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STATE OF MAINE
DEPARTMENT OF
PROFESSIONAL & FINANCIAL REGULATION

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LD 1803 STAKEHOLDER REPORT

January 14, 2026

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Background

Committee's Charge

On June 10, 2025, the Committee on Health Coverage, Insurance and Financial Services (HCIFS) sent a letter to the Department of Professional and Financial Regulation (DPFR) requesting that DPFR convene a stakeholder group to evaluate the sponsor's amendment to LD 1803, *An Act to Amend the Law Governing Optometric Practice*, consistent with the criteria for a Sunrise Review (Title 5, section 12015, subsection 3) and share findings and recommendations for the committee's consideration (See letter Appendix 1). Sunrise review is a tool for state policymakers to assess proposals to expand the scope of practice of a regulated profession or establish new regulatory requirements for a previously unregulated profession. Because most of the Sunrise Review questions are more relevant to determining whether to regulate an unregulated profession, we focused on the questions set forth by the committee and the arguments for expansion set forth by the proponents while also keeping in mind the spirit of a Sunrise Review.

The committee requested that the report:

A. Consider the laws in other states related to the scope of practice for optometrists, including those state laws that are similar to the proposal in LD 1803.
B. Review and make recommendations for each of the substantive provisions making changes to an optometrist's scope of practice:
    1. The procedures authorized within an optometrist's scope of practice.
    2. The procedures not authorized within an optometrist's scope of practice.
    3. The opioid prescribing authority of an optometrist.
C. Carefully consider the changes to the licensing board's authority to make changes to an optometrist's scope of practice in LD 1803.

This report summarizes the Department's findings and recommendations based on review of data and other information received from stakeholders and additional research. Our review did not include independent statistical analysis.

Process

1. The Department identified stakeholder members by soliciting names from the Maine Optometric Association and the Maine Society of Eye Physicians and Surgeons. (See Appendix 2 for the Stakeholder Roster.)
2. Department staff used the results of a doodle poll to establish three meeting dates convenient for all from September through December and created a publicly accessible web page to share meeting information and materials.[1]
3. The three meetings covered the following topics: (1) Access; (2) Procedures and Proficiency; (3) Prescriptive Authority and Board Capacity. Prior to each meeting, DPFR staff solicited data from stakeholders, who were also offered opportunities to present their data and perspectives at the meeting. Each presentation was followed by a question-and-answer period.

[1] State of Maine Department of Professional and Financial Regulation, "LD 1803 Stakeholder Group" website, accessed 01/10/26 at https://www.Maine.gov/pfr/LD-1803-Stakeholder-Group

4. Following each meeting, staff reviewed the information and data presented and solicited additional information or clarifications, as needed.

Executive Summary

This report evaluates the sponsor's amendment to LD 1803) which proposes to expand the scope of practice for optometrists in Maine by authorizing certain surgical procedures, limited injection authority, and prescriptive authority for hydrocodone combination products (HCPs), and by granting the Board of Optometry exclusive authority to define scope of practice by rule.

Proponents assert that LD 1803 represents a long overdue modernization of optometry practice in Maine. Opponents contend that optometrists, while valued for their role in primary ocular care, have not undergone the rigorous training necessary to undertake the range of surgical and other procedures to ensure patient safety.

The analysis is based on stakeholder discussions, data and information provided by stakeholders and additional staff research. It draws on cross state comparisons, workforce and access data, education and training standards, quality and safety considerations, and governance implications.

Scope of Practice Expansion

LD 1803 would authorize optometrists to perform a defined set of procedures including removal of certain eyelid lesions, steroid injections for chalazions, subconjunctival injections, corneal collagen crosslinking, and several laser procedures (YAG capsulotomy, YAG peripheral iridotomy, and selective laser trabeculoplasty). Alaska is the only state with a scope of practice similar to what is proposed in LD 1803.

Stakeholders were unable to come to consensus regarding the safety or need for the procedures proposed in LD 1803. While proponents characterize these procedures as low risk and consistent with contemporary optometric practice, opponents contend they are higher risk, often non-urgent, and more appropriately performed by ophthalmologists with surgical training.

Additionally, stakeholders were unable to come to consensus on the procedures LD 1803 authorizes and prohibits due to what opponents described as confusing statutory language.

The report finds that Maine aligns with the majority of states that do not authorize optometrists to perform surgery or laser procedures. Fourteen states permit laser surgeries and only 10 of those states permit all three of the laser surgeries proposed in LD 1803. Twenty-two states have enacted some form of eye lid lesion removal authority, but the specific procedures permitted vary across expansion states.

If the legislature determines that scope expansion is warranted, the report recommends amending the bill to clearly identify the permitted procedures.

Prescriptive Authority and Opioid Considerations

LD1803 proposes restoring optometrists' authority to prescribe Hydrocodone products (HCP), which was lost following the federal reclassification of HCPs from Schedule III to Schedule II in 2014. A majority of states (35) permit optometrists to prescribe HCPs. Proponents argue this authority is needed for rare cases of acute ocular pain and would be limited in duration. Opponents

question the clinical necessity, citing infrequent use of opioids in ocular care and concerns related to opioid misuse.

The report finds that LD 1803 does not incorporate the opioid prescribing safeguards currently required of other prescribers in Maine. If opioid prescriptive authority is permitted, the report recommends that optometrists be subject to the same statutory and regulatory requirements that apply to all opioid prescribers.

Patient Access, Workforce

Data show that optometrists outnumber ophthalmologists in Maine and nationally. The number of optometrists is increasing while the number of ophthalmologists is decreasing. Access can be particularly challenging for Mainers living in rural areas who may need to travel significant distances for care.

Proponents contend that Maine's current scope of practice is negatively impacting the state's ability to attract optometrists. The data doesn't show workforce growth necessarily follows a scope expansion. Without an analysis of the factors that play into a health care practitioner's decision of where to locate, it is not clear whether any impact of scope expansion is causation or correlation.

Proponents also contend that current wait time and drive times to see an ophthalmologist are too long. Wait time data present a mixed picture. While some data show extended waits for certain referrals, other data show urgent cases are generally seen promptly. What is clear is that referral patterns - such as directing patients to specialty rather than comprehensive ophthalmologists - affects wait times. Regarding drive times, because optometrists and ophthalmologists practice in similar, high-density areas, it is unclear what impact LD 1803 would have on drive times.

The Department recommends 1) further study to determine whether any scope expansion(s) would negatively impact assess to *primary* ocular care in Maine, and 2) improvements to the current referral system to facilitate referrals to general ophthalmologists with capacity.

Education and Training

The report highlights substantial differences between optometrist and ophthalmologist education and training. For example, ophthalmology residency standards define minimum numbers of surgical cases residents must complete, but there are no similar minimums for student optometrists.

Proponents reject the assertion that historically, optometry schools have provided variable exposure to surgical training and shared the 2020 Association of Schools and Colleges of Optometry's framework for developing optometric curriculum guidelines and educational standards for ophthalmic surgery. As of January 1, 2025, the Accreditation Council on Optometric Education adopted new professional optometric degree program standards that require the optometry schools to prepare their graduates for the "independent practice of contemporary optometry," defined as "the procedures permitted in at least 10% of states".

Training on live patients remains an area of variability for optometrists. Only three schools offer student optometrists and optometrists training on live eyes; most training is done on models. Some schools offer students a rotation at a school that offers live eye training, but those externships are limited. The closest school to Maine offering training on live eyes is in Kentucky. In contrast, an

ophthalmology resident's exposure to surgery progresses from observation to performing procedures on patients.

Quality, Safety, and Adverse Events

There is a threat to the public's health, safety or welfare when any health care procedure, including surgery, is performed by individuals without sufficient education, training and experience – including frequence of recent practice.

Proponents contend that the low numbers of reported adverse events demonstrate overall safety and cite low reported complication rates nationally (2 negative outcomes across 146,403 procedures). Opponents, however, pointed to multiple examples of adverse events identified in Kentucky and Oklahoma. The discrepancy in identified adverse events may, in part, reflect that only seven expansion states have a mandatory reporting requirement; and only one of those states is required to publicly report the information.

Opponents also raised concerns about maintaining proficiency given low procedure volumes among optometrists in expansion states. Proponents pointed to steady malpractice rates as a sign of safety.

The report finds lack of standardization across expansions states regarding credentialing and training requirements for the proposed procedures, with varying requirements for hands-on experience, ongoing competency assessment, etc.

Given inconclusive safety data, the limited opportunities to train on live eyes, the variability of education and credentialing requirements, the report recommends that if the legislature decides to expand the scope of practice to include any of the proposed surgical procedures, the legislature should impose, or require the Board of Optometry to impose, sufficiently rigorous requirements to ensure public safety.

Governance and Board Authority

LD1803 would grant the Board of Optometry exclusive authority to define the scope of optometric practice, a governance structure that differs from all other licensing boards in Maine and from most states nationally. The report underscores that scope of practice determinations are traditionally legislative policy decisions, with boards exercising regulatory authority within statutory boundaries. Granting exclusive authority to the Board of Optometry would significantly reduce legislative oversight and lacks clear statutory guardrails. The report also finds that the Board is currently under-resourced, which raises questions about their ability to undertake the substantial work necessary to implement LD 1803.

Conclusion

Overall, the report finds that LD 1803 proposes changes that are broader and more discretionary than those adopted in most states, raises unresolved questions regarding training, proficiency, patient safety, opioid prescribing safeguards, and access outcomes, and would represent a significant departure from Maine's established approach to legislative oversight of health professions scopes of practice. The report identifies areas where clarification, additional safeguards, and further study would be necessary should the Legislature choose to move forward with any portion of the proposed expansions.

LD 1803 Proposed Procedures

Proponents of LD 1803 contend the bill modernizes the scope of practice for optometrists in Maine by adding new surgical and prescriptive authorities.

To consider this question, we looked at optometrists' scope of practice laws and regulations across the country, and specifically for the expansion states.

Maine's Scope of Practice Compared with Other States

To understand where Maine "fits" within the national landscape, we reviewed statutes and regulations across the country relevant to LD 1803. Because each state has its own laws and regulations regulating optometrists, our work showed a patchwork of approaches across the country. Appendix 3 reflects our best understanding of the status of each state's optometrist scope of practice.

Our research found that Maine is among the: majority of states that do not permit optometrists to perform surgeries; majority of states that allow injections for anaphylaxis; minority of states that do not allow prescribing hydrocodone. [2]

- **Fourteen states authorize optometrists to perform some type of laser surgery.**
    - Maine is among the majority (37) of states, including all New England states, that do not authorize optometrists to perform laser surgeries.
- **Twenty-two states authorize optometrists to remove some forms of lesions from the eyelid** (colloquially referred to as "lumps and bumps").[3]
    - Maine is among the majority (29) states, including all New England states, that do not authorize optometrists to perform eyelid surgery.
- **Forty-three states permit optometrists to have some type of injection authority**. The specific permitted authority varies by state (*e.g.*, some states permit botulinum toxin ["botox"] injections).
    - Eighteen states, including Maine, Connecticut, New Hampshire and Vermont, limit optometrists' injection authority to treating anaphylaxis.
    - Eight states do not authorize optometrists to provide injections.
- **Thirty-five states authorize optometrists to prescribe hydrocodone products.**
    - Maine, along with Massachusetts, New Hampshire and Vermont, is among the minority (17) of states that do not authorize optometrists to prescribe hydrocodone.

Specific Procedures Permitted in Expansion States

Proponents of LD 1803 contend that the legislation is similar to what has passed in other states. When comparing LD 1803 to states that have expanded authorities ("expansion states"), only Alaska has a scope of practice similar to LD 1803 (see Appendix 4).

While there are 24 states that authorize at least one of the proposed advanced procedures, the specific permitted procedures authorized in each state varies greatly. Of the expansion states:

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[2] The District of Columbia is included in the count of states.

[3] It is important to note that "lumps and bumps" is not a medical term and that the types of lesions that optometrists are permitted to remove vary by state.

- **Fourteen expansion states authorize some form of laser surgery**.
  - Eleven states authorize SLT lasers.
  - Twelve states authorize YAG capsulotomies.
  - Thirteen states authorize LPI lasers.
  - Ten states authorize all 3 lasers (YAG capsulotomies, SLTs, and LPIs).
- **Twenty-two expansion states authorize some form of lesion removal from the eyelid**
  - The types of lesions that optometrists are permitted to remove vary by state.
- **Nine expansion states authorize subconjunctival injections.**
  - Five states explicitly authorize, and some interpret another four states' board regulations to authorize.
  - Three states explicitly prohibit.
- **Six expansion states authorize collagen crosslinking.**
  - Four states explicitly authorize, and some interpret another two states' board regulations to authorize.
  - One state specifically prohibits.

Status of Expansion Legislation Introduced in other States

In addition to Maine, there are efforts by optometrists to expand optometrists' scopes of practice across the country. In 2025, at least 21 bills were introduced across 15 states, including Vermont and New Hampshire, that would authorize optometrists to perform surgery or administer injections.[4] Of those bills, three were enacted, two of which permit certain surgical procedures.

Procedure Definitions

LD 1803 proposes to amend the scope of practice of optometrists in Maine to include several new procedures identified below. Additional details, including visuals of the proposed authorized procedures, are provided in Appendix 5.

1. Removing benign skin lesions of the eyelid (*i.e.*, skin tags) and chalazion of the eyelid (*i.e.*, stye [blocked oil gland]).
2. Treating chalazions with Kenalog (steroid) injections.
3. Corneal collagen crosslinking – adding vitamin B12 and applying UV light to reshape a misshapen cornea (the clear part of the eye that covers the colored part of the eye).
4. Subconjunctival injection – injecting medication just below the conjuvicta (the clear tissue that sits on top of the white part of the eye) and above the white part of the eye to treat an inflamed or infected eye.
5. Yttrium aluminum garnet (YAG) laser capsulotomy – using a laser to clean off a film that may build up on an implant after cataract surgery.
6. YAG peripheral iridotomy (LPI) – using a laser to create a small opening in the iris (the colored area of the eye) to lower eye pressure.
7. Selective laser trabeculoplasty (SLT) – using a laser to target pigmented cells in the drainage system of the eye to lower the eye pressure.

LD 1803 also identifies specific unauthorized procedures (see Appendix 6). Opponents found the list confusing and raised questions regarding how that list would be maintained. Opponents also

[4] American Medical Association "Scope of Practice 2025 State Legislative Activity (updated 11/03/25);" accessed 12/16/25 at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ama-assn.org/system/files/scope-of-practice-2025-legislative-summary.pdf.

questioned whether a procedure that isn't listed on either the authorized or unauthorized list might be permitted because it's not explicitly prohibited.

The laser surgery procedures are done using a slit lamp, an instrument that is currently used diagnostically by optometrists for eye exams (see Appendix 7). Proponents argued that they are prepared to provide the proposed surgeries because they involve the use of slit lamps, which optometrists use every day in their practice. Opponents disagreed, noting that there is a significant difference between using a slit lamp for diagnostics versus surgical purposes.

To better understand each procedure, we asked the stakeholders to provide their perspective on the risk level, urgency, and frequency of each of the proposed procedures.

There was almost no consensus between the parties. In general, the proponents argued that the procedures were low risk and high need. Conversely, the opponents argued that the procedures are high risk and some are unnecessary or needed infrequently. See Appendix 8 for additional information.

Prescriptive Authority

LD 1803 also proposes expanding optometrists' prescriptive authority to include hydrocodone combination products (HCPs).[5] Proponents contend that prohibiting optometrists from prescribing these products is outdated and seek to restore their previous prescriptive authority. Opponents question the need for optometrists to prescribe HCPs noting that HCPs are rarely used by ophthalmologists and are at risk for abuse.

The Department notes that there was some confusion regarding the prescriptive authority permitted by LD 1803. Proponents stressed that their intent is to limit any new prescriptive authority to HCPs. Opponents believe the amendment would permit additional prescriptive authority beyond HCPs. If the Legislature chooses to move forward with an expansion of prescriptive authority, the Department recommends clarifying the statutory language.

History of HCPs Relative to the Controlled Substances Act

In 2009, the Maine legislature enacted a law (P.L. 2009, c. 195) allowing optometrists in Maine to prescribe oral medications including Schedule III drugs, which at the time included HCPs. [6] In 2014, the U.S. Drug Enforcement Agency (DEA) rescheduled HCPs from Schedule III to a more restrictive Schedule II of the Controlled Substances Act.[7] The Controlled Substances Act places drugs with accepted medical uses and the greatest potential for harm and abuse in Schedule ll. The reclassification to Schedule II occurred because the hydrocodone combination products were the most commonly prescribed opioid pain relief drugs and at risk for abuse.

Following that 2014 reclassification, Maine optometrists were no longer able to prescribe HCPs because their optometrists' prescriptive authority did not include Schedule II drugs. Currently,

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[5] Hydrocodone combination products combine an opioid with other non-narcotic drugs such as acetaminophen (*e.g.*, Tylenol®).

[6] An Act to Promote Cost-effective and Broad-based Vision Care for Maine Citizens by Clarifying the Scope of Prescription Authority by an Optometrist (P.L. 2009, c. 195) accessed 01/10/26 at https://www.mainelegislature.org/legis/bills/bills_124th/chapters/PUBLIC195.asp

[7] The Controlled Substances Act places all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability.

thirty-five states authorize optometrists to prescribe HCPs (see Appendix 3). Proponents contend that those states amended their laws to maintain optometrists' prescriptive authority for HCPs. In New England, Connecticut is the only state that authorizes optometrists to prescribe HCPs.

Need for HCPs in Ocular Care

Proponents contend that the proposed HCP prescriptive authority would reinstate their previous prescribing authority. They acknowledged that HCPs are rarely prescribed but contend are needed on rare occasions to treat severe ocular pain that cannot be managed with over-the-counter or non-opioid prescription medications. Further, they note that these products are prescribed for no more than 72 hours and limited to acute situations such as corneal abrasions (see Appendix 9).

Opponents agreed that the need for HCPs is infrequent, stressing that HCPs are rarely prescribed or medically necessary for treating ocular issues. In her over twenty-five years of doing ocular surgery, Dr. Feero, one of the ophthalmologist stakeholders, reported that she has never prescribed hydrocodone for any reason.

Data from the Maine Prescription Monitoring Program indicates that between 2019 and 2024, 13% of all narcotics prescribed by ophthalmologists in Maine were for hydrocodone (see Appendix 10). This was behind tramadol (Schedule IV) and oxycodone (Schedule II) and similar to prescriptions for codeine (Schedule III). A 2021 study of the Medicare Part D database concluded that most optometrists do not prescribe opioids and most optometrists who prescribe opioids write only a few prescriptions. [8] From 2013 – 2017, approximately 5.9% of optometrists in the CMS Part D database prescribed opioids.

Opioid Epidemic

In addition to questioning the medical need for prescribing HCPs, opponents also raised concerns about the impact of expanding the authority to prescribe HCPs on Maine's efforts to stem the opioid epidemic.

The opioid epidemic in Maine has resulted in almost 4,600 opioid related overdoses from 2010-2022. Maine's Opioid Response 2023 – 2025 Strategic Plan recommends reducing "the number of prescribed, illegally trafficked, and unsafely stored opioids" and identifies "Improv[ing] the safety of opioid prescribing" as one of its priority strategies. [9]

Although the proposed use of HCPs for post-operative ocular pain control is intended for limited durations, "[a]n estimated 3-12% of people treated with opioids for chronic pain will develop an addiction or abuse with negative consequences. Approximately 8.6 million Americans reported misusing prescription opioids in 2023. People who develop tolerance or dependence to prescription opioids may transition to illegally produced opioids, such as a fentanyl." [10]

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[8] Dryden SC, O'Malley HA, Adams LR, Nix GC, Rho JE, Vacheron AB, Fleming JC, Fowler BT. Opioid Prescribing Patterns of Optometrists in the Medicare Part D Database. Optom Vis Sci. 2022 Jan 1;99(1):31-34. doi: 10.1097/OPX.0000000000001827. PMID: 34882610.

[9] "Maine Opioid Response 2023-2025 Strategic Action Plan," accessed 01/10/26 at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/GOPIF_OpioidReport_2023.pdf

[10] American Psychiatric Association's "Opioid Use Disorder," accessed 01/10/26 at Psychiatry.org - Opioid Use Disorder

Neither LD 1803 as originally drafted, nor the amendment, included any of the statutory requirements imposed on other Maine health care practitioners with opioid prescribing authority. If the legislature chooses to expand optometrists' prescriptive authority to include HCPs, the Department recommends that the bill be amended to require optometrists to comply with all the requirements that apply to all other prescribers of opioids in Maine (see Appendix 11).

Department Findings & Recommendations: Proposed Procedures

- Maine is among the majority of states that:
    - Do not permit optometrists to perform surgeries.
    - Permit optometrists to have some type of injection authority (though Maine is among the minority of states that limits this authority to treating anaphylaxis).
- Maine is among the minority of states that do not allow prescribing hydrocodone.
- Alaska is the only state with a scope of practice similar to what is proposed in LD 1803.
- There is no consensus among stakeholders regarding the safety or need for the procedures or prescriptive authority proposed in LD 1803, or on the procedures LD 1803 authorizes and prohibits due to what opponents described as confusing statutory language.
- If the legislature determines that any scope expansions are warranted, the report recommends the legislation:
    - Clearly identify the permitted procedures.
    - Require optometrists to comply with all the requirements that apply to all other prescribers of opioids in Maine, if opioid prescribing is authorized.

Patient Access to Eye Care in Maine

Proponents of LD 1803 contend that passage of LD 1803 will improve patient access to eye care services by 1) increasing the number of optometrists in Maine by attracting more optometrists to practice in the state, and 2) reducing patient wait times and drive times for the identified surgeries by expanding the types of providers who can provide the proposed surgical procedures.

To consider this question, we looked at workforce data on optometrists nationally, in expansion states, and in New England.

Current Workforce Data

In the United States, the number of ophthalmologists is decreasing while the number of optometrists is increasing.[11] From 1997 to 2022 the profession of optometry grew by 58%, expanding from 30,510 to 48,196 practicing licensees. Looking ahead, the Bureau of Labor Statistics projects that employment of optometrists will grow 8% from 2024 to 2034, much faster than the average for all occupations.[12]

[11] Feng PW, Ahluwalia A, Feng H, Adelman RA. National Trends in the United States Eye Care Workforce from 1995 to 2017. Am J Ophthalmol. 2020 Oct;218:128-135

[12] U.S Bureau of Labor Statistics, "Occupational Outlook Handbook – Optometrists," accessed 01/10/26 at Optometrists : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics

At the same time, according to a 2023 study[13], researchers forecast a large shortage of ophthalmologists relative to demand by the year 2035. While there is no "standard" ratio of ophthalmologists to optometrists or optometrists to a population, data on the distribution of optometrists and ophthalmologists across Maine is provided in Appendix 12 and Appendix 13, respectively. The trend of more optometrists than ophthalmologists will continue and the demand for eye care is expected to increase.

Maine has approximately 258 active, licensed optometrists and 113 active, licensed ophthalmologists serving most of Maine's counties (see Appendix 14). Optometrists are in all of Maine's 16 counties and outnumber ophthalmologists in each county. Ophthalmologists are in 13 of Maine's 16 counties; there are no ophthalmologists in Piscataquis, Washington, or Oxford counties.

Impact of Scope Expansion on Recruitment

Proponents contend that Maine's current scope of practice is negatively impacting the state's ability to attract optometrists by causing optometrists, including recent optometry graduates, to choose to practice in states with expanded scopes of practice. Proponents further contend that expanding Maine's scope of practice to include surgery would improve patient access to current optometry services as well as the proposed procedures by attracting more optometrists to the State of Maine.

Opponents disagree, attributing the growth in the number of optometrists in scope expansion states to the overall, national increase in the number of optometrists rather than an expanded scope of practice.

DPFR reviewed data on the number of licensed optometrists nationally, in states with an expanded scope of practice, and in New England. To compare the national growth rate to the expansion states, we looked at the number of licensees since a state's expansion law was enacted (see Appendix 15).

The most notable increases were in three of the four states whose expansion law has been in place for more than a decade.

- Oklahoma, the state with the oldest law, had 507 practicing optometrists the year their expansion law was enacted (1998), 483 five years after enactment, and 645 practicing optometrists in 2025. *An increase of 138 optometrists over 27 years, representing a 27% overall growth rate*.
- Kentucky had 393 practicing optometrists in the year their expansion law was enacted (2011), 559 five years later, and 651 practicing optometrists in 2025. *An increase of 166 optometrists over 14 years, representing a 66% overall growth rate*.
- Louisiana had 300 practicing optometrists in the year their expansion law was enacted (2013), 397 five years later, and 416 practicing optometrists in 2025. *An increase of 116 optometrists over 12 years, representing a 39% overall growth rate*.

However, not all expansion states saw significant growth following passage of their expansion law.

[13] Berkowitz ST, Finn AP, Parikh R, Kuriyan AE, Patel S. Ophthalmology Workforce Projections in the United States, 2020 to 2035. Ophthalmology. 2024 Feb;131(2):133-139. doi: 10.1016/j.ophtha.2023.09.018. Epub 2023 Sep 20. PMID: 37739231

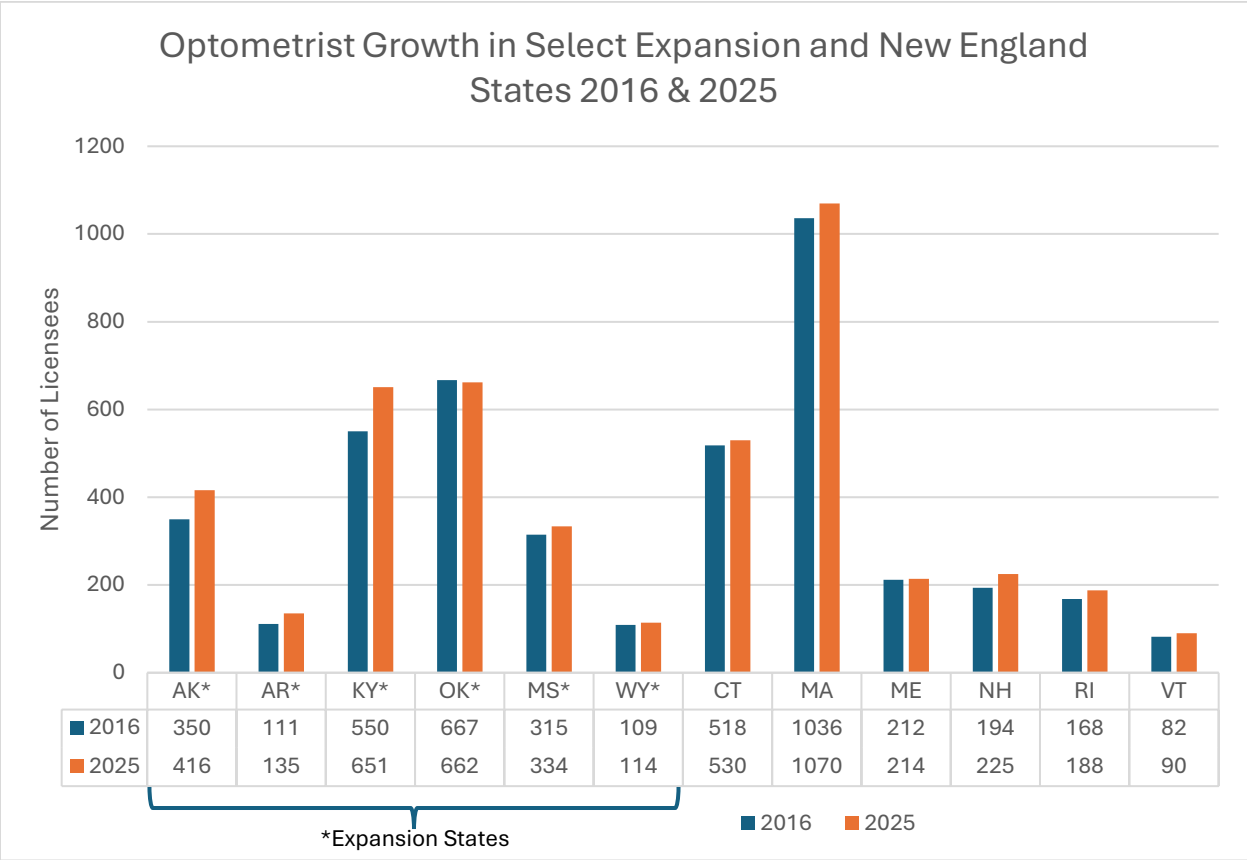
- Alaska had 128 practicing optometrists in the year their expansion law was enacted (2017), 143 five years later, and 135 practicing optometrists in 2025. *An increase of 7 optometrists over 8 years, representing a 5.5% overall growth rate*.
- Arkansas had 392 practicing optometrists in the year their expansion law was enacted (2020), and 402 five years later (2025). *An increase of 10 optometrists over 5 years, representing a 2.6% overall growth rate*.
- Wyoming had 112 practicing optometrists in the year their expansion law was enacted (2021) and 114 four years later. *An increase of 2 optometrists over 4 years, representing a 1.8% overall growth rate*.

