(134th General Assembly)
(Amended House Bill Number 371)

AN ACT

To amend sections 1751.62, 3702.40, 3923.52, 3923.53, and 5164.08 of the Revised Code to revise the laws governing coverage of screening mammography and patient notice of dense breast tissue and to make temporary changes regarding certificates of need.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1751.62, 3702.40, 3923.52, 3923.53, and 5164.08 of the Revised Code be amended to read as follows:

Sec. 1751.62. (A) As used in this section:

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(2) "Medicare reimbursement rate" means the reimbursement rate paid in Ohio under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(3) "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

(B) ~~Every~~ Notwithstanding section 3901.71 of the Revised Code, every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of ~~both~~ all of the following:

(1) ~~Screening mammography to~~ To detect the presence of breast cancer in adult women, screening mammography;

(2) ~~Cytologic screening for~~ To detect the presence of breast cancer in adult women meeting either of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;

(3) To detect the presence of cervical cancer, cytologic screening.

(C)(1) The benefits provided under division (B)(1) of this section shall cover expenses ~~in~~

~~accordance with all of the following:~~

~~(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;~~

~~(2) If a woman is at least forty years of age but under fifty years of age, either of the following:~~

~~(a) One screening mammography every two years;~~

~~(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.~~

~~(3) If a woman is at least fifty years of age but under sixty-five years of age,~~ for one screening mammography every year, including digital breast tomosynthesis.

(2) The benefits provided under division (B)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets either of the following conditions:

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;

(b) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

(D)(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section or a component of the supplemental breast cancer screening benefit in division (B)(2) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) or (2) of this section, the total benefit for a screening mammography or supplemental breast cancer screening shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography or supplemental breast cancer screening. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography or supplemental breast cancer screening or a component of supplemental breast cancer screening, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) or (2) of this section shall be provided only for screening mammographies or supplemental breast cancer screenings that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under ~~divisions (B)(1) and (2)~~ division (B) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division ~~(B)(2)~~ (B)(3) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3702.40. (A) As used in this section, "mammogram" and "facility" have the same meanings as in section 263b(a) of the "Mammography Quality Standards Act of 1992," 106 Stat. 3547 (1992), 42 U.S.C. 263b(a), as amended.

(B) As required by 21 C.F.R. 900.12(c)(2), a facility shall send to each patient who has a mammogram at the facility a summary of the written report containing the results of the patient's mammogram. If, based on the breast imaging reporting and data system established by the American college of radiology, the patient's mammogram demonstrates that the patient has dense breast tissue, the summary shall include the following statement:

"Your mammogram ~~demonstrates~~ shows that ~~you have dense~~ your breast tissue~~, which could hide abnormalities~~ is dense. Dense breast tissue~~, in and of itself,~~ is ~~a relatively~~ very common ~~condition. Therefore, this information is not provided to cause undue concern; rather, it is to raise your awareness and promote discussion with your health care provider regarding the presence of dense breast tissue in addition to other risk factors~~and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and also may increase your risk of developing breast cancer. Because you have dense breast tissue, you could benefit from additional imaging tests such as a screening breast ultrasound or breast magnetic resonance imaging. This information about your breast density is being provided to you to raise your awareness. It is important to continue routine screening mammograms and use this information to speak with your health care provider about your own risk for breast cancer. At that time, ask your health care provider if more screening tests might be useful based on your risk. A report of your mammogram results was sent to your health care provider."

As required by 21 C.F.R. 900.12(c)(3), the facility shall send to the patient's health care provider, if known, a copy of the written report containing the results of the patient's mammogram not later than thirty days after the mammogram was performed.

(C) This section does not do either of the following:

(1) Create a new cause of action or substantive legal right against a person, facility, or other entity;

(2) Create a standard of care, obligation, or duty for a person, facility, or other entity that would provide the basis for a cause of action or substantive legal right, other than the duty to send the summary and written report described in division (B) of this section.

Sec. 3923.52. (A) As used in this section and section 3923.53 of the Revised Code~~, "screening mammography":~~

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening

mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(2) "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

(B) ~~Every~~ Notwithstanding section 3901.71 of the Revised Code, every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of ~~both~~ all of the following:

(1) ~~Screening mammography to~~ To detect the presence of breast cancer in adult women, screening mammography;

(2) ~~Cytologic screening for~~ To detect the presence of breast cancer in adult women meeting either of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;

(3) To detect the presence of cervical cancer, cytologic screening.

(C)(1) The benefits provided under division (B)(1) of this section shall cover expenses ~~in accordance with all of the following:~~

~~(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;~~

~~(2) If a woman is at least forty years of age but under fifty years of age, either of the following:~~

~~(a) One screening mammography every two years;~~

~~(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.~~

~~(3) If a woman is at least fifty years of age but under sixty-five years of age,~~ for one screening mammography every year, including digital breast tomosynthesis.

(2) The benefits provided under division (B)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets either of the following conditions:

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;

(b) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

(D) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in

division (B)(1) of this section or a component of the supplemental breast cancer screening benefit in division (B)(2) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) or (2) of this section, the total benefit for a screening mammography or supplemental breast cancer screening shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography or supplemental breast cancer screening. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography or supplemental breast cancer screening or a component of supplemental breast cancer screening, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) or (2) of this section shall be provided only for screening mammographies or supplemental breast cancer screenings that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under division ~~(B)(2)~~ (B)(3) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

(G) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy that offers only supplemental benefits.

