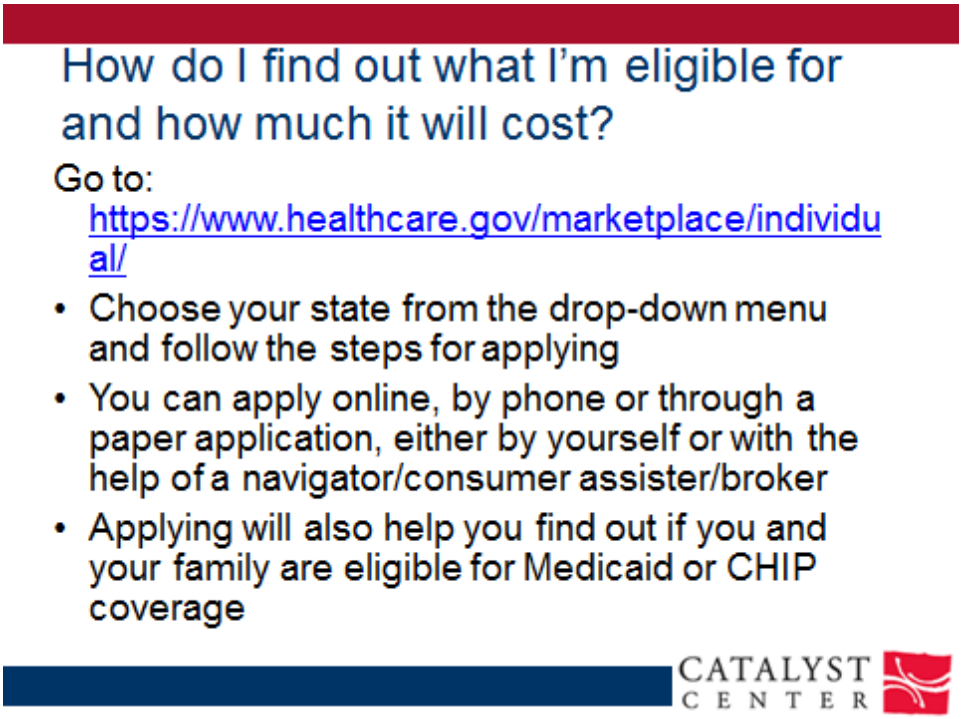
- There is no change allowed in states with higher income eligibility levels till 2019. Sometimes folks look at me with dismay when they hear that the ACA is requiring that States have eligibility for kids at 138% of the federal poverty level; they say our state already goes above and beyond that—are we going to lose something? No, because of a provision in the ACA called Maintenance of Effort or MOE, states are not allowed to lower their income eligibility for children or change their enrollment or renewal processes to make it harder to get into and stay in Medicaid. States CAN raise their income eligibility and in those states where it was below 138% of the FPL for kids, they are required to do so. The floor is going up but the ceiling is not coming down. As I mentioned already, MOE remains in effect for kids until 2019.

- Children in separate CHIP programs with family income of less than 138% of the federal poverty level are going to move to Medicaid

  There is no to very low cost sharing in Medicaid for kids, so this is actually good, the expansion of Medicaid in terms of eligibility for kids across all ages as well as moving kids from separate CHIP programs to Medicaid is actually a good thing because they have access to coverage that has either no or low cost sharing included in it, no premiums, no co-pays, no deductibles. And they have access to a benefit package called EPSDT—Early Periodic

Screening, Diagnosis and Treatment. So there are better benefits than in CHIP or in private insurance.

Alison will go into more detail with regard to specific vision screening and services under EPSDT in just a moment, but this is a good thing for kids in general, not just kids with special health care needs, but in particular for them.



So I've covered a fair amount in a very brief period of time – you may be wondering, what does all this mean for me or the families I work with? How do I find out what I'm eligible for under these new options and how much it will cost? The most straightforward suggestion I can make for a national audience is to go to the weblink on the screen www.healthcare.gov

Choose your state from the drop-down menu and follow the steps for applying

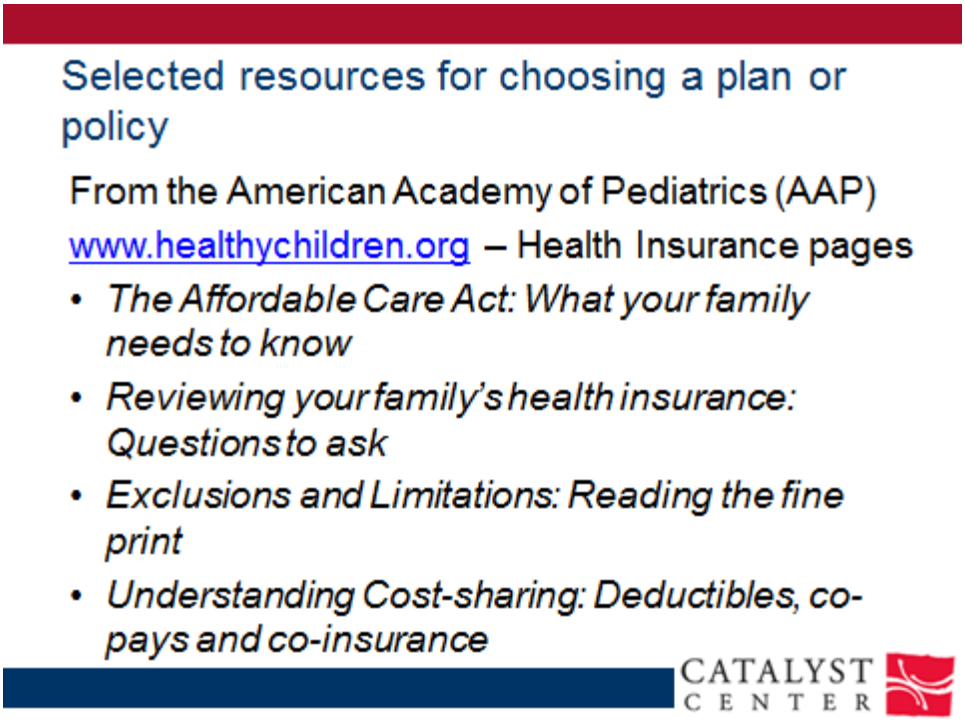
You can apply on this website, or you can just do a comparison to see what you might be eligible for and how much it might cost. You can apply online, by phone, or through a paper application, either by yourself or with the help of a navigator/consumer assister/broker.

Applying will also help you find out if you and members of your family are eligible for Medicaid or CHIP coverage. This is one of the reasons why the rollout of healthcare.gov was as complicated as it is. It's actually doing a lot of different things at the same time. It's looking at what you're eligible for, it's making assessments of your income, what programs are available in your state, and it's also doing an assessment not just of private marketplace and benefit plans, it's also looking at Medicaid and CHIP. And it's doing that for all your different family members.

I understand that it's getting easier to use. We talk to a lot of folks who are navigators and assisters in the individual states, and they're telling us it's getting easier to use, so I would encourage folks to give it a shot and to report to their state Marketplace if they have specific

questions or problems. Working with a navigator or consumer assister can certainly be helpful too.

If you go to the contact us page at https://www.healthcare.gov/contact-us/ you will see phone numbers to call, you can start an online chat, or if you put in your city and state or ZIP code, you can find out who the people and organizations in your community are who can help you apply, enroll, and answer your questions.



Some folks like to read background materials themselves before jumping into health insurance decision-making, either independently or with the help of a navigator or assister. There are a lot of excellent materials out there but one of the primary sources we like comes from the American Academy of Pediatrics. Go to the weblink on the screen: www.healthychildren.org – and then go to the Health Insurance pages. You'll find short articles on a variety of health insurance topics that have been specifically written for parents, including:

The Affordable Care Act: What your family needs to know

Reviewing Your Family's Health Insurance: Questions to ask

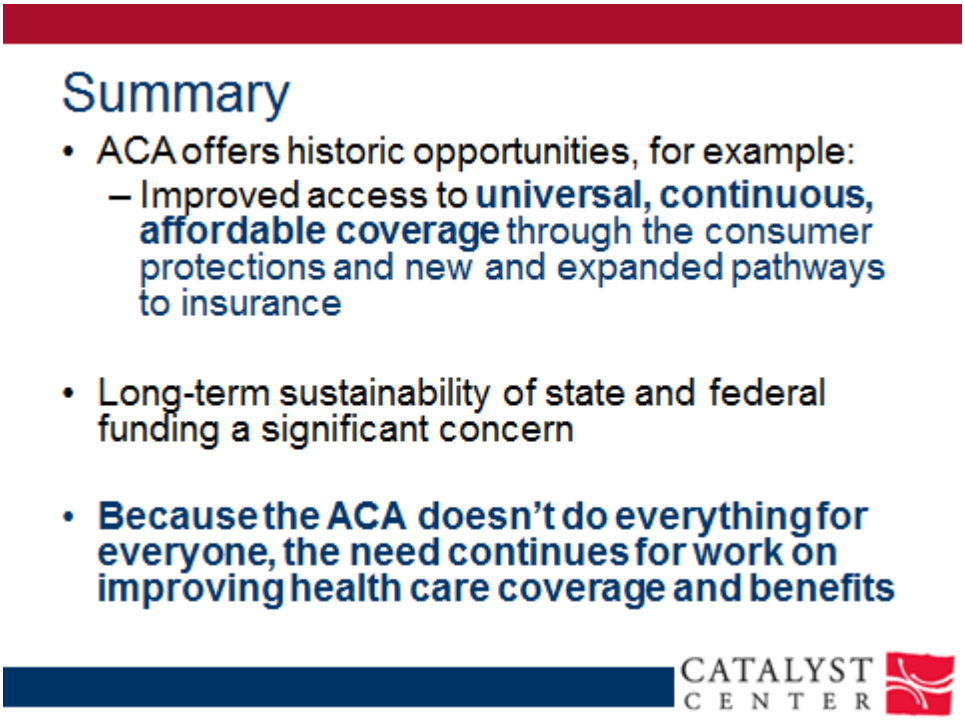
Exclusions and Limitations: Reading the fine print

Understanding Cost-sharing: Deductibles, co-pays and co-insurance

I know a lot of families who have found these pages very useful. They are materials developed by the American Academy of Pediatrics, not just from a professional policy standpoint, but they've also been tested with families, so that's helpful.

Here are some other resources that are available, including:

- the State Family to Family Health Information Centers – there is one in every state and DC and they are staffed by trained, experienced families of kids with special health care needs who not only know ABOUT the system but how it works, because they use it themselves
- The Catalyst Center (this is the shameless plug portion of the presentation) – we have an extensive array of policy briefs, white papers, archived webinars and other resources to help you learn more about the ACA and other strategies for improving health insurance coverage and financing of care
- And finally, as I mentioned previously, healthcare.gov for access to the Marketplace comparison website and contact information for the navigators and assisters in your state. One way to gain access to these folks is though healthcare.gov or through your state marketplace website—they can provide contact information for your state's individual navigators and assisters.