Finally, one of the expansion states experienced a decrease in their number of licensees.

- Mississippi had 340 practicing optometrists in the year their expansion law was enacted (2021) and experienced a decrease to 334 practicing optometrists four years later (2025). *A decrease of 6 optometrists over 4 years, representing a -1.76% overall growth rate*.

To better understand the growth, we compared expansion states with New England states, for the years 2016 and 2025—years for which we had licensing data for each state. The results of that comparison are depicted in Figure 1.

Figure 1. Optometrists Growth in New England and Select Expansion States



The Department did not include states whose scope expansion was enacted less than 4 years ago. Proponents contend that smaller increases in those states may reflect the time it can take to implement a law (*e.g.*, finalize regulations) and for the market to catch up. While the Department appreciates the potential impact of market lag, we question the impact of market lag on attracting recent optometry graduates. Proponents note that it is common for optometry students to ask about a state's scope of practice during their residency. Presumably those students would factor recent changes to a state's scope of practice into their decision of where to practice.

The Department also didn't analyze the growth rate of non-expansion states outside of New England. Presumably there are non-expansion states with growth rates at or near the 58% to account for that national growth statistic.

The mixed results regarding optometrist workforce growth following scope expansion suggest that scope of practice is only one of many factors influencing provider location decisions. Other factors include income tax burdens, salaries, lifestyle and family (*e.g.*, opportunities for spouse), etc. Without comprehensive analysis of all the factors that play into a health care practitioner's decision to locate in a particular state, it is not clear whether any impact of scope expansion is causation or correlation.

Impact on Patient Wait and Drive Times

Proponents contend that Maine's current scope of practice results in Maine patients waiting too long or driving too far to receive the services proposed in LD 1803. Proponents further contend that passage of LD 1803 would improve patient access to the proposed services by reducing wait times

(the average time between a patient receiving an optometrist's referral and the patient seeing an ophthalmologist) and drive times (the length of time it would take a patient to drive from their home to a practitioner's office) for services.

Opponents disagree, noting that referring patients to "comprehensive ophthalmologists" versus "specialty ophthalmologists" would positively impact wait times. (*See discussion of "comprehensive" and "specialty" ophthalmologists" below*), and that optometrists and ophthalmologists generally work in the same areas of higher density populations.

Wait Time Data

Proponents and opponents acknowledged that there are challenges with using wait time as an indicator of access. The timing of a patient's appointment is impacted by several factors, including factors outside of a provider's control such as the patient's own schedule (*e.g.*, a patient needs an appointment on a certain day of the week or time of day, or "snowbirds" who leave the state for the winter), whether the provider is in the network of the patient's health insurer, insurance preauthorization requirements, or whether the patient is a current patient of the provider, needs urgent care, or is medically a good candidate for the procedure.

To provide a snapshot of wait times for referrals to Maine ophthalmologists, stakeholders supplied data from several sources.

Proponents provided data from a 2023 survey by the American Optometric Association of optometrists in expansion states. Eighty-nine percent of survey respondents reported having availability to perform YAG laser procedures within one week. In comparison, 64% of respondents reported that patients waited three weeks or more for an appointment with an ophthalmologist to perform YAG laser prior to scope of expansion.[14]

Looking closer at Maine, proponents provided data from a survey the Maine Optometric Association sent its members (see Appendix 16). The survey was sent to approximately 185 optometrists, 30 of which responded (reflecting a 30% response rate.) The results show that not all requests for referrals have resulted in either an appointment for a consultation or a scheduled procedure. Of the referrals that resulted in a scheduled procedure, the number of days between a referral to an ophthalmologist ranged from a low of 8 to a high of 262; the median was 63.

Opponents provided wait time data based on a survey conducted by the Maine Society of Eye Physicians and Surgeons (see Appendix 17). The survey was sent to approximately 65 ophthalmologists, 45 of which responded (reflecting a 69% response rate.) The data shows that patients with emergent issues are seen quickly, surgeries are prioritized, and less urgent visits (consultations, evaluations, and routine examinations) take the longest to schedule. More specifically:

- At least 74.29% of patients see an ophthalmologist within 1 month or less for the four laser surgeries, lid lesions, and a consult to laser. That number drops to 50% of patients seeking a cataract evaluation, and approximately 29% of patients who need a routine examination.

[14] "Patients benefit from optometric scope expansion authorizing doctors of optometry to perform YAG laser capsulotomies," American Optometric Association's Health Policy Institute, accessed 01/13/26 at HPI study wait time OD OMD YAG procedures (1) - Adobe cloud storage

- Approximately 94.4% of patients with who need an emergent YAG Iridotomy see an ophthalmologist within 3 days or less.

Opponents noted that the proponent's survey results revealed that optometrists sometimes referred patients to ophthalmology specialists rather than comprehensive ophthalmologists[15]. "Ophthalmology specialists" are fellowship-trained surgeons whose practices generally focus on more serious conditions. "Comprehensive ophthalmologists" have a more general practice and more capacity for less urgent procedures. The wait time for consults was 26.3 days for a general ophthalmologist versus 43 days for a fellowship-trained surgeon (1.63 times longer). For the YAG lasers identified in the data, the time from referral to surgery was slightly longer for specialists (33.5 days) than for a general ophthalmologist (30.4 days).

Dr. Feero (a stakeholder), whose wait times were identified in the proponent's survey, questioned the accuracy of the proponent's survey results for her practice. In a review of her practice, she found that her patients wait less than 11 working days for consultation and less than 15 days for surgery. Lid lesions have the longest wait time because they are performed in an in-office minor surgical suite. There were no referrals for LPI surgeries during the study period. (see Appendix 18).

Opponents also noted that some of their patients have experienced delays in receiving primary care from optometrists and expressed concern that expanding optometrists' scope of practice in Maine could create further delays in accessing primary eye care. In response, proponents provided data on wait times for optometric care. A poll of Maine Optometric Association members revealed that new patients wait approximately 7 weeks for an appointment with an optometrist (ranging from 1 week to 8 months) and existing patients wait an average of 5.5 weeks (ranging from 2 weeks to 6 months) (see Appendix 19). Proponents noted that various factors such as location, how long the optometrist has been practicing, patient volume, and individual patient needs impact when a patient can see an optometrist – the same factors that impact ophthalmologist wait times.

Given the wait time data for optometric care provided by the proponents, additional research is recommended to understand whether the proposed expansions would impact patient access to *primary* eye care provided by optometrists.

Additionally, an improved referral system that identifies general ophthalmologists with capacity would be beneficial.

Drive Time Data

Stakeholders also looked at "access" from the perspective of a patient's drive time. As a 2023 study of access at the national level demonstrated found that "most optometrists performing laser eye surgery are doing so where ophthalmologists already practice."[16] An estimated 75%, 91%, and 98% of Americans reside within 15, 30, and 60 minutes of an ophthalmologist, respectively. Furthermore, an estimated 85%, 95%, and 99% of Americans reside within 15, 30, and 60 minutes of an optometrist, respectively.

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[15] A comprehensive ophthalmologist provides general, primary eye care while a specialist ophthalmologist (or subspecialist) has participated in a fellowship to receive additional training in a specific complex disease, part of the eye, etc.

[16] Shaffer J, Rajesh A, Stewart MW, et al. Evaluating Access to Laser Eye Surgery by Driving Times Using Medicare Data and Geographical Mapping. *JAMA Ophthalmol*. 2023;141(8):776–783. doi:10.1001/jamaophthalmol.2023.3061

In reviewing five states with expanded authority, that same study found that in the states of Oklahoma (73.4%), Kentucky (76.1%), and Louisiana (83.9%), a majority of patients reside within a 30-minute travel time to an ophthalmologist who performs LPI, SLT, or YAG procedures. Similarly, except for optometrists performing LPIs in Kentucky and Louisiana, and optometrists performing YAGs in Arkansas, a majority of patients reside within a 30-minute travel time to an optometrist (see Appendix 20).

According to the opponents, similar travel estimates are seen in Maine. They calculate that only seven zip codes with optometry points of service are outside of a 30-mile catchment area of an ophthalmologist and only one zip code is outside a 60-mile catchment area (see Appendix 21). When looking at patient access in Maine from a drive time perspective, approximately 83.3% of Maine's population is within a half-hour drive time to an ophthalmologist; 96.1% is within a one-hour drive (see Appendix 22).

Department Findings & Recommendations: Patient Access

- Optometrists outnumber ophthalmologists in Maine and nationally, and the optometry workforce continues to grow while the number of ophthalmologists is decreasing.
- Researchers forecast a shortage of ophthalmologists in the future to meet demands for eye care, which are expected to increase.
- There are Mainers in rural areas who must travel significant distances for care, including those in counties where there are no ophthalmologists.
- The data doesn't show workforce growth necessarily follows a scope expansion. It is not clear whether any impact of scope expansion is causation or correlation.
- Because optometrists and ophthalmologists practice in similar, high-density areas, it's unclear how much LD 1803 would impact patient drive times.
- Wait time data presents a mixed picture. While some data show extended waits for certain referrals, other data show urgent cases are generally seen promptly. Referral patterns - such as directing patients to specialty rather than comprehensive ophthalmologists - affect wait times.
- Patient wait time for optometric care currently averages 7 weeks for new patients and 5.5 for existing patients. The Department questions whether expanding scope has an impact on access to optometric primary ocular care.
- The Department recommends:
    - Further study to determine whether any scope expansion(s) would impact assess to *primary* ocular care in Maine.
    - Improvements to the current referral system to facilitate referrals to general ophthalmologists with capacity.

Education & Training

Proponents of LD 1803 contend that optometrists have or can obtain the education and training to prepare them to provide the proposed procedures in LD 1803.

To consider this question, we looked at the training for optometrists and ophthalmologists.

Optometrists

Optometrists, after receiving an undergraduate degree, complete a four-year, doctoral level degree and may choose to also pursue a one- or two-year residency (see Appendix 23).

Proponents contend that while some schools of optometry began including laser training in their curriculum in the late 1980's following the enactment of Oklahoma's expansion law, "no optometry students have graduated in the 2020s without training in advanced procedures."

In 2020 the Association of Schools and Colleges of Optometry Board of Directors adopted a framework for developing optometric curriculum guidelines and educational standards for ophthalmic surgery. The "Framework for Developing Optometric Curriculum Guidelines and Educational Standards for Ophthalmic Surgery"[17] "does not specify an exact number of credit hours, contact hours, observations or performance,...is a starting point and is not meant as a prescriptive list of activities to restrict, limit, or regulate." Proponents note, "The ACOE does not merely require that these courses be offered; it requires that all students successfully complete the didactic and laboratory components in order for a program to maintain accreditation and for a student to graduate."

Also, as of January 1, 2025, the Accreditation Council on Optometric Education (ACOE) recognized new professional optometric degree program standards that seek to prepare graduates for the "independent practice of *contemporary optometry*" (emphasis added), which is defined as "the performance of procedures that are allowable in at least 10% of states' scope of practice."[18] Accredited optometry schools that provide laser surgery training do so through didactic methods (*i.e.*, classroom lectures) and lab training. While a minority of optometrists train on live patients, most optometrists conduct their lab training on simulated eyes (see Appendix 24). Three schools of optometry are located in states that authorize optometrists to perform surgeries thereby permitting students to train on live patients (Northeastern State University Oklahoma College of Pharmacy, Kentucky College of Optometry, and Indiana College of Optometry.)

Some schools of optometry offer a rotation in a state that allows training on live patients, but those externships are limited in the number of students they can accommodate. For example, according to proponents, the Houston College of Optometry sends 3-6 students each rotation to do a 3 – 4 month rotation that includes laser training.

Optometrists who graduated from optometry school without laser training or who seek a refresher course can attend single-day or weekend workshops (see section on credentialling below). For example, Northeastern State University Oklahoma College of Optometry Advanced Procedures Couse includes a 16-hour Surgical Procedure Course and a 16-hour Laser Procedure Course (see Appendix 25 for an example of training curriculum).

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[17] Association of Schools and Colleges of Optometry "Framework for Developing Optometric Curriculum Guidelines and Educational Standards for Ophthalmic Surgery," accessed 01/10/26 at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://optometriceducation.org/files/Curriculum-Framework-for-Ophthalmic-Surgical-Procedures.pdf

[18] Accreditation Council on Optometric Education "Glossary," published 11-2025, accessed 01/10/26 at Current ACOE Glossary.pdf

Ophthalmologists

Ophthalmologists, after receiving an undergraduate degree, complete a four-year, doctoral level medical degree followed by a four-year residency in ophthalmology. Ophthalmologists may choose to also pursue a 1- to 2-year fellowship to further specialize (see Appendix 26 for an example of a medical school's curriculum).

Ophthalmology residents spend four years focused on various elements of surgery (see Appendix 27). Surgical training standards for ophthalmologists are set by the Accreditation Council for Graduate Medical Education (ACGME), which establishes for certain procedures a minimum number of cases that a residency program must include in their curriculum. The minimum number of procedures for YAG capsulotomies, laser trabeculoplasties (which includes SLTs), and laser iridotomies (which includes LPIs) are 5, 5, and 4 respectively. Those minimums represent a small subset (14 hours) of the total 205 hours of required minimum procedures in an ophthalmology residency (see Appendix 28).

These minimum case numbers help standardize ophthalmology training in the U.S. and are intended to ensure that residents are "familiar with" each procedure. [19] An ophthalmologist's competency is measured over their four-year residency based on several criteria that are also established by ACGME (see Appendix 29). These competency levels range from describing the elements of care to performing the procedure under various levels (*e.g.*, direct, indirect) supervision. According to data provided by opponents, ophthalmology residents completing programs in 2024-2025 completed an average of 27.7 YAG Capsulotomy cases, 20.6 Laser Trabeculoplasty (includes SLT) cases, 11.2 Iridotomy (LPI) cases, 11.7 Laceration cases, and 8.2 Chalazion Excision cases (see Appendix 30).

There is no standard for the number of surgery cases an optometrist must undertake in their training while ophthalmologists must undertake a minimum number of cases training specific to eye laser surgery through various levels of engagement (*e.g.*, observer, assistant).

Table 1. Simplified Comparison of Optometry and Ophthalmology Education

Optometry	Ophthalmology
Undergraduate: Bachelor's Degree	**Undergraduate:** Bachelor's Degree
Graduate: Four-year Optometry School	**Graduate:** Four-year Medical School[20]
Optional Residency: *One- to two-years*	**Mandatory Residency:** Four-year Surgical Residency
	Optional Fellowship: *One- to two-years*

[19] Defined by ACGME as able to perform a procedure with assistance

[20] Proponents report that medical students' surgical exposure typically starts with observation but progresses to performing bedside procedures such as suturing lacerations. Medical students also participate in surgeries that take place in a sterile operating room environment and are tasked with suturing surgical incisions or acting as an assistant to an attending surgeon. Depending on a school's resources, some training may occur in a simulation lab; however, all medical students ultimately gain surgical experience with live patients.

Department Findings & Recommendations: Education & Training

- The education and training of optometrists and ophthalmologists is very different.
- The foundation of optometric training is primary eye care.
- Certain surgical procedures have been incorporated into the curriculum of schools of optometry. In 2020 the profession released a framework for developing optometric curriculum guidelines and educational standards for ophthalmic surgery. And as of January 1, 2025, the profession's accrediting body recognized new professional optometric degree program standards that include "contemporary optometry," which is defined as the procedures permitted in at least 10% of states. Neither the framework nor the standards identify minimum number of surgical cases that must be completed.
- There are limited opportunities for student optometrists or optometrists to train on live eyes; most training is done on models.
- Ophthalmologists are trained to provide specialty medical care, including surgical care in and around the eye.
- Ophthalmologists must complete a minimum number of surgical cases. Their surgical exposure progresses from observation to performing procedures on patients.

Maintaining and Measuring Quality

Proponents contend that licensure requirements, including continuing education (CE), that optometrists must fulfill in states with expanded authorities help ensure that optometrists are and remain proficient in the proposed procedures. Opponents disagree, noting that experience is also important and questioned whether optometrists with expanded authorities can maintain proficiency while performing few surgeries.

To consider the question of proficiency, we looked at credentialing and CE requirements, frequency of procedures, and adverse events. Although the stakeholder group did not discuss CE in detail, information on all education requirements (including CE) is provided in Appendix 31.

Credentialing Requirements

There is no standard approach to credentialing requirements across expansion states. All boards of optometry require successful completion of a board-approved course. Beyond that, boards' credentialing requirements are more varied than standardized and include elements such as course length, required curriculum, clinical/laboratory experience, hands-on or in-vivo experience, etc. Table 2 provides a snapshot of the requirements in these select states. Additionally, some states also require proctored training or a preceptorship. [21], [22] For example:

- **Colorado** licensees must satisfactorily complete a proctored clinical session within two years prior to performing laser procedures or treating ocular adnexa. Applicants who have not performed a laser procedure in the previous two years are required to complete a proctored clinical session prior to performing any laser procedures.

[21] A proctored session is an exam supervised by a neutral party (proctor) or software to ensure academic integrity.

[22] A preceptor is an experienced professional who provides direct, hands-on training to a student/learner for a defined period of time to help develop specific skills (*e.g.*, clinical skills).

- **Kentucky** requires licensees seeking to be credentialed to utilize expanded therapeutic laser procedures to provide documentation from a board-approved preceptor indicating that the licensee has demonstrated clinical proficiency in the performance of the procedure on a living human eye.
- **Mississipp**i requires optometrists wishing to be certified to provide primary eye care procedures, including YAG lasers, to participate in 8 additional hours of working under a preceptor (either an ophthalmologist or a licensed credentialed optometrist) who is licensed to perform the YAG procedures. The training must occur within the state in which the preceptor is licensed to perform such procedures. The preceptorship must be completed within 3 months of passage of a skills assessment.
- **South Dakota** requires licensees to demonstrate competency for expanded scope of practice procedures. Licensees must have a proctor observe various procedures for which minimums are set. For example, SLTs must be performed on at least 5 human eyes and YAG capsulotomies must be performed on at least ten human eyes.
- **Virginia** requires applicants for laser surgery certification who have not provided the board with a passing score on the Laser Section of the LSPE to submit evidence of at least two proctored sessions for each of the following lasers: LPI, SLT, YAG.
- **West Virginia** requires documentation of the completion of each required number of proctored procedures on a living human eye:(5)YAG, (5)SLT,(4) LPI.
- **Wyoming** requires licensees to satisfactorily complete a proctored session within 2 years prior to performing laser surgical procedures. If a licensee has not performed a laser procedure within 2 years, the licensee shall satisfactorily complete another proctored session.

Table 2. Comparison of Post-Graduate Education Requirements for Advanced Procedures in Select Expansion States

Requirement	AK	AR	CO	KY	LA	MS	MT	OK	SD	VA	WV	WY
Board-approved course required	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minimum 32 clock hours specified	✓	✓		✓	✓	✓	✓		✓			
Detailed didactic curriculum listed in rule/statute	✓	✓		✓	✓	✓				✓		
Clinical/laboratory experience required	✓	✓		✓		✓						
Hands-on or in vivo experience explicitly required	✓			✓		✓						
Written examination required	✓			✓				✓				
Clinical/practical examination required	✓			✓								
Recency or post-graduation timing requirement	✓	✓				✓					✓	

Frequency of Performed Procedures

Opponents contend that individual optometrists credentialed to provide the proposed procedures in expansion states are conducting so few procedures that it is difficult for an optometrist to maintain proficiency in these procedures.

According to 2023 Medicare Claims Data, in four of seven states with expanded authorities (Alaska, Arkansas, Mississippi, and Wyoming) optometrists represented less than 5% of the Medicare fee-for-service claims filed for YAG laser surgeries in each state. Of the remaining three states measured, (Louisiana, Kentucky, and Oklahoma), optometrists' claims represented 7%, 8%, and 15% of total claims, respectively. Even fewer SLT surgeries were performed in Oklahoma. In the state with the highest percent of optometrists submitting Medicare FFS claims for SLT procedures, optometrists' claims represented 1.6% of total claims (see Appendix 32).

Proponents disagree with the premise that optometrists won't be able to provide enough procedures to remain proficient. They also contend that Maine is underutilizing some of the proposed surgeries. Proponents' data on the number of Medicare Advantage procedures from 2018-2023 for SLT and LPI procedures indicates that New England has a lower incidence of YAG capsulotomies than the national average (see Appendix 33).

Opponents agree that the incidence of YAGs is lower in New England but suggest that the lower number may reflect an older population that is less likely to need or want YAG lasers, and other health care consumption patterns in New England. More research would be necessary to determine why the YAG rates differ in New England and whether YAG rates in New England represent appropriate utilization of this type of procedure.

The Department notes that procedure infrequency is a safety concern. Colorado and Wyoming, for example, address this concern by requiring an optometrist to repeat a clinical proctored session if more than 2 years lapse between laser procedures.

Adverse Events

Proponents contend that the small number of reported adverse events in states with expanded authorities indicates that optometrists can perform these surgeries safely. Proponents shared data indicating that of the 146,403 laser procedures performed by optometrists across the US, there have been only two negative outcomes. [23]

Opponents disagree, noting that more than half of states that authorize optometrists to perform surgical procedures have no outcome reporting requirements, and most of that reported information is not public (unless, for example, it results in official Board action). Only the state of Washington has a statutory requirement to have an annual report on lid surgery outcomes publicly available (2025 was the first year Washington collected this data from optometrists) (see Appendix 34).

Letters from the ophthalmology associations in Kentucky and Oklahoma included descriptions of 11 adverse events as a small sample of examples of adverse outcomes (see Appendix 35 and 36). Below are just two examples from those letters:

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[23] Lighthizer, N., Patel, K., Cockrell, D., Leung, S., Harle, D. E., Varia, J., … Alam, K. (2025). Establishment and review of educational programs to train optometrists in laser procedures and injections. *Clinical and Experimental Optometry*, *108*(3), 248–257. https://doi.org/10.1080/08164622.2024.2380075

- A Kentucky optometrist lasered the vital capsule that was separating the two chambers of the eye, causing a severe glaucoma with eye pressures three times what is normal, resulting in permanent harm to the optic nerve.
- An Oklahoma optometrist performed a laser iridotomy in both eyes of the patient. The patient continued to experience visual distortion and sought a second opinion from an ophthalmologist. Upon review, there was nothing in the patient's record finding that the patient even needed the laser surgeries the optometrist performed.

Proponents also contend that malpractice rates, which have remained relatively steady would increase if optometrists were not providing the proposed services safely (see Appendix 37). Opponents disagree, noting that currently there are too few optometrists providing the proposed procedures to influence malpractice rates.

Department Findings & Recommendations: Maintaining and Measuring Quality

- There can be a threat to the public's health, safety or welfare when health care procedures, including surgery, are performed by individuals without sufficient education, training and experience - including frequency of recent practice.
- There is no standard approach to credentialing requirements across expansion states.
- The incidence of some of the proposed procedures is lower in New England than the rest of the country; the cause is unclear.
- A minority of expansion states require reporting of adverse events. Only one state requires that information to be public. There is evidence of adverse events having occurred.
- It's unclear if enough of the advanced procedures are being performed to influence malpractice rates
- If the legislature decides to expand the scope of practice to include any of the proposed surgical procedures, the Department recommends setting sufficiently rigorous requirements to ensure public safety either in statute or through the Board of Optometry

Board of Optometry Authority

LD 1803 proposes to grant the Maine Board of Optometry "exclusive authority" to determine scope of practice as follows:

> §19201-A. Exclusive authority. The board has exclusive authority to determine what constitutes the practice of optometry as set out in section 19102 and as further defined by the board by rule. This chapter may not be construed to permit any agency, board or other entity of this State other than the board to determine what constitutes the practice of optometry. The board has sole jurisdiction to exercise any other powers and duties of the board established under this chapter.

LD 1803 also states the board has "sole jurisdiction" to exercise any other powers and duties of the board established under the enabling act.

Proponents contend requiring legislative action to expand the profession's scope of practice in Maine is inefficient and impedes licensed optometrists' ability to utilize new technologies.

Opponents disagree, noting that the current law is consistent with that of other Maine licensing boards and is an important guardrail to ensure public safety.

To consider the potential impact of LD 1803, we examined delegation of legislative authority to a licensing board and whether major substantive rulemaking under the Maine Administrative Procedure Act (MAPA) is an adequate procedural safeguard if the Board of Optometry is granted "exclusive authority" to determine what constitutes the practice of optometry. We also reviewed the board's capacity to undertake significant major substantive rulemaking under MAPA when it is supported by a single staff member and up to .10 full-time equivalent (FTE) of an Assistant Attorney General.

Roles of State Legislatures and Licensing Boards in Determining Scopes of Practice

The right to practice a profession is not an absolute or unfettered right. As established in *Dent v. West Virginia*, 129 U.S. 114 (1889) and the resulting progeny of case law, the state authority to regulate a profession is rooted in the state's police power and its interest in protection of the public health, safety and welfare.[24]

Generally, state legislatures establish a statutory scheme for licensing through an enabling act. The enabling act sets forth:[25]

- A declaration of policy or purpose stating the need for regulation (*i.e.*, public health, safety and welfare);[26]
- Definitions, including the scope of the regulated occupation or profession;
- Establishment of a board or commission, including the number of members, the appointment authority, removal and vacancies, officers and meetings;
- The powers and duties of the board, including to administer and enforce the enabling statute, engage in rulemaking, examine and determine qualifications;
- Qualifications for licensure, including any required examinations;
- Reciprocity and/or endorsement;
- Requirements for renewal;
- Exemptions to licensure;
- Required fees; and
- Acts or conduct that can result in application denial or discipline of a license.

While the enabling statute sets forth the purpose of the law and the general parameters of regulating and licensing of a profession for public protection, enabling acts explicitly delegate some of this legislative authority to the executive branch. The legislature authorizes a licensing board to approve applicants (*i.e.,* give them a license), as an exercise of the state's regulatory or police powers.[27] The legislature also authorizes a state licensing board to investigate and adjudicate

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[24] *See Doane v. HHS*, 2021 ME 28, ¶ 33 (noting the state exercises its police power to regulate the medical profession on behalf of the general public through the Board of Medicine's professional licensing) (citation omitted).
[25] Jeffrey P. Gray, In Defense of Occupational Licensing: A Legal Practitioner's Perspective, 43 CAMPBELL L. REV. 423, 433 (2021).
[26] *See* 10 M.R.S. § 8008 ("The sole purpose of an occupational and professional regulatory board is to protect the public health and welfare.")
[27] *See Doane v. HHS*, 2017 ME 193, ¶ 29.

complaints, impose discipline including restrictions on a practitioner's license, and to set standards of practice.[28]

Delegation of legislative authority to a licensing board is not only permitted but can be necessary. It may be impractical for the legislature to address all regulation in the enabling statute, particularly when it comes to public health.[29] Indeed, the Department has advocated for detailed standards to be filled in by professional and occupational boards as they consist mostly of members of the profession and have subject matter expertise needed to engage in required rulemaking.

