OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

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Sub. H.B. 111*

132nd General Assembly
(As Reported by S. Health, Human Services and Medicaid)

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BILL SUMMARY

Opioid treatment program (OTP) licensure

- Requires, beginning 12 months after the bill's effective date, that all types of opioid treatment programs (OTPs), rather than only methadone treatment programs, be licensed by the Ohio Department of Mental Health and Addiction Services (ODMHAS).

- Specifies that a community addiction services provider is ineligible for OTP licensure for three years after having had an adverse action taken against it.

- Prohibits a proposed OTP from being located within 500 feet of a school, child day-care center, or child-serving agency regulated by ODMHAS.

- Specifies other requirements for the OTP license that are generally similar to existing requirements for licensure of methadone treatment programs.

- Gives ODMHAS authority to conduct OTP inspections, enforcement actions, and other responsibilities similar to the existing authority it exercises in regulating methadone treatment programs.

* This analysis was prepared before the report of the Senate Health, Human Services and Medicaid Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

- Specifies that failure to obtain OTP license when required to do so is a fifth degree felony.

Methadone treatment program licensure

- Applies to methadone treatment programs, for the 12-month period that ODMHAS continues to issue licenses to maintain methadone treatment, the same program location and adverse action look-back period requirements the bill applies to OTPs.

- Makes conforming changes to account for the replacement of the license to maintain methadone treatment with the license to operate an OTP.

Mandatory certification of addiction services

- Generally prohibits, beginning 15 months after the bill's effective date, a person or government entity from providing three types of services (withdrawal management addiction services provided in settings other than acute care hospitals, addiction services provided in a residential treatment setting, and outpatient addiction services) unless the services have been certified by the ODMHAS Director.

- Specifies that violation of the prohibition is a fifth degree felony.

- Authorizes ODMHAS and its Director to take actions needed to prepare for the mandatory certification of these services and the replacement of the methadone treatment program licensure with OTP licensure.

Advanced practice registered nurses (APRNs)

- Permits a clinical nurse specialist or certified nurse practitioner who is certified as a psychiatric-mental health nurse to have an individual involuntarily hospitalized for mental health treatment in an emergency.

- Authorizes an APRN who is a certified nurse practitioner specializing in mental health to enter into agreement standard care arrangement with a psychiatrist, pediatrician, or primary care or family care physician.

- Authorizes an APRN to refer a patient to a physician or podiatrist who is not the collaborating practitioner and to consult with a noncollaborating practitioner.

- Re-enacts provisions, repealed in 2013, that exempted certain "grandfathered" APRNs from having to meet educational and examination requirements generally required for licensure.

- Authorizes the grandfathered APRNs to meet different advanced pharmacology documentation requirements than similar in-state licensure applicants.

- Declares an emergency with respect to the provisions pertaining to grandfathered APRN applicants.

Dialysis technician applicants

- Reduces to six (from twelve) the minimum number of months that an applicant for dialysis technician licensure must have performed dialysis care as a condition of attaining licensure.

Orthotists, prosthetists, and pedorthists

- Extends to two years (from one) the license renewal period for orthotists, prosthetists, and pedorthists.

- Requires the Occupational Therapy, Physical Therapy, and Athletic Trainers Board to adopt rules establishing a specific license renewal schedule for those practitioners, as well as continuing education requirements, to account for the extension of the license renewal period.

State Medical Board

- Eliminates the requirement that each physician assistant supervision agreement be submitted to, and reviewed by, the Medical Board.

- Increases to $5,000 (from $1,000) the amount of the civil penalty that the Medical Board may impose if it finds that a physician failed to comply with the law governing those supervision agreements.

- Makes changes to the law governing the State Medical Board's issuance or renewal of certain licenses, certificates, or permits, including physician training certificates, podiatrist licenses, and limited permits to practice respiratory care and to Medical Board investigatory procedures.

Hospital facilities of a county charter hospital

- Authorizes a board of county hospital trustees of a charter county hospital to purchase, acquire, lease, construct, own, operate, or manage hospital facilities in a county contiguous to a charter county.

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OPIOID TREATMENT PROGRAM (OTP) LICENSURE

Overview

Beginning 12 months after the bill's effective date, the bill requires state licensure of opioid treatment programs (OTPs). This replaces the current licensure system, which applies only to methadone treatment programs. As with methadone programs, OTP licenses are to be issued by the Ohio Department of Mental Health and Addiction Services (ODMHAS).

