As Introduced

136th General Assembly
Regular Session
2025-2026

S. B. No. 387

Senator Blessing

A BILL

To enact section 5167.124 of the Revised Code regarding coverage of pharmacogenomic testing by Medicaid managed care organizations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 5167.124 of the Revised Code be enacted to read as follows:

Sec. 5167.124. (A) As used in this section, "pharmacogenomic testing" means laboratory genetic testing, including single-gene and multi-gene panel testing, conducted to evaluate how an individual's genetic profile may impact the efficacy, safety, or toxicity of a prescribed drug, including drugs prescribed for the treatment of mental or behavioral health conditions.

(B) The department of medicaid shall include in the care management system pharmacogenomic testing that is considered to be medically necessary. For purposes of this section, pharacogenomic testing shall be considered medically necessary if all of the following criteria are satisfied:

(1) The pharmacogenomic testing is ordered by a treating prescriber of a medicaid enrollee who has been diagnosed with

depression or anxiety.

(2) A treating prescriber is considering a change, dose adjustment, or augmentation of a drug prescribed to a medicaid enrollee described in division (B)(1) of this section, and the drug or drugs under consideration have a known gene-drug interaction. A multi-gene panel shall be considered medically necessary if more than one gene on the panel has a known gene-drug interaction for the drug or drugs under consideration or if multiple drugs under consideration have different relevant gene interactions.

(3) The pharmacogenomic test is covered by the medicare program under a local coverage determination issued by a medicare administrative contractor.

(C)(1) A medicaid managed care organization may impose prior authorization requirements for pharmacogenomic testing, subject to section 5160.34 of the Revised Code and all of the following:

(a) Prior authorization requirements shall provide a clear and meaningful pathway to coverage and ensure timely testing for medicaid enrollees for whom testing is considered medically necessary.

(b) Prior authorization requirements shall require only the minimum amount of documentation from a treating prescriber that is necessary to confirm that pharmacogenomic testing is medically necessary.

(c) A laboratory test requisition form shall be considered part of the medical record. Only in instances where a test requisition form is missing information should additional clinic notes or medical records be required.

(d) Prior authorization requirements shall allow for a thirty-day authorization window following specimen collection for the submission of authorization requests and claims related to pharmacogenomic testing.

(2) Any prior authorization requirements established in accordance with division (C)(1) of this section shall not create undue administrative burdens or delays that create barriers to care for medicaid enrollees for whom testing is medically necessary.

(3) The department shall periodically review and monitor prior authorization requirements established in accordance with division (C)(1) of this section. The department may require a medicaid managed care organization to take corrective action if the department determines that a prior authorization requirement is overly restrictive or inconsistent with the requirements of this section.

(D)(1) Each medicaid managed care organization shall comply with the requirements of this section. The department may take any of the following actions against a medicaid managed care organization that violates any provision of this section:

(a) Impose a fine of up to ten thousand dollars per instance of noncompliance with the requirements of this section. The department may impose an additional penalty of one thousand dollars per day for each day of noncompliance following notification from the department.

(b) Require a medicaid managed care organization to submit and implement a corrective action plan within thirty days of receiving notice of a violation of this section. The department may suspend or terminate the contract of a medicaid managed care

organization that fails to implement a corrective action plan required under this section.

(c) Withhold payment to, reduce capitation rates for, or terminate the contract of a medicaid managed care organization found to be in persistent or egregious violation of this section.

(2) A medicaid managed care organization may appeal any penalty imposed under division (D)(1) of this section.

(E) The department shall establish a process for enrollees, prescribers, and laboratories to report instances of noncompliance with this section. The establishment of this process shall be in addition to the grievance procedures that each medicaid managed care organization must establish under section 5167.11 of the Revised Code.