However, the statute must contain sufficient standards to guide the board so that the regulation is consistent with legislative intent.[30] "A statute that gives unlimited regulatory power to a commission, board or agency with no prescribed restraints nor criterion to guide its actions offends the Constitution as a delegation of legislative power. The board must be corralled in some reasonable degree and must not be permitted to range at large and determine for itself the conditions under which a law should exist and pass the law it thinks appropriate."[31]

On its face, it is difficult to ascertain what explicit or implicit guidance is given to the Board should it decide to adopt rules to "further define" or "further expand the scope of optometry *as appropriate*." There are no limitations restraining the Board when it would have "exclusive authority" to determine what constitutes the practice of optometry and "sole jurisdiction" to exercise *any other powers and duties* of the board established under the enabling act. Proponents contend that the major substantive rulemaking requirement proposed in the amendment allows for sufficient legislative oversight and conceivably would be the safeguard that would counterbalance the delegation of discretionary authority to the Board to exclusively determine scope of practice.

The Department questions whether proposed major substantive rulemaking would be a safeguard in this instance because the delegation of "exclusive authority" would narrow, almost render meaningless, the basis of the legislature's review. The legislature's review of major substantive rulemaking must include "[w]hether the agency has exceeded the scope of its statutory authority in approving the provisionally adopted rule" and "[w]hether the provisionally adopted rule is in conformity with the legislative intent of the statute the rule is intended to *implement, extend, apply, interpret or make specific* 5 M.R.S. § 8072(4) A), (B) (emphasis added).

Given that the Committee's review would be guided by the board's "exclusive authority" to determine what constitutes the practice of optometry and the provision stating "[t]his chapter may not be construed to permit any agency, board or other entity of this State other than the board to

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[28] *See Doane v. HHS*, 2021 ME 28, ¶ 31.

[29] *See Doane*, 2021 ME 28, ¶ 27 ("[W]hile the amount of discretion the Legislature can bestow upon a state is not boundless, latitude must be given in areas where the statutory enactment of detailed specific standards is unworkable."); *see also id.* ¶ 22 ("Especially where it would not be feasible for the Legislature to supply precise standards, the presence of adequate procedural safeguards may be properly considered in resolving the constitutionality of the delegation of power." (citation omitted)).

[30] "We have consistently endorsed the fundamental constitutional requirement that legislation delegating discretionary authority to administrative agencies must contain standards sufficient to guide administrative action . . . The basic requirement . . . is that there be sufficient standards – specific or generalized, explicit or implicit to guide the agency in its exercise of authority so that (1) regulation can proceed in accordance with basic policy determinations made by those who represent the electorate and (2) some safeguard is provided to assist in preventing arbitrariness in the exercise of power." *Lewis v. State Dep't of Human Servs.*, 433 A.2d 743, 747 (Me. 1981) (citations and internal quotation marks omitted).

[31] *Small v. Me. Bd. Of Registration & Examination in Optometry*, 293 A.2d 786, 788 (Me. 1972) (internal citations omitted).

determine what constitutes the practice of optometry" it is not clear on what basis the Committee would question or reject a substantive rule – other than whether the rulemaking followed the requirements of the MAPA.

Furthermore, the plain language of MAPA contemplates that an agency rule will "implement, extend, apply, interpret or make specific" the law, supporting the position that the board is not meant to write the law but rather adopt rules that will clarify and explain the statute.

Second, and more pressing for the Department, is that this broad discretionary legislative scheme contemplates extensive, detailed and complicated rulemaking. And major substantive rulemaking is even more detailed and complicated. As discussed more fully in the section "Board Capacity," the required research, legal advice and drafting expertise, adherence to strict procedural requirements and administrative burden to accomplish the rulemaking contemplated by LD 1803 would demand far more resources than the Department believes the Board has at its disposal or will have for the foreseeable future.

The proposed grant of exclusive authority to the Board of Optometry to determine scope of practice for optometrists is unusual. In Maine, the scope of practice for professions and occupations regulated by agencies within DPFR are set forth in statute. Those who seek to amend or expand a profession's scope do so by introducing legislation to amend the enabling act.

Proponents claim two Maine boards do have the authority to determine scope of practice: the Maine Emergency Medical Services' Board (EMS) and the Board of Complementary Health Care Providers. While these boards have been delegated some more discretionary authority than others to "fill in the gaps" to determine the professions' scope of practice, both are distinguishable from the proposal in LD 1803.

An obvious distinction for both EMS and the Complementary Health Care Providers Board is that neither of their enabling acts grant a board "exclusive authority" to determine scope of practice.

EMS is an agency within the Department of Public Safety, consisting of several boards with different functions. Boards within EMS include the Board of Emergency Medical Services, the Licensing Board, and the Medical Direction and Practices Board. While EMS as an agency has been delegated more authority to establish their profession's scope of practice and standards of care, there are well-defined statutory goals, including a clear statement of purpose, a recognized national standard that is incorporated into its rules, and a breadth of non-EMS experts charged with establishing the scope and standards.

Additional important distinctions between the Board of Optometry and EMS include:

- The EMS Medical Direction board is *separate and distinct* from the EMS Licensing Board.
- The EMS Licensing Board does not set the scope of practice.
- The EMS Medical Direction and Practices Board is charged by statute with creating, adopting and maintaining the Maine EMS protocols, which complement the scope of practice by establishing the standard of care. (32 M.R.S. § 88-B). [32]

[32] Protocols are written statements, developed by the Medical Direction and Practices Board, specifying the conditions under which emergency medical care is to be given by emergency medical services persons. (32 M.R.S. § 83(19)).

- The EMS Medical Direction and Practices Board is comprised of 12 physician members, 1 pharmacist member, 1 paramedic and 1 EMT. The Board of Optometry is composed only of optometrists (5) and a public member (1).[33]

The Board of Complementary Medicine regulates three categories of professions: acupuncturists, naturopathic doctors, and midwives. The scope of practice for acupuncturists (32 M.R.S. § 12513-A) and naturopathic doctors (32 M.R.S. § 12522) is set forth in statute and does not mention the board's role in determining scope. By contrast, the provisions for the scope of practice for midwives state that the board may adopt rules to *clarify* the scope of practice, but the statute simultaneously limits scope of practice to be aligned at all times with established national standards (32 M.R.S. §§ 12535, 12537). Moreover, the statutory language does not vest exclusive authority to the board and, therefore, does not exclude the legislature, as proposed in LD 1803. Therefore, any expansion of scope beyond a clarification of the scope of practice and standards delineated by the national standards requires legislative amendment.

Data shared by the proponents and opponents identifies only one state, Alaska, that grants full authority to the licensing board comparable to the authority proposed in LD 1803. The proponents also shared a list of six additional states that they contend" grant State Boards of Optometry the ability *to approve future procedures with safeguards"* (emphasis added) (see Appendix 38).

Board Capacity

Proponents contend that the Maine State Board of Optometry has the capacity to implement the expansion proposed in LD 1803. Furthermore, that states that have implemented advanced procedures have done so within their board's current infrastructure and without significant new spending.

In considering the board's capacity, the Department looked at the Board's staffing and financial resources.

Current Board Resources

The Board has a single staff member (Office Specialist II). When this sole staff member is out of the office for any reason (illness/vacation), the office has no back up staff to serve the public. The Board also has budgeted for up to .10 FTE of an Assistant Attorney General

In addition, the Board has upcoming staffing changes and additional known expenses for which it must budget. These other known expenses include moving into a new leased space and assuming the costs of maintaining their website. Their long-time staff member is retiring, and there are significant costs associated with that retirement (vacation pay out, temp contracts, etc.) The Board would be well served to use this retirement to establish a higher-level staff person (*e.g.*, Executive Director versus Office Specialist II). According to proponents' data, in the eight expansion states for

[33] "Medical Direction and Practices Board" means the board consisting of each regional and associate regional medical director, an emergency physician representing the Maine Chapter of the American College of Emergency Medicine Physicians, an at large member, a toxicologist or licensed pharmacist, a person licensed under section to provide basic emergency medical treatment, a person licensed under section to provide advanced emergency medical treatment, a pediatric physician, the statewide associate emergency medical services medical director and the statewide emergency medical services medical director. (Maine EMS Rules, Ch. 2 § 29)

which they provided information, each of those boards of optometry has a director or an executive director (Appendix 39).[34]

The Board has a budget deficit (*i.e.,* projected revenue is insufficient to cover budgeted expenses) and relies on cash reserves to cover the gap. Based on budget and revenue projections, to maintain the status quo the Board will need to spend approximately $61,000 more than they receive in licensing fees over the Fiscal Year 2026/2027 biennium. To generate sufficient revenue to continue operations, the Board must increase fees. The Board recently initiated a rulemaking to increase fees from $490 to $600. However, even raising fees to $600 will not generate sufficient revenue to maintain their status quo and the proposed fee increase does not contemplate the additional expenses identified above nor any rulemaking that the Board might need to undertake if any of the expansions in LD 1803 are implemented. Because their statutory fee cap is $600, additional fee increases will require legislative action to amend the fee cap.

Anticipated Board Resources to Implement LD 1803

Proponents noted that implementing the legislation would require the board to develop or identify board-approved education, a competency exam, other licensing standards and continuing education requirements all with associated rulemaking. States with expanded scopes of practice approach these licensing requirements differently and if the Board is charged with developing those standards it will require a substantial amount of work to assess and determine those requirements for Maine. (For more information on expansion of state's varying credentialing requirements see "Credentialing Requirements.")

The Maine State Board of Optometry believes it can handle the work associated with the implementation of LD 1803 within existing board expertise and resources. The Chair stated that in looking at the experience of boards of optometry in expansion states, the roll out of new authorities are "very front end heavy, that rulemaking can be time consuming, and that designing the application processes can involve a significant amount of work." Despite describing that work as a "significant lift," the Board Chair said it would rely heavily on what other states have done and other public sources such as the Association of Regulatory Boards of Optometry, the American Optometric Association, and the Maine Optometric Association.

The Board Chair also believes there is adequate administrative and legal support to implement the new law and that the board can contract for additional administrative and legal support as needed. From an ongoing oversight perspective, the Board believes there would be a minimum impact on the Board. The Board believes they can implement LD 1803 without raising fees but will pursue an additional fee if one is needed.

The Department disagrees and believes that the Board is currently understaffed and under resourced to undertake this effort. While we respect the commitment and expertise of each of the board members and the board's current staff person, we believe that the workload is more complicated and time-consuming than can be easily accomplished by a volunteer board with a single staff at the OSII level and less than 10% of the time of an AAG.

While the Board identified their recent "repeal and replace" of their law and rules as an example of a heavy lift they were able to accomplish within existing resources, the Department notes that the

[34] Arkansas, Colorado, Kentucky, Indiana, Mississippi, Montana, Virginia, and West Virginia

repeal and replace was primarily a reorganization of their existing laws and rules[35] and, according to the Board chair, that effort took four years.

This important public protection work should not be a simple cut and paste from other states. Significant research and drafting is necessary to carefully craft standards and rules. APA rulemaking is complicated, and major substantive rulemaking is even more complicated. Rules must be "prepared by a person skilled in developing, organizing, and writing rules."[36] While the Office of the Attorney General reviews the rule as to form and legality, board staff leads the effort to develop and draft the rules. Draft rulemaking requires advance research by board staff and members, often numerous discussions of drafts for each rule - which must be done in public meetings as board members cannot communicate with each other outside of board meetings. Rulemaking also requires preparing records for notice and comment and holding a comment period or public hearing, tracking, summarizing and responding to each public comment received, amending the rule as needed in response to comments and potentially offering another comment period if the rule changes substantively. For major substantive rules, materials must then be forwarded to the Executive Director for the Legislative Council, and the rule is subject to the committee's review of the rule pursuant to 5 M.R.S. § 8072. Only after legislative review is concluded, and the legislature approves the rule, does the board move to finally adopt the rule.

Depending on which of LD 1803's expansions, if any, were permitted this rulemaking effort would require numerous rulemakings, or numerous provisions of a single rule, to address requirements specific to each of the expanded procedures (*e.g.*, education, training, course approvals, exams or certifications to license qualifications) to ensure that optometrists are sufficiently trained to perform surgeries permitted by an expanded scope of practice.

Department Findings: Board of Optometry

- LD 1803 would transfer unprecedented authority to the Board of Optometry to determine their scope of practice without sufficient safeguards to protect the public.
    - No board in Maine grants a board "exclusive authority" to determine scopes of practice.
    - Alaska is the only state that grants full authority to the licensing board comparable to the authority proposed in LD 1803.
- The Board is not currently resourced to undertake the heavy lift necessary to implement the proposal.
    - The Board has a single staff member (Office Specialist II) and has budgeted for up to .10 FTE of an Assistant Attorney General.
    - The Board has a budget deficit and relies on cash reserves to cover the gap.
    - To generate sufficient revenue to continue operations, the Board must increase fees. The recently initiated rulemaking to increase fees to their current fee cap ($600) will not generate sufficient revenue. Legislation will be required to amend the fee cap to facilitate additional fee increases.
- The Board is underestimating the resources that would be required to implement LD 1803.

[35] The repeal and replace also included two new rules 1) implementing the American Optometric Association's Code of Ethics by reference (with certain exception) and 2) establishing telehealth standards.
[36] Executive Order 4-A FY 19/20 [sic] (March 29, 2023). *See generally* Executive Order 4A: An Order Regarding Administrative Rulemaking (Amended, PDF).

Appendices

Appendix 1 HCIFS Committee Request

STATE OF MAINE
ONE HUNDRED AND THIRTY SECOND LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 10, 2025

Joan Cohen
Commissioner
Department of Professional and Financial Regulation
35 State House Station
Augusta, Maine 04333-0035

Dear Commissioner Cohen:

As you know, the Joint Standing Committee on Health Coverage, Insurance and Financial Services recently considered LD 1803, An Act to Amend the Laws Governing Optometric Practice. The bill, as amended, proposes to expand the scope of practice of licensed optometrists. While the committee notes the proposal meets the criteria for a sunrise review pursuant to the Maine Revised Statutes, Title 5, section 12015 and Title 32, chapter 1-A, subchapter 2, the committee agrees with the suggestion made by your staff that the convening of a stakeholder group to review the proposal will satisfy the committee's belief that the proposal needs additional time for your staff and the proponents and opponents of the bill to thoroughly review and discuss the proposal before moving forward with any statutory changes.

We are writing to request that you convene a stakeholder group to evaluate the proposal consistent with the criteria for a sunrise review and make any findings and recommendations for the committee's consideration. For the purposes of this review, the committee would like the stakeholder group to consider the laws in other states related to the scope of practice for optometrists, including those state laws that are similar to the proposal in LD 1803. The committee would also like the stakeholders to review and make recommendations for each of the substantive provisions making changes to an optometrist's scope of practice: the procedures authorized within an optometrist's scope of practice; the procedures not authorized within an optometrist's scope of practice; and the opioid prescribing authority of an optometrist. Finally, the committee would like the group to carefully consider the changes to the licensing board's authority to make changes to an optometrist's scope of practice in the bill.

As you know, the committee has carried over LD 1803 to the Second Regular Session. We request that the stakeholder group complete its work in a timely manner so that you may report its findings and recommendations to the committee no later than January 15, 2026 so the committee can take final action on the bill before the end of the Second Regular Session. If you

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100 TELEPHONE 207-287-1327

have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid.

Sincerely,

Sen. Donna Bailey
Senate Chair

Rep. Kristi Michele Mathieson
House Chair

cc: Penny Vaillancourt, Deputy Commissioner
Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services

Appendix 2 LD 1803 Stakeholder Group Roster

STATE OF MAINE
DEPARTMENT OF
PROFESSIONAL & FINANCIAL REGULATION

Janet T. Mills
Governor

Joan F. Cohen
Commissioner

LD 1803 Stakeholder Group

Stakeholders

Maroulla Gleaton, MD
Augusta, Maine
Past President, Maine Board of Licensure in Medicine
Representing the Maine Board of Licensure in Medicine

Laura Green, MD
Baltimore, Maryland
Vice Chair, Faculty Development for the Department of Ophthalmology at Sinai Hospital of Baltimore
Assistant Dean for Student Affairs, George Washington School of Medicine and Health Sciences
Immediate Past Chair ACGME Ophthalmology Review Committee
Representing a School of Ophthalmology

Michelle Harris, MD
Brunswick, Maine
President, Maine Society of Eye Physicians and Surgeons
Representing Practicing Ophthalmologists

Ian Jones, OD
Bangor, Maine
Representing Practicing Optometrists

Nate Lighthizer, OD
Tahlequah, Oklahoma
Associate Dean, Northeastern State University Oklahoma College of Optometry
Representing a School of Optometry

Jessilin Quint, OD
Augusta, Maine
President, Maine Optometric Association
Representing Practicing Optometrists

Linda Schumacher-Feero, MD
Augusta, Maine
Past President, Maine Society of Eye Physicians and Surgeons
Representing Practicing Ophthalmologists

James "Pat" Smith, OD
Augusta, Maine
Chair, Maine Board of Optometry
Representing the Maine Board of Optometry

Staff

Joan Cohen, Commissioner
Department of Professional and Financial Regulation

Kristina Lunner, Acting Advisor to the Commissioner

Appendix 3 Elements of State Optometry Practice Acts

State	Controlled Substance Prescriptive Authority (DEA Schedules)	Injectable Authority	Scalpel ("Lumps and Bumps") Surgery	Laser Surgery
Alabama	III-V	A[37]		
Alaska	II (hydrocodone only) – V	X	X	X
Arizona	II (hydrocodone only) – V	A		
Arkansas	II (hydrocodone only) – V	X	X	X
California	II (hydrocodone only) – V	X		
Colorado	II (hydrocodone only) – V	A	X	X
Connecticut	**II (hydrocodone only) – V**	**A**		
Delaware	II (hydrocodone only) – V	A		
District of Columbia	IV – V or no authority	A		
Florida	III - V	A		
Georgia	II (hydrocodone only) – V	X		
Hawaii	IV – V or no authority	A		
Idaho	II (hydrocodone only) – V	X	X	
Illinois	II (hydrocodone only) – V	A		
Indiana	IV – V or no authority	X	X	X
Iowa	II (hydrocodone only) – V	X	X	
Kansas	II (hydrocodone only) – V			
Kentucky	II (hydrocodone only) – V	X	X	X
Louisiana	II (hydrocodone only) – V	X	X	X
Maine	**III – V**	**A**		
Maryland	IV – V or no authority	A		
Massachusetts	**IV – V or no authority**			
Michigan	II (hydrocodone only) – V			
Minnesota	IV – V or no authority	X	X	
Mississippi	II (hydrocodone only) – V	X	X	X
Missouri	II (hydrocodone only) – V			
Montana	II (hydrocodone only) – V	X	X	X
Nebraska	III – V	A		
Nevada	III – V			
New Hampshire	**III – V**	**A**		
New Jersey	II (hydrocodone only) – V	A		
New Mexico	II (hydrocodone only) – V	X	X	
New York	IV – V or no authority			
North Carolina	II (hydrocodone only) – V	X		
North Dakota	III – V	X		

[37] Only for the treatment of anaphylaxis (a severe, potentially life-threatening allergic reaction that can occur rapidly after exposure to an allergen)

State	Controlled Substance Prescriptive Authority (DEA Schedules)	Injectable Authority	Scalpel ("Lumps and Bumps") Surgery	Laser Surgery
Ohio	II (hydrocodone only) – V	A		
Oklahoma	II (hydrocodone only) – V	X	X	X
Oregon	II (hydrocodone only) – V	X	X	
Pennsylvania	II (hydrocodone only) – V	A		
Rhode Island	**II (hydrocodone only) – V**			
South Carolina	II (hydrocodone only) – V			
South Dakota	II (hydrocodone only) – V	X	X	X
Tennessee	II (hydrocodone only) – V	X	X	
Texas	III – V	A		
Utah	II (hydrocodone only) – V	X	X	
Vermont	**III – V**	**A**		
Virginia	II (hydrocodone only) – V	X	X	X
Washington	II (hydrocodone only) – V	X	X	
West Virginia	II (hydrocodone only) – V	X	X	X
Wisconsin	II (hydrocodone only) – V	X	X[38]	X[39]
Wyoming	II (hydrocodone only) – V	X	X	X

[38] Wisconsin's law does not explicitly list surgeries. However, some report surgeries are occurring in Wisconsin. The authority is based on an interpretation of the statue that an optometrist's scope of practice is based on the optometrist's assurances that they are competent and trained before providing any advanced procedure. Accessed on 12/17/25 at https://www.reviewofoptometry.com/article/wisconsin-ods-embrace-expansive-scope-brace-for-md-challenge#:~:text=The%20current%20law%20on%20the,10%2C%20as%20is%20commonly%20believed.

[39] ibid

Appendix 4 Comparison of Expansion State Procedures and LD 1803

	Subcon-junctival Injection	Corneal Collagen Crosslinking	YAG Laser Capsulotomy	SLT Laser	LPI Laser
1. Alaska	O[40]	X	X	X	X
2. Arkansas			X	X	
3. Colorado		X	X	X	X
4. Georgia	X				
5. Idaho					
6. Indiana[41]			O	O	O
7. Iowa	X				
8. Kentucky[42]	X		X	X	X
9. Louisiana	Prohibits		X	X	X
Maine	**LD 1803**	**LD 1803**	**LD 1803**	**LD 1803**	**LD 1803**
10. Minnesota					
11. Mississippi	X		X	X	X
12. Montana[43]		O[44]			X
13. New Mexico					
14. North Carolina	O				
15. Oklahoma[45]	O	X	X	X	X
16. Oregon	Prohibits				
17. South Dakota		X	X	X	X
18. Tennessee					
19. Utah					
20. Virginia			X	X	X
21. Washington	X				
22. West Virginia[46]	O[47]	O			X
23. Wisconsin			X[48]		X

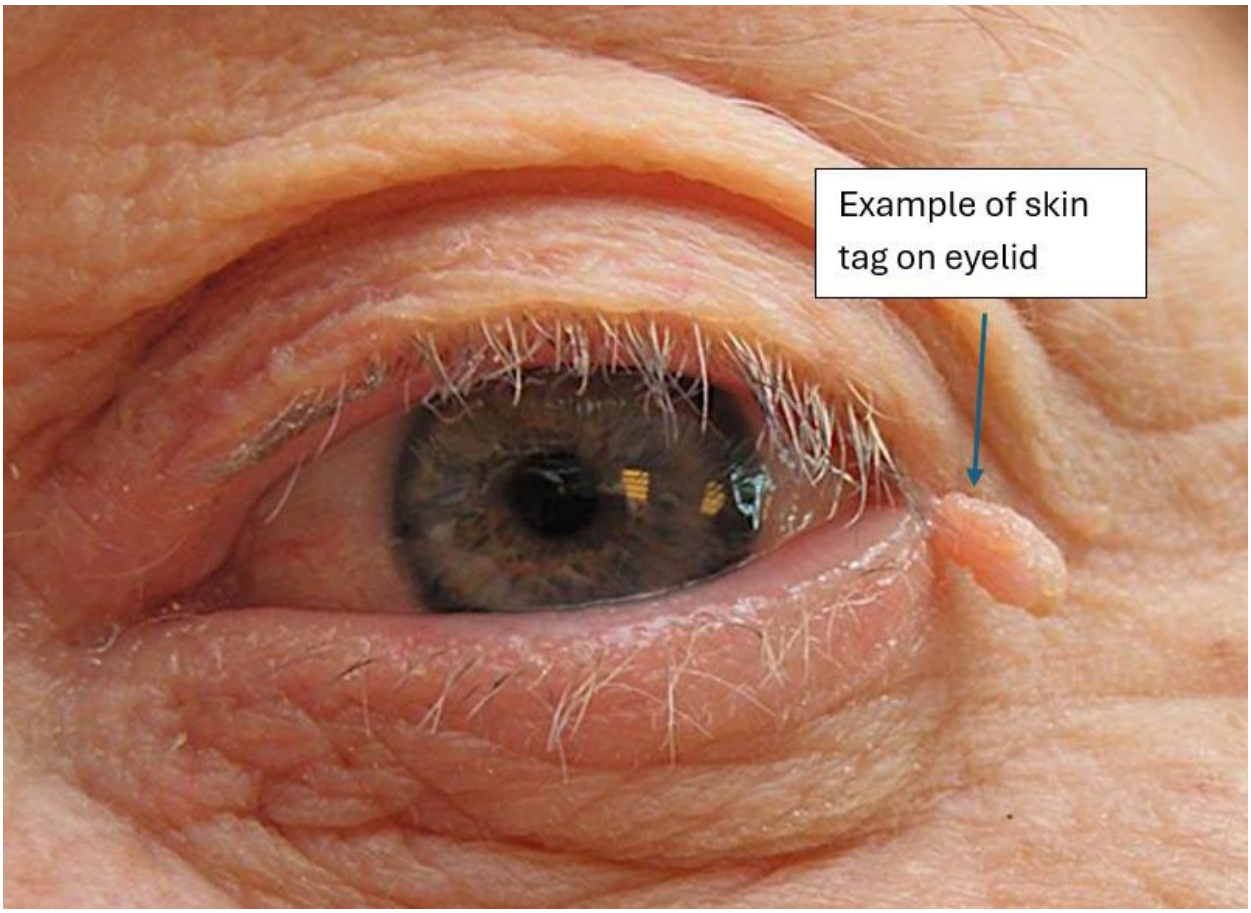
[40] Not explicitly authorized. Some proponents interpret state law to include.
[41] Proponents contend that a 2019 Indiana Attorney General Opinion upheld Indiana Board of Optometry's interpretation that the state's open-ended statute allows optometrists to perform laser surgeries.
[42] Kentucky's law lists unauthorized procedures such as LASIK and directs the Optometry Board to determine what procedures are allowed.
[43] Lasers limited to the anterior segment of the eye includes YAG, SLT, and LPI.
[44] The new law went into effect on July 1, 2025. The Montana Board of Optometry will determine whether this procedure is included.
[45] Oklahoma also authorizes Photorefractive Keratectomy (PRK), which is similar to LASIK.
[46] Law defines "Ophthalmic Laser" as any of the commercially available light amplification by stimulated emission of radiation (LASER) devices approved by the U.S. Food and Drug Administration for use on the human eye and adnexa. Also includes definitions of "posterior capsulotomy" (YAG), "peripheral iridotomy" (LPI), and "selective laser trabeculoplasty" (SLT).
[47] West Virginia leaves open the possibility to get certified in this procedure.
[48] Wisconsin's law does not explicitly list surgeries. However, some report surgeries are occurring in Wisconsin. The authority is based on an interpretation of the statue that an optometrist's scope of practice is based on the optometrist's assurances that they are competent and trained before providing any advanced procedure. Accessed on 12/17/25 at https://www.reviewofoptometry.com/article/wisconsin-ods-embrace-

	Subcon-junctival Injection	Corneal Collagen Crosslinking	YAG Laser Capsulotomy	SLT Laser	LPI Laser
24. Wyoming	Prohibits	Prohibits	X	X	X

expansive-scope-brace-for-md-challenge#:~:text=The%20current%20law%20on%20the,10%2C%20as%20is%20commonly%20believed