To summarize, the ACA offers historic opportunities for improving health insurance for CSHCN, for example:

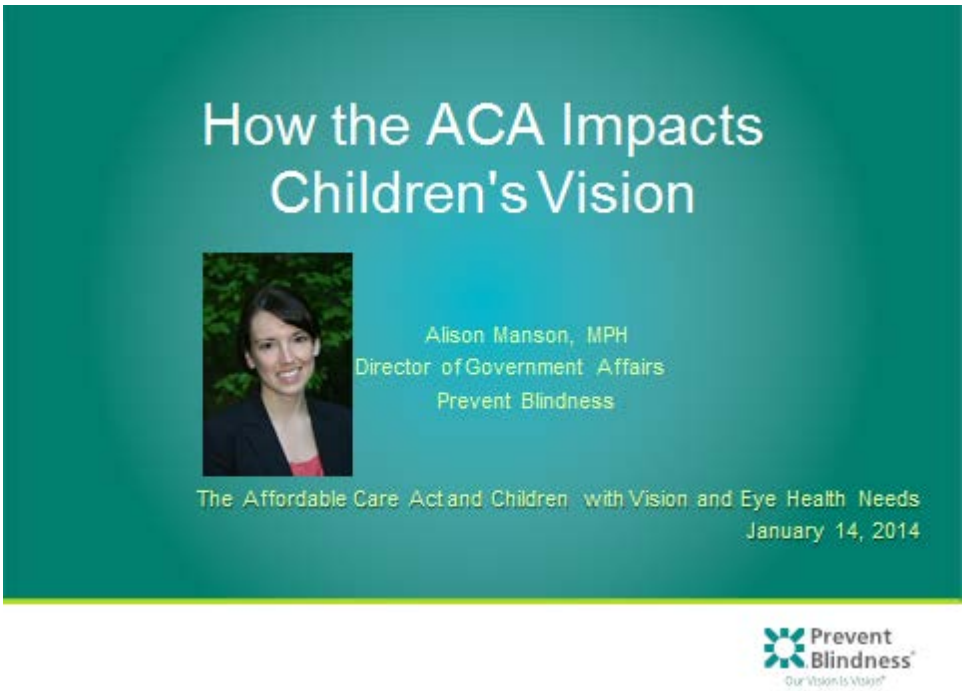
Through Improved access to **universal, continuous, affordable coverage** via the consumer protections and new and expanded pathways to coverage

Whether these opportunities turn into real progress remains to be seen but we're tracking with our family leader partners what's happening on the ground for kids with special health care needs and their families and we'll keep you informed

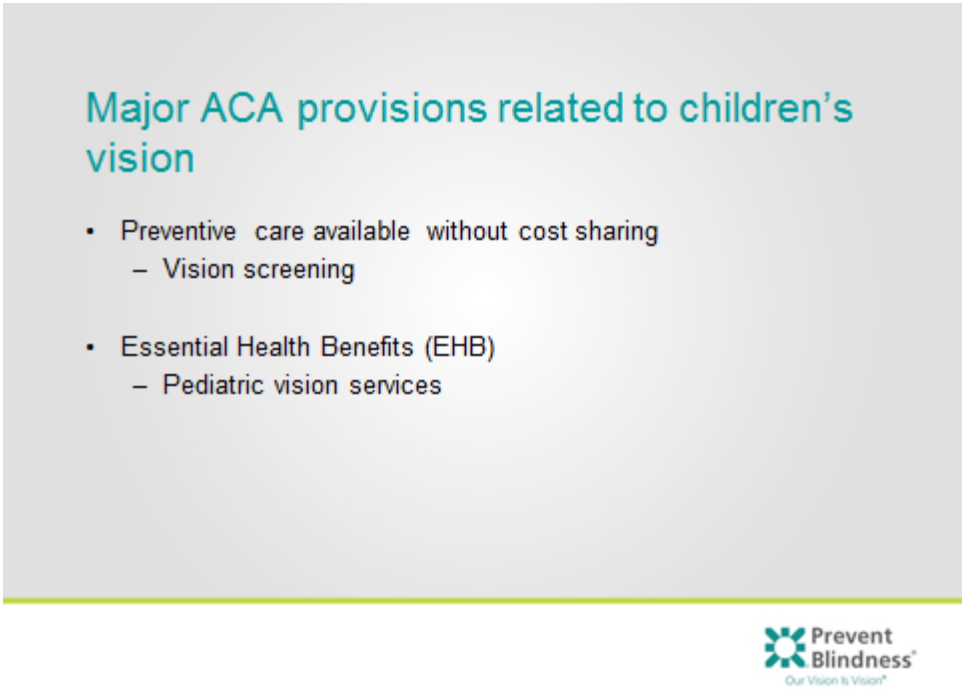
Long-term sustainability of state and federal funding is a significant concern, so that's something we all need to be aware of and keep an eye on.

And finally, because the ACA doesn't do everything for everyone—and Alison is going to go into a bit more detail on this—the need will continue for work on improving health care coverage and benefits for kids with special health care needs.

I'm going to turn this over now to Alison Manson. Alison, the floor is yours

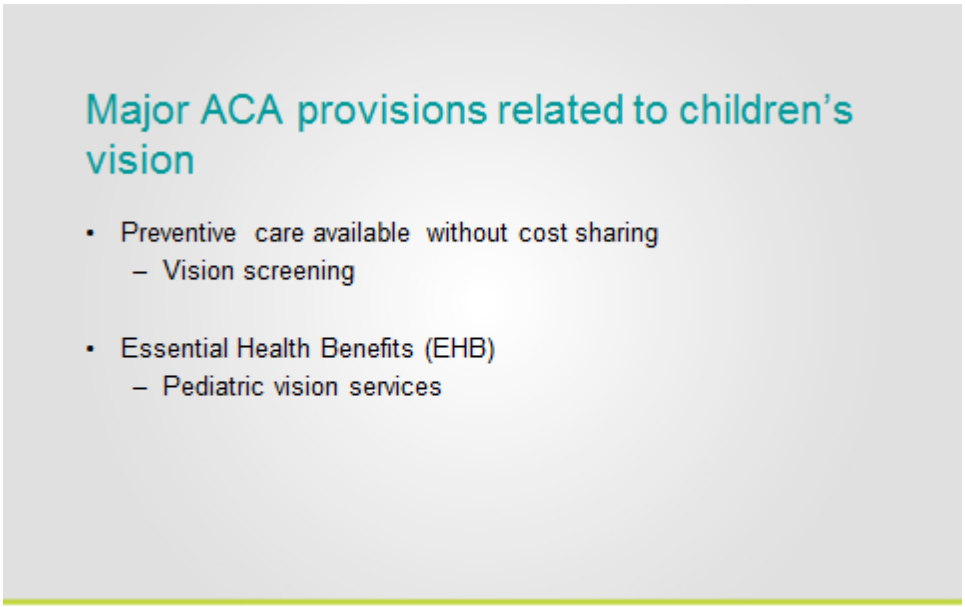


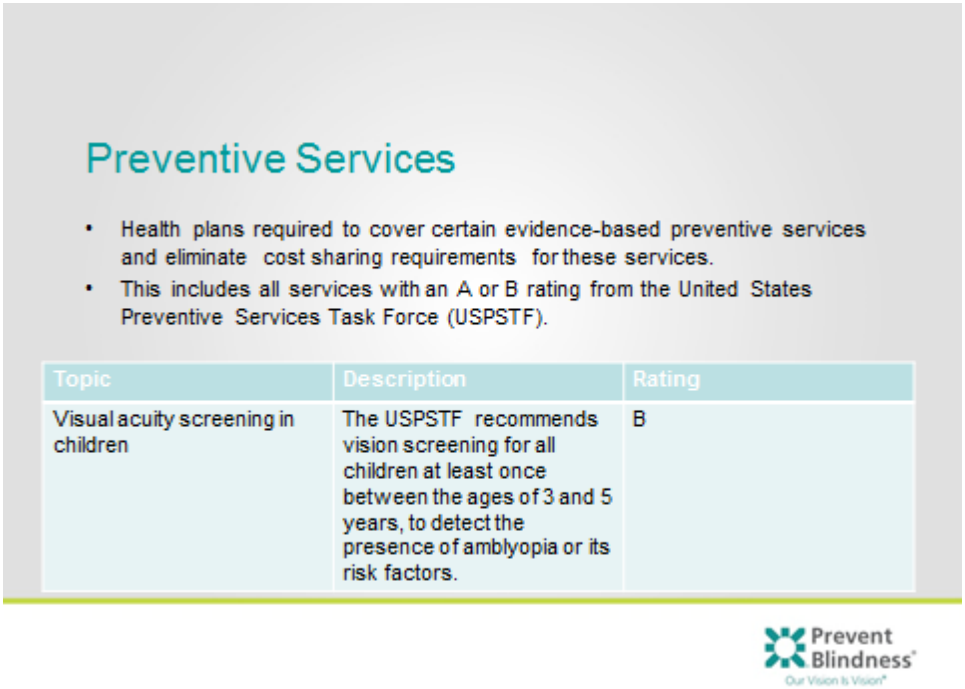
Alison Manson: Thanks Meg. I want to start by saying that Prevent Blindness is the nation's leading volunteer eye health and safety organization. We're dedicated to fighting blindness and saving sight in a variety of ways. We are also the home to the National Center for Children's Vision & Eye Health. I want to reiterate what Meg said. The ACA should increase the number of people covered. It should increase people's points of contact with the health care system, and that is a good thing for helping kids to get eye care.



I'm going to talk first about what's in the law, what it's designed to do, but in the end I'm going to throw in a bunch of caveats. There are two major ACA provisions related to children's vision. The first is that preventive care is now available without cost sharing. That includes vision screening.

The second is the creation of Essential Health Benefits—10 categories of services that have to be covered through qualified health plans, and it does include pediatric vision services.





Health plans are required to cover a certain set of preventive services with no cost sharing--No copays, no coinsurance, no deductibles, as long as you're in network, and those services are in part determined by the U.S. Preventive Services Task Force (USPSTF).

What is the USPSTF? An independent panel of primary care providers, experts in prevention and evidence-based medicine. They review the available scientific evidence for a broad range of

clinical preventive services and then make recommendations and give ratings for those services. An A or B rating from the USPSTF means the services are covered as a preventive service without cost sharing. That includes visual acuity screening in children.

