

STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS

Regarding HB49 – Interested Party

THE SENATE FINANCE COMMITTEE

June 7, 2017

Chairman Oelslager, Vice-Chair Manning, Ranking Member Skindell, and Members of the Committee, thank you for granting the opportunity to appear again, following our testimonies in subcommittee and regarding your 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. That testimony was given to a committee on the Senate side then chaired by Sen. Burke, who at that time indicated some concern about our status and an interest in working toward a solution. Then as now, items of much larger budgetary magnitude demanded more attention from members and their staffs.

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, Prosthesis 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 5 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 competent 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.

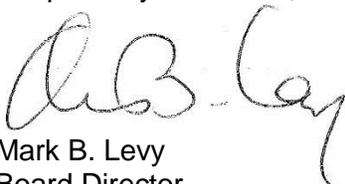
Failing the adoption of any alternative consolidation model, or the patience to allow the affected agencies to work in partnership to present a plan for review during the next fiscal year, I would urge legislative leaders to place the licensing functions of Chapter 4779 under a different licensing agency.

Because pictures can sometimes speak louder than words, I am appending to my testimony a few slides from testimony given by one of our licensees, a local practitioner and a former member and president of the Board. This presentation gives a graphic argument in favor of licensing for this professional class of healthcare provider, given the state of Ohio's established policy of licensing in the interests of the health and safety of its residents.

To be clear: 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 as regards this budgetary line item.. 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, and the patients they serve who deserve more than a mail-order device delivery experience for their customized orthotic and prosthetic needs.

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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Licensure is Important for the Protection of the Citizens of Ohio

This requires a license in Ohio



Barbering

This should continue to require a license in Ohio



Cranial Remolding Orthotic Helmets

Licensure is Important for the Protection of the Citizens of Ohio

This requires a license in Ohio



Cosmetic Skin Care

This should continue to require a license in Ohio



HALO bracing for spine immobilizations

Licensure is Important for the Protection of the Citizens of Ohio

This requires a license in Ohio



Massage therapy

This should continue to require a license in Ohio



Customized TLSO bracing for spinal curvature

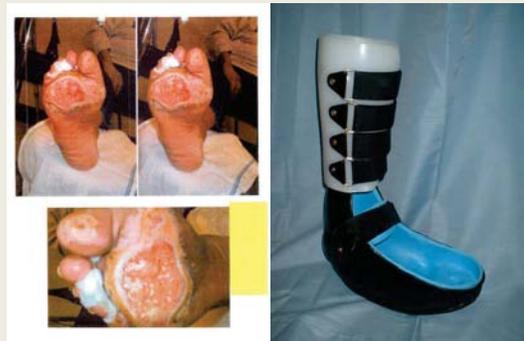
Licensure is Important for the Protection of the Citizens of Ohio

This requires a license in Ohio



Manicure/pedicure nail techs

This should continue to require a license in Ohio



Ankle-foot and Knee-ankle-foot orthotics for severe deformities and ulcerations

Licensure is Important for the Protection of the Citizens of Ohio

This requires a license in Ohio



Boxing and Mixed Martial Arts

This should continue to require a license in Ohio



Limb Prosthetics

ALTERNATIVE CONSOLIDATION PROPOSAL:

OHIO RESPIRATORY CARE and MEDICAL EQUIPMENT PROVIDERS BOARD

Home Medical Equipment provider licensing/regulation was added to the responsibilities of the Ohio Respiratory Care Board in 2004. That enactment was logical from a regulatory standpoint because Respiratory Therapists have responsibility for recommending and attenuating appropriate devices for respiratory care patient utilization, and those devices are regulated at the federal level as components of the “DME Sector” (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies). Similarly, the devices within the jurisdiction of the Home Medical Equipment provisions are regulated within the same sector. The Respiratory Care Board primarily provided for licensing of individual caregivers; the HME provisions largely focused on facility and/or business entity regulation.

What has been missing from the Orthotics, Prosthetics and Pedorthics Practice chapter, enacted in the year 2000, has been the facility side of the picture.

The federal CMS Facility Accreditation Quality Standards, while setting forth standards for all medical equipment and supplies-providing vendors who wish to provide services to the Medicare/Medicaid populations, single out specific requirements for three major customizable and individually-expensive device or equipment-based types: (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 three categories identify devices the dispensation of which require, for maximum patient/consumer benefit, the informed, educated and highly knowledgeable attention of well-trained professionals.

Instead of abandoning the expertise and efficiencies developed through RC/HME regulation over the past six biennial budget cycles, this proposal would build on those efficiencies in a consolidation framework that would more effectively and even-handedly provide a state-based regulatory structure more in line with the federal policy requirements that govern the sector.

CHAPTER 4761

- Re-brand the state agency as the Ohio Respiratory Care and Medical Equipment Providers Board, adding two Orthotic and Prosthetic provider seats to the board member ranks, and reducing the overall board member load by 5 positions.
- Vest license administration for Chapter 4779 licensees with the RC/ME board, and establish facility licensing/registration for Orthotic and Prosthetic facilities, including registration for out-of-state non-custom orthotic device shippers.
- Provide a more robust inspection and investigative capacity for the O&P sector while capturing the economies of scale that will allow for a reduction in license fee assessments for individual licensed practitioners

- Incorporate the biennial license renewal term called for in the current version of HB49.
- Incorporate a prohibition against client exploitation and sexual misconduct with a client or former client in the board's disciplinary code

CHAPTER 4752

- Establish/align licensure or certification of Orthotic and Prosthetic provider facilities with HME facility regulation

CHAPTER 4779

- Update definitions of orthotic and prosthetic practice and devices to more clearly delineate that license requirements attach to patient caregivers and not to manufacturers who are not engaged in direct service marketing
- Update the Pedorthic scope of practice to align with national standards
- Repeal: Sections 4779.05 (state board); 4779.06 (board organization); 4779.07 (removing member); Section 4779.16 (grandfathering); Sections 4779.28 - 4779.30, 4779.33 – 4779.34 (Disciplinary/enforcement actions – default to Chapter 4761 provisions)
- Delete the expired alternative pathway provisions of Sections 4779.10, 4779.11, 4779.12, and 4779.13
- Specify license renewal as a biennial requirement and update the CE requirements attendant to license renewal
- Correct and update the language in Section 4779.27 to align with current residency program national requirements
- Update Section 4779.32 to eliminate archaic language and vest complaint investigation authority with the RC/ME board.