The OTP license recognizes the fact that methadone is no longer the only drug used in medication-assisted treatment for drug addiction. Under current law not modified by the bill, "medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the U.S. Food and Drug Administration for the treatment of alcoholism or drug addiction, prevention of relapse of alcoholism or drug addiction, or both.[1]

OTPs are already subject to federal regulation, as well as state regulation by some professional licensing boards. At the federal level, OTPs are prohibited from operating without certification by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services.[2] If an OTP administers and dispenses schedule II controlled substances for use in medication-assisted treatment, the OTP also must possess a separate registration issued by the U.S. Drug Enforcement Administration (DEA).[3] At the state level, OTPs are currently regulated by the Ohio State Board of Pharmacy, because they must possess a terminal distributor of dangerous drugs license issued by the Board before dispensing drugs used in medication-assisted treatment. They are also indirectly regulated by the State Medical and Nursing Boards, because those boards license the prescribers who work in them.[4]

Associated with the transition to a new ODMHAS-issued license, the bill generally prohibits a person or government entity from operating an OTP requiring

[1] R.C. 340.01(A)(2).

[2] 42 C.F.R. part 8.

[3] U.S. Drug Enforcement Administration, *Practitioner's Manual, Section VI – Opioid (Narcotic) Addiction Treatment Programs*, available at https://www.deadiversion.usdoj.gov/pubs/manuals/pract/section6.htm.

[4] R.C. Chapters 4723., 4730., and 4731.

SAMSHA certification unless the person or government entity is a community addiction services provider and the program possesses the ODMHAS-issued license.[5] The bill slightly modifies the current definition of "community addiction services provider" to specify that it is an agency, association, corporation *or other legal entity*, individual, or program that provides, among other services, alcohol and drug addiction services that are certified by the Director of Mental Health and Addiction Services.[6] Exempt from this prohibition are programs operated by the U.S. Department of Veterans Affairs.[7]

In general, the provisions the bill enacts governing OTPs are identical or similar to provisions that currently govern methadone treatment programs.

Application; license requirements

A community addiction services provider seeking to operate an OTP must apply to ODMHAS, which is required to review all applications received.[8] The bill permits ODMHAS to issue a license to operate an OTP to a community addiction services provider only if all of the following apply:[9]

(1) During the three-year period immediately preceding the date of application, the provider or any owner, sponsor, medical director, administrator, or principal of the provider has been in good standing to operate an OTP in all other locations where the provider or other person has been operating a similar program. Good standing is to be evidenced by:

--Not having been denied a license, certificate, or similar approval to operate an OTP in Ohio or another jurisdiction; and

--Not having been the subject of any of the following in Ohio or another jurisdiction: an action that resulted in suspension of a license, certificate, or similar approval; a voluntary relinquishment, withdrawal, or other action taken by a provider or other person to avoid suspension or revocation of the license, certificate, or similar approval; or a disciplinary action that was based, in whole or in part, on the provider or

[5] R.C. 5119.37(A)(1)(a).

[6] R.C. 5119.01(A)(7).

[7] R.C. 5119.37(A)(1)(b).

[8] R.C. 5119.37(B).

[9] R.C. 5119.37(C).

other person engaging in the inappropriate prescribing, dispensing, administering, personally furnishing, diverting, storing, supplying, compounding, or selling of a controlled substance or other dangerous drug.

Under current law, a community addiction services provider may not attain licensure to maintain methadone treatment if the provider had been denied such licensure, or had its license withdrawn or revoked, within the *five-year* period immediately preceding the date of application. The bill reduces that look-back period to *three years* for methadone treatment programs in the 12-month period between the bill's effective date and when the bill's OTP licensure system begins.[10]

(2) It affirmatively appears to ODMHAS that the provider is adequately staffed and equipped to operate an OTP;

(3) It affirmatively appears to ODMHAS that the provider will operate an OTP in strict compliance with all drug abuse laws and ODMHAS rules;

(4) In general, if the community addiction services provider is seeking an initial license to operate an OTP for a particular location, the proposed location is not located within 500 feet of the property of a school, child day-care center, or ODMHAS-regulated child-serving agency; and

(5) The provider meets any additional requirements established by ODMHAS in rules.

The bill permits ODMHAS to waive the requirement in (4), above, if it receives, from each school, day-care center, or child-serving agency that is within the 500-feet area, a letter of support for the location. ODMHAS must determine whether a letter of support is satisfactory.[11]

License duration

A license to operate an OTP expires one year from the date of issuance. Licenses may be renewed.[12]

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[10] R.C. 5119.391(C)(1).

[11] R.C. 5119.37(D).

[12] R.C. 5119.37(E).

Inspections

The bill requires ODMHAS to inspect all community addiction services providers licensed to operate an OTP. Inspections must be conducted at least annually and may be conducted more frequently. In addition, ODMHAS may inspect any provider or other person that it reasonably believes to be operating an OTP without a license.[13]

When conducting an inspection, ODMHAS may (1) examine and copy all records, accounts, and other documents relating to the provider's or other person's operations, including records pertaining to patients or clients, and (2) conduct interviews with any individual employed by, contracted, or otherwise associated with the provider or the person including an administrator, staff person, patient, or client.[14]

A person or government entity is prohibited from interfering with a state or local government official acting on behalf of ODMHAS while conducting an investigation.[15]

Prohibitions on drug administration and dispensing

The bill prohibits a community addiction services provider from doing either of the following:[16]

--Administering or dispensing methadone in a tablet, powder, or intravenous form. (Methadone must be administered or dispensed only in a liquid form intended for ingestion.)

