Ohio Legislative Service Commission

Bill Analysis

Audra Tidball and other LSC staff

Sub. S.B. 319*

131st General Assembly
(As Reported by H. Finance)

Sens. Eklund, Manning, Beagle, Tavares, Brown, Coley, Faber, Jones, Obhof, Skindell, Thomas, Uecker, Williams

BILL SUMMARY

PHARMACY AND DRUG LAWS

Pharmacy technician registration

- Establishes a system of registration through the State Board of Pharmacy for registered pharmacy technicians, certified pharmacy technicians, and pharmacy technician trainees that replaces existing law governing employment as a pharmacy technician.

- Specifies requirements for registration, including age, education and experience, character, criminal records check, and certification requirements.

- Specifies certain activities, excluding any that require the exercise of professional judgment, that a pharmacy technician or trainee may, under the direct supervision of a pharmacist, engage in at a location licensed as a terminal distributor of dangerous drugs.

- Specifies conduct for which the Board may impose disciplinary sanctions on a pharmacy technician or trainee.

- Requires the Board to suspend the registration of a pharmacy technician or trainee who is or becomes addicted to controlled substances.

* This analysis was prepared before the report of the House Finance Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

Pharmacist and pharmacy intern discipline

- Authorizes the Board to restrict a pharmacist or pharmacy intern's license or reprimand the license holder.

- Makes changes to the conduct for which the Board can impose sanctions, including specifying additional actions that constitute unprofessional conduct in the practice of pharmacy.

Selling, purchasing, distributing, delivering, or possessing dangerous drugs

- Makes changes to provisions regarding the occasional sale of drugs at wholesale.

- Prohibits the unauthorized distribution of dangerous drugs at retail, which is in addition to the existing prohibition on the unauthorized retail sale and possession of dangerous drugs for sale at retail.

- Provides that a registered wholesale distributor of dangerous drugs is exempt only from the prohibition on possession of dangerous drugs, and is not exempt from the prohibition on selling, or possessing for sale, dangerous drugs at retail.

- Specifies that business entities whose members are authorized to provide the professional services being offered by the entity are exempt from the prohibition on possession of dangerous drugs.

- Requires prescribers and certain business entities through which prescribers provide professional services to be licensed as terminal distributors of dangerous drugs to possess, have custody or control of, or distribute schedule I, II, III, IV, or V controlled substances.

- Establishes a reduced fee of $60 for certain business entities and other persons required by the bill to obtain licenses as terminal distributors of dangerous drugs.

- Reorganizes, with certain modifications, other laws governing the authority to sell, purchase, distribute, deliver, or possess dangerous drugs.

Board powers, duties, and procedures

- Authorizes the Board to maintain its books and records in electronic format.

- Authorizes the Board to adopt rules requiring a licensee or registrant to report to the Board a violation of state or federal law, including any rule adopted under the authority of the Pharmacy Law.

- Requires pharmacy interns, pharmacy technicians, pharmacy technician trainees, terminal distributors of dangerous drugs, and wholesale distributors of dangerous drugs to cooperate with federal, state, and local government investigations and to divulge all relevant information when requested by a government agency.

- Authorizes the Board to designate certain attorneys as hearing examiners to conduct any administrative hearing the Board is empowered to hold or undertake.

Disciplinary action – controlled substances and dangerous drugs

- Expands the circumstances under which a licensing board may suspend a license, certificate, or evidence of registration without a hearing for actions related to controlled substances and extends this authority to actions related to other dangerous drugs.

NALOXONE

Access and administration

- Permits naloxone to be available for administration at locations that serve individuals who may be at risk of experiencing an opioid-related overdose.

- Permits a board of health to authorize one or more individuals to personally furnish a supply of naloxone to certain individuals.

- Modifies a board of health's authority to authorize a pharmacist or pharmacy intern to dispense naloxone without a prescription.

- Specifies that peace officers are entitled to qualified immunity for any act or omission associated with procuring, maintaining, accessing, or using naloxone.

Project DAWN grants

- Authorizes county health departments to use grant funding to provide naloxone through a Project DAWN program within the county if the funds currently available for naloxone grants are not being used by local law enforcement, emergency personnel, and first responders.

OPIOID ANALGESICS

Outpatient prescriptions limited

- Limits the authority of a pharmacist, pharmacy intern, or terminal distributor of dangerous drugs to dispense or sell an opioid analgesic pursuant to an outpatient prescription.

- Specifies that not more than a 90-day supply may be dispensed or sold and that a prescription cannot be filled if more than 14 days have elapsed since it was issued or, if the prescription specifies the earliest date on which it may be filled and other conditions are satisfied, 14 days since that date.

For chronic pain – prior authorization and utilization review

- Requires certain health insurers and the Medicaid program to apply prior authorization requirements or utilization review measures as conditions of providing coverage of opioid analgesics prescribed for the treatment of chronic pain, except in specified circumstances.

PHARMACY BENEFIT MANAGERS

- Amends the law related to pharmacy benefit managers and maximum allowable cost reimbursements.

OFFICE-BASED OPIOID TREATMENT

Licensure as terminal distributors

- Requires the State Board of Pharmacy to regulate facilities, clinics, or other locations at which office-based opioid treatment is provided to more than 30 patients, or that meet criteria specified in Board rules, through a licensing process that is similar to the Board's licensure of pain management clinics.

- Provides for such facilities, clinics, or other locations to be licensed as category III terminal distributors of dangerous drugs with an office-based opioid treatment classification.

- Authorizes the imposition of sanctions against a person who fails to obtain the required licensure or fails to comply with the bill's requirements for office-based opioid treatment.

METHADONE TREATMENT FACILITIES

Licensing requirements

- Eliminates existing provisions that require an applicant for a license to maintain a methadone treatment facility to (1) be operated by a nonprofit or government entity and (2) have been a fully certified services provider for at least two years immediately preceding the application date.

- Requires the Department of Mental Health and Addiction Services (ODMHAS) to adopt rules specifying any additional licensing requirements.

- Requires ODMHAS to conduct an analysis of unmet needs for methadone treatment in Ohio and the impact of the changes to the licensing requirements on the overall treatment capacity in Ohio.

DRUG COURT PROGRAMS

Medication-assisted treatment

- Authorizes a community addiction services provider to provide access to time-limited recovery supports as part of providing medication-assisted treatment services for certain addicted offenders.

- Specifies that recovery support is a form of assistance intended to help initiate and sustain recovery from alcoholism, drug addiction, or mental illness, but it does not include treatment or prevention services.

DRUG TREATMENT FOR PREGNANT WOMEN

Encouraging treatment

- Requires certain health care professionals to encourage drug treatment for pregnant patients under certain circumstances.

- With respect to that requirement, grants those health care professionals limited immunity from civil or criminal liability.

- Requires the Department of Mental Health and Addiction Services, as part of an existing program, to give priority to treating addicted pregnant women.

- Prohibits a community addiction services provider that receives public funds from refusing to treat a pregnant woman solely because she is pregnant if the provider offers appropriate treatment.

Child welfare proceedings

- Prohibits a public children services agency from filing a complaint alleging that a newborn is abused, neglected, or dependent solely because the mother used a controlled substance while pregnant if the mother (1) enrolled in drug treatment before the end of her 20th week of pregnancy, (2) completed treatment or is in the process of completing treatment, and (3) maintained her regularly scheduled appointments and prenatal care.

- Permits a court to hold such a complaint in abeyance if the mother (1) enrolled in drug treatment ***after*** her 20th week of pregnancy, (2) is in the process of completing a treatment program, and (3) maintained her regularly scheduled appointments and prenatal care.

- Permits a court to dismiss such a complaint if the mother (1) enrolled in drug treatment ***after*** the end of her 20th week of pregnancy, (2) completed a treatment program, and (3) maintained her regularly scheduled appointments and prenatal care.

Admissibility of prenatal screening and tests in criminal proceedings

- Provides that evidence obtained through a screening or test to determine pregnancy or provide prenatal care is not admissible in a criminal proceeding against the woman who was screened or tested.

COMMUNITY ADDICTION AND MENTAL HEALTH SERVICES

- Provides that the term "mental health services," as used in laws governing the Ohio Department of Mental Health and Addiction Services (ODMHAS) and boards of alcohol, drug addiction, and mental health services (ADAMHS boards), includes services for the prevention of mental illness.

- Provides that services for the treatment of persons with gambling addictions are not subject to ODMHAS certification.

- Provides for ADAMHS boards to make recovery supports available, and to perform related functions, as part of the process of making addiction services and mental health services available.

- Provides for ODMHAS to perform the same types of administrative functions for recovery supports that ODMHAS performs for addiction services and mental health services.

- Defines "recovery supports" as assistance that is intended to help an individual who is an alcoholic or has a drug addiction or mental illness, or a member of such an individual's family, initiate and sustain the individual's recovery from alcoholism, drug addiction, or mental illness.

- Requires the ODMHAS Director to adopt rules specifying the types of recovery supports for which certification must be obtained from the Director.

- Prohibits an ADAMHS board from contracting for recovery supports that are required by the ODMHAS Director to meet quality criteria or core competencies unless the recovery supports meet those standards.

- Revises the list of services and supports that must be included in an ADAMHS board's continuum of care.

- Permits the ODMHAS Director to issue to an ADAMHS board a time-limited waiver of the requirement that the board's continuum of care include all of the otherwise required essential elements if the Director determines that the board has made reasonable efforts to include in the continuum the elements being waived.

- Requires that the addiction services and recovery supports for opioid and co-occurring drug addiction that are part of a continuum of care include peer support, residential services, and multiple paths to recovery such as 12-step approaches.

- Permits the ODMHAS Director to issue to an ADAMHS board a waiver of a requirement that addiction services and recovery supports for opioid and co-occurring drug addiction include ambulatory detoxification and medication-assisted treatment if the Director makes certain determinations.

- Provides that medication-assisted treatment includes services that are accompanied by medication approved for the treatment or prevention of alcoholism.

- Provides that an individual is not to be denied a service or support for opioid and co-occurring drug addiction included in a continuum of care on the basis of the individual's prior experience with the service or support.

- Revises community addiction services providers' duties to maintain waiting lists for addiction services and recovery supports for opioid and co-occurring drug addiction included in a continuum of care.

- Requires community addiction services providers to submit reports about the waiting lists to ODMHAS instead of ADAMHS boards and revises the contents of the reports.

- Requires ODMHAS to make the reports available to ADAMHS boards in a manner that provides the information about an individual contained in a report to the ADAMHS board that serves the individual's county.

- Requires an ADAMHS board (1) to determine, using the information in the reports, whether any addiction services and recovery supports are not meeting the needs of the board's district and (2) to inform ODMHAS of its determination.

- Requires that an ADAMHS board's annual plan address ODMHAS's priorities for facility services, addiction services, mental health services, and recovery supports and requires ODMHAS to inform all ADAMHS boards of the priorities in a timely manner.

- Requires ODMHAS, beginning July 1, 2017, to withhold in whole or part, instead of in whole, funds otherwise to be allocated to an ADAMHS board if the board's use of state and federal funds fails to comply with the board's approved budget.

- Maintains a requirement that ODMHAS provide assistance to *any* county for certain ADAMHS board-related activities by eliminating a requirement, effective July 1, 2017, that ODMHAS provide assistance to *each* county for the activities.

- Provides that ODMHAS is to provide the assistance for one or more of the activities instead of all of the activities.

- Specifies that one of the activities is the provision of addiction services, mental health services, and recovery supports included in an ODMHAS-approved list instead of the provision of services included in a continuum of care.

- Provides that a community addiction services provider or community mental health services provider is not required to be providing services supported by an ADAMHS board in order for the board's executive director to consult with the provider.

OTHER ODMHAS AND ADAMHS BOARD PROVISIONS

- Provides that a law governing the Ohio Department of Administrative Services' purchases of services and supplies does not apply to ODMHAS contracts for addiction services or recovery supports provided to alcoholics or individuals addicted to drugs or gambling.

- Requires that an annual report ODMHAS submits to the Governor include the number and types of addiction services and recovery supports provided to severely mentally disabled persons.

- Requires that ODMHAS compile statistics and other information on the care, treatment, and rehabilitation of persons with, or in danger of developing, a gambling addiction.

- Eliminates a prohibition against ODMHAS disclosing to the Ohio Department of Rehabilitation and Correction and the Ohio Department of Youth Services certain mental health information about an inmate or offender unless the inmate or offender is notified, receives the information, and does not object.

- Eliminates a requirement that an ADAMHS board's executive director encourage the development and expansion of rehabilitative services in the fields of addiction services and mental health services.

- Removes creed from, and adds ancestry and military status to, the classes that are protected against discrimination by ADAMHS boards, community addiction services providers, and community mental health services providers for purposes of services, employment, and contracts.

- Specifies that the residential facilities for which ADAMHS boards must perform referral duties are residential facilities in the category known as "class two."

- Specifies that a residential facility must be a class two residential facility to be a permissible living arrangement for a recipient of the Residential State Supplement program.

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CONTENT AND OPERATION

PHARMACY AND DRUG LAWS

Pharmacy technician registration

The bill establishes a system of registration for two kinds of pharmacy technicians (registered pharmacy technicians and certified pharmacy technicians) and pharmacy technician trainees. Under current law, pharmacy technicians are not licensed or registered. Instead, persons who meet certain age, education, examination, and criminal background check requirements are designated as "qualified pharmacy technicians." Current law prohibits anyone who is not a pharmacist, pharmacy intern, or qualified pharmacy technician from engaging in certain activities that constitute part of the practice of pharmacy. Pharmacists, as well as pharmacy owners and managers, cannot allow this prohibition to be violated by any person they employ or otherwise control.[1]

The bill repeals those provisions and instead creates a registration requirement for pharmacy technicians and trainees. The registration process is to be administered by the State Board of Pharmacy.

Registration of registered and certified pharmacy technicians

Registered pharmacy technicians – eligibility

The bill requires an applicant for registration as a registered pharmacy technician to meet all of the following conditions:

(1) Be at least 18 years old;

(2) Possess a high school diploma or certificate of high school equivalence (often referred to as a general equivalence diploma or GED), or have been employed continuously since before April 8, 2009, as a pharmacy technician without a high school diploma or GED;

(3) Be of good moral character, as defined in rules adopted by the Board;

(4) Comply with certain criminal records check requirements in existing law or, if the applicant meets the requirements to be a qualified pharmacy technician under

[1] R.C. 4729.90, 4729.901, 4729.92, and 4729.921; R.C. 4729.42, repealed.

existing law and had a criminal records check conducted within 24 months of the application date, authorize release of those results;

(5) Obtain from a pharmacy's responsible person an attestation that the applicant has successfully completed education and training that meets the requirements established by the Board in rules the bill requires the Board to adopt, except that for two years after the bill takes effect, an applicant who meets the requirements in existing law to be a qualified pharmacy technician may submit an attestation from a pharmacy's responsible person that the applicant has completed a pharmacy training and education program that is appropriate for a qualified pharmacy technician under current rules (including instruction in packaging and labeling drugs; pharmacy terminology; basic drug information; basic calculations; quality control procedures; non-sterile drug compounding; and state and federal statutes, rules, and regulations).[2]

Under the bill, "responsible person" has the same meaning as in rules adopted by the Board.[3]

Under current law repealed by the bill, a qualified pharmacy technician must meet the same age and education (or experience if employed continuously since before April 8, 2009, without a high school diploma or GED) requirements as a registered pharmacy technician under the bill. Under current law, qualified pharmacy technician applicants also must comply with requesting and reporting requirements of criminal records check provisions that are applicable to applicants for an initial or restored license from a licensing agency and pass a competency examination approved by the Board.

