Senate Health and Human Services
February 21, 2025
2025-0554s
05/11

Amendment to SB 120-FN

Amend RSA 420-J:20, III-IV as inserted by section 1 of the bill by replacing it with the following:

III. "Clinical utility" means a biomarker test result that provides information used in the formulation of a treatment or monitoring strategy that informs a covered person's outcomes and impacts the treating provider's clinical decisions. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

IV. "Consensus statements" mean statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. These statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

V. "Nationally recognized clinical practice guidelines" mean evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

Amend RSA 420-J:21, II as inserted by section 1 of the bill by replacing it with the following:

II. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test provides clinical utility and is demonstrated by the following medical and scientific evidence, including but not limited to any of the following:

(a) Labeled indications for an FDA-approved or -cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

(e) Nationally recognized clinical practice guidelines and consensus statements.

Amend RSA 420-J:21, IV as inserted by section 1 of the bill by replacing it with the following:

IV. If utilization review, including but not limited to prior authorization, is required, the health carrier, utilization review entity, or any third party acting on behalf of an organization or entity subject to this subdivision shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider, and any entity requesting authorization of the service within 14 days for non-urgent requests or within 72 hours for urgent requests.

Amend RSA 167:4-g, II as inserted by section 2 of the bill by replacing it with the following:

II. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the department of health and human services determines that the test provides clinical utility, as defined in RSA 420-J:20, III and is demonstrated by the following medical and scientific evidence, including but not limited to any of the following:

(a) Labeled indications for an FDA-approved or -cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

(e) Nationally recognized clinical practice guidelines and consensus statements.

Amend RSA 167:4-g, V as inserted by section 2 of the bill by replacing it with the following:

V. If utilization review, including but not limited to prior authorization, is required, the state Medicaid plan, utilization review entity, or any third party acting on behalf of an organization or entity subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider, and any entity requesting authorization of the service within 14 days for non-urgent requests or within 72 hours for urgent requests.