--Administering or dispensing a medication used for medication-assisted treatment to an individual for pain or other medical reasons.

Prohibition on certain employment relationships

The bill prohibits a community addiction services provider from employing an individual who receives, from that provider, a medication used in medication-assisted treatment. In addition, the bill prohibits a provider from permitting an individual to act as a program sponsor, medical director, or director of the provider if the individual is

[13] R.C. 5119.37(G)(1).

[14] R.C. 5119.37(G)(2).

[15] R.C. 5119.37(G)(3).

[16] R.C. 5119.37(H).

receiving that medication or treatment from any community addiction services provider.[17]

"Program sponsor" is defined as a person who assumes responsibility for the operation and employees of the OTP component of a community addiction services provider's operations.[18]

Rules for licensing, inspections, and supervision

The bill requires ODMHAS to establish procedures and adopt rules for licensing, inspection, and supervision of community addiction services providers that operate an OTP. The rules must establish standards for the control, storage, furnishing, use, dispensing, and administering of medications used for medication-assisted treatment; prescribe minimum standards for the operation of the OTP component of the provider's operations, and comply with federal law.[19]

The rules must be adopted in accordance with the Ohio Administrative Procedure Act (R.C. Chapter 119.). In addition, all actions that ODMHAS takes regarding provider licensing must generally be conducted in accordance with those administrative procedures.[20]

Enforcement actions

The bill authorizes ODMHAS to issue orders to ensure compliance with all drug abuse laws. In addition, ODMHAS may hold hearings, require the production of relevant matter, compel testimony, issue subpoenas, and make adjudications. If a person fails to obey a subpoena or produce relevant matter, ODMHAS may apply for an order to compel compliance.[21]

The bill permits ODMHAS to refuse to issue, or withdraw or revoke, a license to operate an OTP. A license may be refused if a community addiction services provider does not meet the bill's requirements. A license may be withdrawn at any time ODMHAS determines that the provider no longer meets licensure requirements. A

[17] R.C. 5119.37(I)

[18] R.C. 5119.37(I).

[19] R.C. 5119.37(F).

[20] R.C. 5119.37(F).

[21] R.C. 5119.37(J).

license may be revoked in accordance with the bill's revocation procedure (see "**License revocation**," below).[22]

Once a license is issued, ODMHAS may not apply the prohibition the bill enacts regarding OTP location (i.e., not within a 500 linear-foot radius of a school, child day-care, or ODMHAS-regulated child-serving agency) in determining whether to renew, withdraw, or revoke the license or whether to reissue the license as a result of a change in ownership.[23]

License revocation

The bill permits ODMHAS to issue an order immediately revoking a license to operate an OTP if ODMHAS finds reasonable cause to believe that a community addiction services provider with such a license is in violation of any state or federal drug abuse law. ODMHAS must set a hearing date not more than 15 days later than the date of the revocation order for the purpose of considering continuation or cancellation of the revocation. For good cause, ODMHAS may continue a hearing on the application of any interested party, and ODMHAS has all authority and power described above in conducting the hearing (see "**Enforcement actions**").[24]

Following a hearing, ODMHAS must either confirm or cancel the revocation. The hearing must be conducted in accordance with the Ohio Administrative Procedure Act, except that a provider is not to be permitted to operate an OTP pending the hearing or an appeal. The bill prohibits a court from staying or suspending an order of revocation pending judicial appeal.[25]

The bill prohibits ODMHAS from revoking a license to operate an OTP unless all clients receiving medication used in medication-assisted treatment are provided adequate substitute treatment. ODMHAS may transfer the clients to other licensed OTPs or replace any or all of the provider's administrators and staff with ODMHAS representatives who must continue on a provisional basis the opioid treatment component of the provider's operations.[26]

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[22] R.C. 5119.37(K).

[23] R.C. 5119.37(K).

[24] R.C. 5119.37(L).

[25] R.C. 5119.37(L).

[26] R.C. 5119.391(M).