Certified pharmacy technicians – eligibility

The bill requires an applicant for registration as a certified pharmacy technician to comply with the same age, moral character, and criminal records check requirements as an applicant for registration as a registered pharmacy technician. The applicant must also meet all of the following:

(1) Possess a high school diploma or GED;

(2) Obtain from a pharmacy's responsible person an attestation that the applicant has successfully completed education and training that meets the requirements established by the Board in rules the bill requires the Board to adopt, except that for two years after the bill takes effect, an applicant who meets the requirements in existing law

[2] R.C. 4729.90, 4776.02, and 4776.04; R.C. 4729.42, repealed.

[3] R.C. 4729.90(A).

to be a qualified pharmacy technician may submit an attestation from a pharmacy's responsible person that the applicant has completed a pharmacy training and education program that is appropriate under current rules (described above) plus instruction on sterile drug compounding and on preparing and mixing intravenous drugs that are to be injected into a human being;

(3) Have a current pharmacy technician certification from an organization that has been recognized by the Board.[4]

Application process

The bill requires an applicant for registration as a pharmacy technician to file an application with the Board in the form and manner prescribed by the Board in rules the bill requires the Board to adopt. The application must be accompanied by a nonrefundable $55 application fee.

If the Board is satisfied that the applicant meets the requirements discussed above and any additional requirements the Board establishes, and if the Board determines that the results of the criminal records check do not make the applicant ineligible, the Board is required to register the applicant as a registered pharmacy technician or certified pharmacy technician, as applicable. A pharmacist or pharmacy intern whose license has been denied, revoked, suspended, or otherwise restricted by the Board cannot be registered as a pharmacy technician under the bill.

Registration is valid for a period specified by the Board in rules the bill requires the Board to adopt, but the period cannot exceed 24 months unless the Board extends the period in the rules to adjust license renewal schedules.[5]

Registration renewal

A registered pharmacy technician or certified pharmacy technician who wishes to renew must file an application for registration renewal in the form and manner prescribed by the Board in rules the bill requires the Board to adopt. Registration must be renewed in accordance with the Board's rules and standard renewal procedures established under existing law. The renewal fee is $25 per year.

A registered pharmacy technician or certified pharmacy technician who fails to renew registration in accordance with the bill's requirements is prohibited from engaging in authorized activities, which are discussed below.

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[4] R.C. 4729.90; R.C. 4729.42, repealed.

[5] R.C. 4729.901.

If a registration not renewed by the date specified in the rules has not lapsed for more than 90 days, it may be reinstated if the applicant submits a renewal application, the renewal fee, and a late fee of $50. Registration that has lapsed for more than 90 days cannot be renewed, but the registration holder may reapply for registration.[6]

Authorized activities

The bill provides that registered pharmacy technicians and certified pharmacy technicians may, under the direct supervision of a pharmacist, engage in certain activities at a location licensed as a terminal distributor of dangerous drugs to the extent that the activities do not require the exercise of professional judgment. Terminal distributors of dangerous drugs are entities, such as pharmacies, that sell prescription drugs at retail.

For registered pharmacy technicians, the activities authorized by the bill are:

(1) Accepting new prescription orders from a prescriber or a prescriber's agent;

(2) Entering information into and retrieving information from a database or patient profile;

(3) Preparing and affixing labels;

(4) Stocking dangerous drugs and retrieving those drugs from inventory;

(5) Counting and pouring dangerous drugs into containers;

(6) Placing dangerous drugs into patient storage containers;

(7) Non-sterile drug compounding as authorized in rules the Board is required to adopt under the bill;

(8) Other activities specified by the Board in rules to be adopted under the bill.[7]

Certified pharmacy technicians are authorized to conduct all of the activities a registered pharmacy technician is authorized to conduct plus the following:

(1) Accepting or requesting refill authorizations for dangerous drugs that are not controlled substances from a prescriber or the prescriber's agent, so long as there is no change from the original prescription;

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[6] R.C. 4729.902.

[7] R.C. 4729.91(A).

(2) Sterile drug compounding as authorized in rules the Board is required to adopt under the bill;

(3) Other activities specified by the Board in rules to be adopted under the bill.[8]

Pharmacy technician trainee registration

Eligibility

The bill requires an applicant for registration as a pharmacy technician trainee to comply with the same age, high school diploma (or GED or continuous employment since before April 8, 2009), and moral character requirements as an applicant for registration as a registered pharmacy technician, as discussed above. The applicant must be enrolled in or plan to enroll in education and training that will allow the applicant to meet the requirements established by the Board in rules to be adopted under the bill. The applicant also must comply with criminal records check requirements in existing law.[9]

Application process

A pharmacy technician trainee applicant is required by the bill to file an application with the Board in the form and manner prescribed by the Board in rules required to be adopted under the bill. The application must include a nonrefundable $25 application fee.

The Board is required to register the applicant as a pharmacy technician trainee if it is satisfied that the applicant meets the requirements described above plus any additional requirements established by the Board and determines that the results of the criminal records check do not make the applicant ineligible. A pharmacist or pharmacy intern whose license has been denied, revoked, suspended, or otherwise restricted by the Board cannot be registered as a pharmacy technician trainee.

Registration is valid for one year from the date of registration and is not renewable. However, an individual may reapply if the individual's previous registration has lapsed for more than five years or with Board approval.[10]

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[8] R.C. 4729.91(B).

[9] R.C. 4729.92.

[10] R.C. 4729.921.

Authorized activities

A pharmacy technician trainee may, under the direct supervision of a pharmacist, engage in the same activities as a registered pharmacy technician, as described above.[11]

Sanctions for registered pharmacy technicians and trainees

The bill specifies that the Board, after notice and a hearing in accordance with the Administrative Procedure Act (R.C. Chapter 119.), may impose certain sanctions if a registered pharmacy technician, certified pharmacy technician, or pharmacy technician trainee is found to:

(1) Have been convicted of a felony, or a crime of moral turpitude, as defined under existing law;

(2) Have engaged in dishonesty or unprofessional conduct, as prescribed in rules the Board is required to adopt under the bill;

(3) Be addicted to or abusing alcohol or drugs, or impaired physically or mentally to such a degree as to render the individual unable to perform the individual's duties;

(4) Have violated, conspired to violate, attempted to violate, or aided and abetted the violation of any provisions of the Pharmacy Law, Drug Offenses Law, Controlled Substances Law, certain provisions of the Pure Food and Drug Law, or any rules adopted by the Board under any of those laws;

(5) Have committed fraud, misrepresentation, or deception in applying for or securing a registration issued by the Board;

(6) Have failed to comply with an order of the Board or a settlement agreement;

(7) Have engaged in any other conduct for which the Board may impose discipline as set forth in rules that the Board is required to adopt under the bill.

The sanctions the Board may impose are:

(1) Revoking, suspending, restricting, limiting, or refusing to grant or renew a registration;

(2) Reprimanding or placing the registration holder on probation;

[11] R.C. 4729.93.

(3) Imposing a fine or forfeiture not to exceed in severity any fine designated under existing law for a similar offense, or if existing law does not have a penalty, a fine or forfeiture not to exceed $500. [12]

The bill states that if the Administrative Procedure Act requires the Board to give notice of an opportunity for a hearing and an applicant or registrant does not make a timely request for a hearing in accordance with the Act, the Board is not required to hold a hearing, but may adopt a final order that contains the Board's findings. In the final order, the Board may impose any of the sanctions listed above.[13]

The bill provides that an individual authorized to practice as a pharmacy technician trainee, registered pharmacy technician, or certified pharmacy technician accepts the privilege of practicing in this state subject to supervision by the Board. The act of filing an application for or holding registration constitutes consent to submitting to a mental or physical examination when ordered by the Board in writing, as well as a waiver of all objections to the admissibility of testimony or examination reports that constitute privileged communications.

The bill authorizes the Board to require a pharmacy technician or trainee to submit to a physical or mental examination, or both, if the Board has reasonable cause to believe that the individual is physically or mentally impaired. The bill specifies that the expense of the examination is the responsibility of the individual to be examined.

If the individual fails to submit to the ordered examination, absent circumstances beyond the individual's control, the allegations will be deemed admitted and a suspension order must be entered without taking testimony or presenting evidence. Any subsequent administrative hearing concerning the failure to submit to an examination is limited to consideration of whether the failure was beyond the individual's control.

If, based on the results of an ordered examination, the Board determines that the individual's ability to practice is impaired, the Board is required to suspend the individual's registration or deny the individual's application. The Board must require submission to a physical or mental examination and treatment as a condition of initial, continued, reinstated, or renewed registration to practice.

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[12] R.C. 4729.96(A).

[13] R.C. 4729.96(D).

An order of suspension issued by the Board cannot be suspended by a court while an administrative appeal is pending.[14]

Regarding the sealing of records, the bill provides that, notwithstanding existing law that specifies that if records pertaining to a criminal case are sealed the proceedings are deemed not to have occurred, sealing the following records on which the Board has based an action for sanctions does not have an effect on the Board's action or any sanction imposed: records of any conviction, guilty plea, judicial finding of guilt resulting from a plea of no contest, or a judicial finding of eligibility for a pretrial diversion program or intervention in lieu of conviction. The bill provides that the Board is not required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.[15]

Criminal acts

The bill prohibits a registered pharmacy technician, certified pharmacy technician, or pharmacy technician trainee from knowingly engaging in any of the following:

(1) Dishonesty or unprofessional conduct, as prescribed in rules the Board is required to adopt under the bill;

(2) Violation, or conspiracy, attempting, or aiding in the violation of, any provisions of the Pharmacy Law, Drug Offenses Law, Controlled Substances Law, certain provisions of the Pure Food and Drug Law, or any rules adopted by the Board under any of those laws;

(3) Fraud, misrepresentation, or deception in applying for or securing a registration issued by the Board;

(4) Any other conduct for which the Board may impose discipline as set forth in rules that the Board is required to adopt under the bill.

Under the bill, a violation of the prohibition described above is a minor misdemeanor, unless a different penalty is specified in the Revised Code.[16]

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[14] R.C. 4729.96(C).

[15] R.C. 4729.96(E).

[16] R.C. 4729.96(F) and 4729.99.

License suspension for controlled substance addiction or other harm

The bill adds persons who are registered pharmacy technicians, certified pharmacy technicians, or pharmacy technician trainees to the licensed health professionals whose license, certificate, or registration must be suspended by the board that issued it if the person is or becomes addicted to the use of controlled substances. The State Board of Pharmacy may suspend a technician or trainee's registration under that provision by telephone conference call. Under existing law maintained by the bill, the suspension lasts until the person offers satisfactory proof that the person is no longer addicted to the use of controlled substances.[17]

Current law also provides that if the issuing board determines that there is clear and convincing evidence that the continuation of a person's professional practice or method of prescribing or personally furnishing controlled substances presents a danger of immediate and serious harm to others, the board may suspend the person's license, certificate, or registration without a hearing. The bill provides that such a summary suspension is also authorized when dangerous drugs are involved, as well as if the person's administration or dispensing of controlled substances or other dangerous drugs presents the danger of immediate or serious harm.

Prohibitions and penalties

The bill prohibits a person who is not a pharmacist, pharmacy intern, registered pharmacy technician, certified pharmacy technician, or pharmacy technician trainee from knowingly engaging in any of the activities that a registered pharmacy technician or certified pharmacy technician is authorized to engage in at a location licensed as a terminal distributor of dangerous drugs, or while performing the function of a terminal distributor. However, the bill provides that it does not prevent a licensed health professional from engaging in activities that are authorized as part of the health professional's practice. A person who violates this prohibition is guilty of unauthorized pharmacy-related drug conduct, which is a second degree misdemeanor unless the offender previously has been convicted of or pleaded guilty to a violation of that prohibition or the prohibitions discussed below.[18]

Current law contains a similar prohibition and penalty for pharmacists, pharmacy interns, and qualified pharmacy technicians, except that it only prohibits engaging in the compounding of any drug, packaging or labeling any drug, and preparing or mixing any intravenous drug to be injected.

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[17] R.C. 3719.121(A) and 4729.96(B).

[18] R.C. 3719.21, 4729.95 and 4729.99; R.C. 4729.42, repealed.

The bill, similar to current law, also prohibits (1) a pharmacist from knowingly allowing any person employed by or otherwise under the control of the pharmacist to violate the prohibition described above, and (2) a terminal distributor of dangerous drugs from knowingly allowing any person employed by or otherwise under the control of the person who owns, manages, or conducts the terminal distributor to violate the prohibition described above. As under current law, a person who violates this prohibition is guilty of permitting unauthorized pharmacy-related drug conduct, which is a second degree misdemeanor unless the person is a repeat offender.

The bill does not maintain current law that prohibits a qualified pharmacy technician from modifying or altering, or allowing another to modify or alter any item, record, or information contained in a criminal records check report or to submit or use it for any purpose or in any manner that would constitute the crime of falsification under existing law. Under current law, an individual who violates the provision being eliminated by the bill is guilty of the crime of falsification and forever disqualified from performing services as a qualified pharmacy technician, health care professional, or health care worker. However, as discussed above, the bill does permit the Board to discipline for committing fraud, misrepresentation, or deception in applying for or securing a registration issued by the Board.

Rules on registration of pharmacy technicians and trainees

In addition to the rules described above concerning forms, education and training requirements, additional authorized activities, compounding requirements, and conduct for which a technician may be disciplined, the bill requires the Board to adopt rules specifying continuing education requirements. The Board may also adopt other rules that it considers appropriate to implement the provisions regarding registered pharmacy technicians, certified pharmacy technicians, and pharmacy technician trainees.[19]

Other eliminated provisions regarding qualified pharmacy technicians

In requiring registration for pharmacy technicians and trainees, in addition to the changes discussed above, the bill eliminates a provision stating that examination materials submitted to the Board by a person that develops or administers a pharmacy technician examination are not public records under Ohio's Public Records Law. It also eliminates several "grandfathering" provisions that apply to qualified pharmacy technicians employed as pharmacy technicians after April 8, 2009.[20]

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[19] R.C. 4729.94.

[20] R.C. 4729.42, repealed.

Disciplinary actions and penalties for pharmacists and pharmacy interns

Restrictions and reprimands

The bill makes several changes to existing provisions authorizing the State Board of Pharmacy to impose sanctions on pharmacists and pharmacy interns.[21] Under current law, the Board may revoke, suspend, limit, place on probation, or refuse to grant or renew an identification card. Alternatively, the Board may impose a fine or forfeiture not to exceed in severity any fine designated for a similar offense, or in the case of a violation that does not bear a penalty, a fine or forfeiture of not more than $500. The bill adds that the Board also may restrict a license and reprimand a license holder.

Grounds for discipline

The bill also makes several changes concerning the conduct for which a licensee may be disciplined.[22] Under current law, one reason a sanction may be imposed is if the Board finds a pharmacist or pharmacy intern guilty of a felony or gross immorality. The bill instead permits a sanction to be imposed if the Board finds that the individual has been convicted of a felony or a crime of moral turpitude, as defined under existing law. Additionally, the bill authorizes the Board to impose sanctions if a pharmacist or pharmacy intern has done either of the following:

(1) Failed to comply with an order of the Board or a settlement agreement;

(2) Engaged in any other conduct for which the Board may impose discipline as set forth in rules the Board may adopt under the bill.

Another circumstance in which the Board may impose sanctions under current law is if the person has engaged in unprofessional conduct in the practice of pharmacy. Current law defines the unprofessional practice of pharmacy and the bill adds that it also includes the following:

(1) Failing to conform to prevailing standards of care of similar pharmacists or pharmacy interns under the same or similar circumstances, whether or not actual injury to the patient is established;

(2) Engaging in any other conduct that the Board specifies as unprofessional conduct in the practice of pharmacy in rules that the bill authorizes the Board to adopt.

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[21] R.C. 4729.16.

[22] R.C. 4729.16.