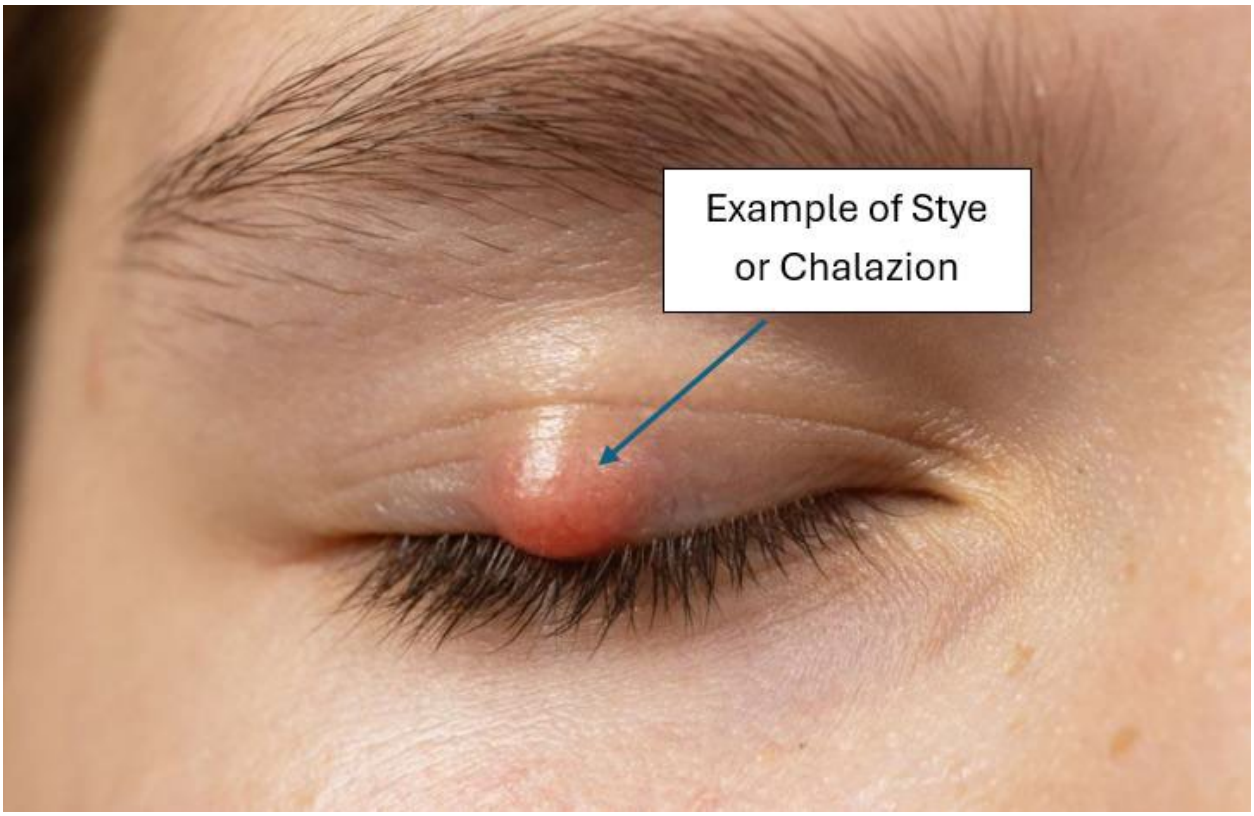
Appendix 5 Procedure Descriptions[49]

Procedure #1: Removal of benign skin lesions (skin tag) of the eyelid and removal of chalazion of the eyelid. Independently order biopsy, bloodwork, and other testing

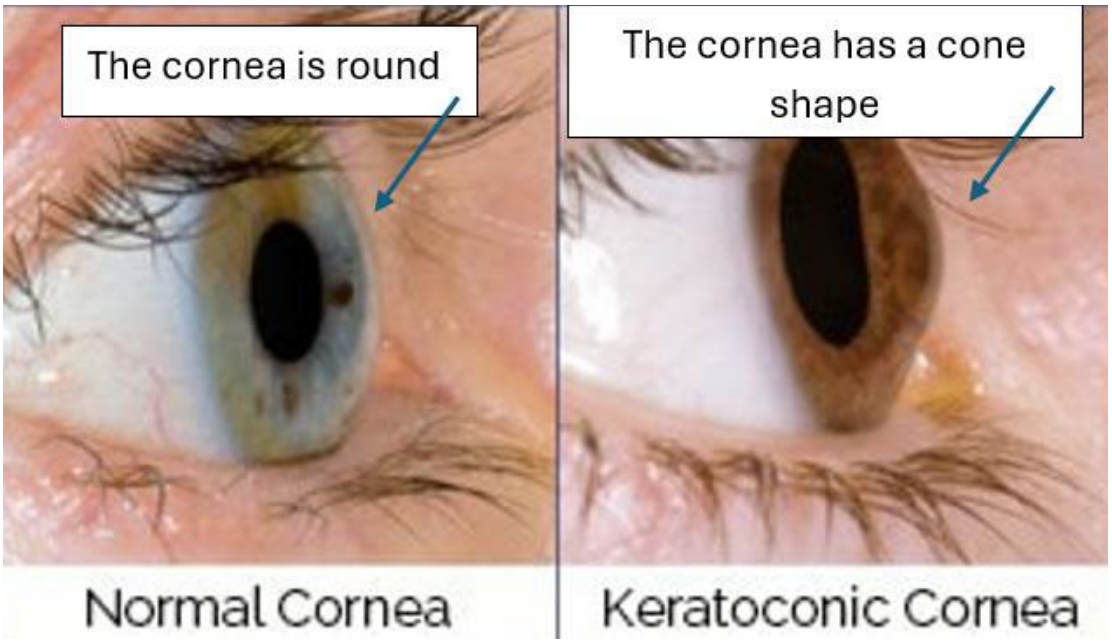


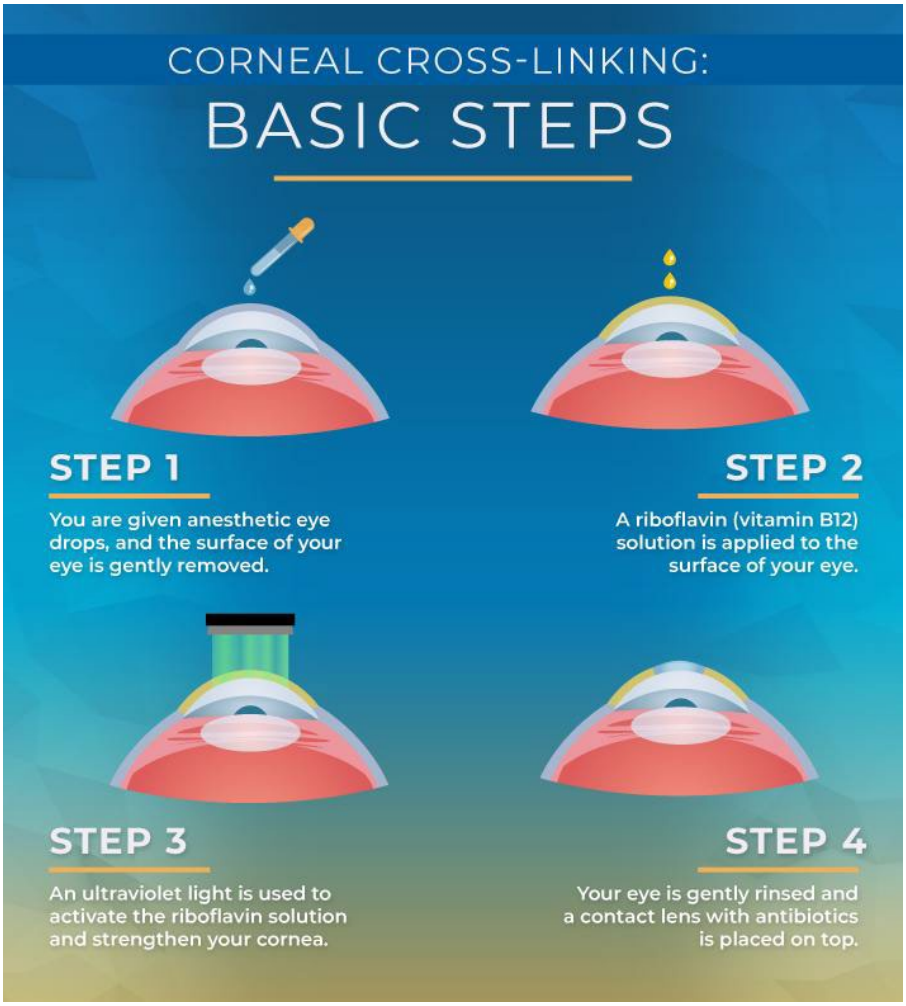
[49] Data provided by the Maine Optometric Association

Procedure #2: Kenalog injection for chalazions

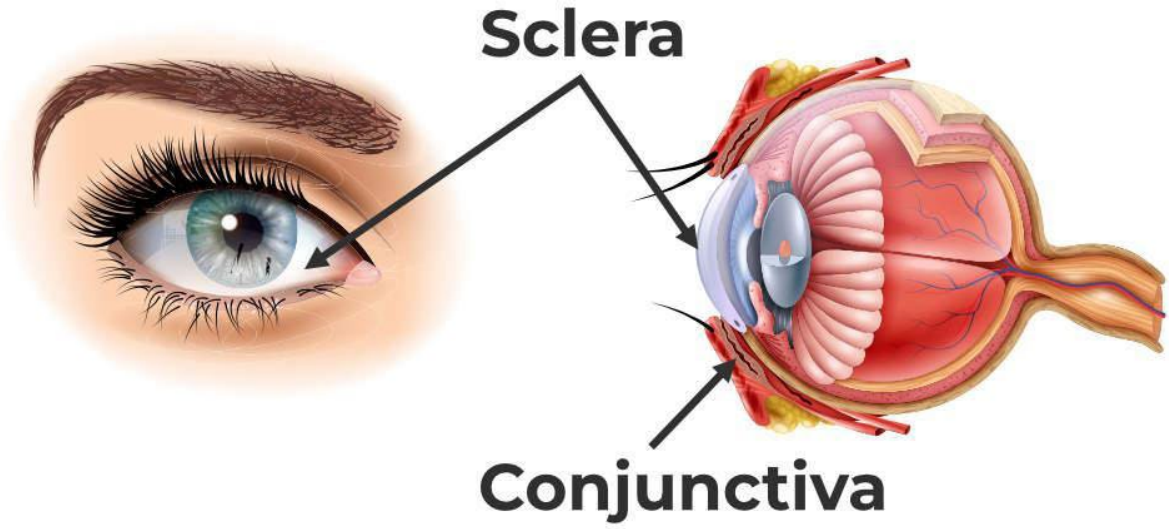


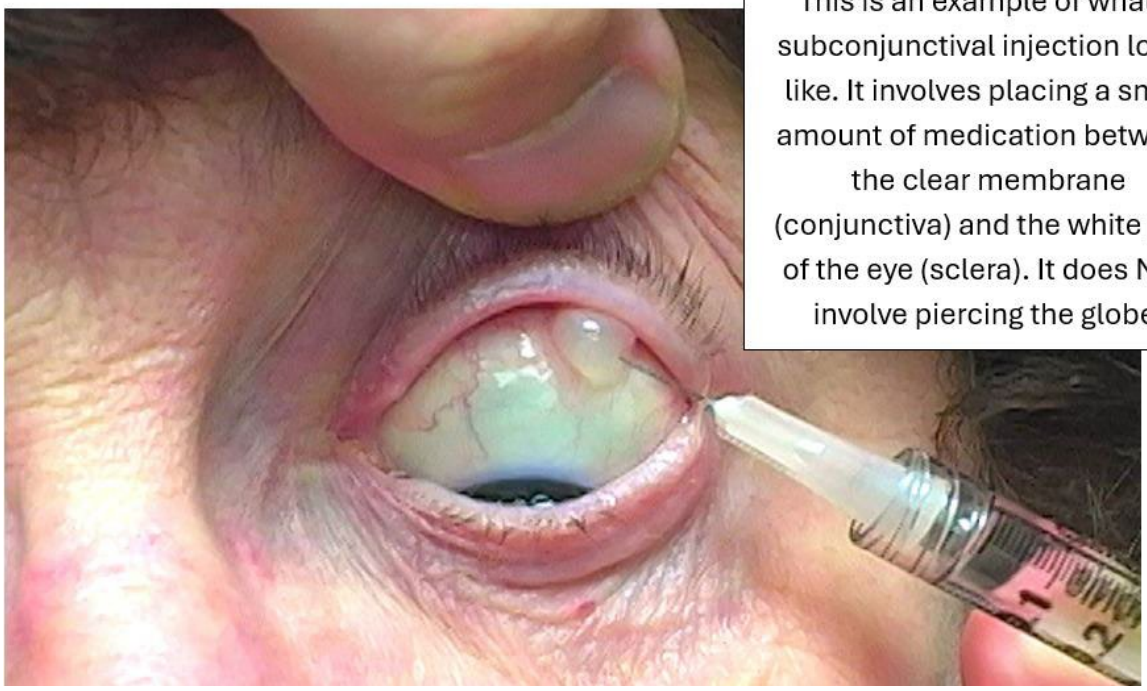
Procedure #3: Independently perform corneal collagen crosslinking





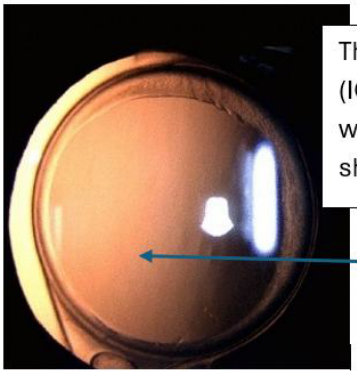
Procedure #4: Independently perform subconjunctival injections





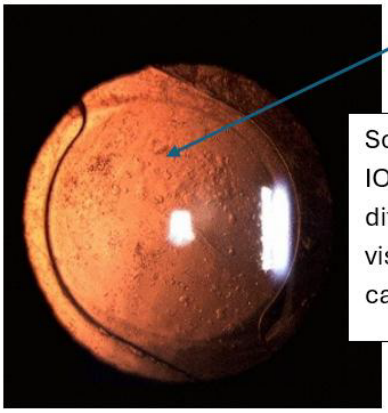
This is an example of what a subconjunctival injection looks like. It involves placing a small amount of medication between the clear membrane (conjunctiva) and the white part of the eye (sclera). It does NOT involve piercing the globe.

Procedure 5: Perform YAG capsulotomy



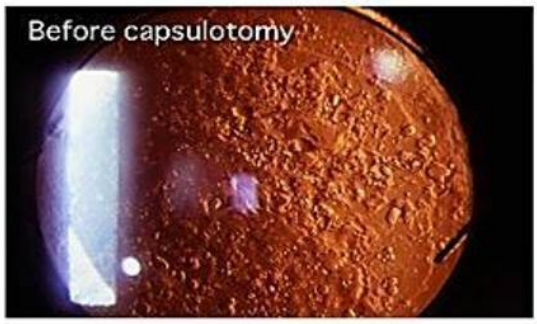
This is a photo of an intraocular lens (IOL) implant that is inserted into the eye when a cataract is removed. The IOL should be clear to keep vision clear.

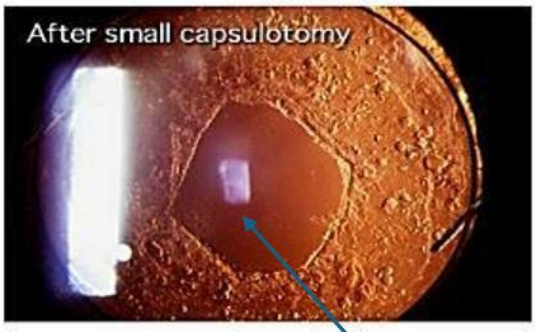
Clear lens



Film over lens

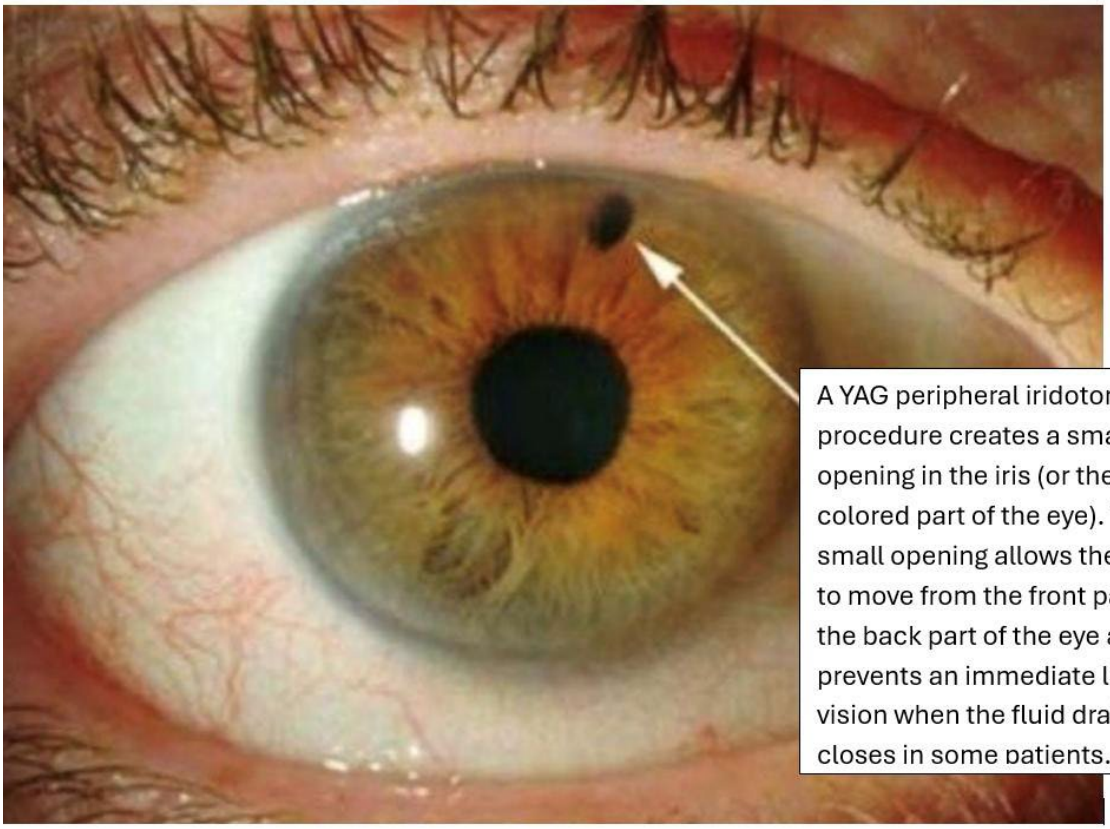
Sometimes the cells in the body will produce a film that grows over the IOL implant. This film will make a patient's vision blurry making it difficult to see clearly. Glasses or contact lenses will not make this vision clear. The film must be removed by a treatment called a YAG capsulotomy for the patient to see clearly again.





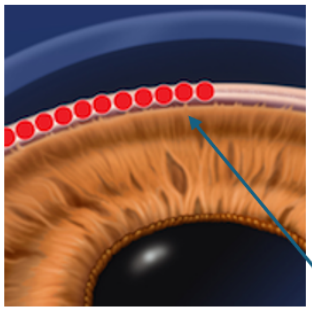
A YAG laser breaks up the film so a patient can see clearly again.

Procedure #6: Perform YAG peripheral iridotomy



A YAG peripheral iridotomy procedure creates a small opening in the iris (or the colored part of the eye). This small opening allows the fluid to move from the front part to the back part of the eye and prevents an immediate loss of vision when the fluid drain closes in some patients.

Procedure #7: Perform Selective laser trabeculoplasty (SLT)



A SLT procedure involves targets pigmented cells in the eye's drainage system to improve fluid drainage and lower the eye's pressure. This procedure can often delay patient from using eye drop to lower the eye pressure in cases of glaucoma. Eye drops can be expensive for patients, require instillation of the drops 1-3x/day, and often cause eye redness, pain, and irritation. A SLT typically takes 5-10 minutes in the office and does not cause pain or long-term redness or irritation.

The red dots are the where the SLT is applied in the eye.

Appendix 6 Proposed Unauthorized Procedures[50]

There are numerous procedures listed in LD 1803 that optometrists will NOT be authorized to perform. Any procedure not listed above would NOT be allowed. LD 1803 specifically outlines what procedures are allowed and lists examples of what procedures are not allowed so there is no ambiguity.

1. **Retina laser procedures -** laser treatments performed by an *ophthalmologist* on the back of the eye (the retina) to treat or prevent eye diseases, such as diabetic retinopathy, retinal tears, or macular problems. The laser is used to seal or repair damaged blood vessels or tissue, helping to preserve vision and prevent further vision loss.
2. **Penetrating keratoplasty or corneal transplant of any kind -** A surgical procedure performed by an *ophthalmologist* to replace a damaged or diseased cornea (the clear front layer of the eye) with a healthy donor cornea. This helps to restore vision, improve clarity, and maintain the structural integrity of the eye.
3. **Surgery performed with general anesthesia, regional anesthesia or monitored anesthesia care or the administration of such anesthesia** - A surgical procedure in which medications are used to block pain or induce unconsciousness. This can involve general anesthesia (putting the patient fully to sleep), regional anesthesia (numbing a specific part of the body), or monitored anesthesia care (sedation with close monitoring).
4. I**njection into the vitreous chamber of the eye to treat any retinal or macular disease -** A precise injection of medicine directly into the gel-like center of the eye (called the vitreous), performed by an *ophthalmologist,* to treat diseases of the retina or macula, such as diabetic eye disease or age-related macular degeneration.
5. **Laser-assisted in situ keratomileusis -** Also known as LASIK, is a procedure performed by an *ophthalmologist* to correct vision problems such as nearsightedness, farsightedness, or astigmatism. The procedure reshapes the cornea (the clear front surface of the eye) so that light focuses properly on the retina.
6. **Corneal implants -** Small devices or rings inserted into the cornea (the clear front part of the eye) by an *ophthalmologist* to improve vision or correct certain eye conditions, such as keratoconus or severe nearsightedness. The implants reshape or support the cornea to help light focus properly on the retina, enhancing clarity of vision.
7. **Surgery related to removal of the eye from a living human being -** This is performed to treat severe trauma, uncontrollable disease, or malignancy, and is done in an operating room by an *ophthalmologist*. It is a major, highly specialized procedure.
8. **Surgery requiring full thickness incision or excision of the cornea or sclera -** Surgical procedure where the entire thickness of the cornea (the clear front of the eye) or sclera (the white part of the eye) is cut or removed. This type of surgery is done to treat serious eye conditions, repair damage, or restore vision, and is performed in an operating room by an *ophthalmologist*.
9. **Surgery requiring incision of the iris and ciliary body, including diathermy or cryotherapy -** A surgical procedure where the colored part of the eye (iris) and the ciliary body (which helps control eye pressure and focus) are cut or treated using techniques like

[50] Data provided by the Maine Optometric Association

heat (diathermy) or freezing (cryotherapy). This type of surgery is performed to treat serious eye conditions, control eye pressure, or repair structural problems, and is done in an operating room by an *ophthalmologist*.

10. **Vitrectomy -** a surgical procedure to remove the vitreous gel from the center of the eye. This is done to treat retinal or macular diseases, remove blood or scar tissue, or repair retinal detachments. The procedure helps restore or preserve vision and is performed in an operating room by an *ophthalmologist*.
11. **Retinal surgery** - Surgical procedures performed on the retina, the light-sensitive layer at the back of the eye, to treat conditions such as retinal tears, detachments, diabetic retinopathy, or macular disease. These surgeries help preserve or restore vision and are performed in an operating room by an *ophthalmologist*.
12. **Surgical extraction of an intraocular or crystalline lens -** Commonly known as cataract surgery, this is a surgical procedure to remove the natural lens of the eye (crystalline lens) or a previously implanted artificial lens. This is typically done to treat cataracts, correct severe lens problems, or replace a faulty lens. The procedure is performed in an operating room or surgical center by an *ophthalmologist*.
13. **Surgical implantation of an intraocular lens -** A surgical procedure to place an artificial lens inside the eye to replace the natural lens removed during cataract surgery or to correct vision problems. The procedure is performed in an operating room or surgical center by an *ophthalmologist*.
14. **Incisional or excisional surgery of the extraocular muscles -** A surgical procedure that cuts, repositions, or removes part of the muscles controlling eye movement (the extraocular muscles). This surgery is performed to correct misalignment of the eyes (strabismus), improve eye movement, or treat other eye muscle disorders. It is done in an operating room by an *ophthalmologist*.
15. **Surgery of the eyelid for confirmed malignancies or for incisional cosmetic or incisional mechanical -** A surgical procedure on the eyelid performed to remove cancerous growths, correct functional problems (such as drooping or obstruction), or address cosmetic concerns. The surgery involves making precise incisions to remove or reshape tissue and is performed in an operating room by an *ophthalmologist*.

Appendix 7 Slit Lamp[51]

[51] Data provided by the Maine Optometric Association

Appendix 8 LD 1803 Proposed Authorized Procedures

Procedure	Description	Risk[52]	Urgency	Frequency
1. **A. Removal of Benign Skin Lesions** **B. Removal of Chalazion of the Eyelid**	A. Skin tag and other lid growths B. Chalazion (clogged oil gland)	***Proponents:*** Low as only involves superficial tissue; risk aligns to what optometrists see every day ***Opponents:*** High risk of perforating the eye because eyelid skin is so thin. Most Family Physicians and some dermatologists prefer to refer these procedures to ophthalmologists because of the delicate anatomy of the eyelid. See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications: Bruising, swelling, hematoma, milia formation. Less common complications: Conjunctival chemosis, infection, scarring,	***Proponents:*** High (patients can be in discomfort, can impact vision). ***Opponents:*** Non-urgent	***Proponents:*** Moderate; needed when optometrist has exhausted all other options including topicals. About 21% of patients are at risk of developing a stye; ~50% of adults will experience a stye in their lifetime ***Opponents:*** The majority of chalazia resolve and don't need surgical intervention

[52] Opponents to LD 1803 provided their perspective on the level of risk for some procedures but generally cautioned against setting a specific risk level because of the variables involved. They argued that assessing risk is often a matter of perspective. Many patients express anxiety about any intervention involving their eyes, and some may even feel uneasy during a routine eye examination. Ophthalmologists typically discuss surgical risks in terms of expected outcomes, which depend largely on the patient's concurrent medical conditions and the surgeon's experience, proficiency (frequency of performing specific surgeries) and training. These factors are also considered when discussing the rate of specific complications. It is always prudent to remind patients that, even under the best circumstances, unforeseen complications can still occur.

Procedure	Description	Risk[52]	Urgency	Frequency
		granuloma formation, suture reaction, wound dehiscence, recurrent lesion growth, lid malposition (ptosis, ectropion, lid retraction), double vision, damage to the nasolacrimal system, globe injury, orbital hemorrhage, vision loss.		
2. Kenalog (steroid) Injection for Chalazions	Injecting a steroid into an eyelid chalazion with a sharp needle.	***Proponents:*** Low; carries no greater risk than other office procedures ***Opponents:*** See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications: inadequate resolution, visible medication deposit, skin depigmentation. Uncommon complications: increased intraocular pressure, hemorrhage and bruising, infection, corneal perforation, traumatic cataract, retinal artery occlusion, subconjunctival lid fat atrophy, central serous chorioretinopathy.	***Proponents***: High; if left untreated it can leave patient in pain and distort vision ***Opponents:*** Non-urgent	***Proponents:*** Moderate ***Opponents:*** Over 50% of chalazia resolve by 30 days and don't need a steroid injection

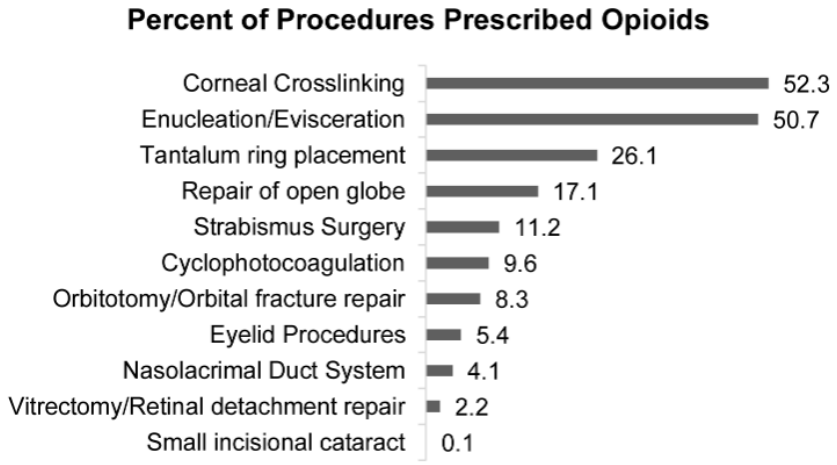
Procedure	Description	Risk[52]	Urgency	Frequency
3. Corneal Collagen Crosslinking	Adding vitamin B12 and applying UV light to reshape the cornea, which has become cone-shaped thereby impairing vision. The cornea is the clear part of the eye that covers the colored part of the eye.	***Proponents:*** Low, especially with all the advances in automated technology especially with epi-on procedures ***Opponents:*** Usually done by cornea specialists. Most ophthalmologists do not perform this procedure. See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications: Pain, corneal haze, delayed corneal healing, disease progression (treatment failure). Uncommon complications: Corneal scarring, infectious keratitis, contact lens related difficulties (loss of lens, tight lens), corneal melt, endothelial decompensation, sterile corneal infiltrates.	***Proponents:*** High; this is a sight threatening condition that if left untreated will impact a patient's life ***Opponents:*** Nonurgent. Doctors monitor cornea for progression of condition and indication for treatment over years.	***Proponents:*** Moderate (infects 1 in 667 patients) ***Opponents:*** Uncommon. A very specific procedure. One indication, keratoconus, is very rare (~1% of population). And only about 20% of those might need surgery.
4. Subconjunctival Injection	Injecting medication just below the conjuvicta and above the white part of the eye to treat an inflamed or infected eye. The Conjuvicta is clear tissue that sits on top of the white part of the eye	***Proponents:*** Low ***Opponents:*** See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training.	***Proponents:*** High ***Opponents:*** Semi-urgent to non-urgent	***Proponents:*** Moderate ***Opponents:*** uncommonly performed in the office for treatment of eye inflammation or infection. Topical

Procedure	Description	Risk[52]	Urgency	Frequency
	"Uses same size needle and syringe that optometrists use for common procedure, "macrofil," that injects hyrolaunic acid gel into the pumpton to help the ocular surface." *Opponents:* Clarification—"Lacrifill" is injected using a blunt cannula. Subconjunctival injections require use of a sharp needle directly adjacent to the wall of eye (*i.e.* Risk of eye perforation)	Common complications: hemorrhage, ocular irritation. Uncommon complications: infection, corneal abrasion, iritis, globe perforation.		drops are usually used for these conditions. When done, it is more commonly done in an OR setting in combination with other surgeries**.**
5. YAG Capsulotomy	Using a laser to clean the film behind an implant after cataract surgery. The film can impact a patient's vision and develops slowly over years. The laser uses focused energy pulses to separate the tissue at a micron level.	***Proponents:*** Low (does not involve incision; procedure takes a couple of minutes) ***Opponents:*** See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications: floaters, intraocular lens pitting. Uncommon complications: corneal abrasion, intraocular pressure elevation, macular	***Proponents:*** High (making a patient wait months for a consultation can have a real impact on their daily lives) ***Opponents:*** Non-urgent	***Proponents:*** High (about 50% of patients that have cataract surgery will need one) ***Opponents:*** ~20-30% post cataract surgery. Only needed once in a lifetime.