ADAMHS board notification

Each time that ODMHAS receives an application from a community addiction services provider for a license to operate an OTP, issues or refuses to issue such a license, or withdraws or revokes a license, ODMHAS must notify the alcohol, drug addiction, and mental health services (ADAMHS) board of the district in which the provider operates.[27]

Initiation of criminal proceedings

The bill permits ODMHAS to request the initiation of criminal proceedings against a community addiction services provider if ODMHAS has evidence or receives a complaint, or other information, that a provider has engaged in an illegal practice or violated state or federal drug abuse laws, or when ODMHAS believes that initiation of criminal proceedings is in the best interest of the public and necessary for public protection.[28]

List of licensees

The bill requires ODMHAS to maintain a current list of community addiction services providers that are licensed to operate an OTP. The list must identify each licensed provider by name, address, and county of residence. ODMHAS must provide the list, upon request, to any common pleas judge that requests it for a criminal proceeding.[29]

Proposed locations

The bill requires ODMHAS, on application by a community addiction services provider that has purchased or leased real property to be used as the location of an OTP, to determine whether the location of the proposed program complies with the bill's requirement regarding OTP locations (i.e., not within 500 feet of a school, child day-care, or ODMHAS-regulated child-serving agency). If ODMHAS determines that the location is in compliance, ODMHAS must issue a declaration to that effect. The declaration is valid for two years from the issuance date.[30]

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[27] R.C. 5119.37(N).

[28] R.C. 5119.37(O).

[29] R.C. 5119.37(P).

[30] R.C. 5119.371(A).

ODMHAS must provide to the provider either a copy of the declaration or a notice that it has determined that the location is not in compliance with the OTP location requirement. If, before a declaration's expiration, a community addiction services provider applies for a license to operate an OTP, ODMHAS is prohibited from considering the location requirement in determining whether to issue the license.[31]

The bill permits a community addiction services provider seeking to relocate an OTP to apply for and be granted a declaration. If, before a declaration's expiration, the provider applies for issuance of a license due to relocation, ODMHAS is prohibited from considering the location requirement in determining whether to reissue the license due to relocation.[32]

Criminal penalty for failure to attain licensure

The bill specifies that whoever subject to OTP licensure fails to attain that licensure is guilty of a fifth degree felony.[33]

Discretion associated with licensure transition

The bill authorizes ODMHAS and its Director to take any action either considers necessary in preparation for the transition from issuing licenses to maintain methadone treatment to licenses to operate OTPs. These actions may include:[34]

--Acceptance and consideration of applications for OTP licensure;

--Actions necessary to convert a previously issued license to maintain methadone treatment into a license to operate an OTP; and

--Actions necessary to convert a previously issued declaration concerning the location of a methadone treatment program into a two-year declaration concerning such a location, or into a declaration concerning the location of an OTP pursuant to provisions enacted by the bill.

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[31] R.C. 5119.371(A).

[32] R.C. 5119.371(B).

[33] R.C. 5119.99(C).

[34] Section 5.

LICENSURE TO MAINTAIN METHADONE TREATMENT

Conditions on licensure

As discussed above (see "**Overview**"), beginning 12 months after the bill's effective date, the bill replaces the current license to maintain methadone treatment with the new license to operate an OTP. However, for the 12 months until the OTP licensure provisions become effective, the bill applies the same conditions on methadone treatment program locations and the look-back period for adverse actions that it applies to OTP programs. Specifically:[35]

--A community addiction services provider may not attain licensure to maintain methadone treatment if the provider had, within the three-year period immediately preceding the date of application, been denied the license; had the license suspended or revoked; voluntarily relinquished the license, withdrew application for it, or took other action to avoid license suspension or revocation; or had an adverse disciplinary action that was based, in whole or in part, on the provider or other person engaging in inappropriate prescribing, dispensing, administering, personally furnishing, diverting, storing, supplying, compounding, or selling of a controlled substance or other drug. (Under current law, as discussed above, the look-back period is five years.)

--A community addiction services requesting an initial license for a proposed program location may not generally locate the program on a parcel of real estate that is within 500 linear-feet of the boundaries of a parcel of real estate having situated on it a public or private school, licensed child day-care center, or ODMHAS-regulated child-serving agency. ODMHAS may waive this requirement if it receives a letter of support for the location from the school, day-care center, or child-serving agency. (Under current law, the provider cannot be located within a 500 linear-foot radius of a school, day-care center, or child-serving agency, the latter of which is not defined.)

--ODMHAS must determine whether each proposed location of a proposed methadone treatment program complies with the location requirement. If ODMHAS determines that the location is in compliance, ODMHAS must issue a declaration to that effect in the same manner and subject to the same conditions that apply to proposed OTP locations.

[35] R.C. 5119.391.

Conforming changes

The bill makes a number of conforming changes to other Revised Code sections to account for the transition from a license to maintain methadone treatment to a license to operate an OTP.[36] The bill also makes corrective changes to existing erroneous references to ODMHAS itself (instead of the ODMHAS Director) or the former Department of Mental Health.[37]

MANDATORY CERTIFICATION OF ADDICTION SERVICES

Services subject to mandatory certification

Subject to two exceptions, the bill prohibits, beginning 15 months after the bill's effective date, a person or government entity from providing the following alcohol and drug addiction services unless the services have been certified by the ODMHAS Director under law not substantively modified by the bill:[38]

--Withdrawal management addiction services provided in a setting other than an acute care hospital;

--Addiction services provided in a residential treatment setting; and

--Addiction services provided on an outpatient basis.