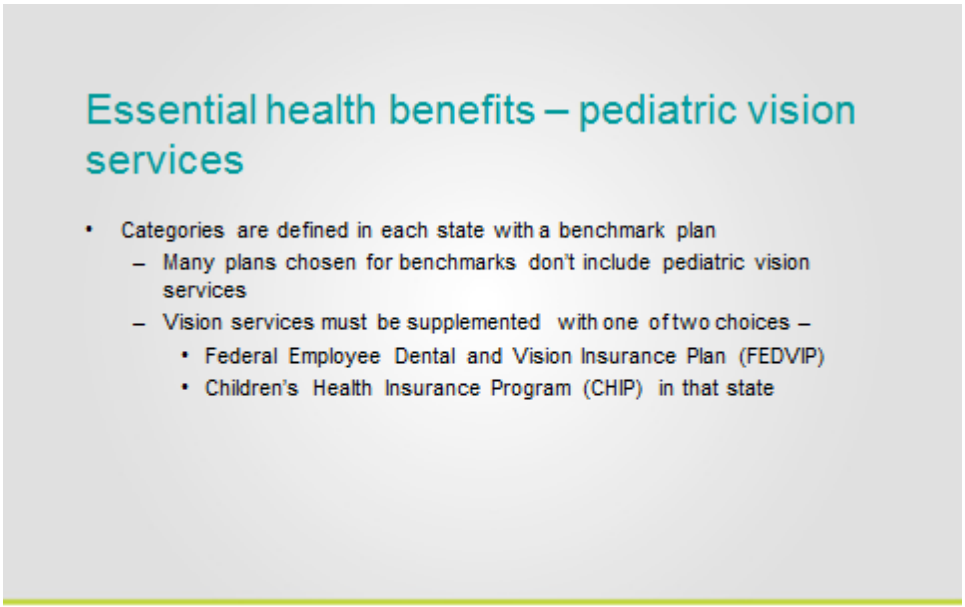
This applies only to children ages three to five, and the vision screening would likely occur in the pediatrician's office as part of a well-child visit.

Kids are also screened in school, in child care, and in public health settings, but those screeners are likely not reimbursed because those entities don't have a relationship with the insurance company. So you're only going to see reimbursement for services that are offered by your doctor or your doctor's office.

There are, of course, a number of children who won't be screened in the pediatric setting for a huge variety of reasons, so I want to stress that those other screenings are likely to remain important. This does not eliminate the need for screening in all those other settings. They are going to be key for access to the health care system for a lot of kids.

But it does mean if your family was previously charged for a vision screening at the pediatrician's office, that service will now be free for you, in network.

Among those 10 categories of essential health benefits, pediatric services, including oral and vision care, are one of the ten. But the law doesn't specify what exactly each category has to include.



In order to define those categories, each state has a benchmark plan. Those are essentially examples of broadly used plans—the largest small-employer plan in the state or the state employee plan, plans like that that already have a reasonable market share that were thought to represent reasonable definitions of these benefits. However, a lot of those benchmark plans didn't actually include pediatric vision services. So in order to get that included in the benchmark, they had to supplement them. For the most part, they were supplemented with the Federal Employee Dental and Vision Insurance Plan (FEDVIP). Forty-two states chose to use the FEDVIP benefit. Otherwise they could also supplement with the Children's Health Insurance Program (CHIP) vision benefit.

Plan	FEDVIP	CHIP	Included in plan
Eye Exam	Covered, 1 per year	Covered, frequency varies by state	Mostly covered, varies by state
Glasses	Covered, one pair frames and lenses per year	Covered, frequency varies by state	Sometimes covered, varies by state
Number of states choosing	42	3	6

Prevent Blindness
Our Vision Is Vision®

Under FEDVIP, there is one eye exam a year and one pair of frames and lenses every year. In 42 states, that's the vast majority of kids who are going to be affected by the essential health benefits. CHIP programs provide vision benefits a little bit differently. They do cover eye exams and they do cover glasses, but with different frequencies. It might be a pair of lenses every year but only a pair of frames every other year, and maybe it's only an eye exam every two years. For 6 states, the benchmark plan they chose included vision services from the very beginning. So they vary even more and they are less likely to cover glasses.

Pediatric vision services in each state

States choosing FEDVIP: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

States choosing CHIP: Kansas, Kentucky, North Dakota

States with pediatric vision services included in benchmark plan: Colorado, Maine, Massachusetts, New Mexico, New York, Utah

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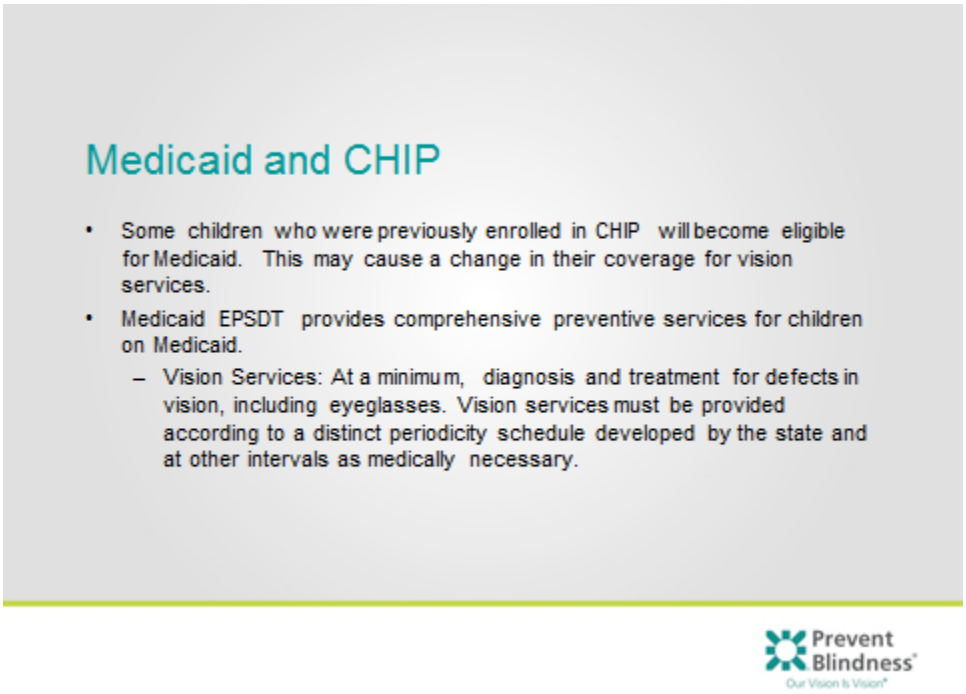
For your reference, these are the states that chose each of the three options, so you know what your state is doing for vision services.

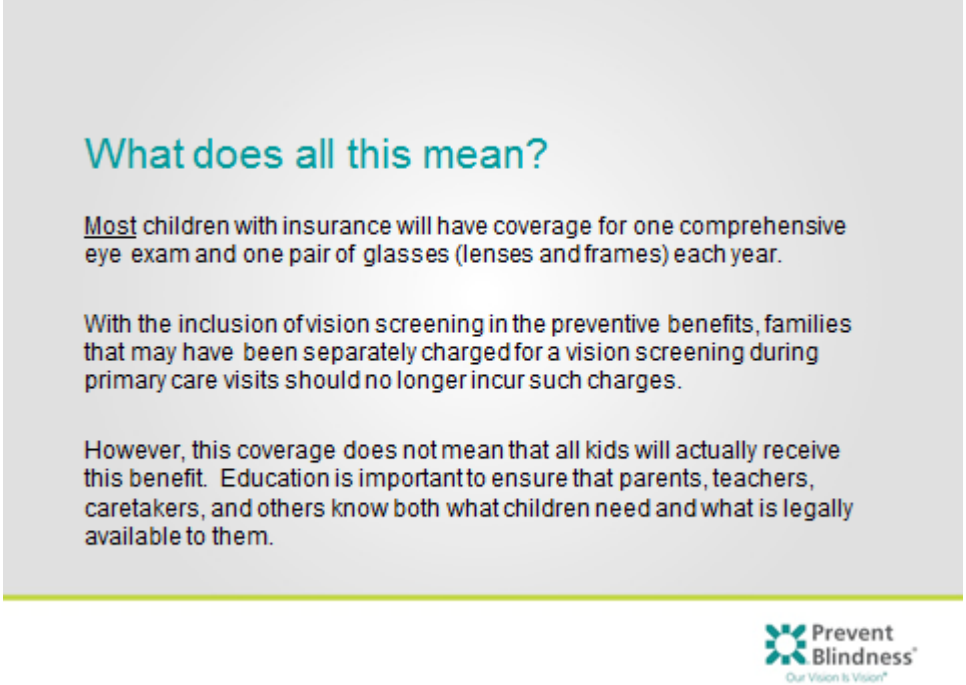
Essential health benefits don't apply to everyone. They do apply to all health plans in the individual and small-group market, both inside and outside of the insurance exchanges. But it doesn't cover large-group plans, grandfathered plans that don't have to submit to the ACA requirements, self-funded plans, or ERISA plans. The assumption behind that exemption is that those large plans already are very generous and cover most of the essential health benefit categories. But it does mean that there isn't a guarantee for kids covered by those plans.



As Meg mentioned, some children who were previously enrolled in CHIP will be moved into the Medicaid program. That's going to be a change for their vision services. It's mostly a good change; Medicaid coverage is pretty good. Medicaid varies by state but has some basic required benefits. This includes the Early and Periodic Screening Diagnostic and Treatment benefit. It sets the minimum for what vision services have to include: diagnosis and treatment including eye exams. Now the states can of course decide on the frequency of those benefits on their own, so the frequency of the vision benefit in Medicaid varies by state. But it's a decent benefit—kids in Medicaid are going to get pretty good eye care.

CHIP is structured a bit differently and so benefits vary by state.

We have a fact sheet available on our website that summarizes all of the things you need to know about children's vision and the Affordable care Act.