Procedure	Description	Risk[52]	Urgency	Frequency
		edema, iritis, retinal detachment, macula hole, retinal tear, corneal edema, intraocular lens dislocation, foveal burn.		
6. YAG Laser Peripheral Iridotomy (LPI)	Using a laser to create a small opening in the iris (colored area of the eye) to lower the eye pressure. Requires use of equipment that optometrists use often, if not every day.	***Proponents:*** Low (in-office procedure) ***Opponents:*** LPIs are extremely challenging in angle closure with high risk of complications such as bleeding in the eye that may require emergency surgery in an operating room. For treatment of Anatomic Narrow Angles, see footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications: increased intraocular pressure, photophobia, need for repeat laser, closure of the iridotomy, hyphema, pain, glare and photopsia. Uncommon complications: corneal abrasion, epiretinal membrane, iritis, macular edema, aborted procedure, pigment dispersion, blurred vision, cataract formation, retinal or choroidal detachment,	***Proponents:*** High (need to prevent a closed angle glaucoma) ***Opponents:*** There are two types: 1) angle closure (ICD-10 H40.219) is an emergency; 2) Anatomic Narrow Angles (ICD-10 H40.03) are non-urgent and often are observed. When there is a clear indication, most OPHTH prefer cataract surgery instead of LPIs.	***Proponents:*** Low to moderate (don't see a ton; but when patient needs it, it is urgent) ***Opponents:*** Low. Only needed once in a lifetime.

Procedure	Description	Risk[52]	Urgency	Frequency
		corneal endothelial damage, malignant glaucoma.		
7. Selective Laser Trabeculoplasty (SLT)	Using a laser to target pigmented cells in the drainage system of the eye to lower the eye pressure. It is becoming a first-line treatment for glaucoma. Requires use equipment that optometrists use often, if not every day.	***Proponents:*** Low; complications are not unique to this procedure; rather, they are things that OPT treat every day ***Opponents:*** Evaluation and treatment of patient anatomy (gonioscopy) can be challenging. Must be able to correctly classify the type of glaucoma to ensure the patient is a candidate for laser. See footnote. Difficult to assign risk given the many variables including patient's condition and providers experience and training. Common complications include poor response (failure of treatment) and iritis (inflammation). Less common complications: pain, redness, corneal abrasion, elevated eye pressure, scarring, corneal edema or inflammation (keratitis), bleeding in the eye, retinal swelling, lamellar keratitis.	***Proponents:*** Very High ***Opponents:*** Non-urgent.	***Proponents:*** High (when a patient has glaucoma they want first line treatment. Not readily available in Maine.) ***Opponents:*** Widely available in Maine**.** Surgery is effective for years on average and is repeatable. SLT is accepted as primary treatment for certain types of glaucoma but is not indicated for ALL types of glaucoma. (There are over 10 ICD-10 codes for glaucoma depending on cause).

Appendix 9 Opioid Prescribing at a Large Teaching Hospital[53],[54]



Patients and ophthalmic procedures receiving an opioid prescription. The percent of procedures receiving an opioid prescription was calculated as the number of patients receiving opioids/number of total procedures performed for each type of procedure. Orbitotomy/orbital fracture repair procedures included those with or without bone flap; eyelid procedures included blepharoplasty, lid ptosis repair, entropion/ectropion repair and canthoplasty; vitrectomy/retinal detachment repair procedures included those with or without scleral buckle

[53] Data provided by the Maine Society of Eye Physicians and Surgeons

[54] Boychev N, Lin LY, Tainsh LT, et al. Cornea specialists are the highest opioid prescribers at a large academic eye institute in the USA. BMJ Open Ophthalmology 2025;10:e002012. doi:10.1136/ bmjophth-2024-002012

Appendix 10 Maine Prescription Monitoring Program 2019 – 2024[55]

The table below shows the unique number of patients and prescriptions written by individuals who identify as ophthalmologists in the PMP from 2019-2024. The first line shows the number of hydrocodone patients and prescriptions, while the remaining lines show the numbers for other opioids. The number of hydrocodone prescriptions is included in the overall total at the bottom of the table. It is also worth noting that there were prescriptions in the PMP for fentanyl citrate/PF and hydromorphone, but due to the low number of prescriptions those were excluded to ensure patient confidentiality. If you have any questions about these data or would like to discuss further, please contact our supervisor Jessica Benson-Yang (Jessica.Benson-Yang@Maine.gov).

Opioid Medication	Number of Patients	Number of Prescriptions
Hydrocodone	**76**	**84**
Acetaminophen w/codeine phosphate	75	77
Oxycodone	67	78
Oxycodone w/acetaminophen	46	54
Tramadol	324	335
Total	588	628

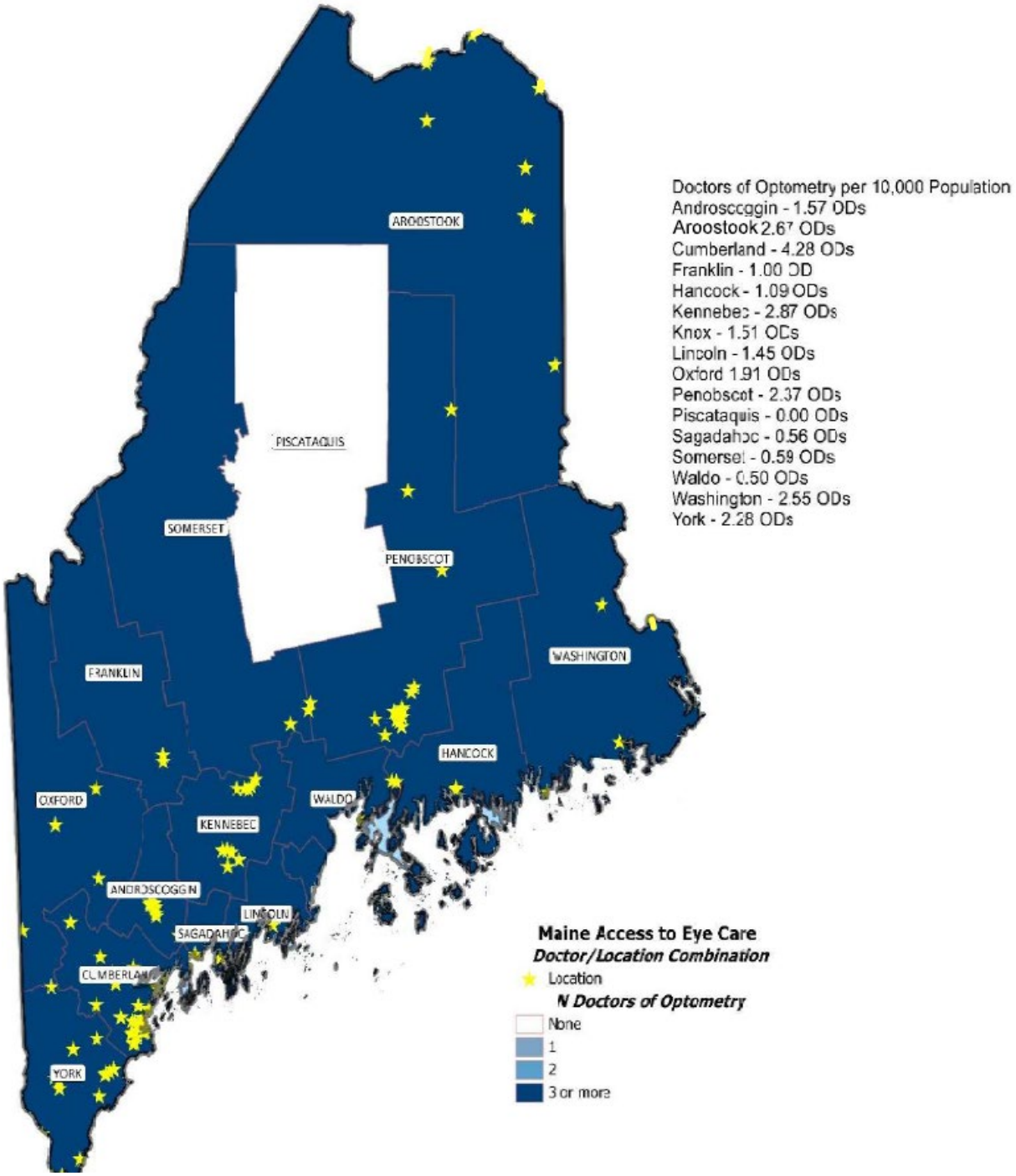
[55] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 11 Examples of Opioid Prescribing Requirements

- The Drug Enforcement Administration requires all prescribers of opioids to complete, one-time, 8 hours of education on the treatment or management of patients with opioid or other substance use disorder.[56]
- The State of Maine has opioid prescribing requirements (Public Law 2016, Chapter 488[57]) that apply to both health care practitioners and veterinarians.
- The Boards of Licensure in Medicine (BOLIM), Nursing (BON), and Osteopathic Licensure (BOL) have a joint rule entitled, "Regarding Office Based Treatment of Opioid Use Disorder."[58]
- BOLIM, BON, and BOL plus the Board of Licensure of Podiatric Medicine have a joint rule entitled, "Use of Controlled Substances for Treatment of Pain"[59] that requires:
    - Clinicians to complete 3 hours of continuing education every two years on the prescribing of opioid medication regardless of whether not they prescribe opioid medication.
    - Clinicians to limit their opioid medication prescribing.
    - Electronic prescribing of opioid medications.
    - Prescribers and dispensers to check prescription monitoring information for benzodiazepines and opioids.

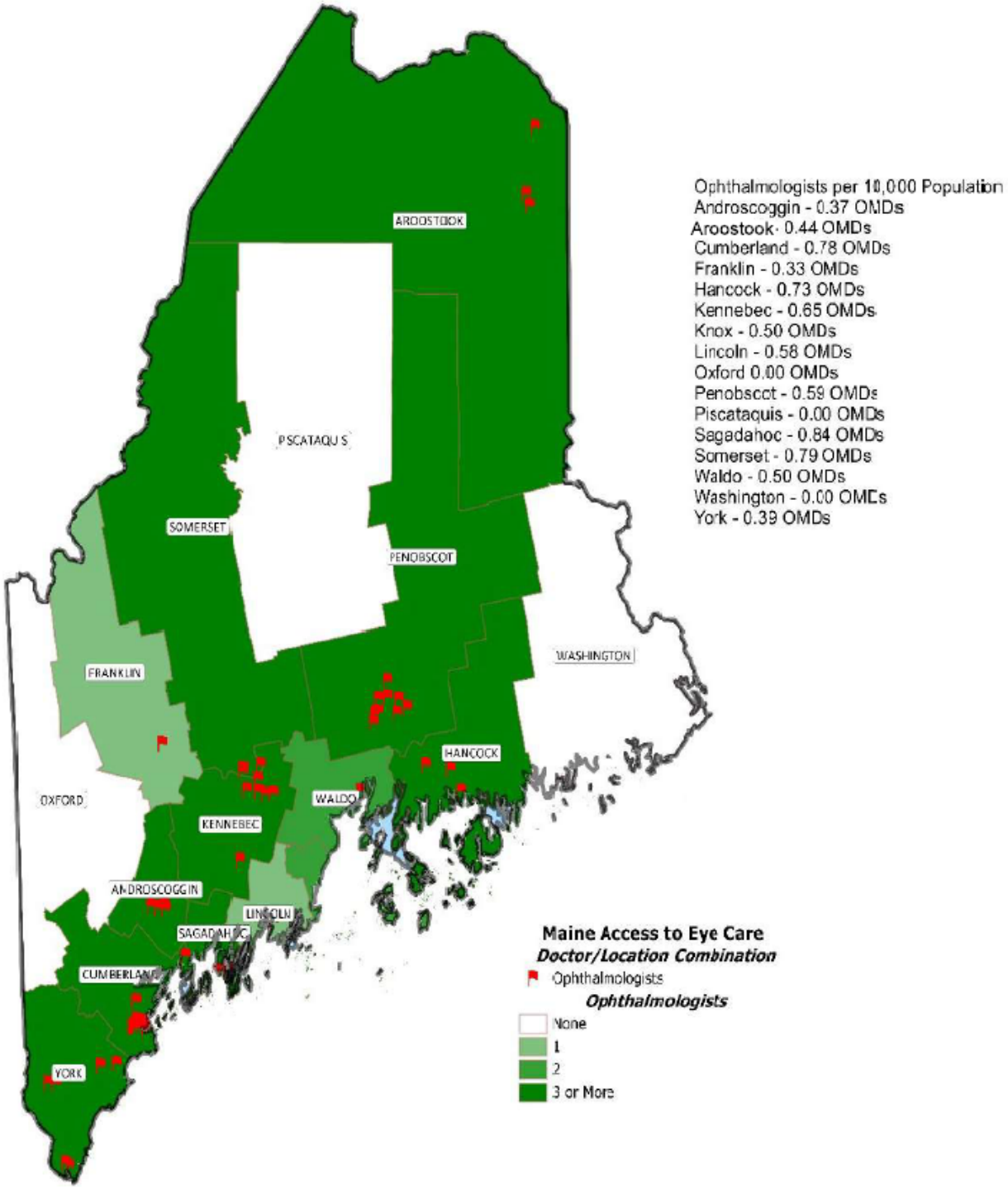
[56] Accessed 12/18/25 at https://www.deadiversion.usdoj.gov/pubs/docs/mate_training.html.
[57] Accessed 12/19/25 at PUBLIC Law, Chapter 488, An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program.
[58] Accessed 12/19/25 at Meeting began at 1:10 p
[59] Accessed 12/19/25 at Meeting began at 1:10 p

Appendix 12 Ratios of Optometrists (per 10,000 people) in Maine by County[60]



[60] Data provided by the Maine Optometric Association

Appendix 13 Ratios of Ophthalmologists (per 10,000 people) in Maine by County[61]



[61] Data provided by the Maine Optometric Association

Appendix 14 Numbers of Licensed Optometrists and Ophthalmologists in Maine, by County[62],[63]

	Optometrists	Ophthalmologists (MD and DO)
Androscoggin	16	2
Aroostook	18	4
Cumberland	78	29
Franklin	3	1
Hancock	4	11
Kennebec	22	5
Knox	5	2
Lincoln	5	1
Oxford	7	0
Penobscot	27	11
Piscataquis	1	0
Sagadahoc	9	2
Somerset	3	2
Waldo	6	3
Washington	3	0
York	32	3
Total	***239***	***76***

[62] Does not include out-of-state licensees that hold a Maine license.
[63] Data provided by the Maine Board of Optometry (September 23, 2025), the Maine Board of Licensure in Medicine (September 26, 2025), and the Maine Board of Osteopathic Licensure (October 27, 2025).

Appendix 15 Licensed Practicing Optometrists in Expansion States[64]

Licensed Practicing Optometrists

State	Scope Pass	Pre 5 yrs	Pre 4 yrs	Pre 3 yrs	Pre 2 yrs	Pre 1 year	Enacted	Post 1 Year	Post 2 Year	Post 3 Year	Post 4 Year	Post 5 Year	*2025*	*1st year pre*	*5th year post*
OK	1998					511	507	498	478	464	457	483	654	*1993*	*2003*
KY	2011	384	384	388	387	391	393	394	393	449	550	559	651	*2006*	*2016*
LA	2013	280	287	291	298	302	300	312	350	372	382	397	416	*2008*	*2018*
AK	2017	110	113	112	111	122	128	146	143	144	140	143	135	*2012*	*2022*
AR	2020	382	378	371	398	398	392	387	381	380	398	402	402	*2015*	*2025*
WY	2021	109	109	110	112	113	112	114	115	112	114		114	*2016*	*2026*
MS	2021	315	317	325	326	336	340	332	330	328	334		334	*2016*	*2026*
CO	2022	897	1009	1007	988	983	985	1003	1030	1049			1049	*2017*	*2027*
VA	2022	1069	1120	1096	1080	1101	1093	1112	1095	1103			1103	*2017*	*2027*
SD	2024	200	198	194	191	189	191	192					192	*2019*	*2029*
MT	2025	184	186	185	187	190	189						189	*2020*	*2030*
WV	2025	221	220	209	216	216	213						213	*2020*	*2030*
IN	NA	1101	1112	1083	1154	1169	1179	1189	1159	1155	1161	1165	1165	**provided 2015 - 2025*	
WI	NA	823	803	857	861	865	868	872	863	856	879	872	872	**provided 2015 - 2025*	

[64] Data provided by the Maine Optometric Association

Appendix 16 Results of Maine Optometric Association Poll of Patient Wait Times for Ophthalmologists' Appointments[65],[66]

Town Patient must travel from Location of Ophthalmology		Category	Date REFERRAL why no appointment set requestedup yet	Date scheduled for CONSULT appointment	Date scheduled for PROCEDURE	number of days between REFERRAL and PROCEDURE	Notes
Kittery	**Portsmouth, NH**	**YAG**	**7/18/2025 see appointment**	**10/1/2025**	**9/15/2025**	**59**	**Originally scheduled 10/2025 date with Eyesight, Pt ended up driving to Manchester for care instead and was seen 9/15/2025**
Kittery	Portsmouth NH	YAG	9/9/2025 see appointment	11/11/2025	11/11/2025	63	Pt had "ASAP" note on referral because vision was 20/150 and 20/200
Kittery	Portsmouth	GLaucoma	8/11/2025 waiting on appointment				Referred to Dr. Sears for narrow angle consult/LPI
Kittery	Portsmouth	GLaucoma	10/6/2025 waiting on appointment				Referred to Dr. Ling for LPI evaluation next available- no response yet
Kittery	Portsmouth	GLaucoma	9/15/2025 waiting on appointment	12/2/2025			Referred to Dr. Sears for LPI evaluation

[65] Data provided by the Maine Optometric Association

[66] A sampling of patient wait times in Maine for referrals from some optometrists to some ophthalmologists. The survey was sent to the approximately 185 members of the Maine Optometric Association (MOA) with a request that they track at least six patient cases. The first request was sent in March, 2025; a follow-up request was sent in October. MOA received information from 30 of their members

Kittery	Portsmouth	GLaucoma	3/14/2025 see appointment	6/24/2025			Being managed by glaucoma specialist
Kittery	Portsmouth	GLaucoma	4/28/2025 see appointment	7/9/2025		72	10/21/2025 still waiting for glaucoma surgery
Kittery	Portland	YAG	3/24/2025 see appointment	5/8/2025	5/8/2025	45	
Kittery	Portsmouth	YAG	2/21/2025 see appointment	3/26/2025	3/26/2025	35	Pt had "ASAP" note on referral
Kittery	Portland	YAG	11/12/2024 see appointment	5/5/2025	5/5/2025	175	Pt left for Florida 12/16/2024 and wasn't able to get in before she left. Had to wait until May for YAG.
Kittery	Portsmouth	SLT	6/13/2025 see appointment	7/8/2025	7/22/2025	39	
Readfield	Waterville/ ECOM	skin tag/Chalazio	12/5/2024 see appointment	4/1/2025	6/10/2025	187	
Vassalboro	Waterville/ ECOM	skin tag/Chalazio	1/20/2025 see appointment	10/9/2025	10/9/2025	262	
Winthrop	Augusta/Atlee Gleaton	YAG	########## see appointment	2/25/2025	2/25/2025	13	
Augusta	Waterville/ ECOM	YAG	3/13/2025 see appointment	4/8/2025	6/20/2025	99	
Vassalboro	Waterville/ ECOM	skin tag/Chalazio	3/25/2025 see appointment	9/18/2025	9/18/2025	177	

Readfield	Portland/EMG	skin tag/Chalazio	4/10/2025 see appointment	6/24/2025	6/24/2025	75	
Mount Vernon	Waterville/ ECOM	other/see notes	4/15/2025 see appointment	5/13/2025	5/13/2025	28	LPI
Augusta	Waterville/ ECOM	YAG	4/17/2025 see appointment	7/31/2025	10/22/2025	188	
Sidney	Waterville/ ECOM	skin tag/Chalazio	4/17/2025 waiting on appointment	10/9/2025		over180	Still waiting on procedure date
Winthrop	Waterville/ ECOM	YAG	6/12/2025 see appointment	8/26/2025	9/11/2025	91	
Gardiner	Portland/Maine Eye	skin tag/Chalazio	8/7/2025 waiting on appointment				Still waiting on consult & procedure appt
Auburn	Waterville/ ECOM	skin tag/Chalazio	8/13/2025 waiting on appointment				Still waiting on consult & procedure appt
Augusta	Waterville/ ECOM	YAG	9/9/2025 waiting on appointment	12/18/2025			Waiting on consult to happen for procedure to be scheduled
Manchester	Waterville/ ECOM	skin tag/Chalazio	10/6/2025 waiting on appointment				Still waiting on consult & procedure appt
Sidney	Waterville/ ECOM	skin tag/Chalazio	10/6/2025 waiting on appointment				Still waiting on consult & procedure appt

Wayne	Waterville/ ECOM	YAG	10/21/2025 waiting on appointment				Still waiting on consult & procedure appt
Brewer	Bangor/EMEA	YAG	4/18/2025 see appointment	6/24/2025			
Bangor	Coastal Eye Care/Elsworth	skin tag/Chalazio	10/22/2025 waiting on appointment	1/8/2025			
Bangor	Easter Maine Eye Associates/BYAG		10/28/2025 see appointment	1/15/2026			
Hermon	Eastern Maine Eye Associates/ YAG		7/22/2025 see appointment	10/1/2025	2/12/2026	204	
Brewer	Eastern Maine Eye Associates/ SLT		9/10/2025 see appointment	3/10/2026			
Bangor	Dr Piazza	YAG	10/14/2025 see appointment	12/17/2026			
Mexico, ME	Lewiston, ME	YAG	12/15/2024 see appointment		4/2/2025	114	referral to Dr. Lonsdale
Greenwood, ME	Lewiston, ME	YAG	3/13/2025 see appointment	4/9/2025	4/29/2025	76	referral to Dr. Whitaker

Bethel, ME	Westford, Mass	YAG	5/19/2025 see appointment	5/27/2025	5/27/2025	8	Lexington Eye Associates , MA
Rumford, ME	Portland, ME	YAG	11/4/2024 see appointment	12/30/2024	12/30/2024	56	referral to Dr. Sise

Rumford, ME	Lewiston, ME	YAG	12/13/2024 see appointment	1/8/2025		26	referral to Dr. Hein
Center Conway, NH	Lewiston, ME	YAG	12/5/2024 see appointment	12/26/2024		21	referral to Dr. Whitaker
Carthage, ME	Waterville, ME	YAG	12/2/2024 see appointment	2/3/2025	3/18/2025	107	referral to Dr. Witkin
Rumford, ME	Waterville, ME	YAG	11/18/2024 see appointment	4/15/2025		148	referral to Dr. Kohler
Newry, ME	Lewiston, ME	YAG	3/18/2025 see appointment	5/28/2025		71	referral to Dr. Hein
Bryant Pond, ME	Lewiston, ME	YAG	2/24/2025 see appointment	4/3/2025		39	referral to Dr. Whitaker
Wiscasset, ME	Damariscotta, ME	YAG	11/10/2025 see appointment	12/1/2025		21	referral to Dr. Nolan
Damariscotta, ME	Damariscotta, ME	YAG	4/22/2025 see appointment	5/23/2025	5/23/2025	31	referral to Dr. Nolan
Waldoboro, ME	Damariscotta, ME	YAG	9/4/2024 see appointment	10/23/2024	10/23/2024	49	referral to Dr. Nolan
Walpole, ME	Damariscotta, ME	YAG	6/30/2025 see appointment	8/29/2025	8/29/2025	60	referral to Dr. Nolan
East Boothbay, ME	Damariscotta, ME	YAG	4/7/2025 see appointment	5/21/2025	5/21/2025	44	referral to Dr. Nolan
Falmouth office	EMG Portland	YAG	9/8/2024	10/18/2024		40	
Falmouth office	EMG Portland	YAG	9/25/2024	10/25/2024		30	
Falmouth office	EMG Portland	YAG	9/25/2024	10/25/2024		30	
Falmouth office	EMG Portland	YAG	10/2/2024	10/31/2024		29	
Falmouth office	EMG Portland	YAG	11/2/2024	5/14/2024		194	
Falmouth office	EMG Portland	YAG	12/20/2024	6/24/2024		187	
Falmouth office	EMG Portland	YAG	1/22/2025	3/6/2025		59	
Falmouth office	EMG Portland	YAG	4/23/2025	5/22/2025		29	
Falmouth office	EMG Portland	YAG	5/15/2024	6/19/2025		35	
Falmouth office	MEC/Portland	YAG	9/19/2024	2/21/2025		155	

