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Medicaid Coverage of Emergency Medical Conditions: An Update

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Recent reports estimate that undocumented immigrants represent over 29 percent (over 10 million people) of the total foreign born population in the United States and that this percentage is growing.[1]

Officials in ten states surveyed by the United States General Accounting Office reported that most of the $2 billion they spent on emergency Medicaid services in fiscal year 2002 was attributable to undocumented aliens, particularly pregnant women's labor and delivery services.[2] These states also reported that emergency Medicaid expenditures, while a small portion of total Medicaid spending, have increased over the past several years.[3]

A more recent study of Medicaid expenditures in North Carolina found that total spending under emergency Medicaid increased 28 percent from 2001 through 2004, but accounted for less than one percent of total Medicaid spending each year.[4] In 2004, the vast majority of spending (82 percent) was for pregnant women; however, spending for the elderly and people with disabilities increased at a faster rate. In 2004, median expenditures were much higher for disabled patients ($8050), than for the elderly ($3603), pregnant women ($2993), families ($1774), or children ($1413). After pregnancy-related services, injury and poisoning accounted for about one third of the remaining spending. Renal failure, gastrointestinal disease and cardiovascular conditions were also noted categories of spending.[5]

This article discusses Medicaid coverage of emergency medical conditions for noncitizens. It describes the legal authority for coverage and addresses common issues.

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[1] *See* C. Annette DuBard and Mark W. Massing, *Trends in Emergency Medicaid expenditures for Recent and Undocumented Immigrants,* 297 J.A.M.A. 1085 (Mar. 14, 2007). (citing Pew Hispanic Center data).
[2] *See* United States General Accounting Office, *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs* at 10 (May 2004) (GAO 04-472) [hereinafter *Undocumented Aliens*].
[3] *Id.* at 11.
[4] *See* C. Annette DuBard and Mark W. Massing, *Trends in Emergency Medicaid expenditures for Recent and Undocumented Immigrants,* 297 J.A.M.A. 1085 (Mar. 14, 2007).
[5] *Id.* at 1087-88.

I. History of the emergency Medicaid provisions

As enacted in 1965, the Medicaid Act did not address the availability of Medicaid to noncitizens. The Department of Health, Education and Welfare (predecessor to the Department of Health and Human Services) interpreted the statute to allow coverage.[6] However, in 1973, Congress amended the Social Security Act to deny social security benefits to noncitizens,[7] and the Department issued a regulation that also denied any Medicaid eligibility to any noncitizen who was not a permanent resident or otherwise permanently residing in the United States under color of law.[8]

In 1986, a federal district court in New York held that the regulation violated the Medicaid statute.[9] Congress responded by amending the Medicaid Act to exclude certain "aliens" from receiving full scope Medicaid assistance but also requiring that Medicaid payments "shall be made" if:[10]

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan . . ., and

(C) such care and services are not related to an organ transplant procedure.[11]

The Act defines the term "emergency medical condition" to mean a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in-

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily function, or

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[6] *See, e.g.,* predecessor regulation 42 C.F.R. § 435.402 (regarding eligibility in the states, District of Columbia, Northern Mariana Islands, and American Samoa) and § 436.402 (regarding eligibility in Guam, Puerto Rico and the Virgin Islands). *See generally* Coye v. U.S. Dept. of Health and Human Services, 973 F.2d 786 (9th Cir. 1992) (finding § 435.402 to be a valid implementation of congressional intent).

[7] *See* Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1471 (1972).

[8] *See* 38 Fed. Reg. 30,259 (1973).

[9] *See* Lewis v. Gross, 663 F. Supp. 1164, 1184 (E.D. N.Y. 1986). For full case history, *see* Lewis v. Thompson, 252 F.3d 567 (2d Cir. 2001).

[10] *See* 42 U.S.C. § 1396b(v), added by Omnibus Budget Reconciliation Act of 1986, § 9406(c) (referring to aliens not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law). The legislative history refers to the *Lewis* decision. *See* H.R. Rep. No. 99-727, at 111, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3701 (1986).

[11] 42 U.S.C. § 1396b(v)(2)(A)-(C) (2004). Subsection (C) was added to exclude organ transplant procedures. *See* Omnibus Budget Reconciliation Act of 1993, § 13604(a), Pub. L. No. 103-66, 107 Stat. 312, 621 (1993), *see also* 8 U.S.C. § 1621(b)(1). The amendment followed a California court requiring coverage of the bone marrow transplant and follow-up care of an immigrant as an emergency medical condition. *See* Dominguez v. Kizer, 276 Cal. Rptr. 564 (Cal. Ct. App. 1990).

