



AMERICAN ACADEMY™  
OF OPHTHALMOLOGY

20 F Street NW  
Suite 400  
Washington DC  
20001-6701

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P.O. Box 7424  
San Francisco, CA  
94120-7424

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T: +1 202.737.6662  
[www.aao.org](http://www.aao.org)

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Dear Rural and Underserved Communities Health Task Force,

The American Academy of Ophthalmology is pleased to offer its input on the Rural and Underserved Communities Health Task Force's Request for Information. The American Academy of Ophthalmology is the largest national member's association of ophthalmologists—medical and osteopathic doctors who provide comprehensive eye care including medical, surgical, and optical care. The Academy seeks to protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public.

**What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?**

While existing data does not reflect significant access challenges to eye care in rural communities, successful telemedicine models have expanded the reach of existing providers and enabled better identification of disease. Two prominent models within ophthalmology are remote screening for diabetic retinopathy (DR) and retinopathy of prematurity (ROP). In most communities across the US, DR is the leading cause of vision loss in working-age adults. Early detection of DR is key to allow intervention before permanent damage and vision loss occur. Unfortunately, many patients are not accessing retinal examinations at appropriate intervals, including those who have been diagnosed with diabetes. Telemedicine programs can improve patient access to the annual diabetic retinopathy screenings through patient imaging in primary care settings. Both the veterans' health care system and the Indian Health Service have large national telemedicine diabetic retinopathy programs that have been tremendously successful.

Remote screening for retinopathy of prematurity (ROP) is another example of how telemedicine can deliver highly specialized care to rural and underserved communities. ROP is a blinding eye disease for which telemedicine holds great promise, as it allows children to stay in nurseries close to their homes and allow consultation and follow up. Telemedicine models have been successful in overcoming geographic challenges and promoting better identification of the disease in pediatric patients. Promotion of increased ROP identification and treatment has been accomplished through using a wide-angle digital retinal camera to take patient images that can be interpreted remotely by an ophthalmologist.

**What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?**

As mentioned above, telemedicine programs can be successful in expanding the reach of existing providers in rural and underserved communities. Most communities in the US currently have access to eye care services but barriers exist beyond the availability of providers. Those barriers include access to insurance coverage, reliable transportation, and limited financial means. Technological advances have created mechanisms for remote imaging and remote monitoring of patients with sight-threatening eye disease. This can be tremendously helpful for patients that have limited mobility or difficulties traveling to receive healthcare services. Additionally, remote monitoring can be effectively done to limit unnecessary travel for follow-up visits while ensuring patients still receive quality care.

One successful model is the VA Technology-Based Eye Care Services program, which has improved access to basic eye care services, resulting in the earlier diagnosis and treatment of eye disease. Rural veterans utilizing a community-based outpatient clinic (CBOC) for primary care can receive an accurate vision check, as well as critical eye-disease screening, as part of their local primary care visit. Veterans receive comprehensive eye screening services for the most common causes of visual impairment: cataract, glaucoma, macular degeneration and diabetic retinopathy. Veterans' satisfaction scores with TECS program are high (more than 95 percent 'strongly agreed' that the clinic provided high-quality service and more than 95 percent of veterans 'definitely would' recommend the clinic to others).

**Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?**

Congress made great strides to improve the Medicare quality reporting programs in the MACRA legislation. Unfortunately, CMS has decided to replace congressional judgement and exercise substantial liberties in the execution of the Quality Payment Program to its detriment. For years, physicians have been struggling with the need to report on meaningless measures. In response to this, and in acknowledgement of the substantial value that qualified clinical data registries (QCDRs) provide via specialty-tailored and meaningful quality measurement, Congress directed CMS to incentivize use of QCDRs for quality reporting. CMS has not done this. In fact, in their latest rule, CMS greatly increased the cost and burden of QCDR operation.

In addition to handicapping QCDRs, CMS has been rapidly pruning the quality measures available, leaving physicians with the choice between reporting measures inappropriate to their specialty and patient population or receiving a 9% payment penalty. This has created a substantial burden which will grow further as QCDRs are depleted and germane measures disappear. This burden falls disproportionately on practices with fewer resources – rural and underserved practices – for which the cost of compliance is rapidly becoming prohibitive.

Finally, CMS has decided to implement a new MIPS Value Pathways (MVPs) in 2021, allowing less than one year to develop pathways and no time for CMS to test it. CMS will base MVPs on electronic health record (EHR) use and on population health measures, despite CMS's acknowledgement that population health measures are inappropriate at the small practice level due to lower reliability. This approach will drive further consolidation in the healthcare system, increasing costs and increasing barriers to care for the most vulnerable populations.

The Academy thanks you for the opportunity to provide input on issues impacting rural and underserved communities. We look forward to future opportunities to highlight successful models and existing barriers that are having impacts on these communities. Please feel free to contact myself or Scott Haber, Manager of Federal Affairs & Public Health, at [shaber@aao.org](mailto:shaber@aao.org) or via phone in our Washington DC office at 202-737-6662

Sincerely,

A handwritten signature in black ink, appearing to read "Michael X. Repka". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Michael X. Repka, MD, MBA  
Medical Director for Governmental Affairs  
American Academy of Ophthalmology