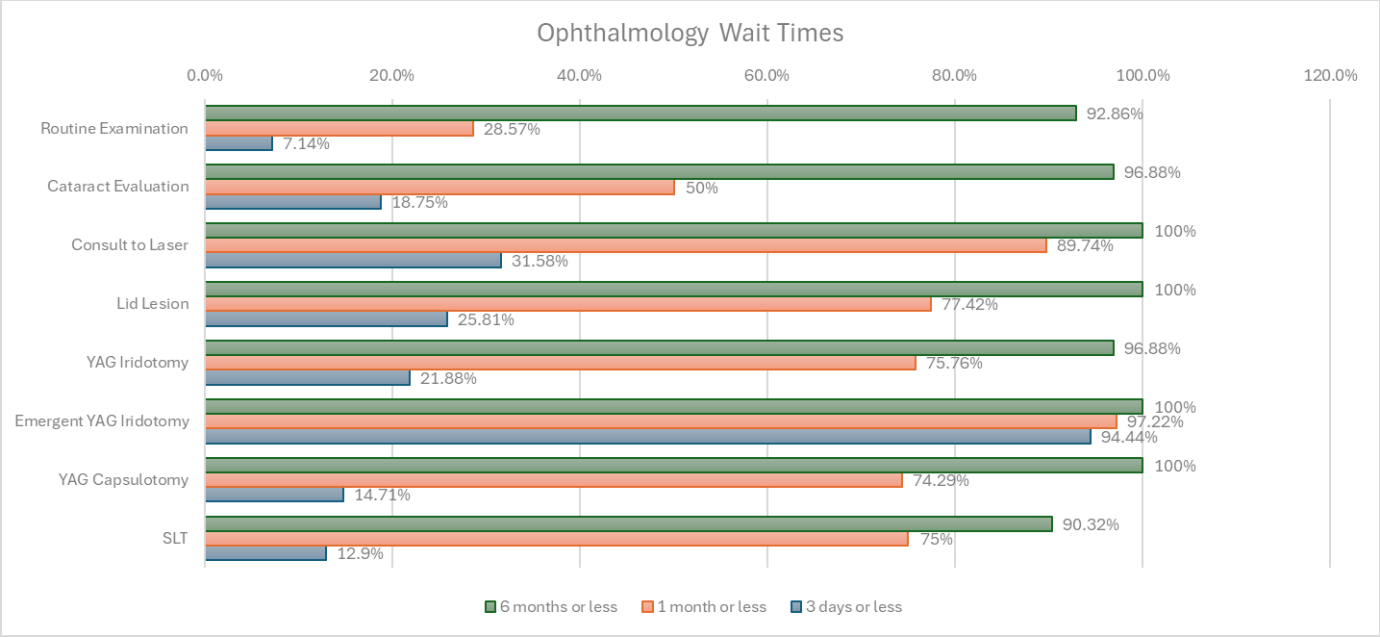
Falmouth office	EMG Portland	YAG	11/14/2024	1/15/2025		62
Falmouth office	EMG Portland	YAG	1/23/2025	3/19/2025		55
Falmouth office	EMG Portland	YAG	3/19/2025	5/21/2025		63
Augusta Office	MEC/Portland	YAG	1/23/2025	3/2/2025	6/2/2025	129
	EMG Portland	YAG	8/22/2024	10/10/2024	11/6/2024	75
	EMG Portland	YAG	2/13/2025	3/7/2025	3/13/2025	60
	Atlee Augusta	YAG	5/9/2024	5/21/2024	5/21/2024	12
	EMG Portland	YAG	7/9/2024	9/9/2024	9/9/2024	62
Augusta office	EMG Portland	YAG	8/28/2024	2/3/2025	2/3/2025	158
Augusta office	EMG Portland	YAG	9/11/2024	10/22/2024	10/22/2024	41
Augusta office	EMG Portland	YAG	1/21/2025	2/20/2025	2/20/2025	29
Augusta office	Atlee Augusta	YAG	2/12/2025	2/25/2025	2/25/2025	13
Augusta office	Atlee Augusta	YAG	5/14/2025	6/25/2025	6/25/2025	42
Augusta office	emg Portland	YAG	1/28/2025	3/26/2025	3/26/2025	57
Bangor Office	Ellsworth	YAG	12/5/2024	1/14/2025	3/12/2025	97
Bangor Office	Waterville	SLT	4/2/2025 waiting on appointment			
Bangor Office	Portland	YAG	1/28/2025	3/6/2025	6/19/2025	142

Bangor Office	Bangor	YAG	9/20/2024	2/10/2025	2/17/2025	149
Bangor Office	Ellsworth	YAG	7/11/2024	10/28/2024	11/14/2024	126
Bangor Office	Ellsworth	YAG	12/5/2024	1/14/2025	3/12/2025	97
Bangor Office	Portland	YAG	1/28/2025	3/6/2025	6/23/2025	147
Kittery area	Portsmouth, NH	YAG	11/2/2024	1/22/2025	3/3/2025	122

Southern Maine	Portsmouth, NH	YAG	1/14/2025	3/25/2025	6/18/2025	155	
	MEC/Portland	YAG	1/15/2025	7/2/2025	8/12/2025	209	
	MEC/Portland	YAG	2/14/2025	3/17/2025	5/12/2025	116	
AugUSTA OFFICE	MEC/Portland	YAG	2/5/2025	5/27/2025	6/13/2025	128	
AugUSTA OFFICE	Central Maine Eye Assc	YAG	2/11/2025	3/4/2025	5/29/2025	108	
Waterville	MEC/Portland	YAG	2/11/2025	3/17/2025	3/17/2025	35	
Durham	emg Portland	skin tag/Chalazioon	10/21/2025 waiting appointment	1/27/2026			
lisbon Falls	Portland	SLT	11/12/2025 waiting on appointment	12/4/2025			
Brunswick	Portsmouth, NH	SLT	9/18/2025 waiting on appointment	12/9/2025			
Brunswick area	Kittery	SLT	10/2/2025 waiting on appointment	12/16/2025			
Brunswick area	OCB-Cape Cod MA	SLT	waiting on appointment				PT preferred this location over Danvers, MA because they have someone they could stay with vs traveling down and back in one day no avail in ME
	Portland	skin tag/Chalazio	10/29/2025 see appointment	11/11/2025			
Topsham	Portland	SLT	10/7/2025 waiting on appointment	11/12/2025			typically see 2-3 months for eye 1, they may have to do a PI and cat consult because that will help with narrow angle.
Bowdoin		SLT	11/12/2025 unable to refer see notes				PT unable to travel out of state, unable to go to Portland not accepting new patients, partner is legally blind so not support to travel
Scarborough	EMG Portland	other/see notes	9/8/2025 waiting on appointment				

Gorham	EMG Portland	skin tag/Chalazio	6/4/2025	12/2/2025		
Biddeford	EMG Portland	YAG	11/4/2025	12/1/2025		
Scarborough	EMG Portland	other/see notes	11/10/2025 waiting on appointment			
Buxton	EMG Portland	YAG	11/10/2025 waiting on appointment			
Bar Mills	MEC,Portland	YAG	10/24/2025 waiting on appointment			
Scarborough	EMG Portland	YAG	10/22/2025	12/12/2025		
Saco	EMG Portland	YAG	10/14/2025	11/24/2025		
Scarborough	EMG Portland	other/see notes	7/17/2025	2/12/2026		Ptasis

Appendix 17 Maine Society of Eye Physicians and Surgeons Survey Results[67],[68]



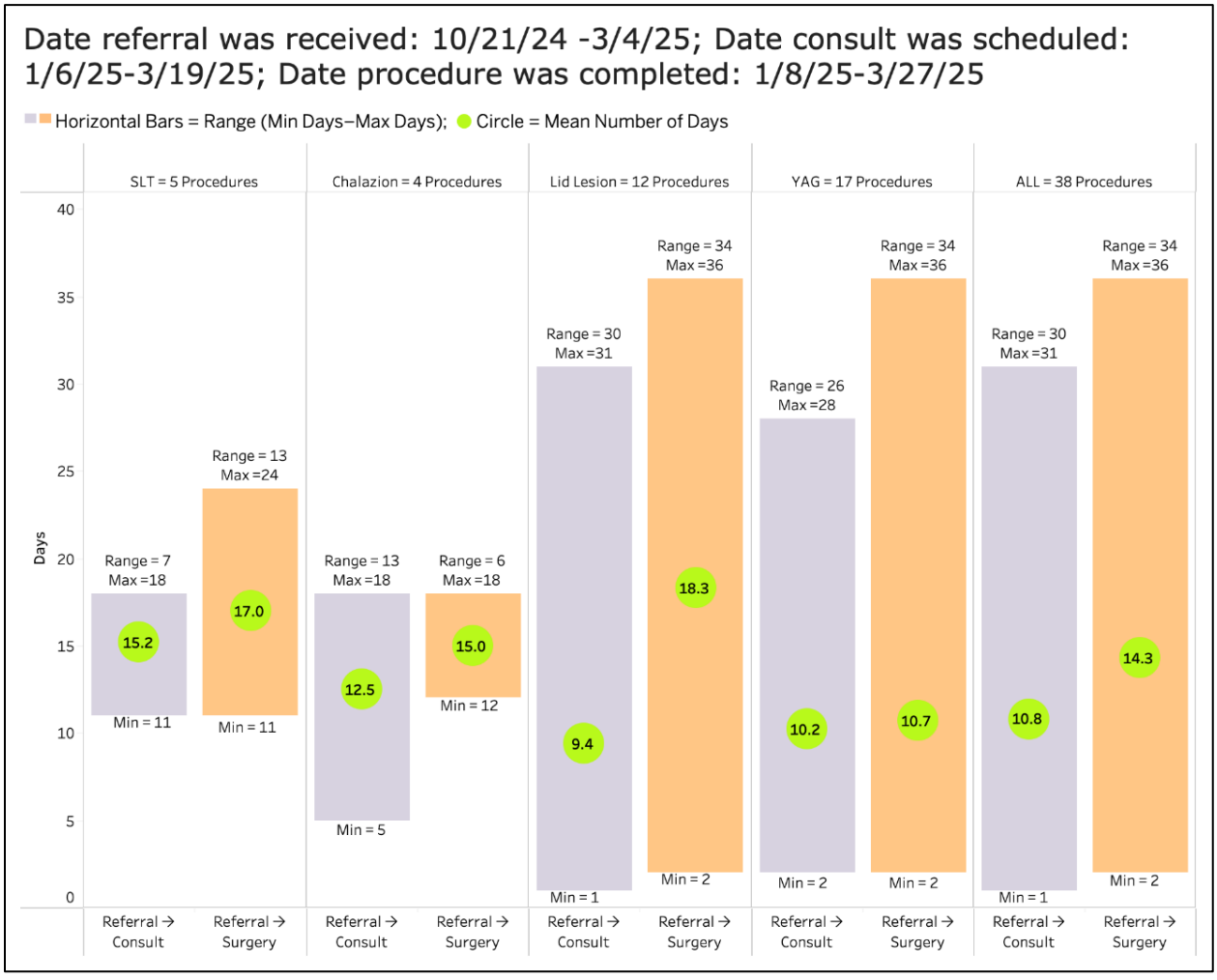
[67] Data provided by the Maine Society of Eye Physicians and Surgeons

[68] A link to the survey was sent to every practicing Maine Society of Eye Physicians and Surgeons (MSEPS) member via email (65). The survey results were collected by MSEPS from 2/19/25 to 4/30/25. Forty-five responses were received; 5 respondents were anonymous. The remaining 40 represent 9 of the 13 counties in Maine, 69% of practicing MSEPS members and 61% of all the practicing ophthalmologists in the state. Counties not represented included Franklin, Oxford and Androscoggin. Piscataquis has no practicing ophthalmologists.

Appendix 18 Sample of Wait Times from Comprehensive Ophthalmologist[69]

Upon hearing at the first stakeholder meeting that Dr. Quint's patients were reportedly waiting up to 18 months—nearly 400 working days—to see an ophthalmologist for surgical consultations, Dr. Feero provided wait time data from her own practice in Augusta. Dr. Feero does not do corneal cross-linking, but the 3 lasers (PI, SLT and YAG) as well as surgical treatment of chalazions and eyelid lesions are all done in Augusta. There were no referrals for a PI laser during the study period. Her office is located 3.3 miles from Dr. Quint's practice, making her the nearest ophthalmologist to that location. Given the short distance, travel time should not be considered a significant barrier.

The time frame used for Dr. Feero's data collection matches that of the MOA's survey, and her findings show that the average wait time in her practice is less than 11 working days for consultation and less than 15 days to completion of surgery for the relevant procedures. Lid lesions have the longest time between the consultation and the surgery because these surgeries are performed in an in-office minor surgical suite.



[69] Data provided by Dr. Feero

Appendix 19 Results of Maine Optometric Association Survey on Patient Wait Times for Optometrists' Appointments[70],[71]

New Patient/Routine	Existing patient/routine	Eye Problem *non-urgent*	Urgent (acute eye problem)
1-2 weeks 6 weeks 2-5month 6-8 months	2 weeks, 1 month 9 weeks 2-3 months 3mnths, 6mnths	Next day appointments to within 1 week depending on the severity	Same day or within 24hrs Depending on urgency ***All practices reported*** ***they have after-hours on call for patients***

Method: poll the membership of the Maine Optometric Association. Via phone and email, request the following:

1. For a New Patient, what would the estimate wait time for a routine eye exam.
2. For an existing patient, what would the estimate wait time be for a routine eye exam
3. New/Existing patient how long is the estimated wait time for an eye problem, and *acute* eye problem. (no difference as new/existing patient) It was noted that the patient would be triaged on the telephone and the appointment would be classified as urgent or non-urgent.

[70] Data provided by the Maine Optometric Association

[71] A sampling of patient wait times in Maine for referrals from some optometrists to some ophthalmologists. The survey was sent to the approximately 185 members of the Maine Optometric Association (MOA) with a request that they track at least six patient cases. The first request was sent in March, 2025; a follow-up request was sent in October. MOA received information from 30 of their members

Appendix 20 Drive Time in Sample Access States[72],[73]

eTable 1. Population within a 30 minute isochrone by state, provider, and procedure

	Oklahoma	Kentucky	Louisiana	Arkansas	Missouri
LPI ophthalmologist	2904042 73.4 %	3543952 78.7 %	3963086 85.1 %	2150983 71.4 %	5096277 82.8 %
LPI optometrist	2443782 61.7 %	1894540 42.1 %	847599 18.2 %	NA	NA
SLT ophthalmologist	3014818 76.1 %	3551942 78.8 %	3905081 83.8 %	2181552 72.4%	5011944 81.4%
SLT optometrist	2953517 74.6 %	2817342 62.5 %	2980150 64.0 %	NA	NA
YAG ophthalmologist	3321536 83.9 %	3923418 87.1 %	4254007 91.3 %	2350106 78.0 %	5512121 89.6 %
YAG optometrist	3461103 87.4 %	3544734 78.7 %	3871661 83.1 %	631842 21.0%	NA

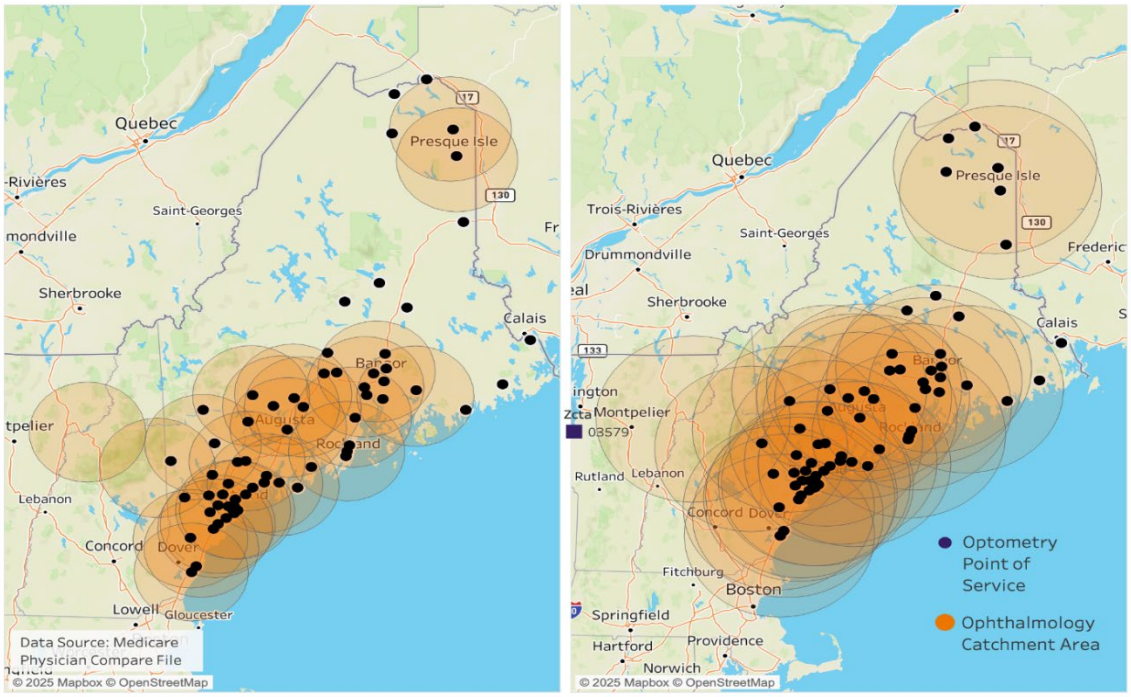
For calculating percentages, the state total populations are OK 3,959,353; KY 4,505,836; LA 4,657,757; AR 3,011,524; and MO 6,154,913.

[72] Data provided by the Maine Society of Eye Physicians and Surgeons

[73] Shaffer J, Rajesh A, Stewart MW, Lee AY, Miller DD, Lee CS, Francis CE. Evaluating Access to Laser Eye Surgery by Driving Times Using Medicare Data and Geographical Mapping. JAMA Ophthalmol. 2023 Aug 1;141(8):776-783. doi: 10.1001/jamaophthalmol.2023.3061. PMID: 37471084; PMCID: PMC10360006.

Appendix 21 Thirty-minute Drive Time in Maine[74]

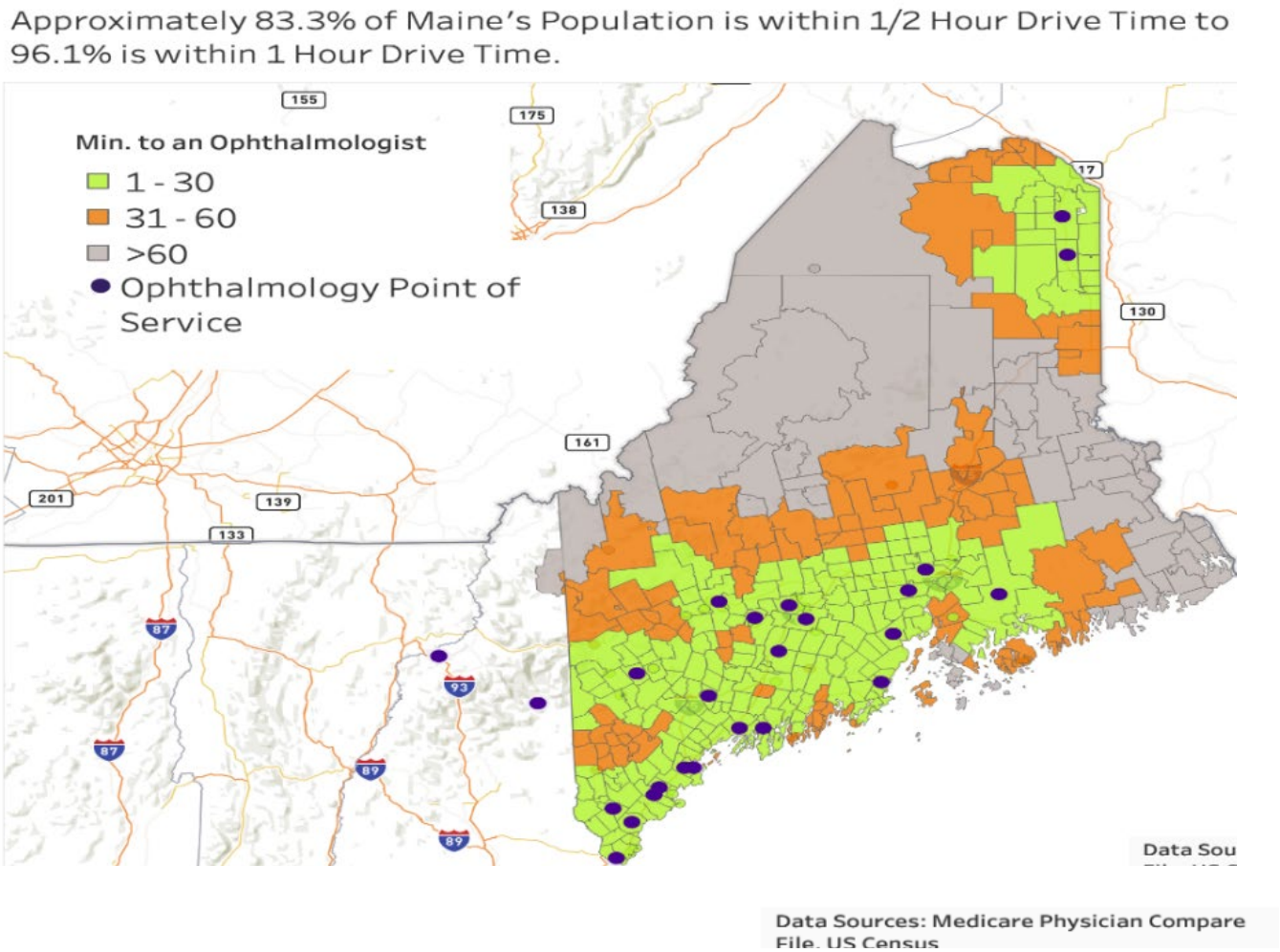
Only 7 Zip Codes with Optometry Points of Service are Outside the 30 Mile Catchment Area of an Ophthalmologist; Only 1 Zip codes is Outside the 60 Mile Catchment Area



To create the first map, the latitude and longitude of each ophthalmologist's ZIP code in the Medicare Physician Compare file were identified using CDX Technologies, a geographic analysis program. This data was imported into Tableau, an industry-standard data visualization program. In Tableau, 30-mile and 60-mile radius circles were then drawn around each coordinate (shown in orange on the right and left maps, respectively) to illustrate the catchment areas. The ZIP codes of optometrists listed in the same Medicare Physician Compare dataset were overlaid to show their locations relative to the catchment areas.

[74] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 22 Drive Time to Ophthalmology Point of Service[75]



To create the second map, CDX Technologies geographic analysis program was used to identify, for every ZIP code in Maine, the geographically closest ophthalmology office listed in the Medicare Physician Compare file. The program then calculated the drive time from the centroid of each ZIP code to the centroid of the nearest ophthalmologist's ZIP code. Population estimates for each Zip Code Tabulation Area, as well as for the state as a whole, were taken from the U.S. Census Bureau's 2020 Census and its subsequent population updates through 2024. This population data was then used to calculate the percentage of the statewide population falling within each drive-time segment. The resulting dataset was plotted in Tableau which overlaid the ZIP codes containing ophthalmology practices onto the color-coded drive-time zones to produce the final map.

[75] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 23 OD Curriculum[76]

2024-2025 Four Year OD Curriculum

Four-Year OD Program: Year 1

Fall Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD10300	Cell Biology, Histology, and Ocular Anatomy	52	4	0	0	3.50	letter
BSD10320	Anatomy and Physiology I	50	16	0	0	3.75	letter
PC12021	Principles and Practice of Optometry I	42	22	0	0	3.50	letter
PC12041	Clinical Reasoning Ia	10	0	0	0	0.75	letter in Spring
PC12125	Patient Care Ia	0	0	20	0	0.75	pass/fail
VS11001	Optics I	54	12	0	0	4.00	letter
VS11221	Visual, Sensation and Perception	51	6	0	0	3.50	letter
	Totals	**259**	**60**	**20**	**0**	**19.75**	

Spring Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD10009	Neuroanatomy	40	0	0	0	2.75	letter
BSD10321	Anatomy and Physiology II	35	6	0	0	2.50	letter
BSD10721	Ocular Disease Principles I	30	2.5	0	0	2.00	letter
PC12022	Principles and Practice of Optometry II	52	32	0	0	4.50	letter
PC12042	Clinical Reasoning Ib	0	0	0	18	1.25	letter
PC12126	Patient Care Ib	0	0	20	0	0.75	pass/fail
VS11002	Optics II	51	32	0	0	4.50	letter
VS11210	Color Vision	20	2	0	0	1.25	letter
	Totals	**228**	**74.5**	**20**	**18**	**19.50**	

Four-Year OD Program: Year 2

Summer Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD10340	Biochemistry	15	0	0	0	1.00	letter
PC22402	Introduction to Public Health	10	0	0	0	0.75	letter
PC22023	Principles and Practice of Optometry III	14	14	14	0	1.75	letter
VS21003	Optics III	40	10	0	0	3.00	letter
	Totals	**79**	**24**	**14**	**0**	**6.50**	

Fall Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD20401	Immunology	30	0	0	0	2.00	letter
BSD20722	Ocular Disease Principles II	74	35	0	0	6.00	letter
BSD-20813	Pharmacology I	30	0	0	0	2.00	letter
PC22125	Patient Care IIa	0	0	50	0	1.75	pass/fail
SAC23002	Contact Lenses I	24	18	0	0	2.25	letter
VS21203	Binocular Vision and Ocular Motility	65	8	0	0	4.50	letter
	Totals	**223**	**61**	**50**	**0**	**18.50**	

Spring Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD20723	Ocular Disease Principles III	34	12.5	0	0	2.75	letter
BSD-20814	Pharmacology II	30	0	0	10	2.00	letter
BSD30901	Clinical Medicine	0	0	0	60	4.00	letter
PC22126	Patient Care IIb	0	0	60	0	2.00	pass/fail
SAC23003	Contact Lenses II	24	21	0	0	2.25	letter
SAC33405	Binocular and Accommodative Anomalies	51	14	0	2	3.75	letter
VS21207	Neural Basis of Vision	49	0	0	0	3.25	letter
	Totals	**188**	**47.5**	**60**	**72**	**20.00**	

[76] Data provided by the Maine Optometric Association

2024-2025 Four Year OD Curriculum

Four-Year OD Program: Year 3

Summer Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
PC22041	Clinical Reasoning II	0	0	0	10	0.75	pass/fail
PC32125	Patient Care IIIa	0	0	120	0	4.00	pass/fail
PC32505	Clinical Ocular Imaging Topics	20	0	0	0	1.25	letter
SAC33403	Development of Vision	24.5	0	0	0	1.75	Letter
Electives	2.00 credits by end of year						
	Totals	**44.5**	**0**	**120**	**10**	**7.75**	

Fall Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD20350	Clinical Neuro-ophthalmic Topics	23	0	0	0	1.50	letter
BSD30701	Advanced Ocular Disease I	56.25	0	0	0	3.75	letter
PC32126	Patient Care IIIb	0	0	120	0	4.00	pass/fail
PC32406	Public Health and Clinical Practice	10	0	0	0	0.75	letter
SAC33203	Low Vision Rehab Throughout the Life Span	42	12	0	0	3.00	letter
SAC33583	Strabismus and Amblyopia	36	6	0	0	2.50	letter
Electives	2.00 credits by end of year						
	Totals	**167.25**	**18**	**120**	**0**	**15.50**	

Spring Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD30702	Advanced Ocular Disease II	72	0	0	15	4.75	letter
BSD30710	Special Topics: Ocul. Dis. and Adv. Clinical Care	20	0	0	0	1.25	pass/fail
PC32006	Advanced Surgical and Laser Procedures	26	18	0	2	2.50	letter
PC32041	Clinical Reasoning III	0	0	0	16	1.00	pass/fail
PC32127	Patient Care IIIc	0	0	120	0	4.00	pass/fail
PC32721	Ophthalmic Business and Management Policy I	10.5	0	0	5	0.75	letter
SAC33605	Pediatric Optometry	36	0	0	8	2.75	letter
Electives	2.00 credits by end of year						
	Totals	**164.5**	**18**	**120**	**46**	**17.00**	

Four-Year OD Program: Year 4

Summer course taken online while students in Rotations - Anterior & Posterior Interactive Case Studies must be completed by end of Fall Term

Course Number	Course Title	Lecture	Lab	Patient Care	Seminar/ Online	Credits	Grade Type
BSD40510-01	Anterior & Posterior Interactive Case Studies	0	0	0	15	1.00	letter
PC32722	Ophthalmic Business and Management Policy II	12	0	0	5	1.00	pass/fail

Fall Terms: course taken online while students in Rotations - must be completed by end of Fall Term

PC32723	Ophthalmic Business and Management Policy III	10	0	0	7	1.00	pass/fail

Final-year Clinical Rotations

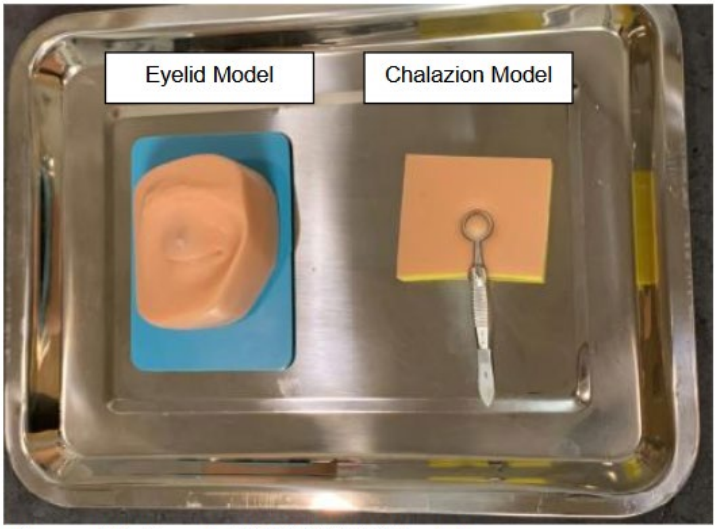
Course Number	Course Title	Patient Care	Credits	Grade Type
ACC4963	Specialty Care Rotation	Minimum of 400	13.25	pass/fail
ECP4918	Primary Care Rotation	Minimum of 400	13.25	pass/fail
ECP4923	Advanced Care Rotation	Minimum of 400	13.25	pass/fail

Each student completes 53 clinical rotation credit hours during their four final year rotations.