(C) serious dysfunction of any bodily organ or part.[12]

The implementing federal regulation tracks the statute, with one important addition—services are limited to those required "after the sudden onset" of a medical condition.[13]

One final legislative action is worth noting. The Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) denies full scope Medicaid benefits to most immigrants.[14] PRWORA divides noncitizens into two groups, qualified and nonqualified aliens. Qualified aliens are further divided into two groups: those lawfully residing in the United States before August 22, 1996, and those arriving in the country after August 22, 1996. Those falling within the former group are eligible for full scope Medicaid benefits while those in the latter group are ineligible for Medicaid for a period of at least five years.[15] Persons who enter the United States without the proper documentation, "nonqualified aliens," are also ineligible for full scope Medicaid benefits. Notwithstanding these disqualifications, both nonqualified aliens and qualified aliens, during the ineligibility period, are eligible for Medicaid coverage of emergency medical conditions.

The PRWORA did not amend the definition of term "emergency medical condition" that had been added to the Medicaid Act by Congress in 1986.[16] However, the PRWORA House Conferees stated their intent that this coverage to be limited:

> The allowance for emergency medical services under Medicaid is very narrow. The conferees intend that it only apply to medical care that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit. The conferees do not intend that emergency medical services include prenatal or delivery care assistance that is not strictly of an emergency nature. . . .[17]

Thus, while greatly reducing the number of persons who are eligible for full Medicaid

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[12] 42 U.S.C. § 1396b(v)(3)(A)-(C) (2004). This same definition is used in the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires each Medicare-participating hospital with an emergency room to conduct a medical examination for any patient who comes to the emergency room to determine if an emergency medical condition exists, to provide stabilizing treatment, and to transfer or discharge the patient only if stabilized. *See* 42 U.S.C. § 1395dd.

[13] *See* 42 C.F.R. § 440.255(c)(1). *See also* 42 C.F.R § 435.406 (regarding eligibility in the states, District of Columbia, Northern Mariana Islands, and American Samoa) and § 436.406 (regarding eligibility in Guam, Puerto Rico, and the Virgin Islands). These regulations replaced the predecessor regulations, 42 C.F.R. §§ 435.402 and 436.402. *See also* CMS, *State Medicaid Manual* § 3211.11 (providing that emergency care or services cannot be "related to either an organ transplant procedure or routine prenatal or post-partum care" and also including requirement that condition have "sudden onset").

[14] *See* 8 U.S.C. §§ 1611(a), 1611(c)(2)(B) (listing qualified alien categories), 1641(c)(1)-(3) (including certain battered spouses and children as qualified aliens). *See* 8 U.S.C. §1611(b)(1)(A) (stating that an "alien who is not a qualified alien . . . is not eligible for any Federal public benefit" with an exception for Medicaid coverage of emergencies).

[15] *See* 8 U.S.C. §§ 1612(b), 1613(a). States can expand the period of ineligibility beyond five years. *Id.* at § 1612b(1).

[16] *See id.* at § 1611(b)(1)(A).

[17] H.R. Conf. Rep. No. 104-725, at 380, *reprinted in* 1996 U.S.C.C.A.N. 2649, 2768 (1996).

benefits, the PRWORA expanded the number of persons who may qualify for Medicaid coverage of their emergency conditions.[18]

II. Issues Surrounding Medicaid and EMCs

A number of questions have arisen about the extent to which Medicaid programs must cover noncitizens who may be experiencing an emergency medical condition. The remainder of this article discusses some of the most frequently raised issues.[19]

1. Application of state residency requirements

According to the Medicaid Act, emergency Medicaid is available to any alien, regardless of immigration status, provided they "otherwise meet[] the eligibility requirements for medical assistance under the State plan."[20] This means that the recipient must belong to a Medicaid-eligible category, such as pregnant women, children under age 19, and meet income and residency requirements. The federal rules require the recipient to be a resident of the state where they are applying for benefits.[21] For most individuals over age 21, this means the state where the individual is "[l]iving with the intention to remain there permanently or for an indefinite period of time."[22] For an individual under age 21 who is not institutionalized or emancipated, residency is that of the parent.[23]