Board-ordered physical or mental examinations

Current law authorizes the Board to require a pharmacist or pharmacy intern to submit to a physical or mental examination, or both, if the Board has reasonable cause to believe that the individual is physically or mentally impaired, based on an adjudication under the Administrative Procedure Act (R.C. Chapter 119.). The bill removes the requirement that the Board's belief be based on an administrative adjudication.

Instead, the bill provides that an individual authorized to practice as a pharmacist or pharmacy intern accepts the privilege of practicing in Ohio subject to supervision of the Board. By filing an application or holding a license to practice as a pharmacist or pharmacy intern, an individual gives consent to submit to a physical or mental examination when ordered to do so by the Board in writing. The individual also waives all objections to the admissibility of testimony or examination reports that constitute privileged communications.

The bill adds that if the individual fails to submit to the ordered examination, absent circumstances beyond the individual's control, the allegations will be deemed admitted and a suspension order must be entered without taking testimony or presenting evidence. Any subsequent administrative hearing concerning failure to submit to an examination is limited to consideration of whether the failure was beyond the individual's control.

If the Board determines, based on the results of an ordered physical or mental examination, that the individual's ability to practice is impaired, the Board is required to suspend the individual's license or deny the individual's application. The Board must require submission to a physical or mental examination and treatment as a condition of an initial, continued, reinstated, or renewed license to practice. The bill specifies that the expense of the examination is the responsibility of the individual to be examined.

An order of suspension issued under the bill's provisions cannot be suspended by a court while an administrative appeal is pending.[23]

Timely requests for hearings

The bill adds a provision regarding hearings conducted by the Board. It provides that if the Administrative Procedure Act requires the Board to give notice of an opportunity for a hearing and an applicant or licensee does not make a timely request for a hearing in accordance with the Act, the Board is not required to hold a hearing, but

[23] R.C. 4729.16(E) and 4729.18.

may adopt a final order that contains the Board's findings. In the final order, the Board may impose any of the sanctions listed above.[24]

Sealing of records

Regarding the sealing of records, the bill provides that, notwithstanding existing law that specifies that if records pertaining to a criminal case are sealed the proceedings are deemed not to have occurred, the sealing of the following records on which the Board has based an action for sanctions does not have an effect on the Board's action or any sanction imposed: records of any conviction, guilty plea, judicial finding of guilt resulting from a plea of no contest, or a judicial finding of eligibility for a pretrial diversion program or intervention in lieu of conviction. The bill provides that the Board is not required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.[25]

Criminal penalties

The bill clarifies the conduct for which the Board may impose a criminal penalty. Under current law, engaging in any conduct for which the Board may impose sanctions constitutes a minor misdemeanor. Instead, the bill specifies that a criminal penalty can be imposed when a person knowingly engages in any of the following sanctionable conduct:

(1) Dishonesty or unprofessional conduct in the practice of pharmacy;

(2) Having violated, conspired to violate, attempted to violate, or aided and abetted the violation of any provisions of the Pharmacy Law, Drug Offenses Law, Controlled Substances Law, certain provisions of the Pure Food and Drug Law, or any rules adopted by the Board under any of those laws;

(3) Permitting someone other than a pharmacist or pharmacy intern to engage in the practice of pharmacy;

(4) Knowingly lending the pharmacist or pharmacy intern's name to an illegal practitioner of pharmacy, or having a professional connection with an illegal practitioner;

(5) Dividing or agreeing to divide remuneration made in the practice of pharmacy with another individual;

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[24] R.C. 4729.16(F).

[25] R.C. 4729.16(G).

(6) Violating the terms of a pharmacist consult agreement;

(7) Committing fraud, misrepresentation, or deception in applying for or securing a license or identification card issued under the Pharmacy Law, the Pure Food and Drug Law, or the Controlled Substances Law;

(8) Engaging in any other conduct for which the Board may impose discipline as set forth in rules adopted by the Board.

The criminal penalty remains a minor misdemeanor under the bill, unless a different penalty is specified in the Revised Code.[26]

Selling, purchasing, distributing, or delivering dangerous drugs

The bill makes both substantive and organizational changes to existing law that governs selling, purchasing, distributing, and delivering dangerous drugs, including changes to which persons are exempt from licensure as a terminal distributor of dangerous drugs.

Who may make wholesale sales of dangerous drugs

As under current law, the bill generally prohibits any person other than a registered wholesale distributor of dangerous drugs from possessing for sale, selling, distributing, or delivering, at wholesale, dangerous drugs. Current law provides for several exceptions to that prohibition, and the bill makes both substantive and organizational changes to those exceptions. The bill provides the following exceptions:

(1) A licensed terminal distributor of dangerous drugs that is a pharmacy may make occasional sales of dangerous drugs at wholesale (instead of current law which provides that a pharmacist who is a licensed terminal distributor, or employed by a licensed terminal distributor, may make occasional sales of dangerous drugs at wholesale);

(2) A licensed terminal distributor of dangerous drugs having more than one licensed location may transfer or deliver dangerous drugs from one licensed location to another licensed location owned by that terminal distributor if the license issued for each location is in effect at the time of the transfer or delivery (instead of current law which refers to a licensed terminal distributor having more than one "establishment or place" instead of "licensed location");

[26] R.C. 4729.16(A) and (H) and 4729.99.

(3) A licensed terminal distributor of dangerous drugs that is not a pharmacy may make occasional sales of naloxone at wholesale (instead of current law which specifies that a board of health or health department may make occasional sales of naloxone at wholesale to state or local law enforcement).[27]

The bill moves one other exception in current law to a new section of the Revised Code. Regarding donation of inhalers and epinephrine autoinjectors, the bill continues to permit a manufacturer of dangerous drugs to donate inhalers and epinephrine autoinjectors to boards of education, community schools, STEM schools, college-preparatory boarding schools, and chartered or nonchartered nonpublic schools.[28]

Who a wholesale distributor may sell dangerous drugs to

The bill continues to prohibit a registered wholesale distributor of dangerous drugs from possessing for sale, or selling, at wholesale, dangerous drugs, and adds that the distributor also may not distribute dangerous drugs, except to specified persons. Current law lists 16 persons to whom a wholesale distributor may sell dangerous drugs. Instead, the bill classifies many of those persons as persons exempt from licensure as a terminal distributor of dangerous drugs. Accordingly, the specified persons to whom a wholesale distributor may sell dangerous drugs to under the bill are the following:

(1) A licensed terminal distributor of dangerous drugs, subject to existing limitations based on the category of the terminal distributor's license;

(2) Any person exempt from licensure as a terminal distributor of dangerous drugs as described in the bill, subject to limitations for prescribers employed by a pain management clinic or an office-based opioid treatment facility (described below);

(3) A registered wholesale distributor of dangerous drugs;

(4) Terminal or wholesale distributors of dangerous drugs that are located in another state, not engaged in the sale of dangerous drugs within Ohio, and actively licensed to engage in the sale of dangerous drugs by the state in which the distributor conducts business.

The bill does not maintain provisions designating the following persons as persons to whom a wholesale distributor may sell dangerous drugs:

(1) A licensed optometrist who holds a topical ocular pharmaceutical agents certificate;

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[27] R.C. 4729.51(A).

[28] R.C. 4729.513.

(2) A manufacturer of dangerous drugs;

(3) Carriers or warehouses for the purpose of carriage or storage.[29]

Limitation on a wholesaler selling dangerous drugs to certain prescribers

Similar to current law, the bill continues to prohibit a registered wholesale distributor of dangerous drugs from possessing for sale, selling, or distributing, at wholesale, dangerous drugs to (1) a prescriber who is employed by a pain management clinic that is not licensed as a terminal distributor of dangerous drugs with a pain management clinic classification issued under existing law, and (2) certain business entities that are, or are operating, a pain management clinic without a license as a terminal distributor with a pain management clinic classification. The bill extends this prohibition to business entities that provide office-based opioid treatment without the licensure required by the bill (discussed below), as well as to prescribers employed by those entities.[30]

Limitation on a wholesaler selling dangerous drugs to a terminal distributor

The bill maintains provisions in current law that restrict the category of dangerous drugs a wholesaler may sell at wholesale to a licensed terminal distributor of dangerous drugs. The bill also applies that restriction to the distribution of such drugs by a registered wholesale distributor to a licensed terminal distributor.[31]

Prohibition on the retail sale and possession of dangerous drugs

Subject to numerous exceptions, current law maintained by the bill prohibits the following:

(1) Selling dangerous drugs at retail;

(2) Possessing dangerous drugs for sale at retail;

(3) Possessing dangerous drugs.

The bill clarifies that the unauthorized distributing of dangerous drugs at retail is also prohibited.[32]

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[29] R.C. 4729.51(B) and 4729.541 (primary) and 2947.231.

[30] R.C. 4729.51(C).

[31] R.C. 4729.51(D).

[32] R.C. 4729.51(E) (primary) and 2929.14.

Exemptions to all three prohibitions

The following persons and entities currently exempt from the prohibitions listed above are maintained by the bill:

(1) A licensed terminal distributor of dangerous drugs;

(2) A person who possesses, or possesses for sale or sells, at retail, a dangerous drug in accordance with the Controlled Substances Law, Pharmacy Law, and laws governing the following licensed health professionals: dentists, nurses, optometrists, pharmacists, physician assistants, physicians, and veterinarians;

(3) An individual who holds a current license, certificate, or registration issued under Title XLVII of the Revised Code and has been certified to conduct diabetes education by a national certifying body if diabetes education is within the individual's scope of practice;

(4) An individual who holds a valid certificate issued by a nationally recognized S.C.U.B.A. diving certifying organization with respect to medical oxygen that will be used for the purpose of emergency care or treatment at the scene of a diving emergency.

Additionally, the bill adds that the following are exempt from all three prohibitions:

(1) A business entity that under Ohio law is a corporation, limited liability company, or professional association if the entity has a sole shareholder who is a prescriber and is authorized to provide the professional services being offered by the entity;

(2) A business entity that under Ohio law is a corporation, limited liability company, partnership or limited liability partnership, or professional association if, to be a shareholder, member, or partner, an individual is required to be licensed, certified, or otherwise legally authorized under Ohio law governing occupations and professions to perform the professional service provided by the entity and each such individual is a prescriber;

(3) A facility that is owned and operated by the United States Departments of Defense or Veterans Affairs.[33]

[33] R.C. 4729.51(E)(2)(a).

Exemptions to the prohibition on possession only

Under current law, a registered wholesale distributor of dangerous drugs is exempt from all three prohibitions listed above. Under the bill, a wholesaler is exempt only from the prohibition on possession of dangerous drugs. Similar to current law, the following remain exempt from the prohibition on possession of dangerous drugs:

(1) Schools and camps possessing epinephrine autoinjectors and inhalers in accordance with existing law;

(2) With respect to naloxone that may be possessed under existing law, a law enforcement agency and its peace officers (under current law, a law enforcement agency or the agency's peace officers are exempt from the prohibition on possessing drugs if the agency or officers possess naloxone for administration to individuals who are apparently experiencing opioid-related overdoses).

The bill also adds to the list of persons exempted from the prohibition on possession a service entity that may possess naloxone under the bill.[34]

Purchase of dangerous drugs

Current law prohibits a licensed terminal distributor of dangerous drugs from purchasing dangerous drugs from any person other than a registered wholesale distributor of dangerous drugs, subject to numerous exceptions. The bill maintains this and adds that persons exempt from licensure under the bill's reorganized provisions[35] (see "**Exemption from licensure as a terminal distributor of dangerous drugs**," below) are also subject to that prohibition.[36]

Exception for occasional purchases

Regarding exceptions to that prohibition, current law provides that a licensed terminal distributor may make occasional purchases of dangerous drugs from a pharmacist who is a licensed terminal distributor or is employed by a licensed terminal distributor. Instead, the bill provides that a licensed terminal distributor or person exempt from licensure under the bill's reorganized provisions may make occasional purchases of dangerous drugs in accordance with the following:

(1) The person is making an occasional purchase of dangerous drugs from a pharmacy that is making an occasional sale of dangerous drugs at wholesale;

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[34] R.C. 4729.51(E)(2)(b).

[35] See R.C. 4729.541.

[36] R.C. 4729.51.

(2) The person is making an occasional purchase of naloxone from a terminal distributor of dangerous drugs that is not a pharmacy and that is making an occasional sale of naloxone at wholesale.[37]

Exception for more than one establishment or place of business

Current law provides that a licensed terminal distributor having more than one establishment or place of business may transfer or receive dangerous drugs from one licensed establishment or place of business to another. The bill generally maintains this but instead refers to a licensed terminal distributor having more than one licensed location, instead of establishment or place of business. This reflects terminology changes elsewhere in the bill. The bill also refers to delivering dangerous drugs from one licensed location to another, instead of receiving dangerous drugs between locations.[38]

Distribution of epinephrine autoinjectors and inhalers in schools

Regarding the existing authorization for schools to deliver epinephrine autoinjectors and inhalers, the bill instead provides that the schools may distribute the autoinjectors and inhalers in accordance with provisions in existing law.[39]

Exemption from licensure as a terminal distributor of dangerous drugs

Subject to several exceptions, current law provides that certain business entities whose members are authorized to provide the professional services being offered by the entity may possess, have custody or control of, and distribute drugs in Category I, II, and III without holding a terminal distributor of dangerous drugs license. Instead, the bill provides that the following are exempt from licensure as a terminal distributor of dangerous drugs:

(1) A licensed health professional authorized to prescribe drugs;

(2) A business entity that is a corporation, limited liability company, or professional association formed under Ohio law if the entity has a sole shareholder who is a prescriber and is authorized to provide the professional services being offered by the entity (current law authorizes such an entity to possess, control, or distribute category I, II, or III drugs without holding a terminal distributor license);

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[37] R.C. 4729.51(F)(1).

[38] R.C. 4729.51(F)(2).

[39] R.C. 4729.51(I).

(3) A business entity that is a corporation, limited liability company, partnership, limited liability partnership, or professional association formed under Ohio law, if, to be a shareholder, member, or partner, an individual is required to be licensed, certified, or otherwise legally authorized under Title XLVII of the Revised Code to perform the professional service provided by the entity and each such individual is a prescriber (current law authorizes such an entity to possess, control, or distribute category I, II, or III drugs without holding a terminal distributor license);

(4) An individual who holds a current license, certificate, or registration issued under Title XLVII of the Revised Code and has been certified to conduct diabetes education by a national certifying body, but only with respect to insulin that will be used for the purpose of diabetes education and only if diabetes education is within the individual's scope of practice under statutes and rules regulating the individual's profession;

(5) An individual who holds a valid certificate issued by a nationally recognized S.C.U.B.A. diving certifying organization approved by the State Board of Pharmacy, but only with respect to medical oxygen that will be used for the purpose of emergency care or treatment at the scene of a diving emergency;

(6) With respect to epinephrine autoinjectors that may be possessed under existing law, any of the following: the board of education of a city, local, exempted village, or joint vocational school district; a chartered or nonchartered nonpublic school; a community school; a STEM school; a college-preparatory boarding school; a residential camp; a child day camp; or a child day camp operated by any county, township, municipal corporation, township park district, park district, or joint recreation district;

(7) With respect to inhalers that may be possessed under existing law, any of the following: the board of education of a city, local, exempted village, or joint vocational school district; a chartered or nonchartered nonpublic school; a community school; a STEM school; a college-preparatory boarding school; a residential camp; a child day camp; or a child day camp operated by any county, township, municipal corporation, township park district, park district; or joint recreation district;

(8) With respect to naloxone that may be possessed under current law,[40] a law enforcement agency and its peace officers;

(9) With respect to naloxone that may be possessed under the bill, a service entity;

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[40] See R.C. 2925.61.

