**02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**371 OFFICE OF PROFESSIONAL AND OCCPUATIONAL REGULATION**

 **MAINE BOARD OF OPTOMETRY LICENSING BOARD**

**BASIS STATEMENT AND SUMMARY AND RESPONSES TO COMMENTS**

**Basis Statement**: The Maine State Board of Optometry was established to protect the public through the regulation of the practice of optometry in the State of Maine so as to maintain high professional standards. The primary responsibilities of the Board are to examine and license qualified applicants to practice the profession of optometry and to hold the title of Optometrist in the State of Maine.

New:

Chapter 1: Licensure by endorsement

Chapter 1: Fees carry over up to 10 credit hours, Military Services

Chapter 2: Treatment of Glaucoma

Chapter 4: Enforcement, Disciplinary Procedures and Appeals

Chapter 5: Telehealth Standards, uses and Limitations

Chapter 6: Code of Ethics

The Board is undergoing a review of all existing chapters including application for examination, license endorsement approved schools, license renewal requirements, fees, ethics, and continuing education. Such broad rulemaking is required because the Governor signed a full repeal and replace of the laws as enacted by the 131st legislative sessions and the new law needs clarifying rules. Rulemaking authority is conferred by 32 M.R.S.A. § 19204

Notice of the proposed rulemaking was published in the Maine Secretary of State weekly notice on July 22, 2024, in the Portland Press Herald, the Kennebec Journal, the Bangor Daily News, and the Sun Journal on July 24, 2024, and uploaded to the Optometry Licensing Board webpage on July 24, 2024.

The Board held a public hearing on August 9, 2024, at 1:00 p.m., to take oral comments, and continued to accept written comments through 5:00 pm on August 20, 2024.

**Summary of Comments and Responses:**

The Board received seven (7) comments on the proposed rule(s).

1. Maine Optometric Association,Steven Hudson **(**PretiFaherty Attorney) (oral comment provided August 9, 2024)

Steven Hudson of PretiFaherty introduced himself as counsel appearing on behalf of the Maine Optometric Association (“MOA”). He briefly commented on the telehealth proposed rules, noting that in person treatment best serves consumers in the State of Maine. He confirmed that the MOA would send a written comment before close of business on August 20, 2024.

* + The Board thanks MOA for its comment and does or does not accept this comment.

2. Alan Beaulieu, OD (Oral comment provided August 9, 2024).

Dr. Alan Beaulieu introduced himself at the hearing as a licensee from Massachusetts. He expressed that the undergoing of the rule process be taken as soon as possible.

* + The Board thanks Dr. Beaulieu does or does not accept this comment.

3. Michael Judkins, OD (written comment provided August 19, 2024)

* Dr. Judkins expressed opposition to the purposed 130% increase in optometric licensing fees. For the past two years he has provided Maine optometrists coverage for doctors participating in military service and vacations, providing continuity of care to patients, an income stream to practice owners, and keeping staff working while permanent doctors are away. Given his limited days of availability providing optometric care in Maine, it does not make economic sense for me to renew my license if the fees increase is adopted. He reports being licensed in two other states (Wyoming and Utah) and being currently a member of the Utah Optometric Licensing Board. He reports that Maine’s new fee level would be higher than Wyoming and Utah, and urges the Board to find ways of saving money rather than increasing fees which would be a deterent to others interested in practicing optometry in Maine.
	+ The Board thanks Dr. Judkins for his comment but does or does not accept this comment. The Board notes that the increase from $380 to $490 in fees is a 28.95% increase, not 130%.

4. Maine Optometric Association, Bruce Gerrity (written comment provided August 20, 2024)

These written comments augment the testimony of Steven Hudson on August 9, 2024. Increased fees will not help. The Association suggests that the fee provision of §(4) be amended at §4(D) to leave the license fee at $380. This licensure fee is more in line with professions that have a two-year renewal. For example, a physician license renewal is a biennial fee of $500. An osteopathic physician has a license renewal every two years, with the fee not to exceed $600. The Association suggests that the fee provision be kept more in line with these other professions.

The Association also notes that the late renewal fee has increased from $100 to $300. §4(C). The late fee should not be increased.