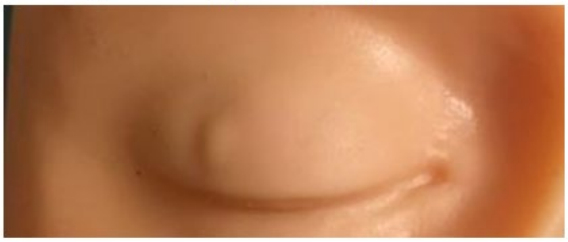
Contact Lenses Clinical Care is included in the rotations.

Appendix 24 Model Eyes[77]

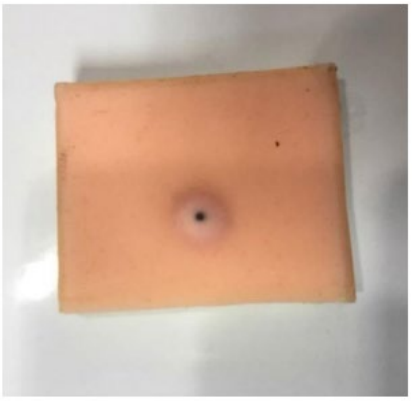
CHALAZION MODEL TRAY



Nasco Life/form LF01046/01047 Facial Suturing Trainer (Eyelid model)



***Limbs & Things* Sebaceous Cyst Pad (Chalazion model)**



LASER SECTION EYE MODELS (Before treatment)

SLT Laser Eye Model

LPI Eye Model

YAG Eye Model

[77] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 25 Optometry Training Course[78]

LD1803 STAKEHOLDER GROUP MEETING #2

Forward Focus

Expanding access, advancing eye care in Maine!

NSUOCO Advanced Procedures
Tahlequah, Oklahoma

Thursday, July 7, 2022

1:00-2:00 p.m. Intro to Optometric Surgery and Ophthalmic Surgical Instruments
Dr. Castillo

2:00-3:00 p.m. Review of Surgical Anatomy of the Face
Dr. Castillo

3:00-4:00 p.m. Oculofacial Surgical Asepsis
Dr. Castillo

4:00-5:00 p.m. Review of Eyelid Anatomy & Eyelid Lesions
Dr. Lighthizer

5:00-6:00 p.m. Dinner Provided

6:00-7:00 p.m. Office-based Local Anesthesia
Dr. Castillo

7:00-8:00 p.m. Radio Frequency Surgery in Optometric Practice
Dr. Lighthizer

8:00-9:00 p.m. Introduction to Oculofacial Biopsy
Dr. Castillo

Friday, July 8, 2022

7:00-8:00 a.m. Hot Breakfast Provided

8:00-9:00 a.m. Chalazion Management
Dr. Lighthizer

9:00-12:00 p.m. Video Grand Rounds & Surgical Concepts
Dr.'s Lighthizer & Castillo

12:00-1:00 p.m. Lunch Provided

1:00-2:00 p.m. Intro to Suturing
Dr. Castillo

2:00-6:00 p.m. Suture Techniques Lab
Dr.'s Castillo, Lighthizer, Miller & Penisten

Lab Rotations
Injection Techniques
Dr.'s Miller & Penisten

Radiosurgical Techniques
Dr. Lighthizer

Oculofacial Biopsy
Dr. Castillo

Saturday, July 9, 2022

7:00-8:00 a.m. Hot Breakfast Provided

8:00-9:00 a.m. Laser Physics, Hazards & Safety
Neal Whittle, OD

9:00-10:00 a.m. Laser Tissue Interactions
Neal Whittle, O.D.

10:00-12:00 p.m. Clinical Workshops: Intro to Therapeutic Lasers
Dr.'s Lighthizer & Whittle

12:00-1:00 p.m. Gonioscopy: How to Interpret What You Are Seeing
Doug Penisten, O.D., Ph.D.

1:00-2:00 p.m. Lunch Provided

2:00-4:00 p.m. Laser Therapy for the Open Angle Glaucomas: ALT & SLT
Nathan Lighthizer, O.D.

Saturday, July 9, 2022

4:00-5:00 p.m. Laser Therapy in Narrow Angles/Angle Closure: LPI and ALPI
Jeff Miller, O.D.

5:00-6:00 p.m. YAG Laser Posterior Capsulotomy
Nathan Lighthizer, O.D.

6:00-7:00 p.m. Managing Potential Laser Complications
Richard Castillo, O.D., D.O.

7:00-8:00 p.m. Medicolegal Aspects of Anterior Segment Laser Procedures: Panel Discussion
Dr.'s Castillo, Lighthizer, Miller & Penisten

Sunday, July 10, 2022

7:00 a.m. Breakfast Provided

7:30-11:30 a.m. Lab Rotations

YAG Capsulotomy
Dr. Castillo

Laser Peripheral Iridotomy
Dr. Miller

Gonioscopy & Laser Lenses
Dr. Penisten

Laser Trabeculoplasty: ALT & SLT
Dr. Lighthizer

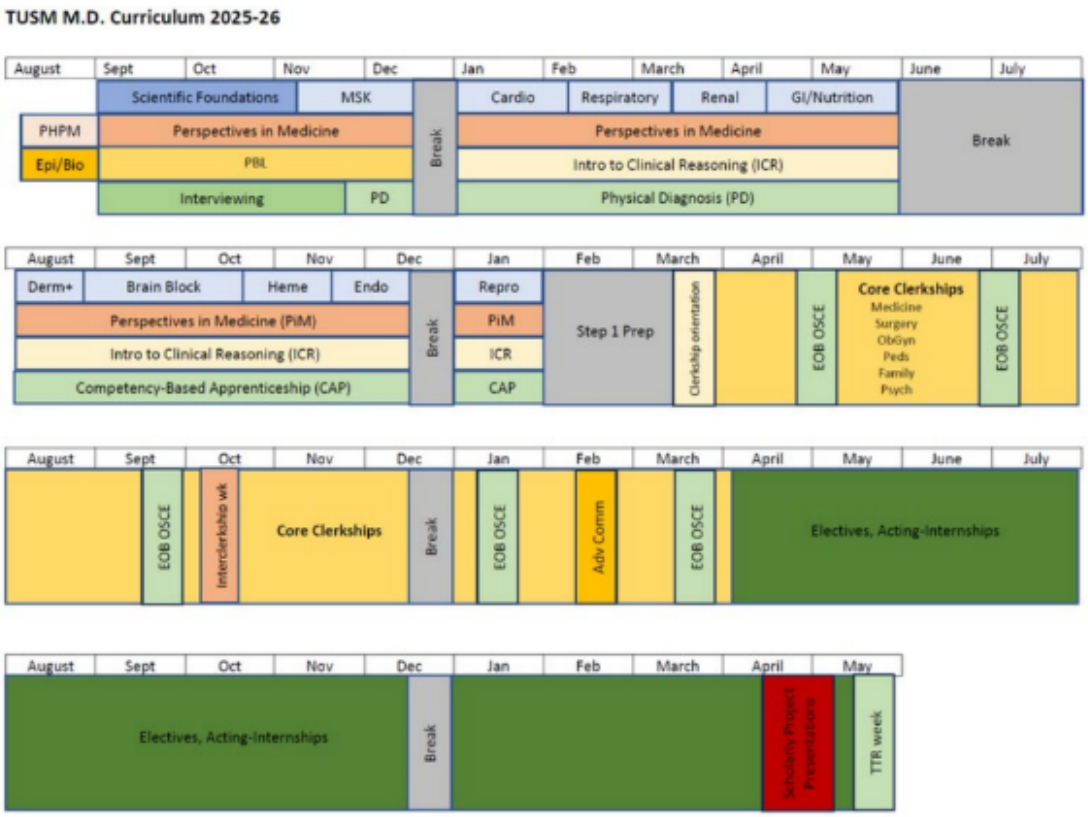
11:30 -1:00 p.m. Review & Final Exam
Nathan Lighthizer

Thank you!

- The NSUOCO Advanced Procedures course has been offered in Maine for doctors of optometry, with over 75 doctors having completed the program and continuing to pursue ongoing education related to the procedures for which they were trained.

Appendix 26 Medical School Curriculum

A schematic of the Tufts Medical School Curriculum for each of the 4 years is located below as an example of medical school education. This is the curriculum that is followed by the Maine Track MD program. Additional information can be found here: https://medicine.tufts.edu/academics/medicine/curriculum.



For ophthalmology residencies, identical accreditation requirements exist for all programs. All training programs have regularly scheduled didactic instruction in the basic and clinical sciences, including an exposure to ophthalmic pathology. The clinical component includes both supervised medical and surgical experience. Each resident participates in a clinical rotation schedule that includes primary responsibility for patient care and provides access to adequate examination facilities. The program is organized to provide a stable, well-coordinated, progressive educational experience for the resident, in addition to providing high-quality health care to patients.

[78] Data provided by the Maine Optometric Association

Appendix 27 Ophthalmology Residency Curriculum[79]

Below is the Curriculum for an Ophthalmology Resident at Boston Medical Center:

Post-graduate year 1 (PGY-1) is devoted to 75% of time in internal medicine training and 25% ophthalmology via 1 of the 4 possible tracks in the graph below:

Block Rotation	WEEK 1	WEEK 2	WEEK 3	WEEK 4
Resident 1 Rotation	Internal Medicine	Internal Medicine	Internal Medicine	Ophthalmology
	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective	Outpatient clinics and surgery
Resident 2 Rotation	Internal Medicine	Internal Medicine	Ophthalmology	Internal Medicine
	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective	Outpatient clinic and surgery	Inpatient/ED/ICU/Elective
Resident 3 Rotation	Internal Medicine	Ophthalmology	Internal Medicine	Internal Medicine
	Inpatient/ED/ICU/Elective	Outpatient clinic and surgery	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective
Resident 4 Rotation	Ophthalmology	Internal Medicine	Internal Medicine	Internal Medicine
	Outpatient clinic and surgery	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective	Inpatient/ED/ICU/Elective

PGY 2-4 are devoted exclusively to ophthalmology as indicated below:

Block Rotation	1	2	3	4
Institution	BOSTON MEDICAL CENTER	BOSTON MEDICAL CENTER	BOSTON MEDICAL CENTER	VA MEDICAL CENTER
PGY 2 Rotation	Triage/ Emergency Consults	Surgery: Plastics/ Laser: Glaucoma Clinics: Comp, Plastics, Pedi, Glaucoma	Clinics: Comp, Retina, Cornea	Clinics: Cataract, Retina
Institution	BOSTON MEDICAL CENTER	BOSTON MEDICAL CENTER	VA MEDICAL CENTER	BOSTON CHILDREN'S HOSPITAL
PGY 3 Rotation	Surgery: Plastics/ Inpatient Consults Clinics: Neuro, Plastics, Low Vision	Surgery: Pedi and Retina/Lasers: Retina Community Health Center	Surgery: Plastics, Pedi Clinics:Plastics, Glaucoma, Retina, Neuro	Surgery: Pedi Pedi Clinic, Pedi Inpatient
Institution	BOSTON MEDICAL CENTER	BOSTON MEDICAL CENTER	BOSTON MEDICAL CENTER	VA MEDICAL CENTER
PGY 4 Rotation	Surgery: Cataract Clinics: Comp, Uveitis, Neuro	Surgery: Cataract, Glaucoma, Refractive Clinics: Comp, CL, Cornea, Glaucoma	Surgery: Cataract, Glaucoma, Cornea Clinics: Cornea, Glaucoma	Surgery: Cataract Clinics: Cornea, Glaucoma

[79] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 28 ACGME Minimum Number of Procedures in an Ophthalmology Residency[80]

Procedural Categories and Minimum Numbers
Effective July 1, 2023

Category	Minimum
Cataract (S)	86
Laser Surgery – YAG capsulotomy (S)	5
Laser Surgery – Laser trabeculoplasty (S)	5
Laser Surgery – Laser iridotomy (S)	4
Laser Surgery – Panretinal laser photocoagulation (S)	10
Keratoplasty (S+A)	5
Pterygium/conjunctival and other cornea (S)	3
Keratorefractive surgery (S+A)	6
Strabismus (S)	10
Glaucoma – Minimally Invasive Glaucoma Surgery (MIGS) (S)*	5
Glaucoma – Tube Shunts and Trabeculectomy (S+A)*	5
Retinal vitreous (S+A)	10
Intravitreal injection (S)	10
Oculoplastic and orbit (S)	28
Oculoplastic and orbit – Eyelid laceration (S)	3
Oculoplastic and orbit – Chalazion excision (S)	3
Oculoplastic and orbit – Ptosis/blepharoplasty (S)	3
Globe trauma (S)	4

S = Surgeon Only
S+A = Surgeon and Assistant
*Subject to citation beginning with the 2025 graduates

[80] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 29 OPHTH Residency Competency[81]

The ACGME also tracks resident improvements over the 4 years of their training on a number of criteria, one of which is in office surgery. The criteria for grading in this category are as follows:

Patient Care 3: Office-Based Procedures				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes essential components of care related to office-based procedures (e.g., informed consent, indications and contraindications, anesthesia, sterile procedure prep)	Administers anesthesia and performs procedure, with direct supervision Recognizes and manages intra- and post-operative complications, with direct supervision	Administers anesthesia and performs procedure, with indirect supervision Manages intra- and post-operative complications, with indirect supervision	Administers anesthesia and performs procedure, with oversight Manages intra- and post-operative complications, with oversight	Incorporates recent advancements in technologies or techniques
☐	☐	☐	☐	☐
Comments:				
			Not Yet Completed Level 1 ☐ Not Yet Assessable ☐	

Data shared by the ACGME for this Milestone in the 2024-2025 year for all ophthalmology residents across the country indicates that over 4 years of training, resident physicians progress from level 1 to level 4. The data confirms that it truly does take years of concentrated training to take a medical school graduate and turn them into a surgeon who can successfully perform in office surgery. This is followed by a graph showing a similar progression in competence for the prior years 2020-2024 over the 4 years of ophthalmology training.

[81] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 30: Numbers of OPHTH Residency Cases, 2024-2025[82]

OPHTHALMOLOGY: NATIONAL RESIDENT REPORT (Main Table)
Reporting Period: Total Experience of Residents Completing Programs in 2024-2025
Residency Review Committee for Ophthalmology
Report Date: September 16, 2025

Number of Programs in the Nation: 122 Number of Residents in the Nation: 512

Surgery	Average# of cases
Total	678.5
YAG Capsulotomy	27.7
Laser Trabeculoplasty	20.6
Iridotomy	11.2
Laceration	11.7
Chalazion Excision	8.2
Biopsy	2.5
Periocular Injection	5.3
Excision/Destruction	6.7

[82] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 31 Expanded States' Education Requirements[83]

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Alaska	graduated from an accredited school of optometry	(2) evidence satisfactory to the board that the licensee successfully completed a course of instruction in an expanded therapeutic procedure approved by the board. (d) To be approved by the board, a course in an expanded therapeutic procedure shall include: (1) didactic classroom instruction in (A) laser physics, hazards, and safety; (B) biophysics of lasers; (C) laser application on clinical optometry; -11- (D) laser tissue interactions; (E) laser indications, contraindication, and potential complications; (F) gonioscopy; (G) laser therapy for open angle glaucoma; (H) laser therapy for angle closure glaucoma; (I) laser posterior capsulotomy; (J) common complication of the lids, lashes, and the lacrimal system; (K) local complications; (L) medicolegal aspects of anterior segment procedures; (M) peripheral iridotomy; (N) laser trabeculoplasty;	no additional state testing	additional proctor not required	36 hours 2 year cycle; 7 hours of Injection education every 4 years. 8 hours of Use and Prescription of Pharmaceutical Agents every 4 years. Can be included in the 36 hours of CE.

[83] Data provided by the Maine Optometric Association

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		(O) minor surgical procedures; (P) an overview of surgical instruments, asepsis, and Occupational Safety and Health Administration regulations; (Q) surgical anatomy of the eyelids; (R) emergency surgical procedures; (S) chalazion management; (T) epiluminescence microscopy; (U) local anesthesia techniques and complications; (V) anaphylaxis and other office emergencies; (W) radiofrequency surgery; and (X) post-operative wound care; (2) clinical or laboratory experience incorporating: (A) video demonstration; (B) in vitro observation or participation; and (C) in vivo observation; (3) passage of a formal clinical or laboratory practical examination; and (4) passage of a written test administered by the educational institution providing the course, that uses the National Board of Examiners in Optometry format. (e) A course of instruction may be considered for approval by the board if the course; (1) meets the requirements of (d) of this section; (2) is provided by an accredited optometry school under (b) of this section; (3) is at least 32 clock hours in length;			

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		(4) is completed after graduation from optometry school; and (5) is completed after January 1, 2016.			

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Arkansas	Optometric Physicians graduated in 2019 or after who provided proof that he/she graduated from an optometry school whose program includes the education requirements for certification pursuant to this rule	b. The applicant provides proof of satisfactory completion of a course of instruction completed not more than 5 years prior to application of credentialing; provided that the course: (1) is provided by an accredited college of optometry, osteopathy or medicine; (2) includes a minimum of 32 clock hours in length; (3) is sponsored by an organization approved by the board,; and (4) includes the following didactic classroom instructions: (a) laser physics, hazards, and safety; (b) biophysics of lasers; (c) laser application on clinical optometry; (d) laser tissue interactions; (e) laser indications, contraindications, and potential complications; (f) gonioscopy; (g) laser therapy for open angle glaucoma; (h) laser therapy for angle closure glaucoma; (i) posterior capsulotomy; (j) common complications: lids, lashes, lacrimal system; (k) medicolegal aspects of anterior segment procedures; (l) peripheral iridotomy; (m) laser trbeculoplasty (n) minor surgical procedures; (o) overview of surgical instruments, asepsis,	a. The applicant must satisfactorily complete a written test administered or approved by the Arkansas State Board of Optometry on aspects of the Arkansas Optometry Practice act pertaining to this rule. b. The applicant must satisfactorily complete a clinical examination administered or approved by the Arkansas State Board of Optometry pertaining to this rule. c. The applicant must	proctor occurs during examination	20 hours annually; 10 hours shall be of general and ocular therapy and pharmacology; 2 hours shall be of continuing education specifically regarding the procedures listed in; no more than 4 hours may be practice management

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		and O.S.H.A. (p) surgical anatomy of the eyelids; (q) emergency surgical procedures; (r) chalazion management; (s) local anesthesia: techniques and complications; (t) anaphylaxis and other office emergencies; (u) radiofrequency surgery; (v) post-operative wound care; and (5) Includes the following clinical or laboratory experience; (a) Video Demonstration; and (b) In Vitro Observation or participation	satisfactorily complete a written jurisprudence examination administered by the Arkansas State Board of Optometry pertaining to this rule.		

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Colorado	(a) Graduate from an accredited college or university of optometry in 2019 or later where the laser procedures and ocular adnexa treatments were taught	(b) Complete a training course approved by the board	no additional testing	satisfactorily complete a proctored clinical session within two years prior to performing laser procedures or treating ocular adnexa. Proctoring may be performed by an optometrist or ophthalmologist licensed to perform the procedures in any jurisdiction.	4 hours every biannual cycle; One hour of CE credit may be obtained for every two hours of observation at a clinical facility specializing in eye care staffed by professors from an accredited optometry or medical school. Only 4 hours of CE may be earned by this method in each 24-month cycle. Practice management topics or drug companies sales pitches are not acceptable; study groups are also not acceptable. All CE must be clinically-based content.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Kentucky	(1) The applicant provides proof that the applicant has graduated from an optometry school with a program that includes all of the education, training, and testing requirements established in Section 1 of this administrative regulation; or (2) By the end of the second licensure renewal period, the licensee shall provide proof of compliance with Section 1 of this administrative regulation.	(a) Is currently therapeutically licensed in Kentucky; and (b) Provides proof of completion of a course approved by the board that includes: 1. Didactic classroom instruction covering: a. Laser physics; hazards and safety; b. Biophysics of laser; c. Laser application in clinical optometry; d. Laser tissue interactions; e. Laser indications; contraindications and potential complications; f. Gonioscopy; g. Laser therapy for open angle glaucoma; h. Laser therapy for angle closure glaucoma; i. Posterior capsulotomy; j. Common complications; lids, lashes, and lacrimal; k. Medicolegal aspects of anterior segment procedures; l. Peripheral iridotomy; m. Laser trabeculoplasty n. Minor surgical procedures; o. Overview of surgical instruments; asepsis and OSHA; p. The surgical anatomy of the eyelids; q. Emergency surgical procedures; r. Chalazion management; s. Epilumeninesence microscopy; t. Suture techniques; u. Local anesthesia; techniques and complications; v. Anaphylaxsis and other office emergencies;	no additional testing	yes; determined by State Board of Optometry	20 hours; Optometrists credentialed in ETP must complete 5 hours of ETP CE annually and none can be completed via the internet. The 5 hours are part of the 20 hours required to renew licenses annually. All optometrists with a DEA number, must register with KASPER and take a 2 hour course annually in pain management/addiction disorders. This 2 hour course is part of the overall number overall number of hours required to renew a license.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		w. Radiofrequency surgery; and x. Post-operative wound care; 2. Clinical or laboratory experience including: a. Video tape demonstration; b. In vitro observation or participation; c. In vivo observation; and d. A formal clinical or laboratory practical examination; and 3. Passage of a written test utilizing the National Board of Examiners in Optometry format. (3) A board approved course shall be: (a) Provided by an accredited optometry or medical school; (b) Taught by full-time or adjunct faculty members of an accredited optometry or medical school; (c) A minimum of thirty-two (32) clock hours in length; and (d) Sponsored by an organization that meets the standards of 201 KAR 5:030.			

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Louisiana	If school provides courses listed in post-school education; no additional education required. (all schools since 2011)	A board-approved course of instruction shall be: a. provided by an accredited optometry, osteopathy or medical school; b. a minimum of 32 clock hours in length; and c. sponsored by an organization approved by the board. approved by the board that may include: i. the following didactic classroom instructions: (a). laser physics, hazards, and safety; (b). biophysics of lasers; (c). laser application; (d). laser tissue interactions; (e). laser indications, contraindications, and potential complications; (f). gonioscopy; (g). laser therapy for open angle glaucoma; (h). laser therapy for angle closure glaucoma; (i). posterior capsulotomy; (j). common complications, lids, lashes, lacrimal system; (k). medicolegal aspects of procedures; (l). peripheral iridotomy; (m). laser trabeculoplasty; (n). minor surgical procedures; (o). overview of surgical instruments, asepsis, and O.S.H.A.; (p). relevant surgical anatomy; (q). emergency surgical procedures;	written test by state board	No proctor	16 hours annually; 8 of the required 16 hours of continuing education shall pertain to ocular and systemic pharmacology and current diagnosis and treatment of ocular disease and shall be obtained through an in-person classroom setting.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		(r). chalazion management; (s). local anesthesia: techniques and complications; (t). anaphalaxsis and other office emergencies; (u). radiofrequency surgery; (v). post-operative wound care; and			

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Mississippi	Those graduating from an accredited school or college of optometry within five (5) years after the effective date of this act may be excluded from course completion requirement, provided that the candidate has successfully passed appropriate coursework to fulfill requirements as determined by the board.	(i) Provided by an accredited optometry, osteopathy or medical school and not completed before May 1,2021. (ii) To be completed in a time that is no longer than two years before final certification date (iii) A minimum of thirty-two (32) clock hours in length that includes at least 6 hours in hands on laboratory work. a. laser physics, hazards, and safety; b. biophysics of lasers; c. laser application on clinical optometry; d. laser tissue interactions; e. laser indications, contraindications, and potential complications; f. gonioscopy; g. laser applications in glaucoma care; h. YAG application in primary eye care i. YAG laser posterior capsulotomy; j. common complications: lids, lashes, lacrimal system; k. medicolegal aspects of anterior segment procedures; l. minor surgical procedures; m.overview of surgical instruments, asepsis, and O.S.H.A.; n.surgical anatomy of the eyelids; o.emergency surgical procedures; p.chalazion management; q.epiluminesence microscopy; r. local anesthesia: techniques and complications;	Satisfactorily completes a written test approved by the board on aspects pertaining to primary eye care procedures including YAG laser posterior capsulotomy and injectable pharmaceuticals. Passage of the state board written exam or the National Board of Examiners in Optometry, Laser and Surgical Procedures Examination, and Injection Skills Examination will be accepted. d) Passes a clinical skills assessment as it pertains to Yag laser posterior	Participates in eight (8) additional hours of working under a preceptor who is either an ophthalmologist or licensed credentialed optometrist .The preceptor must be licensed to perform the ophthalmic YAG laser posterior capsulotomy procedures, and the training shall occur within the state in which the preceptor is licensed to perform such procedures. The preceptorship must be completed within 3 months	20 hours annually; 10 of the 20 hours must be therapeutic.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
		s.injectable pharmaceuticals in primary eye care; t.anaphylaxis and other office emergencies; u.radiofrequency surgery; v.post-operative wound care; w.suturing; x.clinical/lab work (iv) Sponsored by an organization approved by the board	capsulotomy that is approved by the board	of passage of skills assessment.	