(10) A facility that is owned and operated by the United States Department of Defense, United States Department of Veterans Affairs, or any other federal agency.[41]

Exceptions to the exemption from licensure

Pain management clinics and office-based opioid treatment providers

The bill requires persons otherwise exempt from licensure as a terminal distributor of dangerous drugs under the bill to obtain such a license if the person is a pain management clinic or operates a pain management clinic. This is similar to current law that requires a business entity that is or is operating a pain management clinic to hold a license as a terminal distributor of dangerous drugs with a pain management clinic classification. The bill maintains this requirement and applies it to all persons otherwise exempt from licensure as a terminal distributor under the bill's provisions. Therefore, any pain management clinic or person operating a pain management clinic must be licensed as a terminal distributor of dangerous drugs with a pain management clinic classification.

Similar to pain management clinics, the bill adds that the exemption from licensure does not apply to persons operating a facility, clinic, or other location described in the office-based opioid treatment provisions of the bill if those provisions require the person to hold a category III terminal distributor of dangerous drugs license with an office-based opioid treatment classification.[42]

Prescribers and their professional business entities

The bill also contains an exception to the exemption from licensure when certain drugs are involved. It requires licensed health professionals authorized to prescribe drugs and certain business entities held by those professionals to hold a license as a terminal distributor of dangerous drugs to possess, have custody or control of, or distribute both compounded drugs and schedule I, II, III, IV, or V controlled substances.

Under current law, a business entity owned by a health professional to provide professional services is exempt from the requirement to be licensed as a terminal distributor of dangerous drugs, except that such an entity is required to be licensed to possess, have custody or control of, and distribute dangerous drugs that are compounded or used for the purpose of compounding. The bill maintains this exception and applies it to all persons exempted from licensure under the bill.

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[41] R.C. 4729.541(A) (primary) and 4729.68.

[42] R.C. 4729.541(B) and (C).

The bill also limits current law's exemption from licensure for those business entities by providing that the exemption does not apply in the case of possession, custody or control of, or distribution of a schedule I, II, III, IV, or V controlled substance. Because many of the exemptions relate to drugs that are not controlled substances (such as insulin, medical oxygen, epinephrine, medication in inhalers, and naloxone), the primary effect of the bill's provision is to require prescribers and the business entities that they provide professional services through to be licensed as terminal distributors of dangerous drugs to possess, have custody or control of, or distribute controlled substances.

The bill's exception regarding controlled substances replaces an exemption in current law specifically for possession, custody or control of, or distribution of controlled substances containing buprenorphine used to treat drug dependence or addiction.[43]

Terminal distributor fees

The fee for a terminal distributor license ranges from $45 to $150 depending on which drugs the license holder is authorized to possess. Under the bill, the fee is $60 for a person who would otherwise be exempt from licensure but must obtain a license because the person possesses, has custody or control of, or distributes compounded drugs or controlled substances under the exception described above. The bill maintains a reduced fee in current law for business entities organized for the purpose of practicing veterinary medicine. The fee for such entities is $40.[44]

Conditions a wholesale distributor must meet before selling dangerous drugs

Under current law, before a registered wholesale distributor of dangerous drugs may sell dangerous drugs at wholesale to any person, the wholesale distributor generally must obtain from the purchaser a certificate indicating that the purchaser is a licensed terminal distributor of dangerous drugs. Current law exempts from that requirement most persons to whom a wholesaler is authorized to sell to under current law, except for individuals holding valid S.C.U.B.A. diving certifications and business entities whose members are authorized to provide the professional services being offered by the entity. The bill expands the exemption to include those previously unexempted individuals and entities by providing that a wholesale distributor does not

[43] R.C. 4729.541(D).

[44] R.C. 4729.54(G).

have to obtain the certificate from any person exempted from licensure as a terminal distributor of dangerous drugs under the bill's reorganized provisions.[45]

Board powers, duties, and procedures

The bill makes several additional changes to the laws administered by the State Board of Pharmacy.

Books and registers

The bill authorizes the books and registers of the Board to be in electronic format, and also makes changes related to the bill's provisions for registering pharmacy technicians and trainees. Current law requires the Board to keep a record of its proceedings and a record of all identification cards and licenses granted to pharmacists and pharmacy interns, as well as each renewal, suspension, or revocation. The bill specifies that the Board must keep the same records for registrations as it is required to keep for identification cards and licenses.

The bill adds a provision that an official statement from the Board that it appears from the Board's records that a person has been subjected to disciplinary action is prima-facie evidence of the record of the Board in any court or before an officer of the state. Current law contains the same provision with regard to an official statement of the Board concerning whether an identification card or license has been issued, revoked or suspended. The bill applies those provisions to registrations as well.[46]

Duty to report violations to the Board

The bill authorizes the Board to adopt rules requiring a licensee or registrant to report to the Board violation of state or federal law, including any rule adopted under the authority of the Pharmacy Law. In the absence of fraud or bad faith, a person who makes such a report or testifies in an adjudication will not be liable to any person for damages in a civil action as a result of the report or testimony.[47]

Cooperation with investigations

Current law requires pharmacists to cooperate with federal, state, and local government investigations and to divulge all relevant information when requested by a government agency. The bill applies this requirement to pharmacy interns, pharmacy technician trainees, registered pharmacy technicians, certified pharmacy technicians,

[45] R.C. 4729.60 and 4729.541(A).

[46] R.C. 4729.06.

[47] R.C. 4729.10.

licensed terminal distributors of dangerous drugs, and registered wholesale distributors of dangerous drugs.[48]

Selecting generically equivalent drugs

The bill adds a provision specifically prohibiting a pharmacist from knowingly failing to comply with provisions in current law that impose (1) conditions on a pharmacist's substitution of a generically equivalent drug when filling a prescription for a drug prescribed by its brand name, and (2) labeling requirements for dispensed drugs. As under current law, violation of those provisions is a minor misdemeanor.[49]

Hearing examiners

The bill permits the Board to designate one or more attorneys who have been admitted to the practice of law, and who are classified as either administrative law attorney examiners or as administrative law attorney examiner administrators under the State Job Classification Plan adopted under existing law, as hearing examiners, subject to the Administrative Procedure Act. Or, under an exception in the bill, the Board may enter into a personal service contract with an attorney admitted to the practice of law in Ohio to serve as a hearing examiner.[50]

Hearing examiners are permitted to conduct any hearing the Board is empowered to hold or undertake pursuant to the Administrative Procedure Act. Hearing examiners must hear and consider the evidence introduced by the parties and issue in writing proposed findings of fact and conclusions of law to the Board for its consideration within 30 days after the hearing.

The bill requires that the Board be given copies of the transcript of the hearing record and all exhibits and documents presented by the parties at the hearing. The Board is required to render a decision and take action within 90 days following the receipt of the hearing examiner's proposed findings of fact and conclusions of law.

The bill requires the final decision of the Board in any hearing to be in writing and contain findings of fact and conclusions of law. Copies of the decision must be delivered to the parties personally or by certified mail. The decision is final on delivery or mailing, but it may be appealed as provided by the Administrative Procedure Act.

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[48] R.C. 4729.19.

[49] R.C. 4729.38 and 4729.99.

[50] R.C. 4729.40.

Disciplinary action regarding controlled substances and dangerous drugs

The bill expands the circumstances under which a board that licenses professionals may suspend a license, certificate, or evidence of registration without a hearing for actions related to drugs. Under current law, if a licensing board determines there is clear and convincing evidence that continuation of a professional's practice or method of prescribing or personally furnishing controlled substances presents a danger of immediate and serious harm to others, the agency may suspend the license, certificate, or registration without a hearing. The bill permits a board to also take this action based on the professional's method of administering or dispensing controlled substances. This makes the provision applicable to professionals such as nurses who administer controlled substances and pharmacists who dispense them. The bill further permits a licensing board to take action based on the method of prescribing, administering, dispensing, or personally furnishing dangerous drugs that are not controlled substances.[51]

Under continuing law, a dangerous drug is essentially any drug that can legally be dispensed only on a prescription. A controlled substance is a dangerous drug that is subject to additional restrictions because of its potential for abuse. Controlled substances include such drugs as narcotics, depressants, and stimulants.

NALOXONE

Service entities

Procuring naloxone

The bill permits entities, referred to as "service entities," that serve individuals who may be at risk of experiencing an opioid-related overdose to procure naloxone for use in emergency situations.[52] It defines "service entity" as a public or private entity that provides services to individuals who there is reason to believe may be at risk of experiencing an opioid-related overdose. The bill includes the following as service entities: a college or university, school, local health department, community addiction services provider, court, probation department, halfway house, prison, jail, community residential center, homeless shelter, or similar entity.[53]

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[51] R.C. 3719.121(B).

[52] R.C. 4729.514(B).

[53] R.C. 4729.514(A).

With respect to naloxone, the bill exempts service entities from licensure as terminal distributors of dangerous drugs.[54] This exemption permits a service entity to purchase and possess naloxone without obtaining a license from the State Board of Pharmacy.[55]

Authority to administer naloxone

The bill permits a service entity employee, volunteer, or contractor who is authorized to do so by a physician or board of health to administer naloxone to an individual who is apparently experiencing an opioid-related overdose. To be eligible to authorize naloxone administration, a physician or board of health must establish a written protocol for administering naloxone. In the case of a board of health, the protocol must be established through a physician acting as the board's health commissioner or medical director. The protocol must include the following:[56]

(1) A description of the clinical pharmacology of naloxone;

(2) Precautions and contraindications concerning the administration of naloxone;

(3) Any limitations concerning the individuals to whom naloxone may be administered;

(4) The naloxone dosage that may be administered and any variation in the dosage based on circumstances specified in the protocol;

(5) Labeling, storage, record-keeping, and administrative requirements;

(6) Training requirements that must be met before an individual can be authorized to administer naloxone.

An authorized service entity employee, volunteer, or contractor must obtain the naloxone from the service entity, comply with the protocol, and summon emergency services as soon as practicable.[57] An employee, volunteer, or contractor, acting in good faith, who administers naloxone in accordance with the bill to an individual who is apparently experiencing an opioid-related overdose is immune from criminal

[54] R.C. 4729.541(A).

[55] R.C. 4729.51.

[56] R.C. 3707.562(D) and 4731.943(D).

[57] R.C. 3707.562(C) and 4731.943(C).

prosecution for unauthorized practice of medicine or violation of Ohio drug laws.[58] This criminal immunity does not apply to peace officers or emergency medical technicians.[59]

Qualified immunity

The bill provides qualified immunity for acts related to procuring and administering naloxone by service entities and service entity employees, volunteers, and contractors.

Under the bill, a board of health is immune from liability for damages in any civil action for an act or omission of a service entity employee, volunteer, or contractor who the board, in good faith, authorizes to administer naloxone. A physician, including a physician serving as a board's health commissioner or medical director, is immune from liability and is not subject to damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action for an act or omission of a service entity employee, volunteer, or contractor who the physician in good faith authorizes to administer naloxone.[60]

The bill provides further that a service entity or service entity employee, volunteer, or contractor is not liable for damages in any civil action or subject to prosecution in any criminal proceeding or professional disciplinary action for any act or omission associated with procuring, maintaining, accessing, or using naloxone under the bill, unless the act or omission constitutes willful or wanton misconduct. The bill provides that this immunity does not eliminate, limit, or reduce any other immunity or defense to which a service entity or employee, volunteer, or contractor may be entitled under the Revised Code or Ohio's common law.[61] Common law is the law developed over time by custom and court decisions.

Boards of health

Personally furnishing naloxone by individuals

The bill permits a board of health that establishes a protocol that meets specified requirements to authorize one or more individuals to personally furnish a supply of naloxone to either of the following:[62]

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[58] R.C. 2925.61(C).

[59] R.C. 2925.61(D).

[60] R.C. 3707.562(E) and 4731.943(E).

[61] R.C. 3707.562(E), 4729.514(C), and 4731.943(E).

[62] R.C. 3707.561(A).

(1) An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose;

(2) A family member, friend, or other person in a position to assist such an individual.

The authorized individual must comply with the board's protocol and must instruct the individual to whom the naloxone is furnished to summon emergency services as soon as practicable.[63]

A board of health's protocol authorizing personally furnishing naloxone must be established through a physician serving as the board's health commissioner or medical director, be in writing and include the following:[64]

(1) A description of the clinical pharmacology of naloxone;

(2) Precautions and contraindications concerning the furnishing of naloxone;

(3) Any limitations the board specifies concerning the individuals to whom naloxone may be furnished;

(4) The naloxone dosage that may be furnished and any variation in the dosage based on circumstances specified in the protocol;

(5) Labeling, storage, record-keeping, and administrative requirements;

(6) Training requirements that must be met before an individual can be authorized to furnish naloxone;

(7) Any instructions or training that the authorized individual must provide to an individual to whom naloxone is furnished.

The bill provides that a board of health is not liable for damages in any civil action for an act or omission of an individual to whom naloxone is personally furnished, if the board in good faith authorized the individual to personally furnish the naloxone. A physician serving as a board's health commission or medical director who on good faith authorizes an individual to personally furnish naloxone under the bill is not liable for damages in any civil action or subject to prosecution in any criminal proceeding or professional disciplinary action for an act or omission of an individual to whom the naloxone is personally furnished.

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[63] R.C. 3707.561(B).

[64] R.C. 3707.561(C).

An individual authorized under the bill to personally furnish naloxone who does so in good faith is not liable for damages in any civil action or subject to prosecution in any criminal proceeding or professional disciplinary action for any act or omission of the individual to whom the naloxone is furnished.[65]

Dispensing naloxone by pharmacists and pharmacy interns

Current law permits a board of health to authorize a pharmacist or pharmacy intern to dispense naloxone without a prescription pursuant to a protocol established by the State Board of Pharmacy. Under this law, a board of health may extend this authority only to pharmacists and pharmacy interns who work in the board's jurisdiction. Under the bill, a board of health may extend the authority to any pharmacist or pharmacy intern who practices pharmacy in a county that includes all or part of the health district represented by the board.[66] In Ohio, each city constitutes a city health district and the townships and villages in each county are combined as a general health district, so health district boundaries differ from those of counties.[67]

Immunity for peace officers

Under current law, a peace officer is immune from administrative action and criminal prosecution for administering naloxone to an individual who is apparently experiencing an opioid-related overdose if the peace officer is employed by a law enforcement agency and obtains naloxone from that law enforcement agency. The bill provides, in addition, immunity from civil liability for peace officers for any injury, death, or loss to person or property that allegedly arises from obtaining, maintaining, accessing, or administering the naloxone. The bill also removes the conditions that a peace officer must be employed by a law enforcement agency and have obtained the naloxone from that agency to be eligible for the immunity.[68]

The bill expressly states that the provisions providing the civil immunity to peace officers do not eliminate, limit, or reduce any other immunity or defense that an entity or person may be entitled to under any provision of the Revised Code or state common law.[69]

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[65] R.C. 3707.561(D).

[66] R.C. 3707.56.

[67] R.C. 3709.01, not in the bill.

[68] R.C. 2925.61(E)(1).

[69] R.C. 2925.61(E)(2).