Section 5(A) sets forth standards that are required as part of continuing education. The section states that “courses may be completed either in-person, on-line in person, or via video replay.” The Association strongly believes that in-person continuing education is critical. It places an emphasis on interactive professional learning which is lost in remote learning. It also creates an opportunity for optometrists to meet with each other, develop relationships, and leads to a more robust discussion of best practices. Accordingly, the Association urges that the Board require at least 15 hours in continuing education in-person per year.

Section 5(E) of chapter one allows an optometrist to carry forward up to 10 credit hours from the immediate prior year for the continuing education requirements for the following renewal period. The Association suggests that this provision be changed to allow only 5 credit hours to carry over. The Association believes that continuing education should focus on the most current practices and standards.

Chapter 5: Telehealth Standards, Rule and Limitations The Board of Optometry mission statement says, in pertinent part: The Maine State Board of Optometry was established to protect the public through the regulation of optometry in the State of Maine so as to maintain high professional standards. Nothing is more crucial to protecting the public and patients than the in-person care from an optometrist. The proposed Rule fails that test. It violates provisions of the Optometric Code, 32 M.R.S. c.151, its own mission statement and the well-recognized and required historical in person optometrist-patient relationship. The Rule should deal with telehealth in the “traditional” sense, but as drafted it inappropriately and pervasively bleeds over into provisions relating to the in-person optometrist-patient relationship.

MOA suggests that the well accepted purpose for telehealth care is to allow interaction between a patient with an established relationship with an optometrist (including in-person care) with another optometrist or medical specialist (ophthalmology, neurology, etc.) whose expertise will assist in diagnosis and care of a patient. It is not intended to allow carte blanche authority for any ostensibly qualified practitioner to remotely provide the services that require an in-person consultation and examination that are the foundation for high professional optometric care.

The Optometric Code: Numerous provisions in the code maintain the long-standing axiom of optometric care that there is, and must be, an in-person doctor-patient relationship. 32 M.R.S. 19101(21). Section 19101(21) teaches us that the optometrist- patient relationship is directly based on a requirement that there have been “an in person encounter between the licensee and the individual”. The exception to that in-person requirement is narrow. The exception does not apply “unless the standard of care requires that an individual be seen without an in person visit, such as in an emergency situation as reasonably determined by the licensee”. (emphasis added) 32 M.R.S. §19101(21)(C). The exception for the in-person encounter is based on necessity and cannot be expanded upon or abrogated in the Rule.

32 M.R.S. §19309 establishes minimum standards for eye exams. A key requirement is set forth in subsection 19309(1)(C): A physical examination of each eye in an in-person clinical setting by the licensee in accordance with any requirements and restrictions imposed by their chapter and in accordance with the standard of care… (emphasis added). Any notion that the words “standard of care” somehow constitute an exception in telemedical care is misguided. The reference to the standard of care is not intended to promote remote care; it modifies “in-person clinical setting”. This section goes on to state that if performing a refraction, subjective and objective refraction should be done “when practicable”. 32 M.R.S. §19309(1)(F). Subjective refraction can only be done in-person. The “when practicable” language is not intended to eschew the in-person requirement, but to work in concert with section 19101(21). The provisions in the code relating to the ownership and operation of a kiosk also require that its use “must comply with the minimum standards for an eye examination” under Section 19309. 32 M.R.S. §19311. In addition, prescriptions may not be based solely on diagnosis of refraction error generated by a kiosk. 32 M.R.S 19312(F). This requirement applies to physicians as well, further cementing the primacy of the in-person care standard across disciplines. 32 M.R.S. §3300-E. Of note, optometrists are held to the same standard of care as an ophthalmologist. 32 M.R.S. §3300-E. In addition, a “provider” is defined as a licensed optometrist or, someone licensed as an osteopathic physician or a medical doctor who has also completed a residency in ophthalmology. 32 M.R.S. §19601(25).

Telemarketing [Do you mean telehealth?] involves the use of information technology to remotely monitor or further treat or assist in treatment of a patient. 32 M.R.S. §19601(5). In pertinent part §19101(21) defines telehealth services as occurring: Through consultation with another licensed healthcare provider who has an established relationship with the patient upon agreement to participate in or supervise the patient’s care through telehealth… In short, nothing in statute supports the notion of watering down the optometrist-patient in person relationship in the context of telemedicine.