States have denied Medicaid coverage for emergency medical conditions citing the residency provisions. The primary federal guidance document, the *State Medicaid Manual*, provides that "in some cases an alien in a currently valid non-immigrant classification may meet the State residence rules" and, thus, qualify for emergency Medicaid coverage.[24] This exception appears to be limited to noncitizens who hold certain employment authorization documents.[25] The Manual goes on provide that "[a]mong otherwise ineligible aliens" are visitors, tourists, foreign students, members of the foreign press and their families, some workers, and diplomats and their "families and servants" who are currently lawfully admitted as legal non-immigrants.[26]

Courts have generally affirmed states' refusals to cover emergency conditions based on the non-resident status of the noncitizen.[27] In *Okale v. N.C. Department of Health and Human*

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[18] This change to the Medicaid program can be confusing because the Medicaid Act continues to allow full-scope Medicaid coverage for persons "lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law." 42 U.S.C. § 1396b(v)(1).

[19] *See generally* U.S. General Accounting Office, *Undocumented Aliens, supra* n. 1. The GAO also looks at coverage of undocumented aliens through disproportionate share hospital adjustments, 42 U.S.C. § 1396r-4, and through Homeland Security/Border Patrol coverage of emergency medical expenses of persons in the custody of immigration authorities, 42 U.S.C. § 249.

[20] 8 U.S.C. § 1611(b)(1)(A).

[21] *See* 42 C.F.R. § 435.403.

[22] *Id.* at § 435.403(i)(1)(i).

[23] *Id.* at § 435.403(h)(3). For background discussion, *see* 55 Fed. Reg. 36,813, 36,814 (Sept. 7, 1990) (comparing alien and homeless residency requirements).

[24] CMS, *State Medicaid Manual* § 3211.10 (Feb. 1997).

[25] *Id.* (listing Form I-688B or Form I-766).

[26] *Id.* (listing the various types of INS documentation).

[27] *See, e.g.,* Clark v. Div. of Social Services, No. COA02-1278, 2003 N.C. App. LEXIS 1855 (N.C. Ct. App. 2003), *review denied,* 358 N.C. 153 (NC 2004) (denying coverage of dialysis treatment costs for woman

Services,[28] the Medicaid agency refused to recognize the costs associated with childbirth. At the time of the child's birth, she had entered into a lease agreement, opened a checking account, and obtained an identification card and driver's license. The North Carolina Court of Appeals affirmed the denial of coverage finding that Ms. Okale was lawfully in the United States on an unexpired tourist visa at the time of the request for Medicaid payment and, thus, neither she nor her son met the test for state residency.[29] Rejecting the evidence of her intent to remain in North Carolina, the court found that the "unexpired tourist temporary visa creates the verification to doubt Okale's asserted intent to remain in the state. To hold otherwise, we must presume that Okale will violate the law and attempt to illegally stay beyond her latest declared date of departure from this state and country."[30]

2. Application of verification requirements

Noncitizens have complained that they are being asked to submit social security numbers and other verification of eligibility at the time emergency medical services are needed. These activities add to the fear of being discovered by immigration authorities, which is already a significant barrier to care for many noncitizens.[31]

According to federal law, noncitizens who are eligible only for emergency Medicaid need not provide documentation to establish satisfactory immigration status or furnish social security numbers.[32] Thus, the application process should not seek this information, and emergency care providers should not attempt to verify an alien's immigration status as a condition of receipt of emergency services.

A California court allowed that state to require all applicants, including those for restricted benefits, to declare under penalty of perjury whether they are or are not a citizen or an alien with satisfactory immigration status and to provide their social security number unless they declare that they are neither a citizen nor an alien with satisfactory immigration status. According to *Crespin v. Coye*, "Nothing in these provisions precludes the state . . . from requiring an applicant to affirmatively *deny* that he or she has satisfactory immigration status in order to be excused from providing a Social Security number."[33]

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who entered the country on a tourist visa but had applied for asylum before the visa expired); Okale v. N.C. Department of Health and Human Services, 153 N.C. App. 475, 570 S.E. 2d 741 (2002); Salem Hosp. v. Comm'r of Public Works, 410 Mass. 625, 574 N.E.2d 385 (Sup. Jud. Ct. 1991) (upholding residency requirement for noncitizens).

[28] 153 N.C. App. 475, 570 S.E.2d 741 (2002).

[29] 153 N.C. App. at 480, 570 S.E.2d at 744.