The prohibition does not apply to (1) an individual who is authorized to practice a health care profession in Ohio that includes the performance of those services, regardless of whether the services are performed as part of a sole proprietorship, partnership, or group practice, or (2) an individual who provides such services as part of an employment or contractual relationship with a hospital outpatient clinic that is accredited by an accreditation agency or organization that the ODMHAS Director approves.[39]

Under current law, ODMHAS certification applies only as a condition of eligibility to receive government funds (i.e., state funds, federal funds, or local funds

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[36] R.C. 140.01(M), 2925.03(H), 3715.08(B), 3719.13, 3719.27, 3719.61, 3721.01(A), 4729.291(D), 4729.292, 5119.21(A), 5119.34(B), and 5119.361,

[37] R.C. 5119.01(A), 5119.43(A) and (C) (renumbered from R.C. 5119.39), and 5119.431 (renumbered from R.C. 5119.37).

[38] R.C. 5119.35(A).

[39] R.C. 5119.35(B).

from an ADAMHS board) for the provision of alcohol and drug addiction services and supports.[40]

Criminal penalty for failure to obtain ODMHAS certification

The bill specifies that whoever fails to obtain ODMHAS certification for the services subject to mandatory certification is guilty of a fifth degree felony.[41]

Discretion regarding mandatory certification

The bill authorizes ODMHAS and its Director to take any action either considers necessary in preparation for the mandatory certification of certain alcohol and drug addiction services as anticipated by the bill. These actions may include acceptance and consideration of applications for certification, except that certifications cannot be issued for 15 months after the bill's effective date.[42]

ADVANCED PRACTICE REGISTERED NURSES (APRNs)

Emergency hospitalization of the mentally ill

The bill permits a clinical nurse specialist or certified nurse practitioner to have an individual involuntarily hospitalized for mental health treatment in an emergency if the nurse has a psychiatric-mental health certification from the American Nurses Credentialing Center.[43] As with other professionals permitted by current law to have an individual involuntarily hospitalized (see "**Taking an individual into custody**," below), the nurse must have reason to believe that the individual is a mentally ill person subject to court order and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.[44]

This involuntary, emergency hospitalization process may be initiated when there is insufficient time to seek hospitalization through the judicial process that otherwise would apply.[45] With the exception of adding clinical nurse specialists and certified nurse practitioners to the list of professionals that may initiate involuntary

[40] R.C. 5119.36(B).

[41] R.C. 5119.99(C).

[42] Section 6.

[43] R.C. 5122.10(A)(1)(d) and (e).

[44] R.C. 5122.10(A).

[45] Judicial hospitalization is governed by R.C. 5122.11, not in the bill.

hospitalization, the bill maintains the current involuntary hospitalization process, which is discussed below.

Background – emergency hospitalization

Taking an individual into custody

Under current law, a psychiatrist, licensed clinical psychologist, physician, health officer, parole officer, police officer, sheriff, chief of the adult parole authority, or a parole or probation officer with the chief's authority may take a mentally ill individual ("respondent") into custody and transport the respondent to a hospital. The person initiating the transport must do both of the following:[46]

(1) Provide a written statement to the hospital stating why the person believes the respondent meets the requirements of Ohio law to be considered a "mentally ill person subject to court order"[47] and represents a substantial risk of physical harm to self or others, including a statement of the circumstances under which the respondent was taken into custody;

(2) Explain to the respondent who the person is, his or her professional designation and affiliation, that the custody is not a criminal arrest, and that the respondent will be examined at a specified hospital or mental health facility.

Examination by hospital staff

The respondent must be examined within 24 hours after arrival at the hospital. If the hospital's chief clinical officer decides after examination that the respondent is not a mentally ill person subject to court order, the officer must discharge the respondent unless a court has issued a temporary detention order as part of the process of judicial hospitalization of the person or the person has been sentenced to the Ohio Department of Rehabilitation and Correction. If the chief clinical officer decides after the examination that the respondent is a mentally ill person subject to court order, the officer may detain the respondent for no more than three court days following the day of examination. During the three-day period, the chief clinical officer may admit the respondent as a voluntary patient or file an affidavit commencing proceedings for judicial hospitalization.[48]

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[46] R.C. 5122.10(B) and (C).

[47] R.C. 5122.01(B).

[48] R.C. 5122.10(E).

