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Robert A. Malson
President

September 29, 2008

Mr. Robert T. Maruca
Senior Deputy Director
Medical Assistance Administration
Department of Health
825 North Capitol Street, NE, 5th Floor
Washington, DC 20002

Dear Mr. Maruca:

 Thank you for giving the District of Columbia Hospital Association (DCHA) the opportunity to provide comments on the proposed Medical Necessity rule for the Medicaid program. Our hospitals appreciate your efforts to put forth a rule that will provide additional guidance to providers as they work to ensure the best possible care. After a comprehensive review, our hospitals believe that there are significant problems with parts of the rule as written. We urge you to reconsider the following sections of the proposed rule:

Section 9000.2(a)(ii)

While we appreciate the Administration's efforts to provide a comprehensive list of treatment guidelines, the definition of "medical evidence" provided in Section 9000.8(h) and referenced in Section 9000.2 (a)(ii) allows for too much interpretation to ensure a standardized level of care for all patients or to provide any real guidance for providers. Our providers would prefer a more specific statement of what criteria will primarily be used to ensure consistency and inter-rater reliability among decision makers. We suggest the use of an industry-standard, objective utilization criteria—such as Interqual—for making medical necessity decisions. The more standardized the process and the criteria, the more likely the outcomes will be fair and to providers and patients.

Section 9000.2(b)

Legislation recently enacted by the District of Columbia's City Council, the SafeRx Act of 2007, requires providers to inform patients when a drug is prescribed for off-label purposes. As such, the District recognizes the legitimacy and necessity of off-label prescribing. Section 9000.2b creates a tiered system where off-label use is not available for fee-for-service Medicaid patients. This is especially troubling for pediatric patients for whom off-label prescribing is more likely the norm rather than the exception. Applying a Medicare standard to pediatrics is not a workable approach. Providers need the assurance of some flexibility to prescribe medications in a way that is best suited for the care of their patients. As long as the family is aware of the off-label use--as per District law--and provides informed consent, the physician should have the flexibility to prescribe medications in the manner that is best for each individual patient.

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Sections 9000.10 and 9001.1

These sections should be amended to provide language to limit retrospective coverage determinations of medical necessity to those services that have not already received prior or current authorization. Although we recognize the Administration's authority to review coverage determinations for appropriateness, providers and patients should have some security to give and receive needed services without the fear that an authorized service will later be denied. We request that Section 9000.10 be reworded to state that: "a medical necessity coverage determination may be prospective, concurrent or retrospective, in the case that prospective or concurrent authorization has not already been provided." We further request that Section 9001.1 be reworded accordingly to reflect this intent.

Section 9003.2

Although we recognize the Administration's authority to review coverage determinations for appropriateness, concurrent utilization review is an administrative burden to providers. With the use of DRG reimbursement methodology, such review is not necessary until a patient reaches the 7-10 day stay threshold. We would ask that such concurrent reviews, when conducted, be done in a way that is prudent and reasonable.

Section 9003.4

In order to give patients and physicians as many options as possible in pursuing a course of treatment and/or in filing an appeal, decisions of medical necessity or adverse determination should be issued both verbally and in writing; the verbal notification should be issued immediately.

DCHA strongly believes that the Medical Necessity rule must be a useful and credible document that reflects the Administration's desire to provide a needed framework to the Medicaid program. In the current state, however, the rule fails in several respects to provide enough flexibility for patient treatment or certainty for the financial considerations of providers and hospitals. We urge you to reconsider the sections outlined above before releasing the next iteration of this rule.

Sincerely,



Robert A. Malson
President

cc: John McCarthy