**To:** The Ohio Department of Developmental Disabilities

**Date:** March 14, 2024

**Re:** Proposed Amendments to 5123-9-25

On behalf of the of the Ohio Provider Resource Association (OPRA), please consider the below comments related to Proposed Amendments to 5123-9-25 – Home and community-based services waivers – specialized medical equipment and supplies under the individual options and level one waivers. We appreciate the opportunity to offer comment.

In January 2024, the Ohio Department of Developmental Disabilities presented stakeholders with a draft of this rule. At that time, OPRA raised significant concerns regarding the draft. The current version of the rule under review retains those concerns and introduces additional ones that we cannot support. These proposed alterations to the rule represent a significant shift in the service and will adversely effect people with disabilities and providers.

The business impact analysis fails to accurately capture the implications of this rule change. The impact extends beyond mere administrative burden to encompass significant shifts in provider qualifications, effectively excluding current providers from delivering the services. Moreover, the rule introduces new and cumbersome administrative processes, exceeding federal requirements and further complicating service delivery.

**Provider Qualifications**

As defined in 5123-9-25(B)(8), specialized medical equipment (SME) and supplies are explicitly stated as items "not available under the Medicaid state plan," separate from state plan durable medical equipment (DME) outlined in 5160-10. This distinction is reiterated in 5123-9-25(B)(8)(d). However, the proposed amendment significantly alters who can provide SME, limiting it to DME providers rather than agency providers. Despite SME not falling under the category of DME, the amendment restricts its delivery solely to DME providers, as specified in 5123-9-25(C)(1).

Under the proposed amendment, out of the current 93 waiver providers of SME, only those that are or can become a DME provider would be eligible to continue offering this service. Despite not delivering DME, these HCBS providers would be required to meet the following criteria outlined in 5610-10:

1. A basic DME supplier, which furnishes items other than life-sustaining or technologically sophisticated equipment in accordance with Chapter 4752. of the Revised Code:
2. A specialized DME supplier, which furnishes life-sustaining or technologically sophisticated equipment in accordance with Chapter 4752. of the Revised Code; and
3. An orthotics and prosthetics (O&P) supplier, which furnishes orthotic and prosthetic devices in accordance with section [4779.02](https://codes.ohio.gov/ohio-revised-code/section-4779.02) of the Revised Code.

We ask that these **new provider qualifications be removed**.

**Requirements for Service Delivery**

The proposed amendments to rule 5123-9-25 introduce burdensome requirements for service delivery, potentially causing significant delays in services for individuals with disabilities. These changes add layers of confusing prior authorization procedures, particularly regarding the documentation of services not covered under the state plan. While similar waiver services do not require this additional documentation, the draft rule mandates SME providers to seek prior authorization from the Ohio Department of Medicaid. The language surrounding when prior authorization is necessary appears contradictory, leading to confusion among providers.

Prior authorization and certificate of medical necessity have never been required for SME. By adding these to the definition, DODD is in essence recreating the DME service in the waiver – which is not the goal or point of this service. In fact, CMS requires that a waiver service:

* Compliment or expand state plan coverage (e.g. increase in amount, duration, frequency).
* May not offer precisely the same service under an HCBS waiver that it offers under its regular Medicaid program.
* States may add tasks to the scope of services covered under a State Plan in order to create a new waiver service that does not duplicate the State Plan service.

There is no need for a claim to be submitted under state plan and denied. This new requirement in (D)(2) is administratively burdensome, will result in significant delays in service, and is unnecessary.

We ask that the **requirements for service deliver added in (D)(2) and (D)(3) be removed**.

Sincerely,

Ohio Provider Resource Association