[30] 153 N.C. App. at 481, 570 S.E.2d at 745.

[31] *See, e.g,* U.S. General Accounting Office, *Undocumented Aliens, supra* n. 1, at 12 (noting that state Medicaid offices and hospital associations attributed fear of being discovered by immigration authorities as a reason noncitizens do not obtain Medicaid).

[32] *See* 42 U.S.C. § 1320b-7(f). *See also* 55 Fed. Reg. 36,813, 36,815 (Sept. 7, 1990) (preamble) (noting that rules are being revised to remove requirement for social security number and that federal law also has removed the requirement that the noncitizen sign the declaration of satisfactory immigration status and have their immigration status verified with INS); Dept. of Health and Human Services and Department of Agriculture, *Dear State Health and Welfare Officials* (Sept. 21, 2000) (on file with National Health Law Program) (policy guidance regarding inquiries into citizenship status).

[33] 34 Cal. Rptr. 2d at 17. In county offices, noncitizens complete an application for benefits, which asks them to declare citizenship or satisfactory immigration status and whether the applicant has a Social

Although the federal Medicaid agency does not require it, states such as California, Massachusetts, and Washington have avoided the confusion that can surround eligibility questions at the time of an emergency by allowing noncitizens to pre-qualify for emergency Medicaid.[34] For example, the State of Washington has an Alien Emergency Medical Program that allows individuals to qualify for restricted Medicaid coverage for three month periods, if they continue to meet the Medicaid eligibility requirements (except for providing Social Security number, citizenship or alien status).[35]

3. Coverage of pregnancy-related services

The Medicaid Act's definition of "emergency medical condition" limits the term to "medical condition[s] (including emergency labor and delivery). . . ."[36] Pregnant women have questioned the extent to which the benefit includes pregnancy-related services, such as prenatal and post partum care. In *Lewis v. Thompson*,[37] the Second Circuit Court of Appeals found that Medicaid coverage of emergency medical conditions is narrow and does not include conventional prenatal care.[38] The Court did find that the citizen children of excluded pregnant women must be accorded automatic eligibility on terms as favorable as those available to the children of citizen mothers.[39]

Questions have also been raised regarding coverage of scheduled cesarean deliveries. A recent statement from the Centers for Medicare & Medicaid Services (CMS) Regional Office allows states to deny payment for this service.[40] The CMS position rests, in part, on the House

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Security number. *See* California Department of Health Services, *Statement of Citizens, Alienage, and Immigration Status* (Nov. 1999) (MC-13), *available at* http://www.dhs.ca.gov/publications/forms/pdf/mc013.pdf.

[34] *See* California Department of Health Services, *Medi-Cal New Mail-In Application and Instructions* at 5 (Aug. 2001) (mail in application), *available at* http://www.dhs.ca.gov/mcs/medi-calhome/images/MC210.1jpg. Massachusetts allows individuals to apply annually for emergency Medicaid using the uniform application form. Nonqualified immigrants receive the MassHealth card that the provider swipes to determine the scope of coverage. E-mail from Vicky Pulos, Mass. Law Reform Institute, to Jane Perkins, NHeLP (June 15, 2004) (on file with author). At least one state allows undocumented women to enroll in Medicaid during their third trimester of pregnancy. U.S. General Accounting Office, *Undocumented Aliens, supra* n.1, at 12 n.15. Such processes are consistent with the federal agency's acknowledgement that these individuals are in a "special eligibility group" that is eligible for Medicaid with services limited to those specified in § 1396b(v). *See* 55 Fed. Reg. 36,813, 36,816 (Sept. 7, 1990).

[35] *See* Wash. State Department of Social & Health Services, *Eligibility A-Z Manual* at § F (describing W.A.C. 388-438-0110, alien emergency medical program) (Jan. 18, 2004), *available at* http://www1.dshs.wa.gov/esa/EAZManual/Sections/EA_AlienMedical.htm.

[36] 42 U.S.C. § 1396b(v)(3) (2004).

[37] 252 F.3d 567 (2d Cir. 2001).

[38] *Id.* at 580.

[39] *Id.* at 591. *See also* Doe v. Wilson, 67 Cal. Rptr. 2d 187 (Cal. Ct. App. 1 Dist. 1997) (allowing state to terminate coverage of routine prenatal care of illegal immigrants); Doe v. Wilson, No. C-97-2427, 1997 U.S. Dist. LEXIS 21137 (N.D. Cal. Dec. 15, 1997) (finding state termination of coverage for routine prenatal care of undocumented immigrants did not violate Tenth Amendment or Guarantee Clause of the U.S. Constitution).

