

1 STATE OF OKLAHOMA

2 1st Session of the 59th Legislature (2023)

3 COMMITTEE SUBSTITUTE  
4 FOR

5 SENATE BILL 513

By: Rosino and Garvin of the  
Senate

6 and

7 Miller and Fugate of the  
8 House

9  
10 COMMITTEE SUBSTITUTE

11 An Act relating to biomarker testing; defining terms;  
12 requiring coverage of biomarker testing under certain  
13 conditions; requiring certain contract to be provided  
14 with policy; directing plan to limit disruptions in  
15 care with certain evidence; requiring plan to publish  
16 accessible process on certain website for certain  
17 requests; construing provision; amending 56 O.S.  
18 2021, Section 4002.6, as amended by Section 10,  
19 Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2022, Section  
20 4002.6), which relates to the state Medicaid program;  
21 clarifying certain prior authorization requirement;  
22 updating statutory language; defining terms;  
23 requiring certain coverage and provision of biomarker  
24 testing; stipulating prior authorization requirements  
for biomarker testing; directing creation of process  
to request exceptions to certain coverage policies;  
providing for codification; and providing an  
effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

1           SECTION 1.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 6060.5a of Title 36, unless  
3 there is created a duplication in numbering, reads as follows:

4           A. As used in this section:

5           1. "Biomarker" means a biological molecule found in blood,  
6 other body fluids, or tissues that is a sign of a normal or abnormal  
7 process, or of a condition or disease. A biomarker may be used to  
8 see how well the body responds to a treatment for a disease or  
9 condition or for other purposes. Biomarkers shall include but are  
10 not limited to gene mutation or protein expression;

11           2. "Biomarker testing" means the analysis of a patient's  
12 tissue, blood, or other biospecimen for the presence of a biomarker.  
13 Biomarker testing shall include but not be limited to single-analyte  
14 tests, multiplex panel tests, gene or protein expression, and whole  
15 exome, whole genome, and whole transcriptome sequencing;

16           3. "Consensus statement" means a statement that:

17           a. is developed by an independent, multidisciplinary  
18 panel of experts that use a transparent methodology  
19 and reporting structure that includes a conflict of  
20 interest policy,

21           b. is based on the best available evidence for the  
22 purpose of optimizing clinical care outcomes, and

23           c. is aimed at specific clinical circumstances;  
24

1 4. "Health benefit plan" means a plan as defined pursuant to  
2 Section 6060.4 of Title 36 of the Oklahoma Statutes; and

3 5. "Nationally recognized clinical practice guidelines" means  
4 evidence-based clinical practice guidelines that:

5 a. are developed by independent organizations or medical  
6 professional societies using a transparent methodology  
7 and reporting structure and a conflict of interest  
8 policy, and

9 b. establish standards of care that are informed by a  
10 systemic review of evidence and an assessment of the  
11 benefits and costs of alternative care options that  
12 includes recommendations intended to optimize patient  
13 care.

14 B. Any health benefit plan, including the Oklahoma Employees  
15 Insurance Plan, that is offered, issued, or renewed in this state on  
16 or after the effective date of this act shall provide coverage for  
17 biomarker testing. A contract provided with a health benefit plan  
18 under this section shall include biomarker testing for the purpose  
19 of diagnosis, treatment, appropriate management, or ongoing  
20 monitoring of an insured's disease or condition to guide treatment  
21 decisions when the biomarker test is supported by medical and  
22 scientific evidence including, but not limited to:

23 1. Labeled indications for tests that are approved or cleared  
24 by the United States Food and Drug Administration;

1           2. Indicated tests for a drug that is approved by the United  
2 States Food and Drug Administration;

3           3. Warnings and precautions on United States Food and Drug  
4 Administration approved drug labels;

5           4. Centers for Medicare and Medicaid Services national coverage  
6 determinations or Medicare administrative contractor local coverage  
7 determinations; or

8           5. Nationally recognized clinical practice guidelines and  
9 consensus statements.

10          C. A health benefit plan shall ensure that coverage is provided  
11 in a manner that limits disruptions in care, including the need for  
12 multiple biopsies and biospecimen samples.

13          D. An insured and a prescribing practitioner shall have access  
14 to a clear, readily available, and convenient process to request an  
15 exception to a coverage policy of a health benefit plan under this  
16 subsection. The process shall be readily accessible on the plan's  
17 website. This subsection shall not be construed to require a  
18 separate process if the health benefit plan's existing process  
19 complies with this subsection.

20          SECTION 2.           AMENDATORY           56 O.S. 2021, Section 4002.6, as  
21 amended by Section 10, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2022,  
22 Section 4002.6), is amended to read as follows:

23          Section 4002.6. A. A contracted entity shall meet all  
24 requirements established by the Oklahoma Health Care Authority

1 pertaining to prior authorizations. The Authority shall establish  
2 requirements that ensure timely determinations by contracted  
3 entities when prior authorizations are required including expedited  
4 review in urgent and emergent cases that at a minimum meet the  
5 criteria of this section.

6 B. A contracted entity shall make a determination on a request  
7 for an authorization of the transfer of a hospital inpatient to a  
8 post-acute care or long-term acute care facility within twenty-four  
9 (24) hours of receipt of the request.