I want to wrap up by looking at a five-year old, so they can be within that 3-5 age range for screening. The family previously had no health insurance. The family may have made too much money to be covered by Medicaid or CHIP but health insurance premiums were just

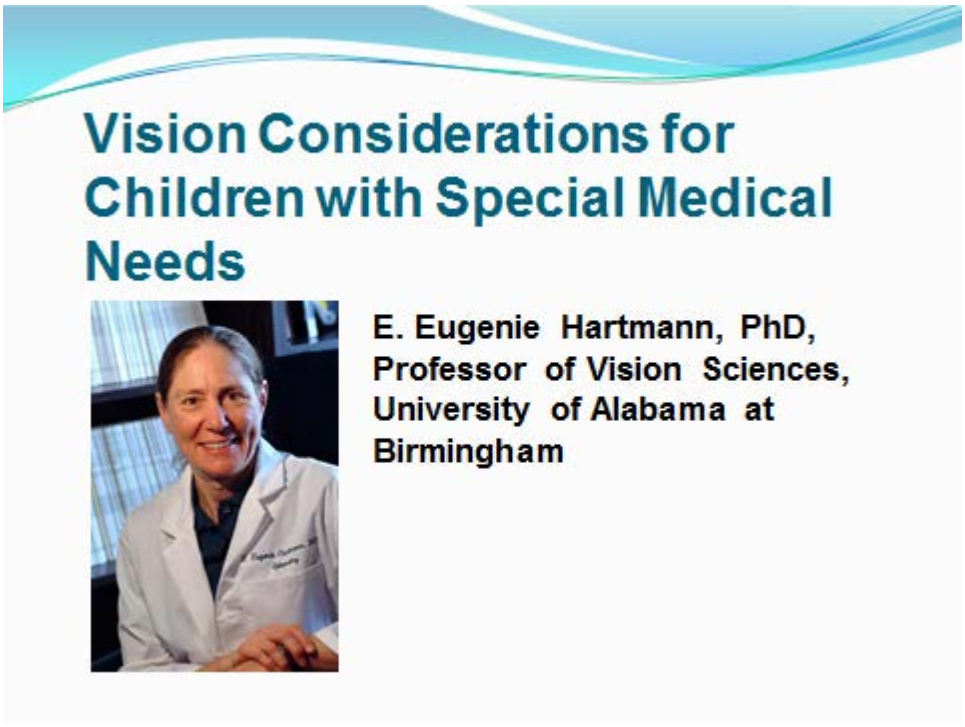
unreasonable. They now are receiving a subsidy and they can purchase insurance through the exchange and the child is now covered. Whereas before, maybe they went to the doctor's office for a well-child visit and they were charged for the vision screening that happened as a part of that, or that vision screening didn't happen because there was an additional charge. Or maybe they were screened at school or their child-care setting, a problem was identified but because they didn't have insurance that would cover an eye exam or glasses or maybe combine it with some other reasons, that child didn't get to the eye doctor's office for follow-up. They never got glasses, their vision was never corrected.

But after the Affordable Care Act, their family now has insurance, that screening was covered as part of the well-child visit, maybe they were also screened at school but that is another conversation to have, a problem was identified, they get to the eye doctor's office where they are able to have a comprehensive eye exam, get a new pair of glasses and frames, and then not only have they corrected their vision for the time being, they also hopefully have established a relationship with that provider so in the future they can keep going back, keep making sure that that prescription is correct, that the kid stays in glasses that fit them, and serve their needs in school, in sports, etc.

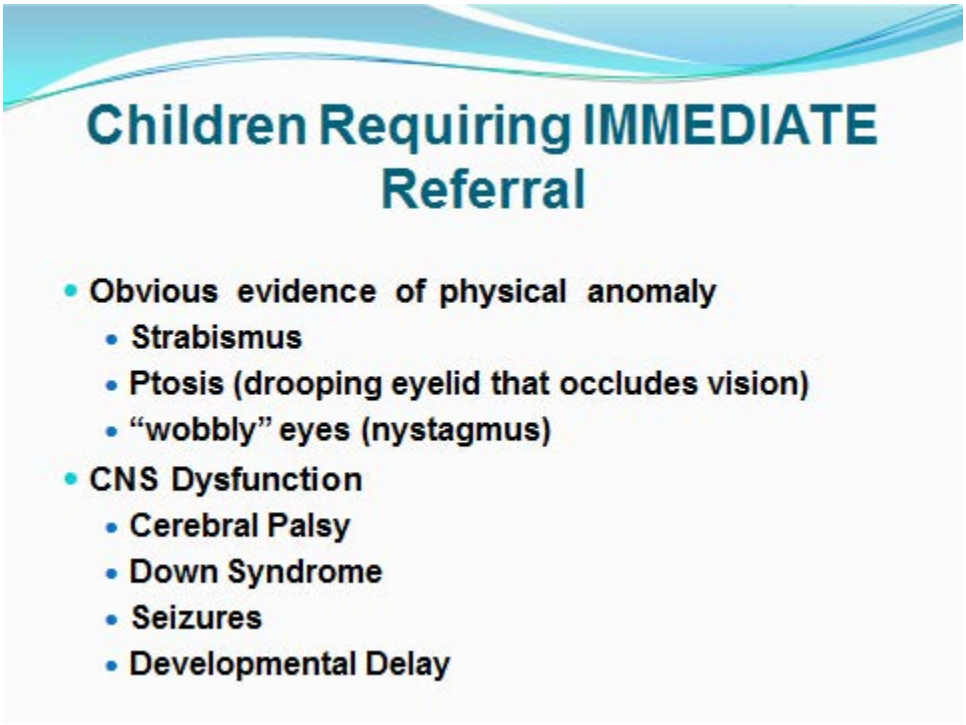
But for that to happen, everything has to go right. There's a whole set of steps. First the kids who are eligible for subsidies or for Medicaid or for CHIP have to be enrolled in those programs. You have to have doctors who are willing to see them, which is a matter of both reimbursement from the health plans or from Medicaid or CHIP, and it's a matter of education, making sure that our health education system is actually producing enough doctors to see the kids, to meet the demand. You also have to have deductibles and copays for those exams, which of course they aren't a preventive service that's available as a copay or cost sharing. The out-of-pocket costs have to be within reach for the family. None of that is guaranteed.

We also know that parents and caregivers don't always understand the importance of the eye exam or the vision screening. There are 100 other reasons that the child doesn't receive the vision care that they need. So all of these systems have to work together in order to get all the pieces, correct their vision and give them a healthy start in life. Most kids though, with health insurance will have coverage for one exam and one pair of glasses per year. And that's a fantastic start.

Now I will hand it off to Dr. Hartmann.



Eugenie Hartmann: Thank you. I'm a vision scientist who has done a lot of work with young kids, trying to figure out how to evaluate their vision.

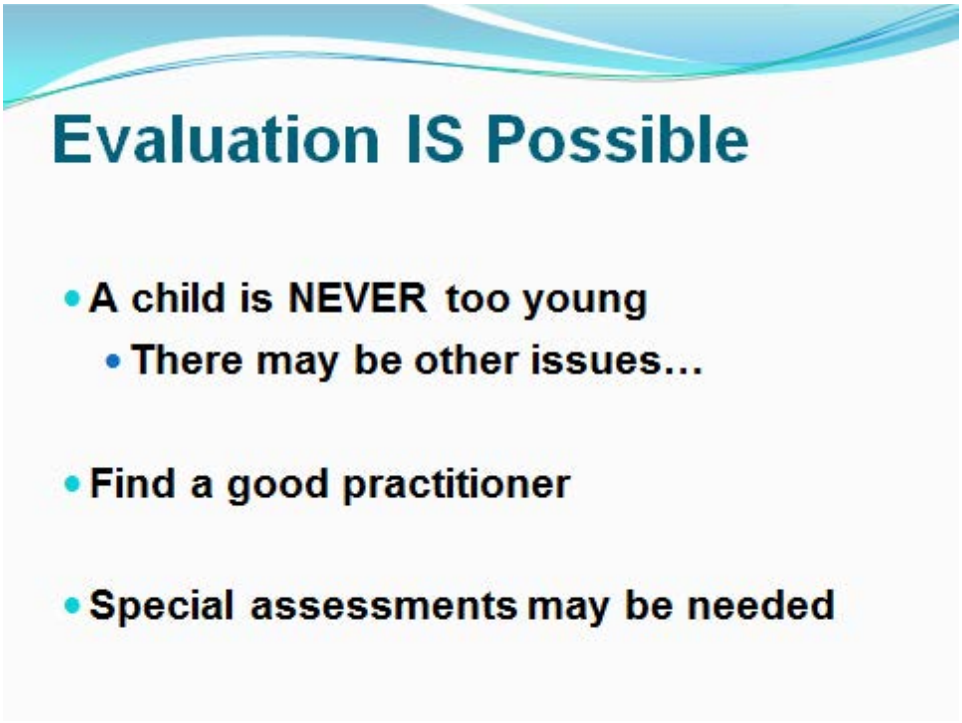


There are some children who should be seen by an eye care specialist from the very beginning, as soon as the parent notices any major issues with the eye, like a crossing of the eyes (strabismus) or if one of the eyelids droops and covers up that eye, or if the kids have wobbly eyes—nystagmus—basically, their eyes are oscillating back and forth all the time. That can happen in really young babies, that their eyes aren't steady all the time, but most of the time, but after about three months, they should be pretty steady.

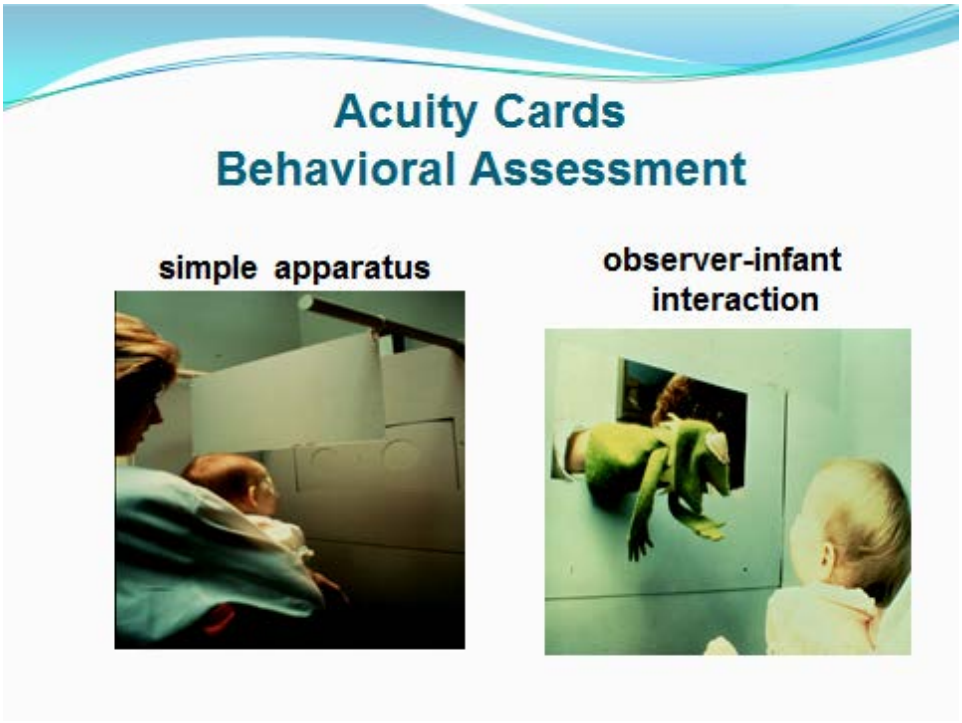
Another group of kids that should be seen by an eye care specialist are any that have a central nervous system dysfunction: kids with cerebral palsy or Down syndrome, seizures or developmental delay. Some of those kids may end up being determined to have cortical vision impairment, which is probably one of the most frustrating diagnoses for a parent to get because often it's really difficult to test those kids and, depending on the provider that you find, you may or may not get a very good answer.