Statutory Application to the Proposed Rule At a minimum sections 3(5), (6) and (8) violate the code and stray from, if not eviscerate, the notion of in-person patient care.

For ease of reference the Association recommends changing the Rule formatting to have subsections be labeled with letters rather than numbers.

Section 3(5) of chapter 5 sets forth requirements for medical history and eye examination: Generally, a licensee shall perform an in-person interview and eye examination for each patient. However, the interview and eye examination may not be in-person if the technology utilizes in a telehealth encounter is sufficient to establish an informed diagnosis as though the interview and eye examination have been performed in person. (emphasis added). The underlined language ignores the protections created in the code. The statutory standard for in-person care is not optional. The standard requires the in-person consult. The Rule, however, impermissibly broadens telehealth to duck that step. Why? For the convenience of the optometrist? For efficiency? How many exams will be conducted remotely by out-of-state providers? By providers willing to jettison or give short shrift to the in-person exam with the intent more to sell a product rather than to provide real care? How many crucial but subtle conditions or diseases of a patient’s eye or other systemic conditions will be missed? How many subtle indicators of what might become a problem will not be caught at an early stage? This proposed rule does not protect the public. The informed consent provision of the proposed practice guidelines, section 3(6), further erodes the importance of an in-person patient encounter.

The section is titled “Necessity of In Person Encounter.” The text is diametrically opposed to that title, however. It circumvents the necessity by stating that if the healthcare provider cannot get “pertinent clinical information” because the “the telemedicine modality” precludes the ability to do so, that a healthcare provider will be allowed to abandon the standard of care “deem[ed] reasonably necessary in the practice of optometry at an acceptable level of safety and quality”. This allows a healthcare provider to provide inadequate care, but then say to the patient, “by the way, you might want to follow up with an optometrist to do it right.” It is a complete work around of the statute. It also puts the Board in the position of promoting an inadequate level of care from the get-go, buttressed only by a notice requirement. What if the patient feels better at first, especially if they get a blasé notification and therefore does not follow through? What if some problem, condition or disease is missed? What if the patient is not given enough information to appreciate the need to follow up? Does the Board really want to endorse this? Hence the prohibition, for example, for the corporate practice of optometry. 32 M.R.S. §19501.

The term, “Healthcare provider” is not defined. The term “provider” is defined in statute (32 M.R.S. §19101(25) and includes only ODs and physicians who have done a residency in ophthalmology. That is pretty rare air and presumably it is what is intended by the Board’s use of the term in this Rule. An even greater irony is that any person who is in the employ of the optometrist and steps in to provide “care” presumably will have the same telemedicine modality impediment.

Interestingly, the language in §3(5) and (6) are contradicted in part by Rule §(3)(16), which exempts the optometrist from the in-person consult and examination only to:

1. Prescribe medication on a short-term basis for a new patient and the optometrist has scheduled an in-person exam,

2. For existing patients in an institutional setting,

3. When the optometrist is taking the call for another licensee with an established optometrist-patient relationship, and

4. Cross coverage situations, again arising out of an underlying licensed optometrist patient relationship.

If one compares proposed §3(5), that it is acceptable to do a remote exam, with §3(16)’s limited exceptions to the in-person standard, then something has to give. If one compares §§3(6)(B) to §3(16), then either the optometrist can eschew the in-person requirement where there is a “modality” factor or the entire subsection is thrown out the window by the statutory primacy of §3 (16). The primacy of §3 (16) is presumed given that these are the kind of very limited exceptions that fit within the parameters of the “such as” exception in 32 M.R.S. § 19101(21)(C). In other words, it is §3 (16) that hews to the statutory mark.

There is no definition of “licensee”, although as used it seems to be limited to an optometrist. The definition section should include a definition of “healthcare provider” or clarify that “licensee” meant a “provider” under the statute. 32 M.R.S. §19101(25).

The Rule should make clear that a “Qualified Technician”, §2(6), is not a healthcare provider. Qualified Technicians are not contemplated in telemedicine in the statute. Period. There is no reference to “Qualified Technician” in the optometric code or other rules of the Board to serve as a basis to allow a non-optometrist to engage in telemedicine. For an optometrist engaged in telemedicine to shuttle a patient to a “Qualified Technician” just because the optometrist “cannot see a patient in person” is grossly inappropriate. §(3)(7).