Standard care arrangements

Law unchanged by the bill requires an advanced practice registered nurse (APRN), other than a certified registered nurse anesthetist, to enter into a standard care arrangement with one or more collaborating physicians or podiatrists and practice in accordance with it.[49] A standard care arrangement is a written, formal guide for planning and evaluating a patient's health care that is developed by one or more collaborating physicians or podiatrists and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

Under current law, an APRN is generally limited to entering into a standard care arrangement with a physician or podiatrist who practices in the same specialty as the APRN. An exception to this limitation exists for clinical nurse specialists whose nursing specialty is mental health or psychiatric mental health. Such a clinical nurse specialist has the option of entering into a standard care arrangement with a physician who practices pediatrics or primary care or family practice.[50] The bill modifies this authority as follows:

(1) The bill refers to the private certification of such a clinical nurse specialist, as opposed to his or her specialty. Under the bill, the clinical nurse specialist must be one who is certified as a psychiatric-mental health clinical nurse specialist by the American Nurses Credentialing Center.[51]

(2) The bill extends the exception to a certified nurse practitioner who is certified as a psychiatric-mental health nurse practitioner by the American Nurses Credentialing Center.[52]

(3) The bill prohibits such a clinical nurse specialist or certified nurse practitioner from collaborating with a podiatrist.[53]

(4) Rather than referring to a collaboration physician who practices in the same specialty as the APRN, the bill refers to a psychiatrist.

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[49] R.C. 4723.431(A).

[50] R.C. 4723.431(A).

[51] R.C. 4723.431(A)(1)(b) and (c).

[52] R.C. 4723.431(A)(1)(c).

[53] R.C. 4723.431(A)(1)(c).

The result is that both clinical nurse specialists and certified nurse practitioners, if their specialty is mental health, may enter into a standard care arrangement with a psychiatrist, pediatrician, or primary care or family care physician.[54]

Referrals and consultations

Under current law, standard care arrangements must contain criteria for patient referrals from an APRN to the APRN's collaborating physician or podiatrist and a process for the APRN to obtain a consultation with the collaborating practitioner. The bill authorizes an APRN to refer a patient to a physician or podiatrist who is not the collaborating practitioner and to obtain a consultation with a practitioner other than the collaborating practitioner.[55]

Educational and examination requirements

Grandfathered APRN applicants

The bill largely reenacts provisions repealed by Sub. H.B. 303 of the 129th General Assembly[56] that exempted certain applicants for APRN licensure from having to attain the typical educational or examination requirements for that licensure. (At the time of H.B. 303's passage, the repealed provisions were characterized as obsolete.[57]) Similar provisions applicable to out-of-state APRNs were not repealed, however, and are still in effect.[58] The bill specifies that the reenacted "grandfather" provisions are subject to an emergency clause and go into immediate effect.[59]

CRNA, certified nurse-midwife, and certified nurse practitioner applicants

Currently, an APRN licensure applicant must generally submit documentation to the Nursing Board of having earned a master's or doctoral degree with a major in a nursing specialty or related field that qualifies the applicant for the applicable Board-approved national certification examination.[60] The bill exempts applicants seeking to

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[54] R.C. 4723.431(A)(1)(b) and (c).

[55] R.C. 4723.431(B)(1) and (2).

[56] *See* R.C. 4723.41(B), (C), and (D), as repealed by Sub. H.B. 303 of the 129th General Assembly.

[57] *See* "Final Analysis for Sub. H.B. 303 of the 129th General Assembly," available here: http://www.lsc.ohio.gov/analyses129/12-hb303-129.pdf.

[58] R.C. 4723.41(B).

[59] Sections 7 and 9.

[60] R.C. 4723.41(B)(2).

practice as a certified registered nurse anesthetist (CRNA), certified nurse-midwife, or certified nurse practitioner from this requirement if all of the following are the case:[61]

(1) Before January 1, 2001, the Board issued to the applicant a certificate of authority to practice as a CRNA, certified nurse-midwife, or certified nurse practitioner;

(2) The applicant submits documentation, satisfactory to the Board, of obtaining certification in the applicant's nursing specialty with a national certifying organization that was approved by the Board before March 20, 2013;[62] and

(3) The applicant submits documentation, satisfactory to the Board, that the applicant has maintained the certification described in (2), above.

Clinical nurse specialist applicants

Currently, an applicant for APRN licensure must generally submit documentation to the Nursing Board of having passed the Board-approved national certification examination applicable to the APRN's nursing specialty.[63] The bill exempts applicants seeking to practice as a clinical nurse specialist from this requirement if both of the following are the case:[64]

(1) Before January 1, 2001, the Board issued to the applicant a certificate of authority to practice as a clinical nurse specialist; and

(2) The applicant submits documentation, satisfactory to the Board, that the applicant earned either of the following:

--A master's or doctoral degree with a major in a clinical area of nursing from an educational institution accredited by a national or regional accreditation organization;

--A master's or doctoral degree in nursing or a related field and was certified as a clinical nurse specialist by the American Nurses Credentialing Center or another national certifying organization that was, at that time, approved by the Board.

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[61] R.C. 4723.41(C).