Some of the kids that are at high risk for other issues and who should be referred to an eye care specialist are:

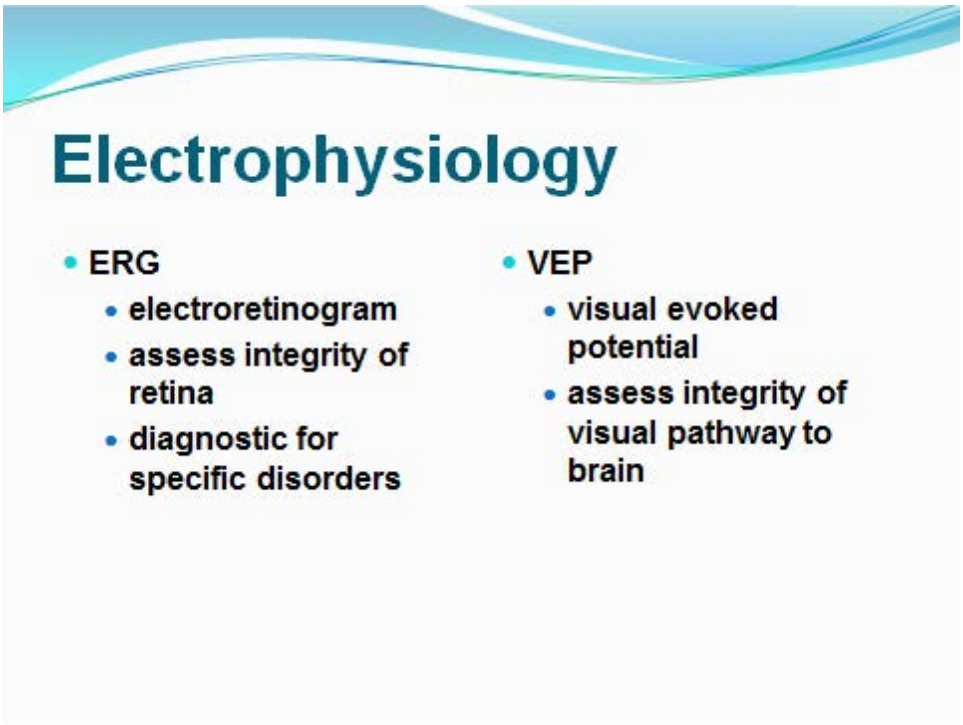
- Kids who are on the autism spectrum
- Any child who is enrolled in an early intervention program should be referred to an eye care specialist. Typically as part of an educational plan, children who are enrolled in an early intervention will get some kind of vision screening but early intervention is from 0 to 3, so a comprehensive eye exam is a good idea for those kids because screening strategies are not terribly reliable at that age.
- Any kids who have a family history where somebody had amblyopia or "lazy eye," any crossing of the eyes, or any other early eye disease. If the parents know that either one of them had some issue, another of their children had an issue, or even a first-degree relative of the parent, it would be worth having that child evaluated by an eye care professional.
- Kids who are products of a high-risk pregnancy, if there was alcohol use or drug use or any sort of maternal infection.
- Any child who is preterm, depending on how early a child might be, they will probably get some exam in the NICU before they are released from the hospital.



As I mentioned, sometimes it's really hard to get your kid evaluated, but age is not a factor. My steady line is a child is never too young. They may be uncooperative but age is not the issue. It's really important that you find a good practitioner and you may need to go out of your way as a parent or an advisor for parents to get special assessments onto the docket for this particular child. But if you're not satisfied with what you're getting from a particular eye care provider, there is probably somebody else who will be more helpful.

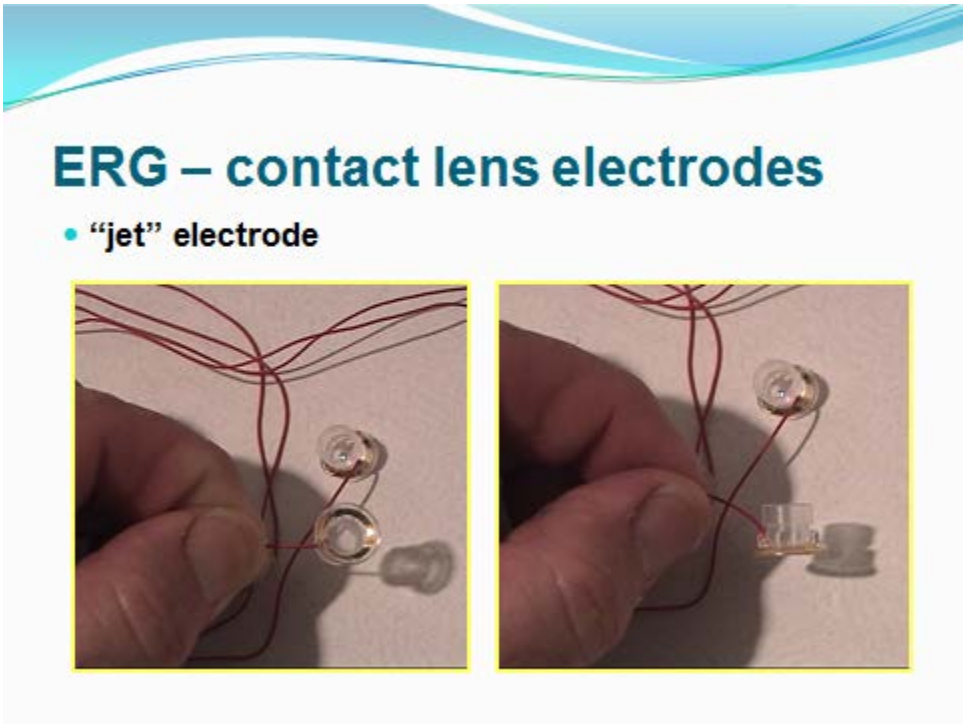


This is one of the assessments that might be done. It's a behavioral assessment: having a child look at stripes on a gray screen and we can actually get a visual acuity from these kids that way. It's something that is not always done by an eye care provider within a general office, but typically at universities or larger medical centers, this kind of testing is available. It's simply watching what the child will look at in a very controlled manner.



Another kind of assessment that might need to be done is an electrophysiology assessment. An ERG is an electroretinogram which assesses the integrity of the retina, the back of the eye where the photo receptors are. That's where the light goes in and starts a cascade of events to get your brain to say what you see. It can be used diagnostically for specific disorders. It's not very often needed, but sometimes it can be very helpful.

A visual evoked potential (VEP) is similar to an EKG or an EEG where we are looking at electrical activity in response to specific visual patterns, and that assesses the integrity of the visual pathway from the back of the eye up to the brain, at least to the first portion of the brain.

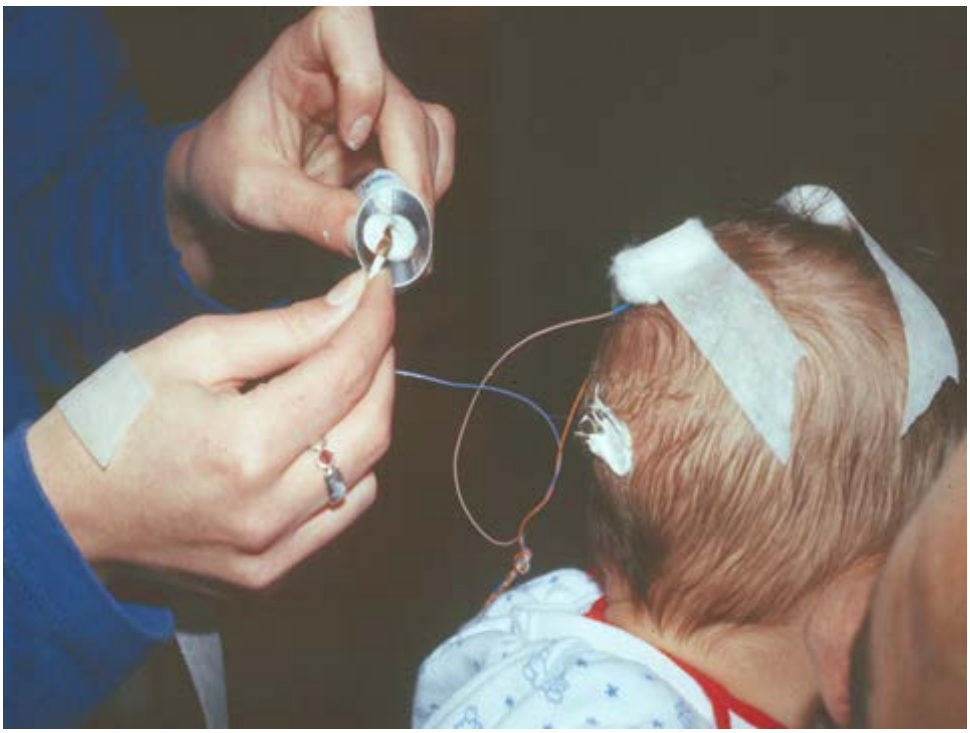


This just shows some of the lenses that are used for ERGs. They sit on the eye, the contact lens.