Grants for Project DAWN

Current law appropriates up to $500,000 in each fiscal year for use by county health departments in enhancing access to naloxone across Ohio through a grant program to local law enforcement, emergency personnel, and first responders. The bill provides that if these entities are not making use of the naloxone grant, the county health department is permitted to use grant funding to provide naloxone through a Project DAWN (Deaths Avoided with Naloxone) program within the county.[70]

According to the Ohio Department of Health, a Project DAWN program is a community-based overdose education and naloxone distribution program. Participants receive training on (1) recognizing the signs and symptoms of overdose, (2) distinguishing between different types of overdose, (3) performing rescue breathing, (4) calling emergency medical services, and (5) administering intranasal naloxone.[71]

OPIOID ANALGESICS

Limits on dispensing or selling

90-day supply

The bill limits the authority of a pharmacist, pharmacy intern, or terminal distributor of dangerous drugs to dispense or sell an opioid analgesic pursuant to a prescription for a drug to be used on an outpatient basis. It prohibits dispensing or selling more than a 90-day supply of the drug, as determined according to the prescription's instructions for use of the drug, regardless of whether the prescription was issued for a greater amount.[72] The bill permits the State Board of Pharmacy to adopt rules that further decrease the 90-day supply limit. The rules must be adopted in accordance with Chapter 119. of the Revised Code.[73]

14-day prescription deadline

The bill generally prohibits a pharmacist, pharmacy intern, or terminal distributor from dispensing or selling an opioid analgesic pursuant to a prescription if

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[70] Sections 3 and 4, amending Section 331.120 of H.B. 64 of the 131st General Assembly, the main operating budget act for fiscal years 2016 and 2017.

[71] Ohio Department of Health, *Project DAWN*, available at <http://www.healthy.ohio.gov/vipp/drug/ProjectDAWN.aspx/>.

[72] R.C. 4729.45(B)(1).

[73] R.C. 4729.45(D).

the drug is to be used on an outpatient basis and more than 14 days have elapsed since the prescription was issued.[74]

The bill exempts an opioid analgesic prescription from the 14-day deadline if all of the following apply:

(1) The prescriber has provided written instructions indicating the earliest date on which the prescription may be filled;

(2) The prescription is one of multiple prescriptions for the opioid analgesic issued by the prescriber to the patient on a single day;

(3) When combined, the prescriptions do not authorize the patient to receive more than a 90-day supply of the opioid analgesic.

A prescription that satisfies these conditions may be filled until 14 days have elapsed since the date indicated on the prescription as the earliest date on which it may be filled.[75]

The bill permits the Board to adopt rules that further decrease the 14-day deadline.[76]

Out-of-state delivery

The bill specifies that these prohibitions do not apply when the pharmacist, pharmacy intern, or terminal distributor dispenses or sells an opioid analgesic that is to be delivered outside of the state by mail, parcel post, or common carrier to a patient who resides outside of the state.[77]

Limitations established in rules

The bill permits a state board that licenses prescribers to adopt rules limiting the amount of an opioid analgesic that may be prescribed by a prescriber licensed by the board pursuant to a single prescription. The rules must be adopted in accordance with Chapter 119. of the Revised Code.[78] The prescribers referred to are physicians, dentists,

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[74] R.C. 4729.45(B)(2).

[75] R.C. 4729.45(B)(3).

[76] R.C. 4729.45(D).

[77] R.C. 4729.45(C).

[78] R.C. 3719.062.

and veterinarians and certain optometrists, physician assistants, and advanced practice registered nurses.

Prior authorization or utilization review for chronic pain treatment

The bill requires that a health insurer or the Medicaid program apply prior authorization requirements or utilization review measures as conditions of providing coverage of opioid analgesics prescribed for the treatment of chronic pain, except in specified circumstances.[79] "Opioid analgesic" is defined as "a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system," while "chronic pain" is defined as pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued for longer than three continuous months.[80]

When implementing the bill's required prior authorization or utilization review, the health insurer or Medicaid program must consider all of the following:[81]

(1) If the course of treatment with the drug continues for more than 90 days, the current law requirements regarding physician management of chronic pain;[82]

(2) If the morphine equivalent daily dose[83] for the drug exceeds 80 milligrams or the individual is being treated with a benzodiazepine[84] at the same time the opioid analgesic is prescribed, the current opioid prescribing guidelines established by the Governor's Cabinet Opiate Action Team.

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[79] R.C. 1739.05, 1751.691, 3923.851, 5164.091, and 5167.12.

[80] R.C. 1751.691(A), 3923.851(A), and 5164.091(A). *See* also R.C. 3719.01 and 4731.052, not in the bill.

[81] R.C. 1739.05(B), 1751.691(B)(2), 3923.851(B)(2), 5164.091(B)(2), and 5167.12(E).

[82] R.C. 4731.052, not in the bill.

[83] A morphine equivalent daily dose is a numerical standard against which the potency of most opioids can be compared. Morphine is used as the basis for this comparison as it is considered the "gold standard" for the treatment of pain. *See* Brandeis University, Prescription Drug Monitoring Program Training and Technical Assistance Center, *Daily Morphine Milligrams Equivalents Calculator and Guide*, available at <www.pdmpassist.org/content/guidelines>.

[84] Benzodiazepines are depressants that produce sedation, induce sleep, relieve anxiety and muscle spasms, and prevent seizures. The most common benzodiazepines are the prescription drugs Valium, Xanax, Halcion, Ativan, and Klonopin. *See* U.S. Department of Justice, Drug Enforcement Administration, *Drugs of Abuse*, available at <www.dea.gov/druginfo/factsheets.shtml>.

Exceptions

A health insurer or the Medicaid program is not required to apply prior authorization requirements or utilization review measures when the opioid analgesic is prescribed under any of the following circumstances:

(1) To a hospice patient in a hospice care program;

(2) To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program;

(3) To an individual who has been diagnosed with cancer or another condition associated with the individual's cancer or history of cancer.[85]

Types of health care coverage affected

Health insurers

The bill applies to the following types of health insurers as part of providing any coverage of prescription drugs:

(1) Health insuring corporations;

(2) Sickness and accident insurers;

(3) Multiple employer welfare arrangements;

(4) Public employee benefit plans.[86]

Medicaid

The bill also applies to the coverage of prescribed drugs under the Medicaid program. Regarding Medicaid managed care, the bill specifies that it applies to the health insuring corporations that are under contract with the Ohio Department of Medicaid to serve as Medicaid managed care organizations by providing or arranging for the provision of health care services to Medicaid recipients.[87]

ERISA

The bill does not govern health care coverage that is part of employee benefits offered by private employers that self-insure their benefit programs. These programs

[85] R.C. 1739.05(B), 1751.691(B)(1), 3923.851(B)(1), 5164.091(B)(1), and 5167.12(E).

[86] R.C. 1739.05, 1751.691, 3923.851, and 5164.091.

[87] R.C. 5164.091 and 5167.12.

are generally precluded from state regulation by the federal Employee Retirement Income Security Act (ERISA). ERISA is a comprehensive federal statute governing the administration of employee benefit plans. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from a sickness and accident insurer or health insuring corporation.

Implementation date

In the case of health insurers, the bill governs policies, contracts, agreements, or plans issued, delivered, renewed, established, or modified in Ohio on or after January 1, 2018. For Medicaid in general, the bill applies beginning January 1, 2018; for Medicaid managed care organizations, it applies to contracts entered into on or after that date.[88]

Definition

Under current law, "opioid analgesic" is defined as a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system. It includes such drugs as buprenorphine, codeine, fentanyl, hydrocodone, methadone, morphine sulfate, and oxycodone.[89]

PHARMACY BENEFIT MANAGERS

Maximum allowable cost pricing information

Current law requires pharmacy benefit managers to provide pharmacies with the pricing information used to determine maximum allowable cost pricing, to update and implement this pricing information at least every seven days, and to provide a means by which a pharmacy may review these updates. The bill clarifies that these pricing updates are to be maximum allowable cost pricing updates, that they are to be in an electronic format, and that they must be in a format that is secure and easily searched. Additionally, the bill requires a pharmacy benefit manager to use the most up-to-date pricing data within one business day when calculating drug product reimbursements.[90]

The bill requires that pharmacy benefit managers must make available to a pharmacy upon request the written procedure the pharmacy benefit manager must

[88] Section 7.

[89] R.C. 3719.01, not in the bill.

[90] R.C. 3959.111(A)(1)(a).

maintain to withdraw a drug from being subject to maximum allowable cost reimbursement.[91]

Drug reimbursement appeals

The bill amends the process by which a pharmacy may appeal a drug product reimbursement. Current law requires a pharmacy benefit manager to maintain a process for appealing drug reimbursements and resolving related disputes. The bill clarifies that this process must be electronic.[92] When denying an appeal of a drug reimbursement, current law requires the pharmacy benefit manager provide a reason for the appeal and must identify a drug that can be purchased *in Ohio* from a national or regional wholesaler at a price at or below the benchmark price determined by the pharmacy benefit manger; the bill eliminates the requirement that the drug be available for purchase in Ohio. Additionally, the bill explicitly requires that if an appeal is upheld, then the pharmacy benefit manager must adjust the drug product reimbursement to the pharmacy's appeal price.[93]

Multiple maximum allowable cost lists

Current law requires a pharmacy benefit manager that uses multiple maximum allowable cost lists to disclose this fact to a plan sponsor, as well as any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor. The bill requires this disclosure to be made in the aggregate.[94]

Additionally, under current law, this disclosure must be made within ten days of either of the following:

- The signing of a contract between a pharmacy benefit manager and a plan sponsor;
- Any update to a maximum allowable cost list.

The bill instead requires the disclosure to be made on a quarterly basis or within ten days of the signing of a contract.[95]

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[91] R.C. 3959.111(A)(1)(b).

[92] R.C. 3959.111(A)(3).

[93] R.C. 3959.111(A)(3)(d) and (e).

[94] R.C. 3959.111(B)(1)(b).

[95] R.C. 3959.111(B)(2).

Finally, the bill exempts Medicare pharmacy benefit plans and pharmacy benefit plans that are subject to the Employee Retirement Income Security Act of 1974, i.e., self-insured, large employer plans, from this disclosure requirement.[96]

Rules

The bill specifically authorizes the Superintendent of Insurance to adopt rules as necessary to implement requirements related to pharmacy benefit managers and maximum allowable cost.[97]

OFFICE-BASED OPIOID TREATMENT

Licensing

Effective 120 days after the bill's general effective date,[98] the bill prohibits a person from knowingly operating a facility, clinic, or other location where a prescriber provides office-based opioid treatment to more than 30 patients, or that meets any other identifying criteria in rules the State Board of Pharmacy must adopt under the bill, without holding a category III terminal distributor of dangerous drugs license with an office-based opioid treatment classification.[99] Under current law, a category III license authorizes the holder to possess, have custody or control of, or distribute any controlled substance. The license fee is $150.[100]

A prescriber who provides the office-based opioid treatment described by the bill must apply for licensure in the same way as other terminal distributors and meet the requirements that apply to terminal distributors, as well as meet the bill's additional requirements for such prescribers. The licensing process established by the bill is similar to the licensing process for pain management clinics under existing law.[101]

"Office-based opioid treatment" is defined by the bill as the treatment of opioid dependence or addiction using a controlled substance.

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[96] R.C. 3959.111(B)(3).

[97] R.C. 3959.111(D).

[98] Section 9(C).

[99] R.C. 4729.553.

[100] R.C. 4729.54.

[101] R.C. 4729.552, not in the bill.

Exemptions

Under the bill, the following are excluded from its office-based opioid treatment licensing requirements: (1) hospitals, (2) facilities for the treatment of opioid dependence or addiction that are operated by a hospital, (3) physician practices owned or controlled, in whole or in part, by a hospital or an entity that owns or controls, in whole or in part, one or more hospitals, (4) facilities that only conduct clinical research and use controlled substances in studies approved by a hospital-based institutional review board or an institutional review board that is accredited by the Association for the Accreditation of Human Research Protections Programs, Inc., (5) facilities that hold a category III terminal distributor of dangerous drugs license for the purpose of treating drug dependence or addiction as part of an opioid treatment program and are already subject to certification by the U.S. Substance and Mental Health Services Administration (SAMHSA), or (6) programs or facilities that are licensed or certified by the Ohio Department of Mental Health and Addiction Services.

Office operation

In addition to meeting the requirements for licensure as a terminal distributor, an applicant for licensure as a terminal distributor with an office-based opioid treatment classification must submit evidence satisfactory to the Board that the applicant's office-based opioid treatment will be operated in accordance with the bill's requirements. Under those requirements, the license holder must do all of the following:

(1) Be in control of a facility that is owned and operated solely by one or more physicians authorized by the State Medical Board to practice medicine or osteopathic medicine;

(2) Comply with requirements for conducting office-based opioid treatment that are established by the Medical Board under existing law;

(3) Require any person with ownership of the facility to submit to a criminal records check and send the result directly to the Pharmacy Board for review;

(4) Require all employees of the facility to submit to a criminal records check and ensure that no person is employed who has previously been convicted of or pleaded guilty to any federal felony theft or drug offense or a felony theft or drug offense in Ohio or another state;

(5) Maintain a list of each person with ownership of the facility and notify the Pharmacy Board of any changes.

The bill prohibits a person from knowingly failing to remain in compliance with these requirements.[102]

Criminal records check

To obtain a criminal records check, a person must submit a request to Ohio's Bureau of Criminal Identification and Investigation (BCII). The request must be accompanied by the appropriate form, a set of fingerprint impressions, and the fee established by BCII. The person must also request that BCII obtain from the Federal Bureau of Investigation (FBI) any information it has on the person. The results of the criminal records check must be sent directly to the Pharmacy Board for review. Information provided by BCII or the FBI is to be made available only to the person who requested the records check and the employer or potential employer specified in the request.[103]

License issuance

If the Pharmacy Board determines that an applicant meets the requirements to provide office-based opioid treatment, the Board must issue the category III terminal distributor license with the office-based opioid treatment classification to the applicant. If the applicant does not meet the requirements, the Board is prohibited from issuing the license.[104]

Sanctions for illegal or improper operation

Pharmacy Board sanctions

The bill authorizes the Pharmacy Board to impose a fine of not more than $5,000 on a person that fails to comply with the requirements for operation of a facility subject to licensure as a terminal distributor with an office-based opioid treatment classification. A separate fine may be imposed for each day of violation. The sanction must be imposed in accordance with the Administrative Procedure Act (R.C. Chapter 119.), which requires the Board to give the terminal distributor notice and an opportunity for a hearing.

In addition, the bill authorizes the Pharmacy Board to suspend, without a prior hearing, the license of a terminal distributor with an office-based opioid treatment classification if the Board determines by clear and convincing evidence that there is

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[102] R.C. 4729.553(C) to (E).

[103] R.C. 4729.071(B), 4776.02(A) and (B)(2), and 4776.04(B).

[104] R.C. 4729.553(C) and 4729.55.

danger of immediate and serious harm to others. If the license holder is a physician, the Board must consult with the secretary of the Medical Board or, if the secretary is unavailable, another physician member of the Board before suspending the license.[105]

Medical Board sanctions

Current law authorizes the Medical Board, by an affirmative vote of not fewer than six members, to take disciplinary action against a physician for any of a number of reasons specified in statute. The Board may limit, revoke, or suspend a physician's certificate to practice, refuse to register a physician, refuse to reinstate a physician's certificate, or reprimand or place a physician on probation. Generally, the Board must impose disciplinary action in accordance with the Administrative Procedure Act. If the Board determines by clear and convincing evidence, however, that a violation of the law governing physicians has occurred and the physician's continued practice presents a danger of immediate and serious harm to the public, the Board may suspend the physician's license without a prior hearing.

The bill authorizes the Medical Board to take professional disciplinary action against a physician who does either of the following:

--Practices at a facility, clinic, or other location that is subject to licensure as a terminal distributor of dangerous drugs with an office-based opioid treatment classification unless the person operating that place has obtained and maintains the license with the classification;

--Owns a facility, clinic, or other location that is subject to licensure as a distributor of dangerous drugs with an office-based opioid treatment classification unless that place is licensed with the classification.[106]

Criminal sanctions

The bill provides that failure to comply with the office-based opioid treatment requirements is a felony of the fifth degree. If the offender has previously been convicted of or pleaded guilty to the same offense or a violation of pharmacy or drug laws, the offense is a felony of the fourth degree. Failure to obtain the required license carries the same criminal penalties.[107]

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[105] R.C. 4729.553(F) and 4729.571.