Proposed section (3)(7) is also inconsistent with the requirements of proposed rule §(3)(1), that any individual who uses telehealth “shall hold an active Maine optometry license.”

Section (3)(13) of the proposed rule should require that patient information be segregated by a portal or some other process to insure confidentiality. See also proposed Rule §3(11),(13).

Section 3(15) states that the optometrist “should be aware of any “implied endorsement” of information, services or products provided by general optometric information. This requirement should prohibit any “implied endorsement” rather than merely require an optometrist to be aware of it.

The Association believes the “short term basis” before an in-person consult and examination should be no more than five days. Section 3(17), paragraph three “encourages” an optometrist to use “informed accurate and error prevention prescribing practices”. The proposed language seems to suggest that the use of accurate and error prevention prescribing practices is merely encouraged, hence it might be okay for the optometrist to decide not to be “encouraged” and not use informed and accurate prescribing practices. This paragraph must be mandatory, not “encouraged”.

Section (3)(17) paragraph two references section 18(A). There appears to be no section 18 in the Rule.

Conclusion The fines of section one of the Rule should not be increased. In-person continuing education should be required to some extent. Credit carry over for continuing education should be limited to five hours. Chapter five of the Rule, as drafted, inappropriately waters down patient protections, allows non-optometrists to practice optometry in telemedicine, is internally inconsistent and guts the in-person requirements that pervade the Optometric Code. Accordingly, the Association urges that the Rule be revised throughout and be set for a new public hearing. The Association also requests notice of any work sessions on the Rule

* + The Board thanks MOA for its comments and does or does not accept this comment.

5. National Association of Retail Optical Companies (written comment provided August 20, 2024)

On behalf of the National Association of Retail Optical Companies (NAROC), a national organization representing the retail optical industry, which includes its members’ thousands of employed opticians and affiliated optometrists. We applaud the Board’s proposed rule to clarify the practice guidelines for use of telehealth by optometrists licensed in Maine. We support all but one of the 17 elements of Section 3 “Practice Guidelines.” We strongly encourage the Board to eliminate Paragraph 7 requiring “Use of Qualified Technicians.” This part of the proposed rule requires that all assistants/technicians assisting the remote optometrist be certified. This requirement is not only overly burdensome and without demonstrated need, it also requires an additional and unnecessary layer of administrative oversight. We recommend that the board reject the adoption of this portion of the rule.

We are also concerned about the Board’s assertion that it has “discretion” in granting a license by endorsement. The statute does not provide for such discretion. Discussion Telehealth. Chapter 5, Section 3 in Paragraph 7 of the proposed rules requires that an optometrist shall use a “qualified technician” if the optometrist cannot see the patient in person. (We note that there is a typographical error in this paragraph.) An examination of the Board’s public website reveals no justification for this rule. The Board should allow optometrists who are not physically present with an assistant the same discretion to train assistants as optometrists who are at the same location with assistants. We support the voluntary third-party certification of assistants and technicians by optometrists, including the use of either AOA or IJCAHPO programs that meet the minimum needs of the supervising optometrist, but we see no need to mandate such requirement for all doctors.

Licensure by Endorsement. We also take exception to the Board granting itself discretion in deciding if a license by endorsement may be granted to the applicant in Chapter 1, Section 3 of the rule proposal. The over-arching optometry statute, in Subchapter 3 - Licensure, does not grant such discretion; rather, requiring that the Board shall grant a license to applicants that meet the requirements of the statute. This should only be a factual decision based on the training, testing, actual scope of practice of the applicant’s home state as well as the applicant’s licensure standing. We request that the Board remove the clause “at its discretion,” from the proposed rule so as to meet the requirements of the controlling statute. We also recommend that if the license by endorsement is declined, that the rule reflect that the Board shall state with specificity what the shortcomings are resulting in the application being declined.

Section 8052, paragraph 5-A of the Administrative Procedure Act calls for the preparation of an economic impact statement where the proposed rule(s) may have an economic impact on such businesses. We note that the Board has not filed one in connection with this rule proposal. Should the Board determine not to delete from the proposed rule the paragraph requiring use of qualified technicians, we believe an economic impact statement is required. In light of the costs involved by the requirement to only use certified assistants/technicians under the telehealth rule, such a statement is clearly necessary. We request that such a statement be prepared and filed before further consideration of any proposed rule with such a requirement. Very truly yours, Joseph B. Neville

* + The Board thanks National Association of Retail Optical Companies and does or does not accept this comment.