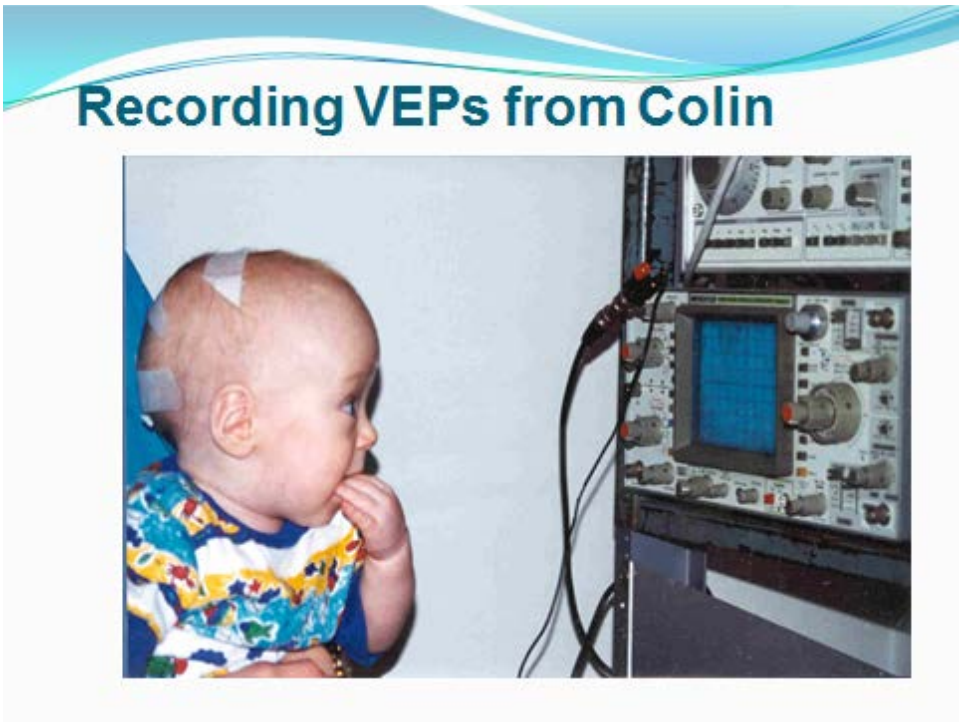
This is a kind of display where a light would flash inside that bowl.

This is a setup that I've used where we have the patient lying down underneath the Ganzfeld. They are very comfortable and we can do this with very young kids.

A visual evoked potential (VEP) is similar to an EKG or an EEG where we are looking at electrical activity in response to specific visual patterns, and that assesses the integrity of the visual pathway from the back of the eye up to the brain, at least to the first portion of the brain.



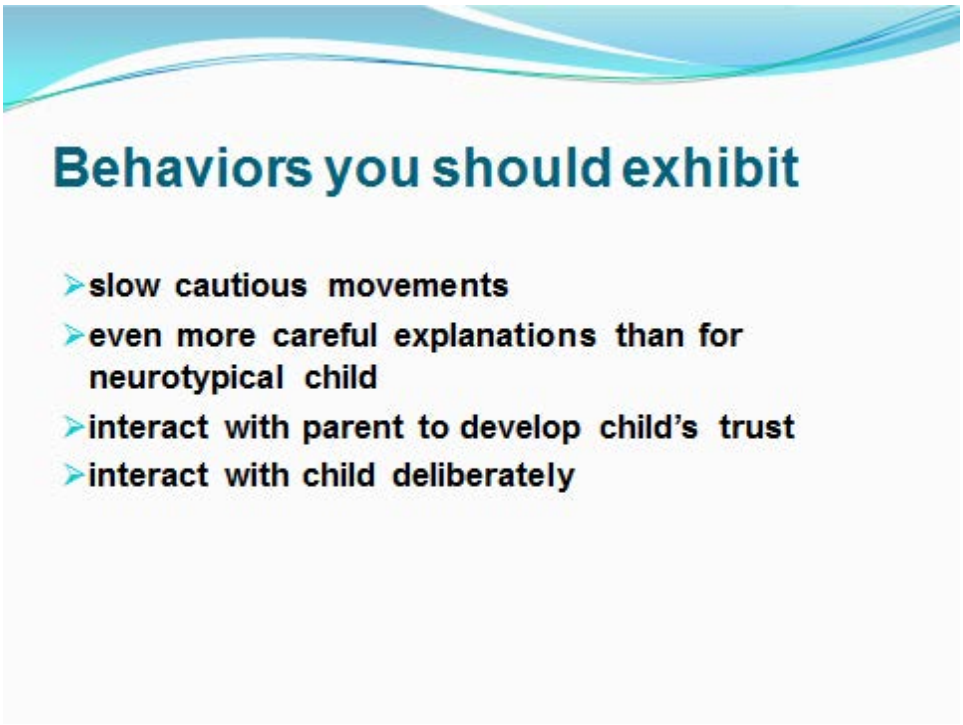
This shows the scalp electrodes being put on a young infant.



This is actually my son a few years ago. He is watching an oscilloscope, that's the blue screen to the right, and he's watching his brain waves.

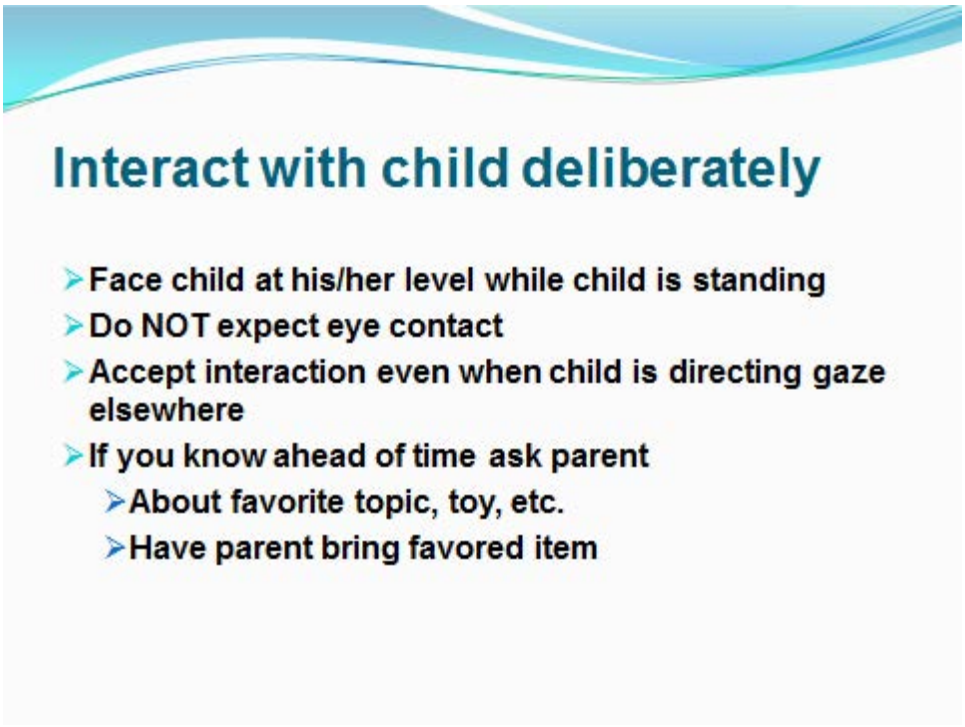
These are some of the guidelines that I've shared with eye care providers to help parents and kids get a good exam. You need an environment where they get to know the person, there's a spirit of cooperation. The provider should be giving good directions so the kid knows what's going on. A 3-5 year old needs to feel like they're participating in all of this.

Some of the things kids might do is be apprehensive. These are specific for kids who are on the autism spectrum, they may demonstrate repetitive behaviors or pedantic types of speech where they seem to be giving a lecture.

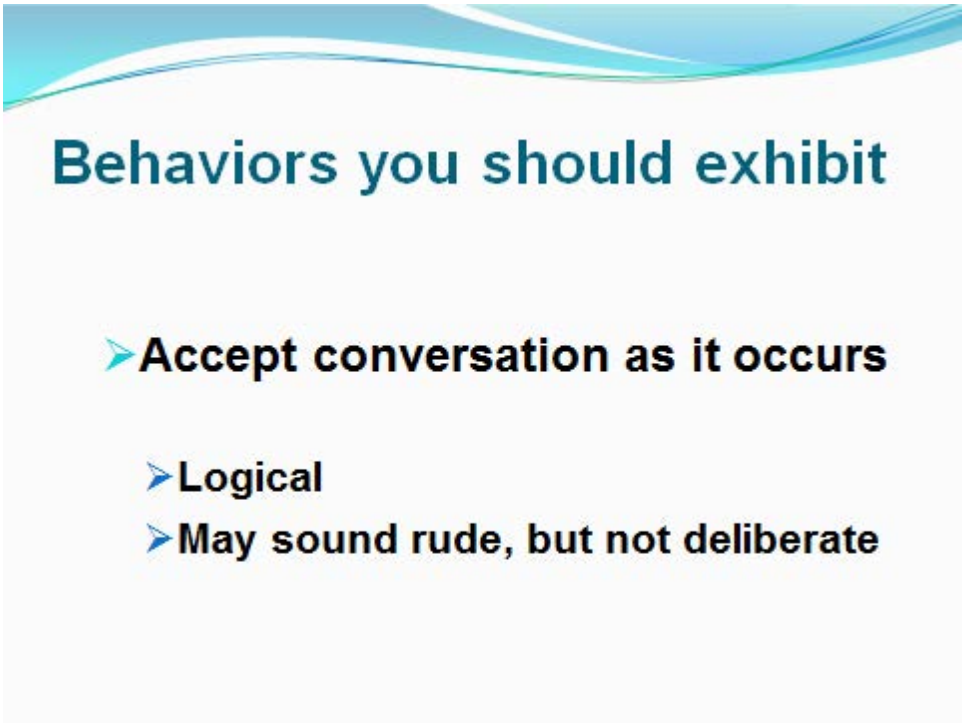


What a provider should do is move very cautiously, interacting with the parent to develop the child's trust, interacting with the child very deliberately. This is a real skill, and I would urge parents to find somebody that they are comfortable with and that they are sure their child is

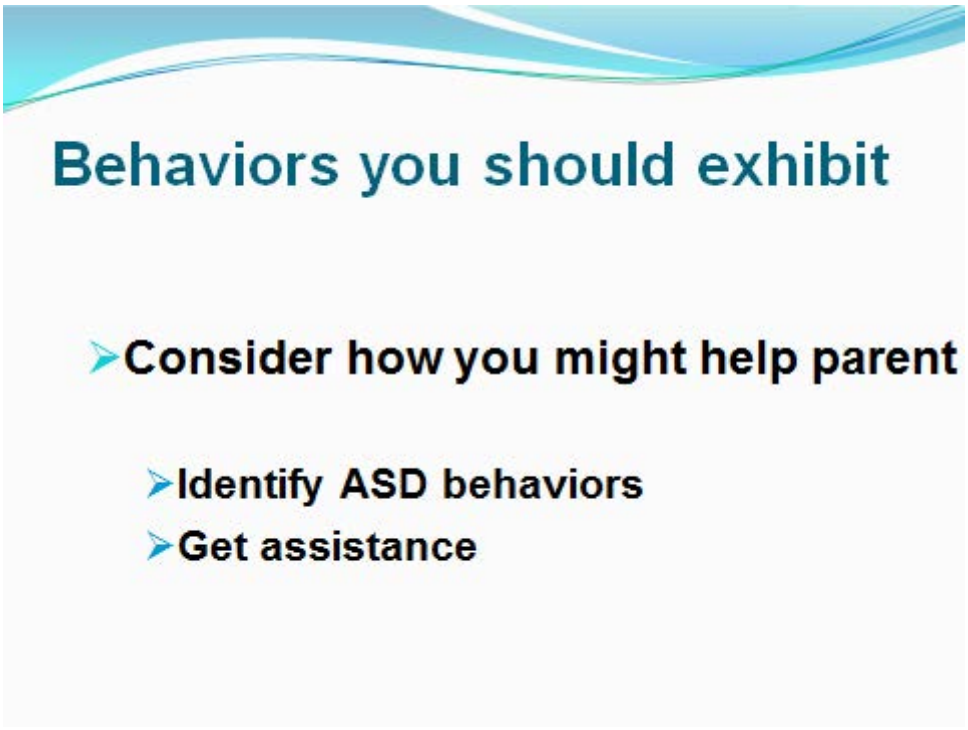
comfortable with. There are a lot of people out there that can do a job, and there are some that do it better than others.