[106] R.C. 4731.22(B)(49) and (50).

[107] R.C. 4729.99(E).

Rules

The bill requires the Pharmacy Board to adopt rules as it considers necessary to implement and administer the provisions regarding licensure of terminal distributors of dangerous drugs with an office-based opioid treatment classification. The rules must be adopted in accordance with the Administrative Procedure Act.[108]

Background – federal law

Federal law generally prohibits a physician from providing opioids to treat addiction unless the opioids are administered as part of a narcotic treatment program (NTP) that has been approved by the U.S. Drug Enforcement Administration (DEA) and SAMHSA.[109] The federal Drug Addiction Treatment Act of 2000 (DATA 2000)[110] waives the NTP requirements for physicians who dispense or prescribe opioids listed in schedules III, IV, or V that have been approved by the U.S. Food and Drug Administration (FDA) for opioid addiction treatment. To qualify for a waiver, a physician must first notify the U.S. Secretary for Health and Human Services (HHS) in writing of the physician's intent to prescribe opioids for opioid addiction and certify that the physician meets the federally mandated qualifications for state licensure, certification, and training or experience in the area of addiction treatment.[111] A physician must obtain both HHS and DEA approval before prescribing opioids under the DATA 2000 waiver.

Federal law currently limits the number of patients to whom a physician may prescribe opioids to treat opioid addiction. For the first year after qualifying for the waiver, that number is 30; thereafter, a physician may request to increase the number to 100. Currently, the only controlled substances listed in schedules III, IV, or V that have been approved by the FDA to treat opioid addiction are certain buprenorphine products, including Suboxone.[112] With the goal of expanding access to medication-assisted treatment, HHS recently finalized a rule that would permit qualified physicians to prescribe buprenorphine to as many as 275 patients.[113] There are two ways

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[108] R.C. 4729.553(G).

[109] 21 United States Code (U.S.C.) 823(g)(1); 21 Code of Federal Regulations (C.F.R.) 1306.07(a).

[110] Title XXXV, Section 3502 of the federal Children's Health Act, Pub. L. 106-310, 21 U.S.C. Sec. 823(g)(2).

[111] 21 C.F.R. 1301.28.

[112] National Association of Boards of Pharmacy, *HHS Proposes Increasing Buprenorphine Patient Limit for Medication-Assisted Treatment*, available at <https://www.nabp.net/news/hhs-proposes-increasing-buprenorphine-patient-limit-for-medication-assisted-treatment>.

[113] 81 Fed. Reg. 44711.

physicians can become eligible to increase their patient limit to 275: (1) by having additional credentialing in addiction medicine or addiction psychiatry from a specialty medical board or professional society, or (2) by working in a qualified practice setting. Additionally, during emergency situations, other physicians who are approved to treat up to 100 patients are eligible to raise their patient limit up to 275 to ensure continuity of care for patients.

METHADONE TREATMENT FACILITIES

License requirements

Effective June 1, 2017,[114] the bill eliminates two of the existing requirements an applicant for licensure to maintain a methadone treatment facility must meet to receive the license from the Department of Mental Health and Addiction Services (ODMHAS). The requirements eliminated relate to the provider and are as follows:

(1) The provider is operated by a private, nonprofit organization or by a government entity;

(2) The provider has been fully certified as a community addiction services provider for at least two years immediately preceding the application.[115]

The bill provides instead that an applicant must meet any additional requirements established by ODMHAS in rules.

The bill requires ODMHAS to adopt rules that revise the requirements governing licensure of methadone treatment providers. The rules must include the following requirements for licensure:

(1) Being in good standing with the Medicaid program, Medicare program, and the United States Drug Enforcement Administration;

(2) Being in good standing in any other jurisdiction in which the community addiction services provider provides services that are comparable to the methadone treatment services authorized by Ohio law;

(3) The ability to meet, and a plan to provide treatment in accordance with, treatment standards established by certain federal regulations (42 Code of Federal Regulations 8.12) and accepted standards of medical care for opioid treatment services established by a nationally recognized standards organization selected by the Director.

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[114] Section 9(A).

[115] R.C. 5119.391(C)(1) and (2).

The bill provides that if ODMHAS has not adopted the rules, or if the rules are not in effect, on June 1, 2017, it cannot issue any licenses to maintain methadone treatment under existing law until the rules are adopted and in effect.

The bill also requires, not later than two years after the bill's effective date, ODMHAS to conduct an analysis of unmet needs for methadone treatment in Ohio and the impact of the elimination of the licensure requirements discussed above on the overall treatment capacity in Ohio. ODMHAS is required to complete a report of its findings within 180 days after beginning the analysis. It must publish the report on its website.[116]

DRUG COURT PROGRAMS

Medication-assisted treatment and recovery supports

Under a current program conducted by ODMHAS and certain courts with certification from the Ohio Supreme Court as a specialized docket program for drugs, medication-assisted treatment for addiction is made available to certain offenders in the criminal justice system. The treatment must be provided by an ODMHAS-certified community addiction services provider. The provider must comply with specified requirements.

The bill permits a participating community addiction services provider to provide access to time-limited recovery supports. For purposes of this provision, the bill specifies that recovery support is a form of assistance intended to help an individual with addiction or mental health needs, or a member of the family of such an individual, to initiate and sustain the individual's recovery from alcoholism, drug addiction, or mental illness. It specifies that a recovery support does not include an addiction or mental health treatment or prevention service.[117]

DRUG TREATMENT FOR PREGNANT WOMEN

Encouraging pregnant women to enroll in drug treatment

The bill requires certain health care professionals who care for pregnant women to encourage enrollment in drug treatment programs. The health care professionals to whom the bill applies are physicians, registered nurses (including clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners),[118] licensed

[116] Section 5.

[117] Sections 3 and 4, amending Section 331.90 of H.B. 64 of the 131st General Assembly.

[118] R.C. 4723.01, not in the bill.

practical nurses, and physician assistants. Such a health care professional who attends to a pregnant woman for conditions relating to pregnancy before the end of the 20th week of pregnancy and who has reason to believe that the woman is using or has used a controlled substance in a manner harmful to the fetus must encourage the woman to enroll in a drug treatment program offered by a provider of addiction services or alcohol and drug addiction services.[119]

The bill defines "addiction services" as services (including intervention) for the treatment of persons with alcohol, drug, or gambling addictions, and for the prevention of such addictions. It defines "alcohol and drug addiction services" as services (including intervention) for the treatment of alcoholics or persons who abuse drugs of abuse and for the prevention of alcoholism and drug addiction.[120]

The health care professionals subject to the bill are immune from civil liability and are not subject to criminal prosecution for (1) failing to recognize a pregnant woman's use of a controlled substance in a manner that is harmful to her fetus, or (2) any action taken in good faith compliance with the bill's requirements.[121]

Treatment priority

The bill requires the Department of Mental Health and Addiction Services to give priority to treating pregnant women addicted to drugs of abuse. Under current law, the Department is required to give priority to developing, and to promptly develop, a program to identify addicted pregnant women and provide intervention and continued monitoring. The program also must provide tracking and treatment, as well as rehabilitation for children born to women who are addicted.

The bill adds a requirement that the program give priority to treating pregnant women who are addicted to drugs of abuse. It also requires a community addiction services provider that receives public funds to give priority to pregnant women referred to treatment. The bill prohibits such a community addiction services provider from refusing to treat a pregnant woman solely because she is pregnant, so long as appropriate treatment is offered by the provider.[122]

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[119] R.C. 3701.59(B).

[120] R.C. 3701.59(A); R.C. 5119.01(A)(2) and (3).

[121] R.C. 3701.59(C).

[122] R.C. 5119.17.

Child welfare proceedings

Public children services agencies (PCSAs)[123] are required to assess and investigate reports of abuse, neglect, or dependency to determine whether a child is safe or at risk. This assessment and investigation is conducted pursuant to Ohio and federal law in accordance with the Child Protective Services Worker Manual developed by the Department of Job and Family Services. In appropriate circumstances, a PCSA may file a complaint with the juvenile court alleging that a child is an abused, neglected, or dependent child.[124] When a complaint has been filed, the court must first determine whether the child is an abused, neglected, or dependent child (referred to as adjudication) and, if so, whether the child should be removed from the parent's custody (referred to as disposition).

The bill prohibits a PCSA from filing such a complaint regarding a newborn[125] solely because the newborn's mother used a controlled substance while pregnant, so long as the mother did all of the following:

(1) Before the end of the 20th week of pregnancy, enrolled in a drug treatment program provided by a provider of addiction services or alcohol and drug addiction services;

(2) Successfully completed the program or is in the process of completing the program and is in compliance with the program's terms and conditions as determined by the program;

(3) Maintained her regularly scheduled appointments and prenatal care recommended by her health care provider for the remaining duration of the pregnancy.[126]

If a pregnant woman enrolled in a drug treatment program after the end of her 20th week of pregnancy, a court may do either of the following instead of considering the complaint:

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[123] According to the Public Children Services Association of Ohio, there are 61 PCSAs located within county departments of job and family services, 21 are separate children services boards, and two fall under the purview of a county administrator or executive.

[124] R.C. 2151.27, not in the bill.

[125] The bill defines a newborn as a child less than 30 days old.

[126] R.C. 2151.26(B).

(1) Hold it in abeyance if the court finds the woman is in the process of completing the program and has maintained her regularly scheduled appointments and prenatal care;

(2) Dismiss it if the court finds that the woman successfully completed the program and maintained her regularly scheduled appointments and prenatal care.[127]

The bill specifies that it does not prevent a PCSA from filing a complaint regarding a newborn if the PCSA determines that the mother, or any other adult caring for the newborn, is unable to provide adequate parental care.[128]

Admissibility of prenatal screening and tests in criminal proceedings

The bill provides that evidence of the use of a controlled substance obtained through a screening or test to determine pregnancy or provide prenatal care is not admissible in a criminal proceeding against the woman who was screened or tested. However, the bill also specifies that it does not prohibit criminal prosecution based on evidence obtained through methods other than prenatal screening or testing or prenatal care.[129]

Maiden's Law

The bill specifies that its provisions regarding the drug treatment for pregnant women are to be known as "Maiden's Law."[130]

Technical correction

The bill corrects a cross-reference in section 5139.01 of the Revised Code. That section refers to section 2151.26, but that section was amended and renumbered by Sub. S.B. 179 of the 123rd General Assembly.

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[127] R.C. 2151.26(C).

[128] R.C. 2151.26(D).

[129] R.C. 2945.65.

[130] Section 8.

COMMUNITY ADDICTION AND MENTAL HEALTH SERVICES

Revisions to and consistent use of terminology

Services

The terms "addiction services," "alcohol and drug addiction services," and "mental health services" are frequently used in the law governing the Ohio Department of Mental Health and Addiction Services (ODMHAS) and boards of alcohol, drug addiction, and mental health services (ADAMHS boards). Current law defines "addiction services" as services, including intervention, for the treatment of persons with alcohol, drug, or gambling addictions, and for the prevention of alcoholism and drug addiction. "Alcohol and drug addiction services" is defined by current law as services, including intervention, for the treatment of alcoholics or persons who abuse drugs of abuse and for the prevention of alcoholism and drug addiction. Current law defines "mental health services" as services for the assessment, care, or treatment of persons who have a mental illness. The bill provides that "mental health services" also means services for the prevention of mental illness.[131]

Certain parts of the law governing ODMHAS and ADAMHS boards are ambiguous because they use similar terms instead of the defined terms. For example, ADAMHS boards are required to evaluate the need for community addiction and mental health services. The bill revises these parts of the law by using the defined terms. In the above example, ADAMHS boards are required by the bill to evaluate the need for addiction services and mental health services rather than community addiction and mental health services.[132]

Providers

"Community addiction services provider" and "community mental health services provider" are other terms frequently used in the law governing ODMHAS and ADAMHS boards. Current law defines "community addiction services provider" as an agency, association, corporation, individual, or program that provides alcohol, drug addiction, or gambling addiction services that are certified by ODMHAS. The bill defines this term instead as an agency, association, corporation, individual, or program that provides one or more of the following: (1) alcohol and drug addiction services certified by ODMHAS, (2) gambling addiction services, or (3) recovery supports that are related to alcohol and drug addiction services or gambling addiction services and paid

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[131] R.C. 5119.01(A)(2), (3), and (15).

[132] R.C. 340.011, 340.03, 340.031, 340.036, 340.037, 340.04, 340.041, 340.08, 340.09, 340.091, 340.10, 340.12, 340.15, 5119.10, 5119.11, 5119.21, 5119.22, 5119.23, 5119.361, 5119.42, 5119.60, and 5119.61.

for with federal, state, or local funds administered by ODMHAS or an ADAMHS board. Current law defines "community mental health services provider" as an agency, association, corporation, individual, or program that provides mental health services certified by ODMHAS. The bill defines this term instead as an agency, association, corporation, individual, or program that provides either or both of the following: (1) mental health services certified by ODMHAS or (2) recovery supports that are related to mental health services and paid for with federal, state, or local funds administered by ODMHAS or an ADAMHS board.[133] (See "**Recovery supports**," below.)

Certain parts of the law governing ODMHAS and ADAMHS boards are ambiguous because they use similar terms instead of the defined terms. For example, current law permits a board of county commissioners, at the request of an ADAMHS board, to appropriate money to the ADAMHS board for the operation, lease, acquisition, construction, renovation, and maintenance of addiction or mental health services providers in accordance with the ADAMHS board's approved budget. The bill revises these parts of the law by using the defined terms. In the above example, a board of county commissioners, at the request of an ADAMHS board, may appropriate money to the ADAMHS board for the operation, lease, acquisition, construction, renovation, and maintenance of community addiction services providers or community mental health services providers in accordance with the ADAMHS board's approved budget.[134]

Certification of services

Current law requires community mental health services providers to obtain certification of their mental health services, and community addiction services providers to obtain certification of their addiction services, from the ODMHAS Director as a condition of the providers receiving state or federal funds or funds administered by ADAMHS boards. As discussed above, addiction services are services for the treatment of persons with alcohol, drug, *or gambling* addictions and for the prevention of alcoholism and drug addiction. (See "**Revisions to and consistent use of terminology**," above.)

The bill revises the certification statutes by providing for the certification of (1) alcohol and drug addiction services, (2) mental health services, and (3) the types of recovery supports that are specified as requiring certification in rules to be adopted by the ODMHAS Director. (See "**Recovery supports**," below.) By providing for the certification of alcohol and drug addiction services instead of addiction services,

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[133] R.C. 5119.01(A)(7) and (8).

[134] R.C. 340.03, 340.036, 340.037, 340.041, 340.05, 340.07, 340.12, 340.15, 2921.22, 5119.21, 5119.22, 5119.36, 5119.366, and 5119.61.

services for the treatment of persons with gambling addictions are not subject to certification under the bill.[135]

Many provisions of state law create an ambiguity because they refer to the community mental health services providers and community addiction services providers being certified rather than their services. The bill revises these provisions by referring to certified mental health services and certified alcohol and drug addiction services rather than certified providers.[136]

Recovery supports

The bill adds recovery supports to many provisions of law regarding addiction services and mental health services with the result that (1) ADAMHS boards are expressly required to make recovery supports available, and perform related functions, as part of the process of making addiction services and mental health services available and (2) ODMHAS is expressly required to perform the same types of administrative functions for recovery supports that current law requires ODMHAS to perform for addiction services and mental health services. "Recovery supports" is defined as assistance that is intended to help an individual who is an alcoholic or has a drug addiction or mental illness, or a member of such an individual's family, initiate and sustain the individual's recovery from alcoholism, drug addiction, or mental illness. Alcohol and drug addiction services and mental health services are not recovery supports.[137]

The bill requires the ODMHAS Director to adopt rules specifying the types of recovery supports for which certification must be obtained from the Director. Recovery housing that is required to be part of the array of addiction services and recovery supports for all levels of opioid and co-occurring drug addiction is not to be subject to certification as a recovery support.[138] (See "**Array of services for opioid and co-occurring drug addiction**," below.)