[62] March 20, 2013, is the effective date of Sub. H.B. 303 of the 129th General Assembly.

[63] R.C. 4723.41(B)(3).

[64] R.C. 4723.41(D).

Advanced pharmacology requirements

Grandfathered APRN applicants

The bill authorizes an applicant for an APRN license who is grandfathered under the provisions discussed above (see "**Educational and examination requirements: Grandfathered APRN applicants**") to submit alternative evidence to the Nursing Board of meeting existing advanced pharmacology requirements. In lieu of meeting the existing requirements, a grandfathered applicant may include evidence of all of the following:[65]

(1) Successfully completing the course of study in advanced pharmacology and related topics required under existing law *more than* five years before application submission date. (Existing law requires completion *not longer than* five years before the application submission date.)

(2) Holding, for a continuous period of at least one year during the three years immediately preceding the date of application, valid authority in any jurisdiction to prescribe therapeutic devices and drugs, including at least some controlled substances; and

(3) Exercising the prescription authority described in (2), above, for the minimum one-year period.

Under law unchanged by the bill, the course of study must not be less than 45 contact hours; meet Board-approved standards; consist of content specific to the applicant's nursing specialty; and include at least 36 contact hours in advanced pharmacology that includes specified elements, as well as instruction in the fiscal and ethical implications of prescriptive authority, state and federal laws governing prescriptive authority, and the prescription of schedule II controlled substances.[66]

The authorization to submit alternative evidence is subject to an emergency clause and goes into immediate effect.[67]

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[65] R.C. 4723.482(D).

[66] R.C. 4723.482(A) and (B).

[67] Sections 7 and 9.

Out-of-state and federal government APRN applicants

The bill clarifies that APRN licensure applicants seeking to practice as clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners, and who are practicing or have practiced outside of Ohio or as federal employees, are subject to different advanced pharmacology requirements than similar in-state applicants. The bill does not change the existing requirements for these applicants; rather, it merely makes clear that such applicants are subject to different requirements.[68]

DIALYSIS TECHNICIAN APPLICANTS

The bill reduces to six (from twelve) the minimum number of months that an applicant for dialysis technician licensure who has completed a dialysis training approved by the Ohio Nursing Board must have performed dialysis care for a dialysis provider immediately before applying for licensure.[69] Similarly, the bill reduces to six (from twelve) the minimum number of months that an out-of-state applicant must have been employed to perform dialysis care in another jurisdiction immediately before applying for licensure.[70]

ORTHOTISTS, PROSTHETISTS, AND PEDORTHISTS

Licensure renewal period; continuing education

The bill requires the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board (Board) to renew licenses to practice orthotics, prosthetics, orthotics and prosthetics, or pedorthics biennially, rather than annually, as is done under current law. Biennial renewal is to occur in accordance with a renewal schedule the Board must adopt in rules.[71]

To be eligible for license renewal, an applicant must complete continuing education requirements. The bill requires the Board to adopt rules prescribing the amount, scope, and nature of the requirements, including waivers of those requirements. Under current law, the number of continuing education units required for annual license renewal is specified in statute.[72]

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[68] R.C. 4723.482(A) and (C).

[69] R.C. 4723.75(B)(1)(a).

[70] R.C. 4723.75(B)(2)(b).

[71] R.C. 4779.08(A)(7) and 4779.19.

[72] R.C. 4779.20(B), repealed by the bill.

The bill requires a license renewal application to be submitted electronically. On the Board's request, an applicant must submit evidence satisfactory to the Board that the continuing requirements prescribed in rules were completed.[73]

For purposes of converting licensure from an annual to biennial renewal period, the bill authorizes the Board to (1) extend the expiration date that applies to an initial or renewed license to accommodate the renewal schedule the Board establishes in rules, (2) adjust continuing education requirements, and (3) take any other action the Board considers necessary.[74]

STATE MEDICAL BOARD

Physician assistant supervision agreements

Law not modified by the bill requires each supervising physician and physician assistant to enter into a supervision agreement. A supervision agreement must contain certain minimum terms outlining a physician assistant's responsibilities and the limitations governing his or her practice. These minimum terms vary depending on whether the physician assistant practices in or outside of a health care facility.[75]

Under current law, a supervising physician is required to submit a copy of each supervision agreement to the State Medical Board. The Board may then review the agreement for compliance with the minimum terms, described above. The bill eliminates the submission and review requirements; however, it maintains law specifying that a supervision agreement may be amended to modify a physician's assistant's responsibilities or to include additional physician assistants.[76]

The bill also increases to $5,000 (from $1,000) the amount of the civil penalty that the Medical Board may impose if it finds that a physician failed to comply with the law governing supervision agreements.[77]

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[73] R.C. 4779.08(A)(13) and 4779.20.

[74] Section 5.

[75] R.C. 4730.19(A) and (B).