Here are some ways to interact with the child deliberately, especially if they are on the autism spectrum. You may not get eye contact and that's OK, that's almost to be expected. Parents can help by bringing something from home to make the child more comfortable.

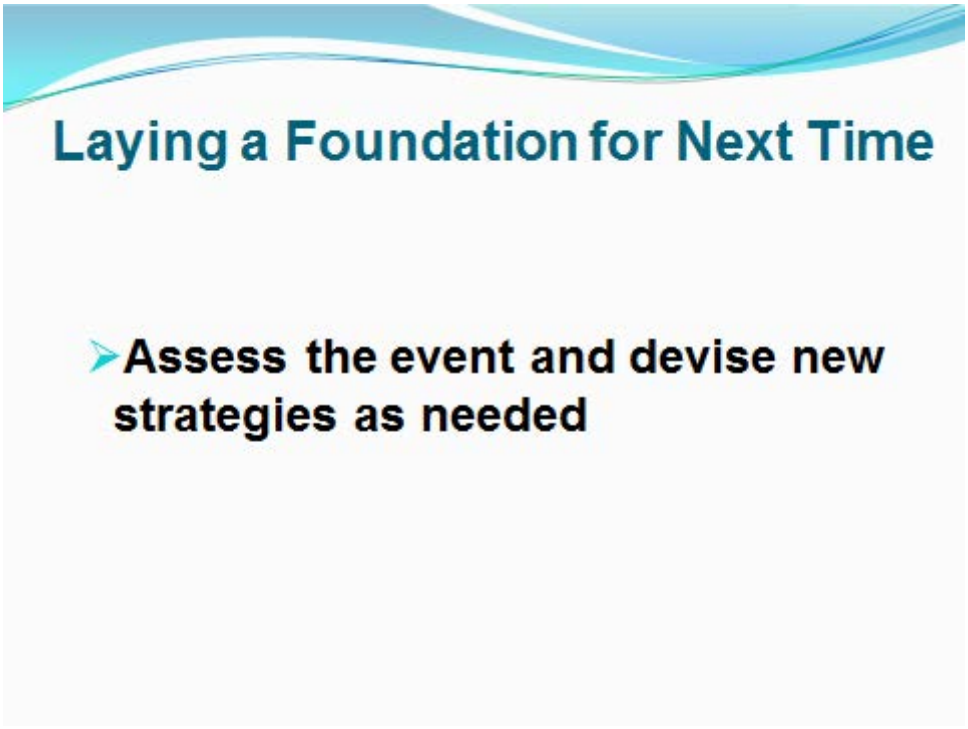


As a provider, you need to accept any conversation that occurs. Kids on the autism spectrum are very logical, and they often blurt out comments that seem rude but are not intended to be rude; they are simply logical.



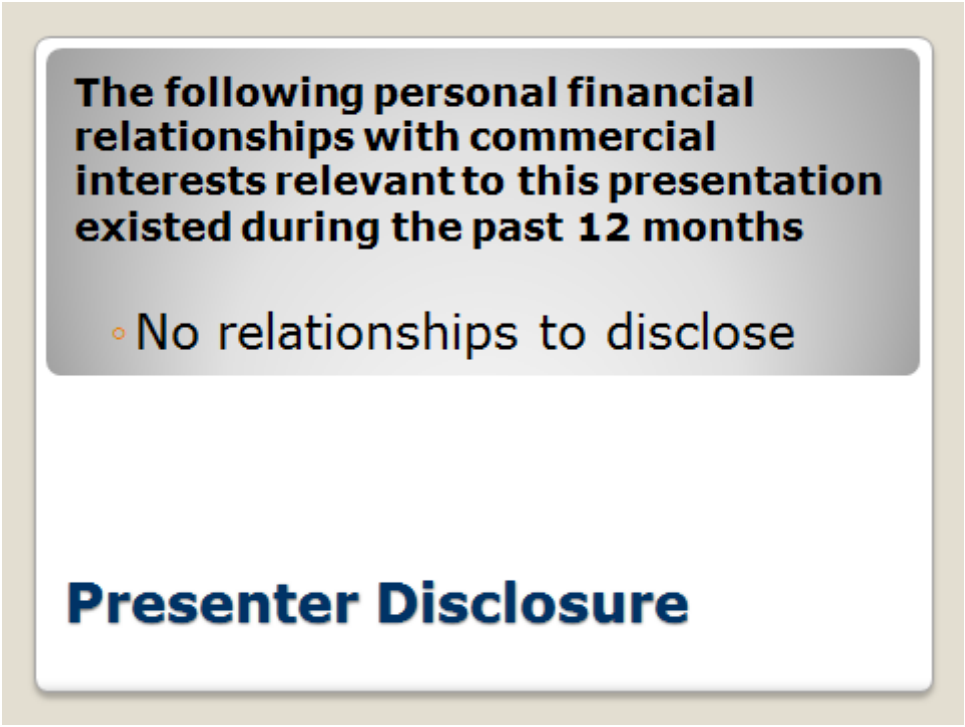
Another thing I have suggested to providers is to consider how they might help a parent if a parent comes in with a child and you as a provider think this child might be on the autism spectrum. What can you offer the parent if the parent isn't tuned in to that.

Part of what you are doing when you examine a child in an eye clinic, and part of what a parent should look for is that they will expect to see that child again, if not for treatment specifically then within another year for ongoing care. Providers should be encouraging positive things and ignoring some of the negative things that these kids might do.



A good provider will try to figure out what worked and what didn't and will stop doing what didn't work.

This is a resource that I found in setting up this communication. I thought it was a very helpful piece of information that links to the Maternal and Child Health Bureau (MCHB) library for children with special health care needs.



And that's the end of my slides. Thank you!

Kira Baldonado: Thank you, Dr. Hartmann. This is Kira Baldonado and I want to remind participants that if you have a question for one of our presenters, go ahead and put it into the chat box. If you want more information about the centers that coordinated today's webinar or any of the topics that have been discussed, the websites for each center is there on your screen: http://www.catalystctr.org and http://nationalcenter.preventblindness.org We will have the emails for each of the presenters at the end of the presentation.

Answers to questions that were asked during the webinar:

Kira Baldonado: I do have a few questions that came through so I'm going to put them out for you to consider. Meg, there's one for you, that came in through the registration:

I have a large population of Hispanic students that do not have Medicaid because they were not born in the US. The voucher programs that they use such as VSP only cover with donor doctors. How can I help my students?

Meg Comeau: The question as I understand it is what does the ACA do for undocumented children who need vision and eye health services. I'm sorry to say that there are significant restrictions in the ACA that prevent the law from directly helping undocumented kids and families. It's not that they got left out, there are specific restrictions that were included. For example, undocumented folks aren't allowed to purchase health insurance coverage through the Marketplace or to qualify for public benefit programs like Medicaid, even under the mandatory income expansion for kids. Families with undocumented members can still purchase health insurance themselves and the consumer protections that I described will apply, but I appreciate that affordability is still a major challenge. Existing programs that serve undocumented kids, while they won't get better under the ACA, aren't required to change and those few states that

have permission to serve undocumented kids through their Medicaid programs are actually required to continue doing so as long as that permission remains in effect. So I'm afraid it's a somewhat disappointing answer to a very good question.

Kira Baldonado: Thank you. A question came through for Alison that I'd like you to consider:

Do gaps in service still exist now that we have the ACA in effect? Are there a lack of providers, deductibles, issues of access to a provider, what do we still need to consider?

Alison Manson: Kira, it's all of the above. There are certainly plans, especially on the lower metal levels…the health plans offered through the Exchanges are on one of four metal levels (silver, bronze, etc.) and reflect different actuarial values. The ones with lower actuarial values have higher deductibles, higher copays, higher coinsurances, which is, of course, an out-of-pocket cost, and affordability is going to be a problem for families as long as there are the kind of limits you see here. There's no question that networks are more limited in some of these plans. Not all doctors see Medicaid patients. We certainly have some access issues as far as providers are concerned. There's also an education gap—the numbers of uninsured people who might be eligible for subsidies who have in fact enrolled in health insurance in the exchange aren't as high as we'd like to see. There remain a whole lot of barriers that we all need to address together within the available legal structure to try to conquer them.

Kira Baldonado: Thanks, Ali. We had a couple of questions around the preventive vision screening: *Is that an annual benefit similar to the comprehensive exam? Or is that on a different schedule? Is there any change to the reimbursement of the vision screening code 99174?* Ali, do you have any insight into those questions?

Alison Manson: I can't answer the question about the code; that would need to be someone with more insurance experience than I have. Vision screening is required to be covered with at least the frequency shown here: http://brightfutures.aap.org/pdfs/AAP_Bright_Futures_Periodicity_Sched_101107.pdf . However, individual insurers might decide to cover it annually for the sake of administrative simplicity.

Kira Baldonado: Another question that came through related to essential health benefit: *Will the vision benefit cover anything other than the visual acuity correction?*

Alison Manson: Most insurance plans cover medical eye care (and did before the Affordable Care Act) for conditions like amblyopia or conjunctivitis. This is care for a specific disease or condition affecting the health of the eye. Correction for refractive error was generally not covered before the ACA, which is why the essential health benefits package was designed to include the requirement. Now, insurance plans generally cover medical eye care and treatment related to refractive error. Some other services, like vision therapy, are generally not covered by insurance plans. Individuals should always check their insurance plan documents to determine exactly what services are and are not covered.