6. American Telemedicine Association’s Action, commented specifically on the amendments to Chapter 3: License by Endorsements and Chapter 5: Telehealth Standards, Uses and Limitations.

ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system – by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs – if only allowed to flourish. The proposals in Chapter 5 align well with ATA Action’s policy principles, embracing the same standards of care for in-person and telehealth patient encounters and not requiring an in-person examination if telehealth modalities can provide the information necessary to meet the standard of care. ATA Action also fully agrees with the Board that if the telemedicine modality is unable to provide the necessary clinical information, then the optometrist should advise in-person care for the patient. This flexibility will be especially beneficial for patients in rural and underserved areas, who are most susceptible to healthcare workforce shortages and care disparities, as the need to take time out of busy schedules and/or travel long distances to meet with providers in person will be reduced.

First, in section two of the proposed rule, audio-only telephone is explicitly excluded from the definition of telehealth. This does not align with Maine Statute, specifically Title 32 Chapter 34-A Subchapter 6 § 2447, which defines a synchronous encounter as being “conducted with interactive audio or video connection,” meaning that audio-only telephone is included in the definition of synchronous telehealth services. While there may be limited circumstances where audio-only telephone care meets the standard of care for optometry, the decision over what modalities will meet the standard of care and best meet the needs of the patient should be left in the hands of licensed professionals. We encourage the Board to adjust the definition of telehealth in the proposed rule to reflect the permitted modalities by Maine’s optometry statute.

Second, ATA Action has concerns with Section 7 of Chapter 5 of the proposed rule which would require Qualified Technicians to be used if a licensed optometrist cannot see a patient in person. This would make it incredibly difficult for optometry care to be delivered via telehealth to patients receiving care from their home, work or anywhere other than a different optometry office where staff is already present. Licensed optometrists should be empowered to decide which patient encounters require in-person care by a licensed optometrist or physician, rather than having this decision directed by regulation. If the condition presented by the patient necessitates the assistance of a Qualified Technician for the delivery of telehealth care, then the optometrist should ensure that arrangements are made for such assistance or refer the patient to in-person care. However, in situations where that is not necessary to meet the standard of care, there is no reason to require certified staff to be present. The Board should rely on the judgement of professional optometrists to determine what personnel assistance is necessary to meet the standard of care in order to most effectively and efficiently serve the needs of patients.

Finally, ATA Action is happy to see the Board adopt language for a licensure by endorsement model which will help to break down arbitrary barriers to care along state lines and ensure qualified and licensed optometrists from across the country can easily treat Maine patients, increasing patient choice and helping to address healthcare provider shortages. However, we do have concerns with the Board’s decision to grant itself “discretion” on issuing licenses to applicants via this model. Recently effective Maine Statue, 32 M.R.S.A. § 19303, grants the Board authority to establish a licensure by endorsement process but provides no mention of discretionary authority to approve or deny applicants. As detailed in statute, qualified optometrists that meet the requirements for licensure by endorsement should be granted licensure without the need for discretionary approval from the Board. We recommended the deletion of the text “at its discretion” from the proposed rule before it is finalized to best align Board regulation with established statute and procedure.

* + The Board thanks American Telemedicine Association’s Action and does or does not accept this comment.

7. The State of Maine Board of Licensure in Medicine, Timothy Terranova (written comment provided August 16, 2024)

 Proposed Chapter 2, Procedure to Become Authorized to Treat Glaucoma, and the formation of a glaucoma consultation subcommittee that includes two physicians appointed by BOLIM. It is BOLIM’s understanding that statutory authorization for the Chapter 2 rule previously existed in the Board of Optometry governing statutes but that such authorization was removed in the current enactment.

 BOLIM also notes that notwithstanding having prior statutory authority, the Board of Optometry never formed a glaucoma consultation subcommittee that included two physicians appointed by BOLIM. Due to the lack of authority to create the glaucoma consultation subcommittee or to impose upon BOLIM the requirement to appoint physician members, BOLIM respectfully requests that the Board of Optometry delete the proposed rule Chapter 2.

* + The Board thanks the Board of Medicine, Timothy Terranova Action and does or does not accept this comment.