[76] R.C. 4730.19(C).

[77] R.C. 4730.19(E)(1).

Physician training certificates

Current law requires a physician or osteopath who is not licensed by the Board but is seeking to pursue an internship, residency, or clinical fellowship program in Ohio to apply to the Board for a training certificate.[78] Under the bill, a physician or osteopath who seeks to participate in an elective clinical rotation in Ohio for not more than one year, but is pursuing an internship, residency, or clinical fellowship program in another state and is not licensed by the Board, also must apply to the Board for a training certificate.

License issuance – podiatrists

Existing law authorizes the Board to impose terms and conditions on a physician or osteopath applicant seeking a license or certificate who has not been practicing or participating in education for more than two years.[79] Under the bill, terms and conditions also may be imposed on a podiatrist applicant.

Subpoenas

Current law permits a subpoena issued by the Board to be served by a sheriff, sheriff's deputy, or Board employee. The bill allows, in addition, an agent designated by the Board to serve a subpoena.[80]

Disciplinary actions

The bill authorizes the Board to discipline a license or certificate holder if the U.S. Department of Health and Human Services (HHS) or other responsible agency terminates or suspends the holder from participating in the Medicare or Medicaid program.[81] Under current law, the Board may discipline the holder if HHS terminates or suspends the holder from either program, but only for acts that also constitute other grounds for Board discipline.

Attestations to the Board

In the case of an applicant seeking a license or certificate to practice medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited

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[78] R.C. 4731.291.

[79] R.C. 4731.222.

[80] R.C. 4731.22(F)(3)(c), 4759.05(B)(3), and 4761.03(E)(3).

[81] R.C. 4731.22(B)(25).

branch of medicine, the bill requires the applicant to provide the Board an attestation that the information submitted in the application is accurate and truthful.[82] Under current law, the applicant instead must submit an affidavit attesting to the application's accuracy and truthfulness.

With respect to an applicant seeking a volunteer's certificate, the bill requires the applicant to submit to the Board an attestation that the applicant will not accept any form of remuneration for volunteer medical services.[83] Current law requires a notarized statement from the applicant. And in the case of an applicant for a certificate of conceded eminence, the bill requires the applicant to include with the application an attestation that the applicant agrees to practice only within the clinical setting of an academic medical center or for the affiliated physician group practice. Existing law instead requires the applicant to provide the Board an affidavit.[84]

Respiratory care professionals

Limited permits

The bill clarifies that a person enrolled in and in good standing in a Board-approved respiratory care educational program who is issued a limited permit to practice respiratory care may practice under the permit for up to three years.[85] It also specifies that the life of a permit may be shortened as follows:

- The permit becomes invalid immediately if the permit holder stops participating in the program.
- The permit becomes invalid one year after the date the holder completes the program.

Renewals

When renewing a license or limited permit to practice respiratory care, the bill requires the holder to certify to the Board completion of continuing education (license holder) or enrollment in and good standing in or graduation from an educational program (limited permit holder).[86] Under existing law, the holder instead must submit

[82] R.C. 4731.09, 4731.19, and 4731.52.

[83] R.C. 4731.295.

[84] R.C. 4731.297.

[85] R.C. 4761.05.

[86] R.C. 4761.06.

to the Board proof of satisfactory completion of continuing education (license holder) or proof of enrollment and good standing in or graduation from an educational program (limited permit holder).

Board investigations

The bill establishes certain procedures for Board investigations of alleged violations of the law governing respiratory care professionals. These procedures correspond to those governing Board investigations of physicians and other health professionals also subject to its oversight.[87] H.B. 49, the main operating budget for fiscal years 2018-2019, abolished the Ohio Respiratory Care Board and transferred its duties to the Medical Board. The Board's regulation of respiratory care professionals began January 21, 2018.

HOSPITAL FACILITIES OF A COUNTY CHARTER HOSPITAL

The bill authorizes a board of county hospital trustees of a charter county hospital to purchase, acquire, lease, construct, own, operate, or manage hospital facilities in a county contiguous to a charter county notwithstanding current law pertaining to the purchase, acquisition, lease, appropriation, or construction of outpatient health facilities by such boards. The bill specifies that these hospital facilities must be operated pursuant to law regulating the operation of county charter hospitals.[88]

Currently, Ohio has only two charter counties: Cuyahoga and Summit. Cuyahoga is the only county that presently has a county hospital – MetroHealth Medical Center. Accordingly, this provision would only affect that hospital unless more charter county hospitals open in the future.

HISTORY

ACTION	DATE
Introduced	03-07-17
Reported, H. Health	03-29-17
Passed House (96-0)	03-30-17
Reported, S. Health, Human Services & Medicaid	---

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[87] R.C. 4761.03. *See, e.g.,* R.C. 4731.22(F).

[88] R.C. 339.01(D).