AMENDED IN SENATE AUGUST 18, 2015

AMENDED IN ASSEMBLY JUNE 1, 2015

AMENDED IN ASSEMBLY APRIL 30, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 68

Introduced by Assembly Member Waldron

December 18, 2014

An act to add Section 14133.06 to the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 68, as amended, Waldron. Medi-Cal.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Covered benefits under the Medi-Cal program include the purchase of prescribed drugs, subject to the Medi-Cal List of Contract Drugs and utilization controls.

This bill, which would be known as the Patient Access to Prescribed Epilepsy Treatments Act, would subject, to the extent permitted by federal law, the denial of coverage by a Medi-Cal managed care plan of any drug in the seizure or epilepsy therapeutic drug class prescribed by a Medi-Cal beneficiary's treating provider to an ~~automatic~~ urgent appeal process, as specified, if the treating provider demonstrates that in his or her reasonable, professional judgment, the drug is medically

necessary and consistent with specified federal rules and regulations, and the drug is not on the Medi-Cal managed care plan formulary.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Patient Access to Prescribed Epilepsy Treatments Act.

SEC. 2. Section 14133.06 is added to the Welfare and Institutions Code, to read:

14133.06. (a) It is the intent of the Legislature in enacting this section that a Medi-Cal beneficiary shall have prompt access to medically necessary drugs for use in the treatment of seizures and epilepsy that have been approved by the federal Food and Drug Administration for use in the treatment of seizures or epilepsy, including drugs that are not on the formulary of a Medi-Cal managed care plan or that are subject to prior authorization.

(b) To the extent permitted by federal law, if any drug used in the treatment of seizures and epilepsy as described in subdivision (a) is prescribed by a Medi-Cal beneficiary's treating provider for the treatment of seizures and epilepsy, and coverage for that prescribed drug is denied by a Medi-Cal managed care plan in which the beneficiary is enrolled, that denial shall be reviewed in accordance with this section.

(c) (1) The denial by a Medi-Cal managed care plan of a drug prescribed for the treatment of seizures and epilepsy and approved by the federal Food and Drug Administration for the use in the treatment of seizures and epilepsy is subject to the ~~automatic~~ urgent appeal process described in paragraph (2), if the treating provider demonstrates, consistent with federal law, that in his or her reasonable, professional judgment, the drug is medically necessary and consistent with the federal Food and Drug Administration's labeling and use rules and regulations, as supported in at least one of the official compendia identified in Section 1927(g)(1)(B)(i) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(g)(1)(B)(i)), and the drug is not on the formulary for the Medi-Cal managed care plan.

(2) In a case in which a plan denies coverage for a drug prescribed for the treatment of seizures and epilepsy and approved

by the federal Food and Drug Administration for the use in the treatment of seizures and epilepsy, the beneficiary shall be entitled to an ~~automatic~~ urgent appeal. For purposes of this section, ~~"automatic urgent~~ *"urgent* appeal" means an appeal in which ~~the plan immediately notifies the department of the denial of coverage, and the beneficiary is not required to take any further action.~~ *the beneficiary, or treatment provider with the consent of the beneficiary, requests an urgent appeal either orally or in writing.* An ~~automatic~~ urgent appeal shall be resolved *by the plan* within ~~48~~ *24* hours after ~~denial by the plan. The 48-hour~~ *the plan receives the request. The 24-hour* period specified in this paragraph shall be in addition to any time prescribed by federal law.

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