Medicaid Enrollees

SPEAK UP

Bobbie has fought with Medicaid for 18 months to cover the oxygen her daughter needs to attend school. Medicaid denied the claim, forcing the Mathews family to go $10,000 in debt to pay for this vital oxygen.

Bobbi, Age 52

Bobbi's youngest child, Katie, has DiGeorge Syndrome. Katie, now 13 years old, is on Medicaid, which pays for her frequent hospitalizations and home nursing care. However, Medicaid denied the claim for the oxygen Katie needs to be able to attend school. Bobbie is appealing the decision (an 18 month process so far) and is going into debt to pay for her daughter's oxygen. Katie's doctors believe this liquid oxygen is medically necessary, but Medicaid does not.

Medicaid takes a bad page from private insurance: denying claims

Bobbi, the proud mother of three children, works as a benefit specialist at a local company. Katie, the youngest, has DiGeorge Syndrome, a costly disease that caused Katie to reach the private insurance company's lifetime cap by the time she was 9.

To meet Katie's ongoing medical needs, Bobbi enrolled her daughter in Medicaid. This program has been vital for hospitalizations, home nursing care, and the different surgeries that Katie needs. Earlier this year, Katie spent 4 months in the intensive care unit, one of her many hospital stays. Otherwise, Katie needs liquid oxygen to be able to breathe and to attend school. Medicaid refuses to pay for the liquid oxygen, because there is a less expensive option (concentrator); however, Katie's doctor says the liquid oxygen is medically necessary for her situation. The Mathews family was forced to pay for it themselves, racking up $10,000 in debt. Bobbi has tried to appeal the denied claims, a process that has lasted 18 months without a resolution in sight. The Mathews family is caught between a rock and a hard place: they can't afford the oxygen Katie needs, but Medicaid refuses to pay for it.

A Policy Solution: Align Medicaid Financing Decisions with Evidence-Based Medicine

In many ways, Medicaid would do well to model itself more after the private insurance market—except in this case. Arbitrarily denying claims to cut costs results in a poor quality care for Medicaid recipients and, in Katie's case, diminished access to educational opportunity. Medicaid needs more transparency around the process for denying and approving claims. Also, an independent arbitrator or ombudsperson should be engaged to help beneficiaries navigate the appeals process.

Our state's already bare-bones Medicaid program is feeling pinched. Medicaid needs to find other ways to cut costs besides denying claims. One idea that has been raised in the health system reform context is the Health Benefits Commission, an ongoing process to re-align all treatment and financing decisions with evidence-based medicine.