Kira Baldonado: Meg, maybe you can add some insight here: *For children in states that have chosen the FEDVIP plan, they would generally receive one pair of glasses and one eye exam per year. Is that without cost sharing, copays, deductibles? Sort of like how women now get a free gynecological exam now?*

Meg Comeau: It's my understanding—and I'll ask Ali to weigh in here, specifically for vision…one of the interesting things about the ACA is that it is so complex that there are many provisions that intersect with one another and trying to figure out what one provision says and what another provision says and how they interact has been a primary challenge. It is my understanding that within the essential health benefits and the benefits that you mention are included under the essential health benefits, the preventative services without cost sharing also applies to those plans. So if you enroll in a Marketplace plan and you have a child who is eligible for that service, that will be provided to you both under the essential health benefits and the preventative services with no cost sharing. But you should be able to get that without a copay or deductible. Ali, is that the way you understand it?

Alison Manson: Not for the eye exam and glasses. I understand that they are not a preventive service, just that they have to be a covered service. How they are covered and at what rate they are covered is going to vary based on the actuarial value of the plan.

Meg Comeau: I'm glad I asked you to check that specifically on that service!

Alison Manson: The screening is considered a preventive service, the eye exam and glasses are not.

Kira Baldonado: Dr. Hartmann, we have a question for you: *Autism spectrum disorders (ASD) are frequently marked by symptoms consistent with attention-deficit/hyperactivity disorder (ADHD), and convergence insufficiency (CI). As such, should children with ADHD be directed directly to an eye care provider for a comprehensive eye exam? Additionally, do you consider children with an individualized education program or a child in an Early Intervention program needing direct referral to an eye care provider?*

Eugenie Hartmann: Yes, with regard to the IEPs and the Early Intervention. Vision screening and hearing screening are part of the preliminary workup for any kid in those programs. Now that's just a screening and my interpretation is it depends on the age of the child and what other issues there might be. It's certainly reasonable if a kid is going into special education that a complete comprehensive eye exam be part of that kid's evaluation at some point. It shouldn't prevent them from getting enrolled in the special education, but given that it's one of the essential health care benefits under the ACA, if I'm understanding things correctly, because this is educational for me as well, I would consider that a valuable thing for a parent to do. As far as ADHD goes and autism, they're really different. There are some reading issues with kids with ADHD, and I'm not really sure about how the essential health benefits would cover treatment for convergence insufficiency. However that is one of the categories that is well accepted as needing some sort of intervention. I don't think that every kid with ADHD would necessarily require an eye exam in the same way a child with autism does.

Kira Baldonado: Several more questions have come in; we'll try to get to one or two more here. For those who weren't able to get their questions answered, we'll have a record of those questions and get back to you.

Meg, one questions that came in*: Is there a national website to direct families to where they can find a Medicaid provider?*

Meg Comeau: There is no national website for finding a Medicaid provider because the Medicaid program is a state/federal partnership. It's regulated by CMS but administered by the state, so the place to find a list of Medicaid providers in your state is to go to your state Medicaid website. To find contact information for your state Medicaid program (website, phone numbers, etc.), go to Insurekidsnow.gov at http://insurekidsnow.gov/index.html and click on "Learn About Programs in Your State".

Kira Baldonado: I want to thank everybody for being on the line today, it was a terrific turnout. I really want to express my thanks to our speakers for the great information today. We have provided contact information here on the screen. If you would like to ask a question that we weren't able to get to directly to our presenters, you can go ahead and email them. And we'll try to follow up on all those questions that we didn't get to today. So thank you for your time and we wish you a great day.

Answers to questions that were asked but not addressed in the webinar:

Q: *You may touch on this later, but just wanted to toss it out there: Would you mind addressing the topic of states that have opted out of the Medicaid expansion and how it may impact the vision screening efforts in those states? Thanks!*

A: (Meg Comeau) Eligibility for children's Medicaid up to 138% of the Federal Poverty Level is not optional for states; only optional for new population of non-pregnant, non-disabled childless low-income adults. EPSDT covers children's vision screening – no changes based on ACA.

Q: (Regarding the annual benefit cap provision*) I thought there was Mental Health Care parity, so the number of mental health visits could NOT be limited?*

A: (Meg Comeau) Visits for any service can still be limited – parity requires that the limits for physical health be the same for covered mental health services. So, for example, if a plan limits PT to 15 sessions, it can limit mental health "visits" to 15 – as long as they're equal, it's allowed.

Q: *Does this mean that vision screening costs charged to parents to help cover cost of a device for instrument-based screening can no longer occur?*

A: (Alison Manson) For families with qualified health plans that are required to cover essential health benefits, vision screening is covered without cost sharing. Providers that participate in an individual health plan negotiate a specific payment rate with the insurer to provide this service and may not charge participants in that plan any additional fees. The fee those providers negotiate is intended to be sufficient to cover the cost of providing that service, including the purchase of required tools and instruments.

Q: *What happens to those children who are ineligible for vision coverage?*

A: (Kira Baldonado) The inclusion of vision as an essential health benefit in the ACA has increased access to eye care for some children in the U.S. There still remain populations of children without coverage for vision services or any health care at all. Fortunately for these populations, there are safety net programs available to provide access to an eye exam and/or eye glasses for those that qualify. Qualifications for program participation vary by each program. A list of available programs can be found at http://preventblindness.org/vision-care-financial-assistance-information . These populations may also be able to seek care at a community health center that also provides vision services. Community Health Centers, also known as Federally Qualified Health Centers, are required to provide services to anyone seeking health assistance. Fees for services may be provided on a sliding scale according to income.

Q: *Does the new healthcare.gov provide insurance to undocumented people?*

A: (Meg Comeau) No. Unfortunately, it's not a matter of undocumented folks being left out of the ACA, they are specifically restricted from receiving direct help in accessing new options for insurance coverage under the law. For example, undocumented folks are not allowed to purchase coverage through the state Marketplaces or enroll in Medicaid.

Families with undocumented members can still purchase their own insurance outside the Marketplaces and the consumer protections included in the ACA that apply to the specific kind of plan they enroll in will still apply to their coverage. That's the good news.

The bad news is, affordability will still be a barrier for many in purchasing their own insurance, as it's always been. Uninsurance among this population is predicted to remain high.

Q: *Did I understand correctly that after screening is done at school because the child is over 5,*

they may have a copay or coinsurance when they go to the eye doctor and for glasses?

A: (Alison Manson) Insurance generally does not cover screenings done in a school setting. Vision screening that is covered by insurance is generally administered in the pediatrician's office. In that case, is required to be covered without cost-sharing with at least the frequency shown here:
http://brightfutures.aap.org/pdfs/AAP_Bright_Futures_Periodicity_Sched_101107.pdf
However, individual insurers might decide to cover it annually for the sake of administrative simplicity.

Children of any age who go to the eye doctor and get glasses may have cost-sharing. Individuals should always check their insurance plan documents to determine exactly their out-of-pocket responsibility for services.

Q: *Are visual evoked potential exams widely used? What is the reliability data ? Is it expensive ? Is it covered by ACA?*
A: (Alison Manson) Visual evoked potential exams are covered in the same way that they previously were – medical eye care is not impacted by the ACA. Individuals should always check their insurance plan documents to determine exactly what services are and are not covered and with what restrictions they might be covered.

(Eugenie Hartmann) Visual evoked potential (VEP) exams are not generally available in a private practitioner's office. You are more likely to access these services in a tertiary hospital or university setting. A knowledgeable examiner (most often an individual with specialized training), working collaboratively with an eye care practitioner can use VEP measures for reliable assessments. Sometimes depending on the severity of the child's disability, the findings may be equivocal; however, the results can be used to support maintaining or integrating visual stimulation as part of a special education or early intervention program. I don't believe that the cost of specific VEP testing is prohibitive – finding the right facility with personnel equipped to do the testing is trickier.

Q: *Currently, the glasses for IL children on Medicaid are made in the prison system and they take 6-12 weeks to receive them. Is this something that will change with the new insurance system?*

A: (Meg Comeau) My guess is it will not; this is a state decision and there's nothing I know of in the ACA that touches on it.

Q: *Is the plusoptiX an acceptable screening method for CSHCN?*

A: (Eugenie Hartmann) This particular device was evaluated by the National Expert Panel for the National Center for Children's Vision and Eye Health. The studies on sensitivity and specificity that are currently available for this device are not as extensive as other devices. However, there are clearly some situations in which this device yields acceptable vision screening results. Ultimately, more data will provide the evidence-based information to determine the value of this vision screening method.

Q: *Under ACA, what providers can provide the annual vision "screening" for the child and is a comprehensive exam an entirely different beast?*

A: (Alison Manson) The ACA does not specify what providers can provide the annual vision screening. In fact, it prohibits insurance companies from discriminating against any health care provider who participates in their plan who is acting within the scope of the applicable state license or state law. The screening will most likely be offered in the office of a pediatrician or family practitioner. The comprehensive eye exam will be performed by an optometrist or ophthalmologist. It diagnoses eye disorders and diseases, and prescribes treatment. A comprehensive eye examination is generally understood to include an evaluation of the refractive state, dilated fundus examination, visual acuity, ocular alignment, binocularity, and color vision testing where appropriate.

In contrast, the purpose of a vision screening is to identify vision problems that require more complete evaluation. Any child who "fails" a vision screening should be referred to an eye care provider for a comprehensive eye exam.

(Eugenie Hartmann) The real issue with vision screening is follow-up care – it is essential that we not only provide the screening, but that the children actually receive a comprehensive eye examination by an eye care provider. Our vision screening protocols are not perfect – sometimes a child will "fail" when there is nothing really wrong with his/her vision. However, we are getting better at identifying the children with eye problems that need to be treated. Hopefully some of the financial barriers to follow-up eye care will be alleviated by the ACA. Unfortunately, there will still be other barriers related to parent understanding of the benefit and need to correct their child's vision. Ideally, the health care providers offering the vision screening will be able to communicate the necessity for follow-up care based on the use of vision screening tests that meet standards of "best practice."

Q: *Is there vision therapy benefit?*

A: (Alison Manson) There is no requirement for a vision therapy benefit and many insurance companies do not cover these services. Individuals should always check their insurance plan documents to determine exactly what services are and are not covered and with what restrictions they might be covered.

Q: *So, once a child is six, there are no vision benefits required?*

A: (Alison Manson) Essential health benefits still provide for eye exams and glasses for children of all ages, with a frequency of once per year in most states. Vision screening is required to be covered with at least the frequency shown here:
http://brightfutures.aap.org/pdfs/AAP_Bright_Futures_Periodicity_Sched_101107.pdf

Q: *Can I apply for continuing education credit for participation in this webinar?*

A: (Kira Baldonado) Unfortunately, we were not able to provide a CEU certificate directly for participation in the "Affordable Care Act and Children with Vision and Eye Health Needs"

webinar from last week. We are happy to assist you if you would like to apply for credit with your professional association. Simply forward a request for the information your professional association requires (presenter backgrounds, learning objectives, outline, etc.) to kbaldonado@preventblindness.org and we can prepare that for you. Thank you!