10 C. A contracted entity shall make a determination on a request  
11 for any member who is not hospitalized at the time of the request  
12 within seventy-two (72) hours of receipt of the request; provided,  
13 that if the request does not include sufficient or adequate  
14 documentation, the review and determination shall occur within a  
15 time frame and in accordance with a process established by the  
16 Authority. The process established by the Authority pursuant to  
17 this subsection shall include a time frame of at least forty-eight  
18 (48) hours within which a provider may submit the necessary  
19 documentation.

20 D. A contracted entity shall make a determination on a request  
21 for services for a hospitalized member including, but not limited  
22 to, acute care inpatient services or equipment necessary to  
23 discharge the member from an inpatient facility within one (1)  
24 business day of receipt of the request.

1 E. Notwithstanding the provisions of subsection C of this  
2 section, a contracted entity shall make a determination on a request  
3 as expeditiously as necessary and, in any event, within twenty-four  
4 (24) hours of receipt of the request for service if adhering to the  
5 provisions of subsection C or D of this section could jeopardize the  
6 member's life, health or ability to attain, maintain or regain  
7 maximum function. In the event of a medically emergent matter, the  
8 contracted entity shall not impose limitations on providers in  
9 coordination of post-emergent stabilization health care including  
10 pre-certification or prior authorization.

11 F. Notwithstanding any other provision of this section, a  
12 contracted entity shall make a determination on a request for  
13 inpatient behavioral health services within twenty-four (24) hours  
14 of receipt of the request.

15 G. A contracted entity shall make a determination on a request  
16 for covered prescription drugs that are required to be prior  
17 authorized by the Authority within twenty-four (24) hours of receipt  
18 of the request. The contracted entity shall not require prior  
19 authorization on any covered prescription drug for which the  
20 Authority does not require prior authorization.

21 H. A contracted entity shall make a determination on a request  
22 for coverage of biomarker testing in accordance with Section 3 of  
23 this act.

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1        I. Upon issuance of an adverse determination on a prior  
2 authorization request under subsection B of this section, the  
3 contracted entity shall provide the requesting provider, within  
4 seventy-two (72) hours of receipt of such issuance, with reasonable  
5 opportunity to participate in a peer-to-peer review process with a  
6 provider who practices in the same specialty, but not necessarily  
7 the same sub-specialty, and who has experience treating the same  
8 population as the patient on whose behalf the request is submitted;  
9 provided, however, if the requesting provider determines the  
10 services to be clinically urgent, the contracted entity shall  
11 provide such opportunity within twenty-four (24) hours of receipt of  
12 such issuance. Services not covered under the state Medicaid  
13 program for the particular patient shall not be subject to peer-to-  
14 peer review.

15        ~~I.~~ J. The Authority shall ensure that a provider offers to  
16 provide to ~~an enrollee~~ a member in a timely manner services  
17 authorized by a contracted entity.

18        ~~J.~~ K. The Authority shall establish requirements for both  
19 internal and external reviews and appeals of adverse determinations  
20 on prior authorization requests or claims that, at a minimum:

21        1. Require contracted entities to provide a detailed  
22 explanation of denials to Medicaid providers and members;

23        2. Require contracted entities to provide a prompt opportunity  
24 for peer-to-peer conversations with licensed clinical staff of the

1 same or similar specialty which shall include, but not be limited  
2 to, Oklahoma-licensed clinical staff upon adverse determination; and

3 3. Establish uniform rules for Medicaid provider or member  
4 appeals across all contracted entities.

5 SECTION 3. NEW LAW A new section of law to be codified  
6 in the Oklahoma Statutes as Section 4003 of Title 56, unless there  
7 is created a duplication in numbering, reads as follows:

8 A. As used in this section:

9 1. "Biomarker", "biomarker testing", "consensus statement", and  
10 "nationally recognized clinical practice guidelines" shall have the  
11 same meaning as provided by Section 1 of this act; and

12 2. "Contracted entity" shall have the same meaning as provided  
13 by Section 4002.2 of Title 56 of the Oklahoma Statutes.

14 B. The state Medicaid program shall cover biomarker testing in  
15 accordance with the requirements provided by this section.

16 C. Biomarker testing shall be covered for the purposes of  
17 diagnosis, treatment, appropriate management, or ongoing monitoring  
18 of a member's disease or condition when the test is supported by  
19 medical and scientific evidence, including, but not limited to:

20 1. Labeled indications for a Food and Drug Administration  
21 (FDA)-approved or -cleared test;

22 2. Indicated tests for an FDA-approved drug;

23 3. Warnings and precautions on FDA-approved drug labels;

24



1 4. Centers for Medicare and Medicaid Services (CMS) national  
2 coverage determinations or Medicare Administrative Contractor (MAC)  
3 local coverage determinations; or

4 5. Nationally recognized clinical practice guidelines and  
5 consensus statements.

6 D. Contracted entities under the state Medicaid program shall  
7 provide biomarker testing at the same scope, duration, and frequency  
8 as the Medicaid program otherwise provides to members.

9 E. If prior authorization is required for biomarker testing,  
10 the contracted entity shall approve or deny a prior authorization  
11 request and notify the member, the member's provider, and any entity  
12 requesting authorization of the service within seventy-two (72)  
13 hours for non-urgent requests or within twenty-four (24) hours for  
14 urgent requests.

15 F. The member and the member's provider shall have access to  
16 clear, readily accessible, and convenient processes to request an  
17 exception to a coverage policy for biomarker testing of the state  
18 Medicaid program. The process shall be made readily accessible to  
19 all participating providers and members online.

20 SECTION 4. This act shall become effective January 1, 2024.

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