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Montana	see post-education requirements	completes course that is: 32 hours in length; approved by the board; includes content related to each procedures	no additional testing	No proctor	36 hours every 2 year cycle; Licensees holding a laser surgical certificate must complete 8 hours of CE relating to lasers or surgery during each CE cycle. (3) Licensees holding a laser surgical certificate or a TPA certificate must complete 2 hours of CE related to pain management during each CE cycle.
Oklahoma	see post-education requirements	You must have passed the Laser Therapy for the Anterior Segment Course offered by Northeastern State University as a prerequisite for taking the Oklahoma Boards	part of licensing examination	no proctor	25 hours annually; All Oklahoma licensed optometrists are required to obtain twenty-five (25) hours of continuing education annually. Included in the twenty-five (25) hours are a maximum of six (6) Practice Management hours, and a maximum of six (6) Remote Learning hours (which includes internet

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
					hours), and a minimum of one (1) Judicious Prescribing hour.
South Dakota	graduated prior to 07/01/2024 from accredited school of optometry	completes course that is: 32 hours in length; approved by the board; includes content related to each procedures	Graduated after 2024 must pass NBEO LSE	OMD or Certified OD	45 CE hours needed every 3-year period (30 must be live and 15 must be self-directed) Five TPA hours are required each year No more than 8 hours of practice management No more than 15 hours of self-directed learning Surgical / Ophthalmologist Observation: 1 hour for every 2 hours of observation - 4 hours maximum All other forms of online / correspondence courses

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Virginia	Board requires certain subjects (similar to NSUOCO course)	. Laser physics, hazards, and safety; b. Biophysics of laser; c. Laser application in clinical optometry; d. Laser tissue interactions; e. Laser indications, contraindications, and potential complications; f. Gonioscopy; g. Laser therapy for open-angle glaucoma; h. Posterior capsulotomy; i. Common complications, lids, lashes, and lacrimal; j. Medicolegal aspects of anterior segment procedures; k. Peripheral iridotomy; and l. Laser trabeculoplasty.	Passage of LSPE, or b. Proctored sessions in compliance with 18VAC105-20-90, which may be obtained during education training described in subdivision 3 of this section.	A. Applicants for laser surgery certification who have not provided the board with a passing score on the Laser Section of the LSPE must submit evidence on a form provided by the board of at least two proctored sessions for each of the following laser procedures: PI, SLT, YAG	20 hours annually. 10 of the required continuing education hours shall be in the areas of ocular and general pharmacology; diagnosis and treatment of the human eye and its adnexa, including treatment with new pharmaceutical agents; new or advanced clinical devices, techniques, modalities, or procedures; or pain management.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
West Virginia	For new Optometry graduates after May 1, 2025, all new applicants must graduate from an accredited Optometry school or College of Optometry AND pass the Laser and Surgical Procedures Examination (LSPE) administered by the National Board of Examiners in Optometry (NBEO) as defined in W. Va. Code §30-8B-5.. For current West Virginia licensees who wish to become laser certified:	Education from accredited college of optometry for those graduated after May 1, 2025. For current WV licensed O.D.s - must take board approved course for injection and laser certification.	Graduates after May 1, 2025: LSPE (NBEO)	Document the completion of each required number of proctored procedures on a living human eye:(5)YAG, (5)SLT,(4) LPI	43 hours every 2 years; Each licensee who prescribes controlled substances must take a 3-hour course in Drug Diversion and Best Practices Prescribing available from the WVAOP every 2 years. The licensee who holds injection certification (IOD or IOD1) must take at least 2 hours of CE in administering injections and keep their CPR certification up to date. Minimum of twelve (12) CE hours in ocular pharmacology or therapeutics. No limit on number of hours taken in practice management. Maximum of ten (10) CE hours of optometric study may be taken by correspondence or via the internet, all others must be live (instructor and student are both in the same room during

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
	Applicants must complete an approved course for injection certification or pass the NEBO ISE exam as well as complete an approved course for ophthalmic laser utilization certification or pass the NBEO LSPE exam. Once your Laser Certification Application is Board approved, please use the WVBO Laser Certification Proctored Report Forms (pdf) to document the completion of				entirety of course). All licensees shall complete two (2) CE hours in injections. Two (2) hours of drug diversion CE is required within one year of receiving an initial West Virginia license (applies to all licensees). All injection certified licensees must maintain and provide proof of current CPR/Basic Life Support certification, which is eligible for CE credit.

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
	each required number of proctored procedures on a living human eye: • Posterior Capsulotomy (YAG CAP) - five (5) proctored procedures required • Selective Laser Trabeculoplasty (SLT) - five (5) proctored procedures required • Peripheral Iridotomy (LPI) - four (4) proctored procedures required You can choose to become certified in each of the three procedures outlined in W.				

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
	Va. State Code 30-8B-4 and noted above, effective as of July 9, 2025. Additionally, not all proctored procedures need to be completed on the same day, but each proctored procedure must be under the supervision of a Board approved laser certified proctor. A list of Board approved laser certified proctors is available upon request. Please be advised, if your proctored sessions take place in another laser-				

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
	certified state, the proctor still needs to be Board approved. And all proctors that are observing procedures within West Virginia must have an active West Virginia Optometry license.				

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
Wyoming	Graduate from an accredited college or university of optometry where the laser procedures in subsection (b) and adnexa treatment were taught and passage of the NBEO Laser and Surgical Procedures Examination, or (II) Complete a board-approved training course	) Complete a board-approved training course	no additional testing	Satisfactorily complete a proctored session within two (2) years prior to performing laser surgical procedures. Proctoring may be performed by: (I) An optometrist or ophthalmologist licensed to perform the procedures in subsection (b) in any jurisdiction; or (II) An optometrist who has previously been proctored. (ii) If a licensee has not performed a laser procedure within two (2)	40 hours of CE biannually 15 hours must address ocular systemic therapeusis. 3 hours must address the responsible prescribing of controlled substances. No more than 6 hours can address practice management. No more than 10 hours can be earned via asynchronous CE (formerly "online" CE)

State	education (new grads)	post-school education requirements (currently licensed ODs)	additional testing	proctor	CE requirements
				years, the licensee shall satisfactorily complete another proctored session.	

Appendix 32 Medicare Part B Fee-for-Service Claims from Optometrists[84]

State*	Total No of OD FFS Claimants	No. of OD Claimants Filing Claims for Performing Yag Capsulotomies (CPT Code 66821)	Percentage of Total Claimants Filing Claims for Performing YAG Capsulotomies
AK	114	2	1.75%
AR	352	9	2.56%
KY	501	39	7.78%
LA	272	18	6.62%
MS	293	14	4.78%
OK	565	83	14.69%
WY	101	2	1.98%
TOTAL	2198	167	7.6%%

*Medicare Fee for Service Claims data is not yet available for CO and VA.

Table X

State*	Total No of OD FFS Claimants	No. of OD Claimants Filing Claims for Performing SLTs/ALTs (CPT Code 65855)	Percentage of Total Claimants Filing Claims for Performing SLT/ALTs (CPT CODE 65855)
AK	114	0	0%
AR	352	3	.85%
KY	501	10	.20%
LA	272	1	.37%
MS	293	0	0%
OK	565	9	1.59%
WY	101	0	0%
TOTAL	2198	23	1.05%

*Medicare Fee for Service Claims data is not yet available for CO and VA.

[84] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 33 Comparison of Rates of SLT and LPI Procedures in US, New England, and Expansion States[85]

Medicare Advantage SLT Procedures 2018 - 2023

	Ophthalmology	Optometry	Total
National	134,554	846	135,400
Northeastern States	8,290	0	8,290
States with SLT Authority	18,461	802	19,263

Medicare Advantage LPI Procedures 2018 – 2023

	Ophthalmology	Optometry	Total
National	32,677	18	32,695
Northeastern States	2,782	0	2,782
States with SLT Authority	1,803	18	1,821

[85] Data provided by the Maine Optometric Association

Appendix 34 Adverse Event Reporting Requirements in Expansion States[86]

State	Procedures Reported	Outcome Reporting
AK	None	No
AR	Lasers Only	Outcomes Reporting
CO	Laser Procedures, Ocular Adnexa Treatments	Adverse Outcome Reporting
IA	None	No
KY	None	No
LA	Ophthalmic Surgery	Outcomes Reporting
MS	Ophthalmic Surgery	Outcomes Reporting
MT	None	No
OK	None	No
SD	None	No
TN	None	No
VA	Lasers Only	Adverse treatment outcomes associated with such procedures that required a referral to an ophthalmologist for treatment
WA	Eyelid Surgery	Outcomes Reporting
WV	Lasers Only	Adverse Outcome Reporting
WY	None	No

[86] Data provided by the Maine Society of Eye Physicians and Surgeons

Appendix 35 Kentucky Academy of Eye Physicians and Surgeons' Examples of Adverse Outcomes[87]

Kentucky Academy of Eye Physicians and Surgeons

John Franklin, M.D., President
Ryan Smith, M.D., President-Elect
Benjamin Proctor, M.D., Secretary/Treasurer
Benjamin Mackey, M.D., Immediate Past President

May 1, 2025

The Honorable Donna Bailey and Kristi Mathieson

Chairs, Committee on Health Coverage, Insurance and
Financial Services Maine Legislature

Maine State House

2 State House Station

Augusta, ME 04333

Dear Chairs Bailey and Mathieson and Members of the Committee:

We understand that your committee is considering LD 1803 in the Maine Legislature. We are writing to inform you about a similar bill that was regretfully enacted in our state in 2011, which was misleadingly titled *Access to Quality Eye Care* (Kentucky Senate Bill 110). Similar to Maine's LD 1803, the bill in Kentucky allowed optometrists—who are not medical doctors or trained surgeons—to perform a wide range of surgery on and around the eyes using lasers and scalpels. Since its enactment, the law has in no measurable way expanded access to quality eye care as it was sold to our lawmakers at the time.

You may be hearing from proponents of LD 1803 who claim there have been "no complaints" or "no adverse outcomes" from optometrists performing the surgeries authorized as part their scope of practice expansion in some other states. Unfortunately, for a number of patients across the Commonwealth of Kentucky, those claims are simply not true. The following cases are just the tip of the iceberg after consulting with only a few ophthalmologists, and many more exist:

- Eastern KY: While performing a needle injection of anesthesia into an eyelid, a Kentucky optometrist and "teacher of optometry surgery" accidentally went through the eyelid and directly into the eye. This is a grave complication, yielding endophthalmitis (blinding eye infection) a retinal detachment, or toxic issue from the drug in the needle.

[87] Data provided by the Maine Society of Eye Physicians and Surgeons

- Central KY: In an adult patient who had pediatric cataract surgery and was stable for decades, an optometrist lasered the vital capsule that was separating the two chambers of the eye, causing a severe glaucoma with eye pressures three times what is normal, resulting in permanent harm to the optic nerve. Fixing this tragedy took two operations by ophthalmologists (medical doctors and trained eye surgeons).
- Eastern KY: While attempting to perform a YAG capsule surgery, another "teacher of optometric surgery" subjected a patient to a multi-hour procedure. This procedure takes a seasoned ophthalmologist about 5 minutes. These struggles yield multiple laser injuries to the lens of the eye and corneal abrasions.
- Eastern KY: While attempting to remove a "benign" eyelid lesion, a "professor of optometry surgery" used another provider's loupe magnifiers and proceeded to use the dull edge of a #11 scalpel.
- Central KY: A patient who saw an optometrist for a peripheral iridotomy on one eye was subjected to having the procedure done multiple times, over multiple visits. For her second eye, the patient begged the practice to have an ophthalmologist perform the surgery so it would be performed correctly the first time.
- Central KY: An optometrist performed a laser peripheral iridotomy (PI) on a patient with neovascular glaucoma, when laser PI isn't indicated at all! This delayed a patient's care causing further glaucoma damage.

These surgical complications are in addition to numerous misdiagnoses, inappropriate therapy and overlooked problems by Kentucky Optometrists that many of our members have personally treated. There are multiple cases of missed corneal infections, inappropriately treated corneal ulcers, and missed glaucoma that were never reported because there is no medical board oversight or supervision of optometrists in Kentucky, and optometrists here are not required to report adverse outcomes or complications to their licensing board. The absence of a malpractice lawsuit or a recorded complaint filed with the board of optometry does not equate to the absence of harm to the patient.

As was the case in Kentucky, you are also probably hearing that LD 1803 will expand "rural access" for patients requiring surgical eye care. While there was already sufficient coverage of ophthalmologists statewide prior to the bill introduction in Kentucky, its enactment over a decade ago has not expanded rural access to these procedures in any statistically significant manner. After a thorough analysis of Medicare claims data, peer-reviewed research has shown that despite expansion of laser privileges to Kentucky optometrists, ophthalmologists continue (as they had prior to 2011) to serve an overwhelmingly higher percentage of the population for these procedures. This conclusion comes as no surprise considering there are only about 33 optometrists statewide performing these procedures, and most of them are in our populous urban cities like Louisville and Lexington.

You may also be told by supporters of LD 1803 that malpractice insurance premiums have remained flat for optometry since being allowed to perform surgery. This is in no way indicative of whether these procedures are safe for them to perform. The stability of optometric malpractice rates is proportional in nature. The majority of optometrists in the United States do not perform laser and incisional surgery. A statistically miniscule number of individuals performing these

procedures on and around the eye will yield a very small number of opportunities for malpractice as compared to the rest of the entire profession. Therefore, this will have a minimal impact on insurance rates—for now. This does not mean that the procedures are safe for optometrists to perform, but rather there are statistically so few of them doing these procedures which in turn, does not expand access to any significant degree. Allowing providers with substandard training to perform surgery on and around the eye is not in any way an increase in "access" to safe quality surgical eye care for rural America.

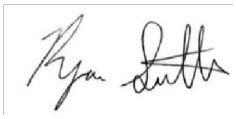
There is nothing "simple" or "minor" about eye surgery and that is why an ophthalmology resident-in-training spends three years diagnosing, treating, and operating on live patients with real conditions under direct one-on-one supervision of an attending ophthalmologist after completing medical school. Regardless of what proponents of LD 1803 may imply, there are frequent complications when it comes to surgery, and it takes the proper level of medical education and training to immediately handle those complications as they arise.

For example, a critical rescue procedure for managing an eyelid bleeding complication simply cannot be experienced in an optometry school, especially given that 22 out of the 25 U.S. schools of optometry are located in states where optometrists are legally prohibited from performing incisional surgery with a scalpel. Furthermore, 23 of the 25 schools are in states where optometrists are prohibited from performing laser surgery. This translates to 95% of optometry students attending schools where optometrists are prohibited from performing laser surgery on live patients. One cannot possibly learn how to become an eye surgeon and manage surgical complications with such an inadequate training curriculum. That's why medical school, internship, and surgical residency exist and are vitally important components of surgical eye care.

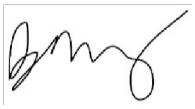
In the interests of patient safety, we do not want to see the state of Maine make the same mistakes as the Commonwealth of Kentucky—mistakes which have led to increased costs for patients, threats to their vision, and no meaningful increase in "rural access" to surgical eye care. We ask that you give our comments full consideration, and that you vote "no" on LD 1803.

Sincerely,


John Franklin, M.D.
President


Ryan Smith, M.D.
President-Elect


Ben Proctor, M.D.
Secretary/Treasurer


Ben Mackey, M.D.
Immediate Past President

P.O. Box 920 . Pewee Valley, KY 40056 . Tel: 859-300-2213

Appendix 36 Oklahoma Academy of Ophthalmology's Examples of Adverse Outcomes[88]

Oklahoma Academy of Ophthalmology
www.oklahomaeyes.org
O: 573-635-2173

May 2, 2025

The Honorable Donna Bailey and Kristi Mathieson

Chairs, Committee on Health Coverage, Insurance and Financial Services

Maine Legislature

Maine State House

2 State House Station

Augusta, ME 04333

Dear Chairs Bailey and Mathieson and Members of the Committee:

We are urging Maine's lawmakers not to enact legislation that was unfortunately adopted in our state of Oklahoma. Specifically, we are writing to ask that you oppose LD 1803, which would allow optometrists—who are not medical doctors or trained surgeons—to perform eye and eyelid surgery on the citizens of Maine.

As the leading organization representing Oklahoma's ophthalmologists—medical doctors specifically trained in eye surgery and comprehensive medical eye care—we have all too often heard those in the optometry profession claim to lawmakers in other states that there have been

"great experiences and no complications" with regards to surgery being performed by optometrists in our state and that there have been "no complaints" made to the state's board of optometry. To hear these assertions is alarming to us, as many of our members have had to treat far too many complications or mistreated patients by optometrists attempting to perform some of the same surgeries (which often turned out to be the incorrect treatment for the patient's conditions) authorized in LD 1803.

[88] Data provided by the Maine Society of Eye Physicians and Surgeons

We would like to share just a handful of professional observations and concerns based on a few sample patients, which demonstrate that a mere weekend worth of "additional training" (32 hours)—which is all that would be required for optometrists to perform the surgeries outlined in LD 1803—is grossly inadequate as a pathway to become properly trained to perform eye surgery. Allowing optometrists to perform surgical procedures in Oklahoma has *not* increased access and has indeed caused patient confusion and complications. The patient summaries below are various examples:

- **Patient #1:** A patient who—after months of evaluation for a painful red eye by not one, but TWO different optometrists—was (finally) sent to the emergency room for pain relief. The medical doctor on staff at the emergency room (not the optometrists) diagnosed chronic angle closure glaucoma and referred the patient to an ophthalmologist. A peripheral iridotomy (which optometrists would be authorized to perform in LD 1803) would have been an appropriate early treatment, but due to delay in diagnosis and scar formation from lack of a proper diagnosis the patient required a much more invasive glaucoma filtering surgery. The two optometrists that repeatedly saw the patient (and failed to properly diagnose or refer to an ophthalmologist) were "laser certified" by the Oklahoma Board of Examiners in Optometry (the same certification requirements that Montana optometrists would need to meet in LD 1803). The patient filed a lawsuit against the optometrists, but died shortly thereafter. While the cause of death was not necessarily due to his ocular issues, it technically ended any litigation against the optometrists.

- **Patient #2:** This patient was a woman with symptoms of visual distortion in one eye. Her optometrist performed a laser iridotomy (which would be authorized for optometrists to perform under Maine's LD 1803). In this surgery, a laser is used to burn a small opening in the iris so that fluid can flow through the hole and move forward, thereby deepening the front chamber of the eye. The objective of performing this procedure is to decrease the pressure in the eye if the drainage system angle is narrow or blocked. In this example, the optometrist performed this surgery in both eyes of the patient. The patient continued to experience visual distortion and sought a second opinion from an ophthalmologist.

    - Records from the optometrist were obtained and reviewed. There was no documentation of history or examination findings to warrant the laser surgeries. There was however, documentation that insurance would pay for the laser surgeries. Only after visiting an ophthalmologist, was the patient that properly diagnosed the cause of her symptoms of distorted vision—a wrinkle in the retina**. The patient did not need the laser surgeries that the optometrist performed, and the insurance company paid for unneeded an unnecessary surgery.** Net result - patient risk without any chance of benefit, and increased health care costs, not to mention failing to diagnose and treat the patient's actual problem. **Exactly the opposite of the goal of medical care which is patient benefit and the lowest risk with reasonable cost.**

- **Patient #3:** Another patient presented emergently to the hospital after an optometrist attempted to perform a laser iridotomy and encountered hemorrhaging at the surgical site. The optometrist could not proceed with the surgery and left the laser opening incomplete.

The optometrist then moved to the second eye and tried to perform a laser iridotomy and once again encountered hemorrhaging and could not complete the procedure. The bleeding in both eyes resulted in very elevated eye pressures, which then became an emergency. An ophthalmologist, a medical doctor and surgeon, came to the aid of the patient, addressing the complication.

- There is no doubt that performing these procedures requires the proper level of medical education, clinical surgical experience and the judgment that comes with years of medical and surgical training to learn not to put patients' vision at risk. A significant part of an ophthalmologist's training consists of performing complete surgical cases on live patients under the direct supervision of an attending surgeon over a period of three years. This cannot be obtained in the optometry school 32hour training course.

- Even with ophthalmology's medical and surgical residency training that is established and proven to be necessary to perform eye surgery proficiently and safely, complications may still occur. If one decreases the education and experience legally required to perform these procedures, there is no doubt there will be *increased* complications. In the case of Patient #2, he realized that he had to go to another doctor who could take care of his problem and he went to the hospital. It later was identified that the patient was on anticoagulants. The patient said he had told the optometrist about his anti-coagulant use, but the optometrist said it would not be a problem. However, to anyone properly trained, it ***should not*** have been surprising for the patient to hemorrhage. The patient was hospitalized and managed by ophthalmologists at the hospital. **Ultimately it was determined that the patient did not even need the laser treatment that the optometrist performed.** From the weekend laser course (which is all the "additional training" required for optometrists in Oklahoma to legally perform the procedure, as it would be in Maine), **the optometrist clearly did not understand if the laser treatment was needed and did not recognize the significant risks for this patient.** The patient suffered damage to both eyes and there were high additional costs that were entirely unnecessary. Poor quality of patient care with increased costs is not what patients in Oklahoma or Maine deserve.

- **Patient #4**: A patient was supposed to receive a YAG capsulotomy (which would be authorized in LD 1803) from an optometrist. However, the optometrist could not adequately visualize the posterior capsule with the slit lamp (a microscope with a bright light used during an eye exam to provide a closer look at the different structures at the front of the eye and inside the eye.) Therefore, a special lens was utilized for improved visualization of and laser administration to the posterior capsule (a thin membrane that forms a physical barrier between the anterior and posterior segments of the eye). **Unfortunately for the patient, the optometrist selected the wrong lens, so the laser was focused on the retina instead of the posterior capsule. A focused YAG laser treatment was administered by the optometrist to the macula (in the back of the eye) resulting in immediate damage with resultant scarring of the retina and permanent blindness in that eye.**

- **Patient # 5:** A patient diagnosed with acute angle closure by an optometrist was referred to an ophthalmologist for laser iridotomy (a surgery authorized in LD 1803), **but only because the optometrist did not have access to a laser at that time.** However, when the patient was examined by the ophthalmologist, the patient did NOT have acute angle closure, but rather had neovascular glaucoma. Not only was a laser iridotomy NOT the correct procedure to perform on this patient, but it would have been extremely harmful if one had been done in the setting of neovascularization of the iris which would have resulted in hemorrhaging in the eye, and worsening of the eye pressure with NO alleviation of the underlying disorder. The patient's condition would have been made worse if this optometrist's diagnosis and treatment plan were followed. If skilled slit lamp exam was utilized instead (which should have been done with this patient, but was not), this would have been diagnosed properly in the first place.

The fact is complications and mistakes indeed happen during some laser eye surgeries. To claim zero complications amongst optometrists or any practicing health practitioner should raise significant questions on: data collection methodology, the practitioners' ability to recognize an adverse event, the practitioners' ability to perform the necessary patient follow up to check for adverse events after surgery, or simply refusal to self-report any complications. Any of which on their own or in combination should raise tremendous concern about professional standards and capabilities.

The five aforementioned patient cases are just the tip of the iceberg. **The truth is that**

Oklahoma's Board of Examiners in Optometry <u>does NOT</u> collect data on surgery outcomes, and as such, Oklahoma optometrists have no reason to self-report complications and adverse outcomes from their surgeries.

Our member-ophthalmologists in Oklahoma have also had certain situations where patients came in and said that while getting new glasses, the optometrist saw a "minor lump or bump" on the eyelid and told them they needed to have it removed. The optometrists wanted to surgically excise the eyelid lesion. Fortunately, the patients did not consent to this. What turned out to be a "minor lump or bump" turned out to be small cysts that did not need to be surgically removed.

The five patient cases highlighted above demonstrate the significant negative impact on the safety and quality of care—*with increased costs*—when a state legislature enacts a bill that decreases the educational and clinical training standards to perform eye surgery.

As a professor of ophthalmology who teaches residents to perform surgery, it is an extended process over the course of three years (but only after they complete medical school) to educate future ophthalmologists on:

- How to medically diagnose;
- How to know what the management should be *if* surgical intervention is even the appropriate option;
- Which procedure is the best treatment for that patient's specific conditions;
- Recognize potential risks of the procedure, and;

- How to immediately handle any surgical complications that arise during or after the procedure.

None of this experience can be gained in optometry school or in any 32-hour weekend course.

In Oklahoma, scope of practice expansion for optometry to include surgery has *not* resulted in increased access, but it has *increased patient risk with higher cost of care* due to lowering of the educational and training standards. For the sake of maintaining patient safety and the quality of surgical eye care, while controlling costs, I urge you and your colleagues to protect the citizens of Maine by rejecting LD 1803.

Sincerely,

Ben J. Harvey, M.D.
President, Oklahoma Academy of Ophthalmology
Clinical Associate Professor of Ophthalmology

Dean McGee Eye Institute

University of Oklahoma College of Medicine

Appendix 37 Lockton Affinity (Malpractice Insurer) Letter of Support[89]

LOCKTON
AFFINITY

October 3, 2024

AOA Excel
Mr. Bob Kehm
243 N. Lindbergh Blvd.
St. Louis, MO 63141

RE: Malpractice Insurance Rates

Dear Bob:

Thank you for your inquiry regarding Malpractice Insurance rates for Doctors of Optometry. At Lockton, we work to insure over ten thousand Doctors of Optometry nationwide. The Malpractice Insurance rates currently being charged reflect the scope of practice in the respective state along with historical loss experience for optometrists across the country. Malpractice Insurance rates are subject to change based on updates to the scope of practice or material change in the historical loss data for each respective state.

A small rate increase was implemented to our program in January 2022. Increasing the rates protects the financial viability of the program, which in turn allows for us to continue to offer cost effective coverage. This was only the second rate increase in the history of our 12-year program and we expect there to be no further rate increases or shifts in our Malpractice Insurance Rates for doctors of Optometry in the immediate future.

Should you have any questions or concerns on this matter, please do not hesitate to contact me.

Thank you,

Kevin Johnson
Senior Vice President
Lockton Affinity, LLC

[89] Data provided by the Maine Optometric Association

Appendix 38 Information on Boards' Exclusive Authority[90]

This section summarizes the main requests from *Stakeholder Meeting Three* regarding prescriptive authority and the Board of Optometry.

1. **Identify which expanded scope states delegate the optometrist's scope of practice authority exclusively to their optometry board (as proposed in LD1803)**

Below are links to relevant statutes and regulations, along with a brief summary. Only one state with expanded scope of practice has full board authority, while many states grant State Boards of Optometry the ability to *approve future procedures with safeguards*.

Alaska 2017-only true board authority

Sec. 08.72.050. Regulations. Sec. 08.72.060. Miscellaneous powers and duties of board.

Sec. 08.72.278. Limitation on practice. (a) A licensee may perform the services of optometry as defined in AS 08.72.300 only if the services are within the scope of the licensee's education, training, and experience as established by regulations adopted by the board.

Alaska is the only state where the optometry board has full authority over its profession. In 2017, HB 103 allowed Alaska optometrists to perform anterior segment laser and lid procedures and gave the board power to set scope of practice based on accredited education.

"*When the Alaska legislature gave this responsibility to the Alaska Board of Optometry, they did so because they felt that licensed professionals within optometry were more qualified to make decisions regarding the education and training of the profession, than they were as legislators. To ensure public safety the Alaska legislature put safeguards in the statute that prevents the Board of Optometry from writing regulations for procedures that are not taught at accredited schools and colleges of optometry, and that are not within the scope of education and training that optometry students receive. Those safeguards also prohibit licensees from self-determining their scope of training.*" Dr. Paul Barney

Indiana (AG Opinion 2019)

Open ended statute allowed for *state board interpretation that ODs can perform* laser surgical procedures. The law has been upheld by an AG opinion.

Wyoming (2021)

Exclusive law which lists those procedures not allowed and *gives the state board the authority to determine future procedures as well*. Can perform laser procedures and injections.

Wisconsin (passed in 1990, reviewed in 2021) Exclusive law which allows for certain laser procedures.

[90] Data provided by the Maine Optometric Association

West Virginia (2025)
Updates the definition of the practice of optometry. “Practice of optometry" means the examining, diagnosing, and treating of any visual defect or abnormal condition of the human eye or its appendages within the scope established in this article or associated rules and the performance of those procedures taught and trained through schools or colleges of optometry accredited by the Accreditation Council on Optometric Education, or its successors or equivalents.

Oklahoma (1998)

Exclusive law which lists those procedures not allowed and gives the state board the authority to determine future procedures as well. Can perform laser procedures and injections.

Kentucky (2011)

Exclusive law which lists those procedures not allowed and gives the state board the authority to determine future procedures as well. Can perform laser procedures and injections.

Appendix 39 Snapshot of Expansion States' Board Makeup[91]

State	Board Members	Meetings	Staff
Arkansas	7-5 OD, 2 public	The Board shall meet at least two (2) times each year	2- 1 Director,1 Fiscal support specialist
Colorado	7- 6 OD, 1 public	4 meetings listed for 2025	1 Program Director
Kentucky	5- 4 OD, 1 public	9 meetings listed in calendar for 2025- must meet at least 1	2 – 1 Executive Director, 1 administrative asst.
Indiana	5 -4OD, 1 public	7 meetings scheduled in 2025	2- 1 director, 1 asst director
Louisiana	6 OD	The board shall hold regular semiannual meetings	unknown
Mississippi	5 OD	8 meetings scheduled in 2025	3- 1 executive director, 1 administrator asst., 1 AG board counsel
Montana	5- 4 OD, 1 public	4 meetings in 2025	1 Executive director
Oklahoma	5-4OD, 1 citizen	4 meetings per year scheduled in 2025/must meet 2x yearly	Unknown
South Dakota	5-4 OD, 1 citizen	3 meetings in 2025	Unknown
Virginia	6-5 OD, 1 citizen	6 meetings scheduled in 2025.	5-1 Executive director,1Deputy Executive director, 1 Discipline Case Specialist,1 board administrator, 1 licensing specialist
West Virginian	7-5OD, 2 public	12 scheduled in 2025/ board shall hold at least two meetings a year	1-Executive director

[91] Data provided by the Maine Optometric Association