The following are the provisions to which recovery supports are added:

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[135] R.C. 5119.01 (primary), 340.01, 340.03, 340.036, 5119.36, and 5119.366.

[136] R.C. 5119.36 (primary), 321.44, 2921.22, 2929.15, 3707.57, 3719.13, 3719.27, 4511.191, 4729.291, 5107.42, 5119.367, 5119.391, 5120.035, and 5167.12.

[137] R.C. 5119.01(A)(16) (primary) and 340.01(A)(1).

[138] R.C. 5119.36(E)(1) (primary), 340.034(B), and 5119.01(A)(6)(c).

(1) The duties that ADAMHS boards have as community addiction and mental health planning agencies are to include evaluating the need, and setting priorities, for recovery supports.[139]

(2) ADAMHS boards' annual community addiction and mental health plans must address ODMHAS's priorities for recovery supports.[140]

(3) ADAMHS boards must investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving recovery supports.[141]

(4) ADAMHS boards must conduct program audits that review and evaluate the quality, effectiveness, and efficiency of recovery supports. ODMHAS is required to assess an ADAMHS board's evaluation of recovery supports.[142]

(5) ADAMHS boards must provide for all contracted recovery supports to be audited at least annually.[143]

(6) ADAMHS boards must recruit and promote local financial support for recovery supports from private and public sources.[144]

(7) ADAMHS boards must approve fee schedules and related charges, or adopt a unit cost schedule or other methods of payment, for contracted recovery supports.[145]

(8) ADAMHS boards must submit to the ODMHAS Director and county commissioners, and make available to the public, annual reports that also address recovery supports.[146]

(9) ADAMHS boards are required to assure that the list of services (including recovery supports) they submit for approval to ODMHAS are available to severely mentally disabled persons residing in their districts.[147]

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[139] R.C. 340.03(A)(1)(a) and (b).

[140] R.C. 340.03(A)(1)(c).

[141] R.C. 340.03(A)(2).

[142] R.C. 340.03(A)(4) and 5119.22(D).

[143] R.C. 340.03(A)(6).

[144] R.C. 340.03(A)(7).

[145] R.C. 340.03(A)(8).

[146] R.C. 340.03(A)(9).

(10) ADAMHS boards must establish a mechanism for obtaining advice and involvement of persons receiving recovery supports on matters pertaining to the supports in their districts.[148]

(11) An ADAMHS board's community-based continuum of care must include as essential elements (a) outreach and engagement activities to locate persons in need of addiction services and mental health services to inform them of available recovery supports, (b) certain recovery supports, and (c) an array of recovery supports for all levels of opioid and co-occurring drug addiction.[149]

(12) ADAMHS boards are to contract with community addiction services providers and community mental health services providers for recovery supports. However, no ADAMHS board may contract for recovery supports that are required by the ODMHAS Director to meet quality criteria or core competencies unless the recovery supports meet the criteria or competencies.[150]

(13) An ADAMHS board's executive director must (a) supervise recovery supports for which the board contracts or supports to determine if the recovery supports are being administered in accordance with state law and rules, (b) recommend to the board changes necessary to increase the effectiveness of recovery supports, (c) encourage the development and expansion of recovery supports, and (d) include information about recovery supports in an annual report to the board.[151]

(14) An ADAMHS board must include, in a list to be submitted to ODMHAS for approval, the recovery supports it intends to make available.[152]

(15) ADAMHS boards are required to contract with community mental health services providers to ensure, through ongoing monitoring, that recovery supports included in the board's approved list of services are available to Residential State Supplement recipients who are referred to the providers.[153]

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[147] R.C. 340.03(A)(11).

[148] R.C. 340.03(A)(13).

[149] R.C. 340.032(A)(2)(a) and (9), 340.033, and 2929.13.

[150] R.C. 340.036 (primary), 307.86, 340.03, 340.091, 340.13, 3313.65, 5119.36, and 5119.366.

[151] R.C. 340.041.

[152] R.C. 340.08(B) and (C), 340.011, 340.09(A)(2), and 5119.22(G).

[153] R.C. 340.091.

(16) The report an ADAMHS board must submit to ODMHAS summarizing complaints concerning the rights of persons seeking or receiving services must also cover complaints concerning the rights of persons seeking or receiving recovery supports.[154]

(17) County treasurers are to be custodians of funds for recovery supports.[155]

(18) The monthly reports that county auditors must submit to ADAMHS boards regarding receipts, disbursements, and ending balances for funds for services must also cover such information for funds for recovery supports.[156]

(19) ADAMHS boards, and community addiction services providers and community mental health services providers under contract with ADAMHS boards, are prohibited from discriminating in the provision of recovery supports under their authority.[157] (See "**Discrimination prohibition**," below.)

(20) ODMHAS is required to provide training, consultation, and technical assistance regarding recovery supports to ODMHAS employees, community addiction services providers, community mental health services providers, and ADAMHS boards.[158]

(21) ODMHAS is required, to the extent it has available resources, to promote and support a full range of recovery supports that are available and accessible to all Ohio residents, especially severely emotionally disturbed children and adolescents, severely mentally disabled adults, pregnant women, parents, guardians, or custodians of children at risk of abuse or neglect, and other special target populations, including racial and ethnic minorities, as determined by ODMHAS.[159]

(22) ODMHAS must develop standards and measures for evaluating the effectiveness of recovery supports and promote, direct, conduct, and coordinate

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[154] R.C. 340.08(E).

[155] R.C. 340.10.

[156] R.C. 340.10.

[157] R.C. 340.12.

[158] R.C. 5119.21(A)(2).

[159] R.C. 5119.21(A)(3).

scientific research, taking ethnic and racial differences into consideration, concerning methods of providing effective recovery supports.[160]

(23) ODMHAS is required to establish a program to protect and promote the rights of persons receiving recovery supports, including the issuance of guidelines on informed consent and other rights.[161]

(24) ODMHAS must promote the involvement of persons who are receiving or have received recovery supports, and families and other persons having a close relationship to a person receiving recovery supports, in the planning, evaluation, delivery, and operation of recovery supports.[162]

(25) ODMHAS is to notify and consult with recovery supports consumers, and the families of such consumers, affected by rules, standards, and guidelines issued by ODMHAS.[163]

(26) ODMHAS may require ADAMHS boards to report, under a community behavioral health system, information on recovery supports provided.[164]

(27) ODMHAS must consult with persons receiving recovery supports when establishing guidelines for the use of funds ODMHAS allocates to ADAMHS boards.[165]

(28) With certain exceptions, all records and reports identifying a person and pertaining to the person's provision of, or payment for, recovery supports are confidential when maintained in connection with a service certified by ODMHAS or recovery supports paid for with funds administered by ODMHAS or an ADAMHS board. The records and reports may be disclosed to staff members of an ADAMHS board or staff members designated by the ODMHAS Director for the purpose of evaluating the quality, effectiveness, and efficiency of recovery supports and determining if recovery supports meet minimum standards. A community mental health services provider that ceases to operate may transfer the records and reports to

[160] R.C. 5119.21(A)(4) and (6).

[161] R.C. 5119.21(A)(8).

[162] R.C. 5119.21(A)(9).

[163] R.C. 5119.21(A)(10).

[164] R.C. 5119.22(E).

[165] R.C. 5119.23(C).

another community mental health services provider that assumes its caseload or to an ADAMHS board.[166]

(29) An annual report that ODMHAS must submit to the Governor is to include the number and types of recovery supports provided to severely mentally disabled persons through state-operated services, community addiction services providers, and community mental health services providers.[167]

(30) ODMHAS is to collect information about recovery supports delivered and persons served for reports and evaluations relating to state and federal funds expended for recovery supports. No community addiction services provider or community mental health services provider may fail to supply statistics and other information within its knowledge and with respect to its recovery supports that ODMHAS requests.[168]

(31) ODMHAS's hospitals, institutions, and other facilities are permitted to exchange psychiatric records and other pertinent information with payers and providers of recovery supports as needed to facilitate a patient's continuity of care or for an individual's emergency treatment.[169]

ADAMHS boards' continuum of care

Each ADAMHS board is required to establish, to the extent resources are available, a continuum of care that provides for prevention, treatment, support, and rehabilitation services and opportunities. Am. Sub. H.B. 483 of the 130th General Assembly revised the law governing the continuum of care and delayed the effective date of the revisions until September 15, 2016. Am. Sub. H.B. 483 of the 131st General Assembly and Sub. S.B. 129 of the 131st General Assembly both further delayed the effective date of the revisions until July 1, 2017.

The bill further revises the law regarding the continuum of care. Under the bill, the continuum of care is referred to as a community-based continuum of care.[170]

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[166] R.C. 5119.28.

[167] R.C. 5119.60.

[168] R.C. 5119.61.

[169] R.C. 5122.31(A)(7).

[170] R.C. 340.032 (primary), 340.01, 340.03, 340.033, 340.034, 340.08, 340.09, 2929.13, 4731.62, 5119.01, 5119.21, 5119.22, and 5119.23.

Essential elements

Under the current law that goes into effect July 1, 2017, the continuum of care must provide for prevention, treatment, support, and rehabilitation services and opportunities and include the following components:

(1) The location of persons in need of addiction or mental health services to inform them of available services and benefits;

(2) Assistance for persons receiving addiction and mental health services to obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;

(3) Addiction and mental health services, including outpatient, residential, partial hospitalization, inpatient care (where appropriate), sub-acute detoxification, intensive and other supports, recovery supports, prevention and wellness management, and an array of treatment and support services for all levels of opioid and co-occurring addiction;

(4) Emergency services and crisis intervention;

(5) Assistance for persons receiving services to obtain vocational services and opportunities for jobs;

(6) The provision of services designed to develop social, community, and personal living skills;

(7) Access to a wide range of housing and the provision of residential treatment and support;

(8) Support, assistance, consultation, and education for families, friends, persons receiving addiction or mental health services, and others;

(9) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and community employment as natural supports for persons receiving addiction or mental health services;

(10) Grievance procedures and protection of the rights of persons receiving addiction or mental health services;

(11) Community psychiatric supportive treatment services, including continual individualized assistance and advocacy to ensure that needed services are offered and procured;

(12) Any additional component ODMHAS determines is necessary to establish the continuum of care.[171]

Under the bill, each ADAMHS board's community-based continuum of care must instead include, except as otherwise authorized by a time-limited waiver, all of the following as essential elements:

(1) Prevention and wellness management services;

(2) At least both of the following outreach and engagement activities: (a) locating persons in need of addiction services and persons in need of mental health services to inform them of available addiction services, mental health services, and recovery supports and (b) helping persons who receive addiction services and persons who receive mental health services obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;

(3) Assessment services;

(4) Care coordination;

(5) Residential services;

(6) At least the following outpatient services: nonintensive, intensive (such as partial hospitalization and assertive community treatment), withdrawal management, and emergency crisis;

(7) At least the following inpatient services (where appropriate): psychiatric care and medically managed alcohol or drug treatment;

(8) At least all of the following recovery supports: peer support; a wide range of housing and support services (including recovery housing); employment, vocational, and educational opportunities; assistance with social, personal, and living skills; multiple paths to recovery such as 12-step approaches and parent advocacy connection; and support, assistance, consultation, and education for families, friends, and persons receiving addiction services, mental health services, and recovery supports;

(9) An array of addiction services and recovery supports for all levels of opioid and co-occurring drug addiction;

(10) Any additional elements ODMHAS determines is necessary to establish the community-based continuum of care.[172]

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[171] R.C. 340.03(A) and 5119.21(A)(1).

The bill permits the ODMHAS Director to issue to an ADAMHS board a time-limited waiver of the requirement that the board's community-based continuum of care include all of the essential elements listed above if the Director determines that the board has made reasonable efforts to include in the continuum the elements being waived. The waiver must specify the amount of time for which it is issued and which of the essential elements are waived. The Director must establish procedures for issuing such time-limited waivers. In establishing the procedures, the Director must consult with ADAMHS board representatives and consider recommendations made by ODMHAS's medical director.[173]

As discussed above, the current law that goes into effect July 1, 2017, requires that the essential elements of the continuum of care include grievance procedures and protection of the rights of persons receiving addiction or mental health services. The bill requires instead that each ADAMHS board ensure that (1) the rights of persons receiving any elements of the community-based continuum of care are protected and (2) persons receiving any elements of the community-based continuum of care are able to utilize grievance procedures applicable to the elements.[174]

Array of services for opioid and co-occurring drug addiction

As discussed above, the current law that goes into effect July 1, 2017, requires an ADAMHS board's continuum of care to include an array of treatment and support services for all levels of opioid and co-occurring drug addiction and the bill instead requires an ADAMHS board's community-based continuum of care to include as an essential element an array of addiction services and recovery supports for all levels of opioid and co-occurring drug addiction.

The current law going into effect July 1, 2017, requires that the array include, among other services, peer mentoring, residential treatment services, and 12-step approaches. The bill requires that the array include, among other unchanged services, peer support instead of peer mentoring and residential services instead of residential treatment services. The current law requires that the array also include 12-step approaches. The bill requires instead that the array also include multiple paths to recovery such as 12-step approaches.[175]

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[172] R.C. 340.032 and 5119.01(A)(13).

[173] R.C. 5119.221 (primary), 340.032(A), 340.08(B), 5119.01(A)(13), and 5119.22(F)(5) and (G).

[174] R.C. 340.03(A) and 340.032.

[175] R.C. 340.033.

The current law going into effect July 1, 2017, requires that the array also include ambulatory detoxification and medication-assisted treatment. The bill permits the ODMHAS Director to issue to an ADAMHS board a waiver of this requirement if the Director determines both of the following:

(1) Ambulatory detoxification and medication-assisted treatment can be made available through one or more contracts between the board and community addiction services providers that are located not more than 30 miles beyond the borders of the board's service district;

(2) The amount of time it takes for residents of the service district to travel to a community addiction services provider that provides ambulatory detoxification and medication-assisted treatment does not impose a significant barrier to successful treatment.[176]

The ODMHAS Director must establish procedures for issuing such waivers. In establishing the procedures, the Director must consult with ADAMHS board representatives and consider recommendations made by ODMHAS's medical director.[177]

"Medication-assisted treatment" is defined in current law that goes into effect July 1, 2017, as alcohol and drug addiction services that are accompanied by medication approved by the U.S. Food and Drug Administration (FDA) for the treatment of drug addiction, prevention of relapse of drug addiction, or both. The bill revises the definition to provide that medication-assisted treatment also means such services that are accompanied by medication approved by the FDA for the treatment of alcoholism, prevention of alcoholism, or both.[178]

The current law going into effect July 1, 2017, requires that the treatment and support services included in the array be made available in a manner that ensures that recipients are able to access the services they need for opioid and co-occurring drug addiction in an integrated manner and without delay when changing or obtaining additional treatment or support services for the addiction. Under the bill, the services and supports included in the array must be made available in a manner that ensures that recipients are able to access the services and supports they need for opioid and co-occurring drug addiction in an integrated manner and in accordance with their assessed

[176] R.C. 5119.221 (primary) and 340.033.

[177] R.C. 5119.22(F)(5).