Sec. 3923.53. (A) ~~Every~~ Notwithstanding section 3901.71 of the Revised Code, every public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of ~~both~~ all of the following:

(1) ~~Screening mammography to~~ To detect the presence of breast cancer in adult women, screening mammography;

(2) ~~Cytologic screening for~~ To detect the presence of breast cancer in adult women meeting any of the conditions described in division (B)(2) of this section, supplemental breast cancer screening;

(3) To detect the presence of cervical cancer, cytologic screening.

(B)(1) The benefits provided under division (A)(1) of this section shall cover expenses ~~in accordance with all of the following:~~

~~(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;~~

~~(2) If a woman is at least forty years of age but under fifty years of age, either of the following:~~

~~(a) One screening mammography every two years;~~

~~(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.~~

~~(3) If a woman is at least fifty years of age but under sixty-five years of age,~~ for one screening mammography every year, including digital breast tomosynthesis.

(2) The benefits provided under division (A)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets any of the following conditions:

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;

(b) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

(C) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (C)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (A)(1) of this section or a component of the supplemental breast cancer screening benefit in division (A)(2) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (A)(1) or (2) of this section, the total benefit for a screening mammography or supplemental breast cancer screening shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography or supplemental breast cancer screening. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography or supplemental breast cancer screening or a component of supplemental breast cancer screening, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (C)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (C)(1) of this section, except for approved deductibles and copayments.

(D) The benefits provided under division (A)(1) or (2) of this section shall be provided only for screening mammographies or supplemental breast cancer screenings that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The benefits provided under division ~~(A)(2)~~ (A)(3) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of

American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 5164.08. (A) As used in this section~~, "screening mammography"~~:

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(2) "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

(B) The medicaid program shall cover ~~both~~ all of the following:

(1) ~~Screening mammography to~~ To detect the presence of breast cancer in adult women, screening mammography;

(2) ~~Cytologic screening for~~ To detect the presence of breast cancer in adult women meeting any of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;

(3) To detect the presence of cervical cancer, cytologic screening.

(C)(1) The medicaid program's coverage ~~of screening mammography~~ pursuant to division (B)(1) of this section shall ~~be provided in accordance with all of the following:~~

~~(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;~~

~~(2) If a woman is at least forty years of age but under fifty years of age, either of the following:~~

~~(a) One screening mammography every two years;~~

~~(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.~~

~~(3) If a woman is at least fifty years of age but under sixty-five years of age,~~cover expenses for one screening mammography every year, including digital breast tomosynthesis.

(2) The medicaid program's coverage pursuant to division (B)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets any of the following conditions:

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;

(b) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

(D) The medicaid program's coverage of screening mammographies pursuant to division (B)

(1) or (2) of this section shall be provided only for screening mammographies or supplemental breast cancer screenings that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The medicaid program's coverage of cytologic screenings pursuant to division ~~(B)(2)~~ (B)(3) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

SECTION 2. That existing sections 1751.62, 3702.40, 3923.52, 3923.53, and 5164.08 of the Revised Code are hereby repealed.

SECTION 3. Section 1751.62 of the Revised Code, as amended by this act, applies only to arrangements, policies, contracts, and agreements that are created, delivered, issued for delivery, or renewed in this state on or after the effective date of the amendment. Section 3923.52 of the Revised Code, as amended by this act, applies only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state on or after the effective date of the amendment. Section 3923.53 of the Revised Code, as amended by this act, applies only to public employee benefit plans that are established or modified in this state on or after the effective date of the amendment.

SECTION 4. Notwithstanding division (A) of section 3702.523 and divisions (A) and (B) of section 3702.524 of the Revised Code, or any other conflicting provision in sections 3702.51 to 3702.62 of the Revised Code, all of the following apply in the case of a certificate of need granted during the period beginning March 9, 2020, and ending June 18, 2021:

(A) The Director of Health shall grant the holder of a certificate of need a twenty-four-month extension to obligate capital expenditures and commence construction for a proposed project. The extension shall be effective during the twenty-four-month period immediately following the expiration date of the twenty-four-month period that otherwise would apply, as described in division (A) of section 3702.524 of the Revised Code. The Director shall notify the holder of the certificate of need of the date on which the twenty-four-month extension expires.

(B)(1) Subject to division (B)(2) of this section, the transfer of a certificate of need, or the transfer of the controlling interest in an entity that holds a certificate of need, prior to completion of the reviewable activity for which the certificate of need was granted, does not void the certificate of need.

(2) In the event of a transfer as described in division (B)(1) of this section, upon receipt of written notice from the transferee that provides sufficient evidence to enable the Director to determine that recognizing the new owner and operator will not cause any of the circumstances specified in division (B) of section 3702.59 of the Revised Code to occur, the Director shall recognize the transfer of ownership of the entity granted the certificate of need to the new owner.

SECTION 5. (A) Subject to division (B) of this section, notwithstanding division (C)(8) of section 3702.52 of the Revised Code and any rules adopted by the Director of Health to the contrary, for a period of twenty-four months after the effective date of this section, the Director of Health shall not impose a civil monetary penalty against any person holding a certificate of need for obligating under the certificate a capital expenditure in an amount between one hundred ten and one hundred fifty per cent of the approved project cost.

(B) This section applies to any certificate of need that was granted on or before the effective date of this section and for which the Director of Health is still monitoring the activities of the person granted the certificate.

Speaker _____ of the House of Representatives.

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

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Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____