[40] Letter from Andrew A. Fredrickson, Associate Regional Admin., Div. of Medicaid, Dallas Regional Office (Region VI [AR, LA, NM, OK, TX]), CMS, to Don Hearn, Medical Advocacy Services for Healthcare, Inc., Fort Worth, Tex. (Dec. 9, 2002) (on file with author). The letter says states are allowed to define emergency

Conferees' statement following passage of the 1996 PRWORA that coverage of emergencies is to be "very narrow."[41] The opinion is also based upon the federal regulatory requirement for "sudden onset" of the condition. However, the Medicaid Act does not require "sudden onset." Rather, it requires "acute symptoms of sufficient severity (including severe pain)" such that absence of immediate attention could result in placing the patient's health in serious jeopardy, serious dysfunction of any body part, or serious impairment of bodily function.[42] Congress used the same statutory definition of emergency medical condition for purposes of the Emergency Medical Treatment and Active Labor Act (EMTALA). Interestingly, while the Medicaid regulation includes the sudden onset requirement, the EMTALA regulation does not.[43]

The addition of a sudden onset requirement is not inconsequential. As noted by one court, the requirement draws a distinction between two classes of patients in need of emergency care and can eliminate coverage for the second class: (1) trauma victims whose symptoms have a very rapid onset, and (2) those who have suffered symptoms for a period of time before they evidence the need for immediate medical attention to preserve health, life or limb.[44]

4. Duration of an emergency medical condition

With respect to restricted Medicaid coverage, complex issues involve when an emergency medical condition ends. Federal guidance regarding the issue has refused to be definitive. According to an eligibility expert at CMS, the agency's position is that "each case needs to be evaluated on its own merits, and the determination of what constitutes an emergency medical service is left to the state Medicaid agency and its medical advisors."[45] With respect to optional Medicaid coverage of women with breast or cervical cancer, CMS has noted that these cancers may be identified at various stages:

> Some women in need of treatment for breast or cervical cancer will have an emergency condition. As with other examples of emergency medical conditions, medical judgement and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.[46]

Over the years, a handful of courts have been asked to decide whether a noncitizen's medical condition qualified as an emergency. In most of these cases, there is no question that the patient has entered the facility because of an emergency. However, at some point the Medicaid

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"as they deem appropriate" to include scheduled cesareans. *Id.*

[41] *See* n. 15 and accompanying text, *supra*.

[42] 42 U.S.C. § 1396b(v)(3).

[43] *See* 42 U.S.C. § 1395dd(e)(1),42 C.F.R. § 489.24(b) (defining emergency medical condition as in the statute, with the addition of "psychiatric disturbances or symptoms of substance abuse").

[44] *See* Arizona Health Care Cost Containment System v. Carondelet, 188 Ariz. 266, 270, 935 P.2d 844, 848 (Ariz. Ct. App. 1996) (holding "AHCCCS administration has created a sudden onset requirement which improperly restricts the legislature's intended scope of coverage for medical emergencies").

[45] United States General Accounting Office, *Undocumented Aliens*, *supra* n. 1, at 13, 31-32. *See also* 55 Fed. Reg. 36813, 36816 (1990) (preamble) ("[T]he significant variety of potential emergencies and the unique combination of physical conditions and the patients' response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions.").

[46] Letter from Timothy M. Westmoreland, Director, Centers for Medicare & Medicaid Services, to Dear State Health Official (Jan. 4, 2001), *available at* http://www.cms.hhs.gov/states/letters/sho01041.asp.

agency has denied additional coverage, usually because the patient's condition has stabilized or is chronic. The disputes most frequently have involved patients who need treatment for traumatic brain injuries,[47] renal failure,[48] or cancer treatment.[49] Courts in Arizona, Connecticut and North Carolina have been most active.[50]

Courts have interpreted the coverage requirements differently. For example, in *Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System (AHCCCS)*,[51] the court emphasized the need to focus on each patient's medical condition. The initial injuries and treatments of the five plaintiff patients differed greatly. While each undisputedly entered the hospital in an emergency, AHCCCS denied payment at the point each patient was stabilized and transferred from an acute care ward to a rehabilitative ward.