[178] R.C. 340.01(A)(2) and 340.033.

needs when changing or obtaining additional addiction services or recovery supports for the addiction.[179]

The current law going into effect July 1, 2017, provides that an individual seeking a treatment or support service for opioid and co-occurring drug addiction included in a continuum of care is not to be denied the service on the basis that the service previously failed. The bill provides instead that an individual seeking a service or support for opioid and co-occurring drug addiction included in a community-based continuum of care is not to be denied the service or support on the basis of the individual's prior experience with the service or support.[180]

Waiting list and reporting duties

The bill revises a current law that goes into effect July 1, 2017, and concerns waiting list and reporting duties of community addiction services providers, duties of ADAMHS boards regarding information from the providers, and ODMHAS's duties regarding reports it receives.

Providers' duties

Under the law that goes into effect July 1, 2017, a community addiction services provider must maintain, in an aggregate form, a waiting list of each individual who has (1) been documented as having a clinical need for alcohol and drug addiction services due to an opioid or co-occurring drug addiction, (2) applied to the provider for a clinically necessary treatment or support service, and (3) not begun to receive the treatment or support service within five days of the individual's application because the provider lacks an available slot for the individual. The provider is required to notify an individual included on the waiting list when the provider has a slot available for the individual and, if the individual does not contact the provider about the slot within a period of time specified in rules to be adopted by the ODMHAS Director, contact the individual to determine why the individual did not contact the provider and to assess whether the individual still needs the treatment or support service.[181]

Under the bill, a community addiction services provider must instead maintain a waiting list for the provider's addiction services and recovery supports included in the array of services and supports for all levels of opioid and co-occurring drug addiction required to be included in an ADAMHS board's community-based continuum of care.

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[179] R.C. 340.033.

[180] R.C. 340.033.

[181] R.C. 5119.362(A)(1) and (2).

The bill maintains the notification requirement and requires a provider to also do all of the following:

(1) Remove an individual from the waiting list if (a) the individual withdraws the request for the addiction services and recovery supports or (b) the individual, after being notified about an available slot, does not contact the provider within a period of time to be specified in the ODMHAS Director's rules or otherwise vacates the slot before beginning to receive the services and supports;

(2) As part of the process of maintaining the waiting list, determine (a) for each individual who seeks the addiction services and recovery supports from the provider, the number of days that starts with the day the individual first contacts the provider about accessing the services and supports and ends on the day of an assessment of the individual's clinical need for the services and supports or, if no assessment is required, the first day the individual accesses the services and supports and (b) for each individual who is required to be assessed for the individual's clinical need for the services and supports, the number of days that starts with the day of the assessment and ends with the first day that the individual accesses the services and supports;

(3) Using information the provider acquires from maintaining the waiting list, determine whether the addiction services and recovery supports are insufficient to meet the needs of individuals on the waiting list.[182]

The law that goes into effect July 1, 2017, requires a community addiction services provider to report all of the following information each month to the ADAMHS boards that serve the county or counties in which the provider provides alcohol and drug addiction services:

(1) An unduplicated count of all individuals who reside in a county that the ADAMHS board serves and were included on the provider's waiting list as of the last day of the immediately preceding month and each type of treatment and support service for which they were waiting;

(2) The total number of days the individuals had been on the waiting list as of the last day of the immediately preceding month;

(3) The last known types of residential settings (identified at least as either institutional or noninstitutional) in which the individuals resided as of the last day of the immediately preceding month;

[182] R.C. 5119.362(A)(1) to (5).

(4) The number of individuals who did not contact the provider after receiving, during the immediately preceding month, the notices about the provider having slots available for the individuals and the reasons the contacts were not made;

(5) The number of individuals who withdrew, in the immediately preceding month, their applications for the treatment and support services, each type of treatment or service for which those individuals had applied, and the reasons the applications were withdrawn;

(6) All other information specified in rules the ODMHAS Director is to adopt.[183]

Each report must maintain the confidentiality of all individuals for whom information is included in the report.[184]

Under the bill, a community addiction services provider instead must report to ODMHAS all of the following information not later than the last day of each month:

(1) An unduplicated count of all individuals who were included on the provider's waiting list during the immediately preceding month and each type of addiction service and recovery support for which they were waiting;

(2) The total number of days each individual had been on the provider's waiting list during the immediately preceding month;

(3) The last known type of residential setting (identified at least as either institutional or noninstitutional) in which each individual resided during the immediately preceding month;

(4) The total number of individuals who did not contact the provider after receiving, during the immediately preceding month, notice about the provider having slots available for them and, if known, the reasons the contacts were not made;

(5) The total number of individuals who withdrew, in the immediately preceding month, their requests for the addiction services and recovery supports, each type of service and support that those individuals had requested or been assessed as having a clinical need for, and, if known, the reasons those individuals withdrew their requests;

(6) An unduplicated count of all individuals who were referred to another community addiction services provider because the referring provider does not provide the type of addiction service or recovery support that those individuals had requested

[183] R.C. 5119.362(A)(3), (B), and (C)(2), as in current law.

[184] R.C. 5119.362(C)(1).

or been assessed as having a clinical need for and each type of service and support for which those individuals were referred;

(7) All other information specified in rules the ODMHAS Director is to adopt.[185]

The bill requires that the reports specify the counties of residence of the individuals in the unduplicated counts and include identifying information required by rules the ODMHAS Director is to adopt so that ODMHAS is able to identify any individuals who are inadvertently duplicated in the counts.[186]

ADAMHS boards' and ODMHAS's duties

Under the law that goes into effect July 1, 2017, each ADAMHS board monthly must (1) compile on an aggregate basis the information the ADAMHS board receives that month from community addiction services providers in the reports discussed above, (2) determine the number of applications for services included in the array of treatment and support services for all levels of opioid and co-occurring drug addiction that the ADAMHS board received in the immediately preceding month and that the ADAMHS board denied that month, each type of service denied, and the reasons for the denials, and (3) report the compiled information and determinations to ODMHAS.[187] ODMHAS is required to make the reports it receives from ADAMHS boards available on its website in a manner that presents the information contained in the reports on both a statewide basis and county-level basis. The information on the website must be updated monthly.[188]

Under the bill, ADAMHS boards no longer have these compilation, determination, and report duties. Instead, ODMHAS is to do both of the following with the reports it is to receive from community addiction services providers: (1) make the reports available on its website and (2) make the reports available in an electronic format to ADAMHS boards in a manner that provides the information about an individual contained in a report to the board that serves the individual's county. The information on ODMHAS's website is to be presented on both a statewide aggregate basis and a county-level aggregate basis. As under the current law going into effect July 1, 2017, the information on the website must be updated monthly.[189] Each ADAMHS

[185] R.C. 5119.362(A)(6) and (B)(2).

[186] R.C. 5119.362(B)(1).

[187] R.C. 340.20.

[188] R.C. 5119.364.

[189] R.C. 5119.364.

board is required to acknowledge to ODMHAS that it has received and reviewed the information ODMHAS makes available. Using the information, an ADAMHS board is to determine whether any addiction services and recovery supports included in the array of services and supports for all levels of opioid and co-occurring drug addiction required to be included in an ADAMHS board's community-based continuum of care are not meeting the needs for addiction services and recovery supports in the ADAMHS board's district. An ADAMHS board must inform ODMHAS of its determination. The notice may include any commentary the ADAMHS board determines necessary.[190]

ADAMHS boards' planning duties

Current law requires each ADAMHS board to serve as the community addiction and mental health services planning agency for the county or counties under its jurisdiction. The bill eliminates "services" from the description of the planning agency.[191]

One of the duties each ADAMHS board has as a planning agency is to annually develop, and submit for ODMHAS's approval, a community addiction and mental health services plan. The bill eliminates "services" from the description of the plan. Under current law, a plan must (1) list community addiction and mental health service needs (including the needs of all residents in the board's district currently receiving inpatient services in state-operated hospitals, other populations as required by state or federal law or programs, and all children for whom a county family and children first council has issued a written determination that directs one or more agencies represented on the council to provide services or funding for services to the children) and (2) prioritize facilities and community addiction and mental health services. Under the bill, a plan must address (1) the needs of the persons specified in current law and (2) ODMHAS's priorities for facility services, addiction services, mental health services, and recovery supports. ODMHAS is required to inform all ADAMHS boards of ODMHAS's priorities in a timely manner that enables the boards to know ODMHAS's priorities before the boards develop and submit their plans.[192]

ODMHAS withholding funds from ADAMHS boards

Current law that goes into effect July 1, 2017, requires the ODMHAS Director to withhold *all* funds otherwise to be allocated to an ADAMHS board if the ADAMHS board's use of state and federal funds fails to comply with the ADAMHS board's budget that has been approved by ODMHAS. Under the bill, the ODMHAS Director instead is

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[190] R.C. 340.20.

[191] R.C. 340.03(A)(1).

[192] R.C. 340.03(A)(1)(c), 340.15, 5119.10, 5119.11, 5119.22, and 5119.42.

to withhold such funds *in whole or in part* under that circumstance beginning July 1, 2017.[193]

ODMHAS assistance to counties

ODMHAS must provide assistance to any county for (1) the operation of ADAMHS boards, (2) the provision of ODMHAS-approved services within the continuum of care, (3) the provision of approved support functions, and the partnership in (or support for) approved continuum of care-related activities. Am. Sub. H.B. 483 of the 131st General Assembly revised this by requiring ODMHAS to provide assistance to each county for all of those activities. The revisions go into effect July 1, 2017. Under the bill, ODMHAS is to continue to be required to provide the assistance to any, instead of each, county. Instead of being required to provide the assistance for all of the activities, ODMHAS is required to provide the assistance for one or more of the activities. The bill also revises the second activity by authorizing assistance for the provision of addiction services, mental health services, and recovery supports included in a list ADAMHS boards are required to submit to ODMHAS for approval instead of services within an ADAMHS board's continuum of care.[194]

Procedures for offering ADAMHS boards technical assistance

ODMHAS is required to offer an ADAMHS board technical assistance to help the board make a proposed community addiction and mental health plan, budget, or list of services the board intends to make available meet criteria for approval. ODMHAS also must offer an ADAMHS board technical assistance to help the board make an amendment to an approved plan, budget, or list acceptable. (See "**ADAMHS boards' planning duties**," above.) The bill requires the ODMHAS Director to establish procedures to follow in offering such technical assistance. In establishing the procedures, the Director must consult with ADAMHS board representatives and consider recommendations made by ODMHAS's medical director.[195]

Collection of personal information under information system

The ODMHAS Director is required, to the extent determined necessary, to develop and operate, or contract for the operation of, a community behavioral health information system or systems. ADAMHS boards, community addiction services providers, and community mental health services providers must submit information

[193] R.C. 340.08 and 5119.25.

[194] R.C. 340.09.

[195] R.C. 5119.22(F)(4).

ODMHAS requests. Current law prohibits ODMHAS from collecting any personal information from ADAMHS boards except as required or permitted by state or federal law for purposes related to payment, health care operations, program and service evaluation, reporting activities, research, system administration, and oversight. The bill also prohibits ODMHAS from collecting any personal information from providers except under such circumstances.[196]

ADAMHS boards' executive directors consulting with providers

Current law requires an ADAMHS board's executive director to consult with community addiction services providers and community mental health services providers that provide services the board supports. The bill eliminates the condition that a provider be providing services the board supports in order for the executive director to consult with the provider.[197]

Effective date

The bill's provisions regarding community addiction and mental health services go into effect July 1,2017.[198]

OTHER ODMHAS AND ADAMHS BOARD PROVISIONS

ODMHAS contracts for services

Current law provides that state law governing the Ohio Department of Administrative Services' purchases of services and supplies, including provisions of that law regarding competitive selection, does not apply to contracts the ODMHAS Director enters into for services provided to individuals with mental illness. The bill provides that, effective July 1, 2017, the Ohio Department of Administrative Services' law does not apply to contracts the ODMHAS Director enters into for addiction services, mental health services, or recovery supports provided to individuals who are alcoholics or addicted to drugs or gambling or to individuals who have a mental illness.[199]

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[196] R.C. 5119.22(E).

[197] R.C. 340.041(C).

[198] Section 9(B).

[199] R.C. 5119.10(B)(8) and Section 9(B).

ODMHAS annual report to the Governor

Current law requires ODMHAS to submit an annual report to the Governor describing the services ODMHAS offers and how appropriated funds have been spent. The report currently must include the number and types of services provided to severely disabled persons through state-operated services and community mental health services providers. The bill instead requires that, effective July 1, 2017, the report include the number and types of addiction services, mental health services, and recovery supports provided to severely mentally disabled persons through state-operated services, community addiction services providers, and community mental health services providers.[200]

ODMHAS's duty to collect and compile statistics and other information

Current law requires ODMHAS to collect and compile statistics and other information on the care and treatment of mentally disabled persons and the care, treatment, and rehabilitation of alcoholics, drug dependent persons, and persons in danger of drug dependence in this state. The bill requires that ODMHAS also compile statistics and other information on the care, treatment, and rehabilitation of persons with, or in danger of developing, a gambling addiction. Under current law, the information must include the type of drug involved in the care, treatment, and rehabilitation. The bill specifies that the information must include the type of drug involved if any drug is involved in the care, treatment, and rehabilitation. These provisions take effect July 1, 2017.[201]

ODMHAS's exchange of mental health records with other state agencies

Current law permits ODMHAS to exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with the Ohio Department of Rehabilitation and Correction and the Ohio Department of Youth Services to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution of one of those Departments. ODMHAS also may exchange the records and information with ADAMHS boards and community mental health services providers to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution and scheduled for release within six months. Current law conditions these exchanges on the inmate or offender being

[200] R.C. 5119.60 and Section 9(B).

[201] R.C. 5119.61 and Section 9(B).

notified, receiving the information, and not objecting to the disclosure. The bill eliminates this condition effective July 1, 2017.[202]

Encouraging rehabilitative services

The bill eliminates, effective July 1, 2017, a requirement that an ADAMHS board executive director encourage the development and expansion of rehabilitative services in the fields of addiction services and mental health services.[203]

Discrimination prohibition

ADAMHS boards and community addiction services providers and community mental health services providers under contract with ADAMHS boards are prohibited from discriminating against certain classes in the provision of services, in employment, and under contracts. The classes are race, color, religion, sex, age, national origin, disability and, under current law, creed. The bill removes creed as a protected class and adds ancestry and military status. This provision takes effect July 1, 2017.[204]

Class two residential facilities

ODMHAS licenses residential facilities under current law, which establishes three categories of residential facilities: class one, class two, and class three. A class two residential facility is a publicly or privately operated home or facility that provides accommodations, supervision, and personal care services to any of the following: one or two unrelated persons with mental illness, one or two unrelated adults receiving Residential State Supplement (RSS) payments, or three to 16 unrelated adults.[205]

An ADAMHS board is required by current law to perform duties established in ODMHAS rules regarding referrals of individuals with mental illness or severe mental disability to residential facilities licensed by ODMHAS. The bill specifies that the referrals are to class two residential facilities licensed by ODMHAS.[206]

ODMHAS administers the RSS program, which helps pay for accommodations, supervision, and personal care services provided to recipients of Social Security, Social Security Disability Insurance, or Supplemental Security Income who ODMHAS

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[202] R.C. 5122.31(A)(13) and Section 9(B).

[203] R.C. 340.041(F) and Section 9(B).

[204] R.C. 340.12 and 5119.25(A)(2) and Section 9(B).

[205] R.C. 5119.34, not in the bill.

[206] R.C. 340.03(A)(14).

determines are at risk of needing institutional care. An individual must reside in certain types of living arrangements to qualify for RSS. Current law specifies that one of the permissible living arrangements is a residential facility licensed by ODMHAS. The bill specifies that the residential facility must be a class two residential facility.[207]

These provisions take effect July 1, 2017.[208]

HISTORY

ACTION	DATE
Introduced	04-25-16
Reported, S. Health & Human Services	05-25-16
Passed Senate (33-0)	05-25-16
Reported, H. Finance	---

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[207] R.C. 5119.41(D)(1)(b).

[208] Section 9(B).