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State Board of Orthotics, Prosthetics, and Pedorthics
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Brian W. Weaver, LPO, Board President

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STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS

Regarding HB49 – Interested Party

THE SENATE FINANCE HEALTH AND MEDICAID SUBCOMMITTEE

May 24, 2017

Chairman Hackett, Vice-Chair Tavares, Members of the Committee, I appreciate the opportunity to appear again, following our testimony on April 6, 2017, during your informal consideration of HB 49 and the board consolidation initiatives contained therein. While I am conscious of my role as an agency administrator in the executive branch and my responsibility to faithfully carry out the agency's mission – or oversee its decommissioning in a measured and appropriate manner – I believe I would be remiss in my responsibility to you and the constituency I have served over the past 15 years if I did not offer some additional information and perspective at this time, given the action on the House side to summarily sunset the agency.

The State Board of Orthotics, Prosthetics and Pedorthics was established as a Professional and Occupational Licensing Board by enactment of the 123rd General Assembly in the year 2000. The lead sponsor of the legislation was then-Senate President Doug White. My understanding is that at that time, other professional boards and their associations were approached as possible hosts for the operational administration of the initiative, but none were found to be receptive. Thus, we were organized on a stand-alone basis. Our first set of licenses were issued in FY2002 under grandfathering.

License fees were adequate to cover organizational expenses for the first few budget cycles, but a combination of factors pushed our revenue to expense ratio out of balance. We recognized that dynamic beginning with budgeting for FY14-15. We noted then that the profession's interest in maintaining licensure and the state's interest in operational efficiencies and level playing field regulation would be well served by an update to the Practice Act. However, no legislative sponsor emerged.

Thus, in preparing our budget under the Executive's direction for the current biennium (FY16-17), we suggested a package of budget language to go along with our request for appropriation based on that language. The newer language would have allowed for additional licensing of common certification types in the sector, as well as creating pathways for military veterans with basic medical assistance training. While the appropriation request was approved by OBM, the language package was not.

As agency administrator, I continued to urge both the O&P Association and the Governor's office to consider engaging with the legislature for the longer-term interests of the licensing initiative, and have suggested more than one model that appeared to make programmatic sense based on shared-mission analyses. In testimony on the FY16-17 budget, we again set forth ideas for improvement and expansion of licensing authority. As an administrator, although I appear before the legislature on behalf of the agency when called to do so, I am not primarily a lobbyist or legislative liaison. I admit and own the fact that I have not been able to effectively advance the argument for legislative reform of Chapter 4779.

As agency administrator, neither am I arguing against an appropriate consolidation initiative. If the Committee is willing to consider an alternative proposal, please note that the OPP Board regulates professional practices that are classified within the federal healthcare regulatory matrix

in the sector known as DMEPOS – which stands for Durable Medical Equipment, Prosthetics and Orthotics, and Supplies. As such, if the Committee might consider "undoing" two other pieces of this puzzle, I would suggest that OPP would fit well, with some further statutory refinement, in the currently-consolidated Respiratory Care/Home Medical Equipment model.

The reason it made sense in the first place to have HME regulation reside with the Respiratory Care Board when that enactment was brought forward in 2004 is/was that the professions are both regulated at the federal level in that same "DME Sector". The federal Center for Medicare/Medicaid Services Facility Accreditation Quality Standards specify requirements for three major customizable and individually-expensive device or equipment-based types in its three appendices:

(A) Respiratory supplies;

(B) Manual and Power Wheelchairs; and

(C) Orthotics and Prosthetics.

As opposed to the vast array of other medical consumables in the DMEPOS inventory, these are identified as devices the dispensation of which require, for maximum patient/consumer benefit, the informed, educated and highly knowledgeable attention of well-trained professionals.

What's been missing from the O&P piece in Ohio regulation, in addition to the lack of licensing or registration for in-sector lower-level actors (fitters and assistants) is the facility piece. So, to the extent that RCB/HME has gained expertise and proficiency in facility registration and regulation while maintaining licensure requirements for individual allied healthcare practitioners, a convincing argument could be made that RCB/HME/OPP consolidation is the "smarter" consolidation move.

- Adding 2 Board positions there would reduce the total Board member “load” by 4 positions.
- Adding registration/certification/accreditation for O&P facilities/providers makes for a more level playing field for the sector regulation in Ohio.

Facility owners would have to be responsible for facility registration, but that would also allow for a reduction in cost of licensure for individual practitioners and would not necessarily require a greater cost burden on the business owners, since they mostly already reimburse their licensed practitioners for their license fees. Thus, it may entail cost-shifting within the sector, but not necessarily a greater cost burden overall.

The Medical Board and Pharmacy Board are certainly to handle their respective assignments (Respiratory Care and HME) under the original consolidation proposal, but one can easily question why with the imminent onset of medical marijuana regulation and the urgent need to address the opioid epidemic the tasks entailed in “onboarding” these additional license types should be imposed on the agencies that will be focusing on those more crucial and critical public policy concerns.

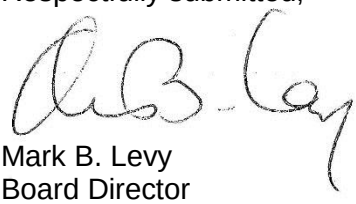
The consideration of something like a Professional Licensing Division that could be of service to a number of the smaller agencies, working in concert with the shared services model of the DAS Central Services Agency, would be another alternative worth study.

Failing the adoption of any alternative consolidation model, or the patience to allow the affected agencies to work in partnership to present a plan for review during the next fiscal year, I would urge legislative leaders to place the licensing functions of Chapter 4779 under a different licensing agency.

I am not here lobbying for my job; I have nearly 23 years of service credit to the state and will be able to look out for my own interests regardless of the action you may take. I am here asking that you accord an appropriate level of respect and consideration for these hands-on consumer care professionals who have invested so much to raise their stature in allied healthcare over these past nearly two decades.

Thank you for your consideration. I welcome the opportunity to answer any questions Members may have, or to stand on these writings as presented.

Respectfully submitted,



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