The court found it impractical to base the decision of whether an emergency exists by simply focusing on stabilization of the initial injury or the type of ward on which the patient happens to be placed.[52] Rather, the court found that under the Medicaid Act the focus must be on whether the patient's current medical condition is manifesting (presently revealing) itself by acute (rapid and short-lived) symptoms such that absence of immediate attention could reasonably be expected to place the patient's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[53] A medical condition manifesting itself by chronic conditions would not qualify as an emergency, even though the absence of care could lead to one of the three consequences listed in the statute.[54] The case was remanded for further proceedings.

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[47] *E.g.* Greenery Rehabilitation Group, Inc. v. Hammon, 150 F.3d 226 (2d Cir. 1998); Scottsdale Healthcare v. Arizona Health Care Cost Containment Sys., 75 P.3d 91 (Ariz. 2003); Mercy Healthcare Arizona, Inc v. Arizona Health Care Cost Containment Sys., 181 Ariz. 95, 887 P.2d 625 (Ariz. Ct. App. 1994). *See generally* Montejo v. Martin Memorial Med. Center, No. 4D03-2638 (Fl. Dist. Ct. App. May 5, 2004) (finding that Medicare discharge planning laws, 42 U.S.C. § 1395xx and 42 C.F.R. § 482,32, require patients to be transferred only to an identified "appropriate facility" and holding these laws were violated when the hospital (despite a pending motion before the court) flew the patient to Guatamala, where appropriate treatment for the patient's traumatic brain injury was not available).

[48] *E.g.* Quiceno v. Dep't of Soc. Serv., 45 Conn. Supp. 580, 728 A.2d 553 (Conn. Super. Ct. 1999) (dialysis); Gaddam v. Rowe, 44 Conn. Supp. 268, 684 A.2d 286 (Conn. Super. Ct. 1995) (dialysis); Norwood Hosp. v. Comm'r of Public Welf., 417 Mass. 54, 627 N.E.2d 914 (Sup. Jud. Ct. 1994) (alcoholic liver disease and renal failure); Padilla v. Biedess, No. CIV 02-176-TUC-WOB (D. Ariz. Sept. 25, 2002) (class certification and preliminary injunction) (dialysis).

[49] *E.g.* Diaz v. Div. of Soc. Serv., 628 S.E.2d 1 (N.C. 2006), *rev'g,* 600 S.E.2d 877 (Ct. App. 2004); Szewczyk v. Dep't of Soc. Serv., 881 A.2d 259 (Conn. 2005), *rev'g*, 77 Conn. App. 38, 822 A.2d 957 (App. Ct. Conn. 2003); Luna v. Div. of Soc. Serv., 589 S.E.2d 917 (N.C. Ct. App. 2004); Medina v. Div. of Soc. Serv., 598 S.E.2d 707 (N.C. Ct. App. 2004); Rosales v. Dep't of Soc. Serv., 2001 Conn. Super. LEXIS 3642 (Conn. Super. Ct. 2001); Yale-New Haven Hosp. v. Dep't of Soc. Serv., 2000 Conn. Super. LEXIS 2177 (Conn. Super. Ct. 2000).

[50] *See* nn. 45-46, *supra*.

[51] 75 P.3d 91 (Ariz. 2003).

[52] 75 P.3d at 97.

[53] The court contrasts the Medicaid Act provisions with those contained in the federal anti-dumping statute, EMTALA, which do focus on whether the patient's condition is stabilized. *Id.* at 97 n.6.

[54] *Id.* at 97. The court said such coverage would amount to long term care, noting that a previous Arizona case had already found that coverage of long term care was not contemplated by the statute. *Id.* at 97-98 (citing Mercy Healthcare v. Arizona Health Care Cost Containment System, 181 Ariz. 98, 887 P.2d at 628 (Ariz. Ct. App. 1994).

In *Scottsdale*, the test focuses on both the patient's current condition and how that current condition may affect the health of the patient in the days to come, when measured against the three adverse consequences listed in the statute. The determination should rely on the expertise of health care providers.

Similar reasoning has been applied by the North Carolina Supreme Court. In *Diaz v. Division of Social Services*,[55] the patient arrived at the hospital in an emergency, experiencing nausea, vomiting, and bleeding gums. The symptoms were diagnosed as acute lymphocytic leukemia. Medicaid covered the first few days of hospitalization, but refused to cover subsequent treatment, which included chemotherapy. The North Carolina Supreme Court reversed the lower court, to hold that an emergency medical condition exists only so long as the condition manifests itself by acute symptoms at the time of treatment and requires immediate treatment to stabilize the condition, such that absence of the treatment would reasonably be expected to cause one of the three results listed in § 1396b(v).[56]

By a split vote, the Connecticut Supreme Court reached a different result based on similar facts. In *Szewczyk v. Department of Social Services*,[57] the majority noted that Mr. Szewczyk presented at the hospital with acute symptoms of leukemia and that, without chemotherapy, he would have died. The court held that an emergency medical condition existed because he required immediate medical treatment, without which his well-being would likely have been put in jeopardy. Interestingly, the supreme court reached its decision without discussing conflicting analysis from the state court of appeals, which had denied Medicaid payment finding, among other things, that coverage for an emergency medical condition lasted only until the direct harm that brought the plaintiff to the emergency room due to leukemia had been eliminated,[58] that the "fatal consequences of the discontinuance of . . . ongoing [dialysis] care does not transform into emergency medical care,"[59] and that neither inpatient chemotherapy treatment nor surgery to remove a tumor would be covered because the patients' conditions did not evidence the required "severity, temporality, and urgency."[60]

Notably, most of the decisions, regardless of how they rule, purport to rely on the leading

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[55] 628 S.E.2d 1 (N.C. 2006).

[56] *Id.* at 5.

[57] 881 A.2d 259, *rev'g,* 822 A.2d 957, 964 (Conn. Ct. App. 2003). For a similar, earlier holding, *see, Gaddam v. Rowe*, 44 Conn. Supp. 268, 272, 684 A.2d 286, 288 (Conn. Sup. Ct. 1995) (refusing to allow the "medical 'Russian roulette' that the state agency position requires, i.e. stop the [dialysis] payment, wait a short time for symptoms to recur, and then hope there is time to get the patient to the hospital to restart the treatment before the patient dies.").

[58] *See* Yale-New Haven Hosp. v. State Dep't of Soc. Serv., No. CV-9904955-48S, 2000 Conn. Super. LEXIS 2177 (Conn. Super. Ct., July 31, 2000).

[59] Quinceno v. Dep't of Soc. Servs., 45 Conn. Supp. 580, 728 A.2d 553 (Conn. Super. Ct. 1999).

[60] Rosales v. Dept. of Social Services, 2001 Conn. Super. LEXIS 3642 (Conn. Super. Ct. Dec 21, 2001) (concerning tumor surgery and noting that, while the plaintiff was extreme ill, her medical condition was not an emergency because the plaintiff could survive three days until the surgery could take place; remanding to determine whether plaintiff's post surgical abscess was a discrete emergency medical condition). For a similar, earlier case, *see* Norwood Hosp. v. Comm'r of Pub. Welfare, 417 Mass. 54, 627 N.E.2d 914 (Mass. 1994) (holding "emergency medical condition" did not include treatment for liver disease brought on by chronic alcoholism, finding that it did not matter whether patient came to the hospital that day or a week later because the outcome would probably have been the same).

case, from the Second Circuit Court of Appeals, *Greenery Rehabilitation Group Inc. v. Hammon.*[61] In *Greenery*, the court appears to find that an emergency medical condition exists only when an unstable patient requires constant care.[62] *Greenery* involved undocumented aliens who suffered sudden and serious head injuries, leaving them with debilitating conditions that required ongoing care. One plaintiff suffered severe brain damage and was a quadriplegic as a result of a car accident. She was tube-fed and totally dependent on nursing staff for eating, bathing, mobility, and monitoring. Another plaintiff experienced severe brain injury from a gunshot wound and was wheelchair bound, unable to speak, incontinent, and needed constant monitoring of his medications.

Despite their ongoing needs, the court of appeals held that coverage of emergency medical conditions for sudden traumatic brain injuries ended after the initial injury was stabilized and did not include the continuous and regimented treatment of the patients' subsequent symptoms. In reaching its decision, the court read the statute's requirements for "acute symptoms" and "immediate medical attention" to require the condition to exhibit severity, temporality and urgency.[63] According to *Greenery*, the care at issue in the case did not need to be covered by Medicaid because "the statutory language unambiguously conveys the meaning that emergency medical conditions are sudden, severe and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm."[64]

6. Relief for disproportionate providers

Some states' Medicaid programs serve a disproportionate number of noncitizens. Recent federal legislation has provided some redress to selected states; however, these enactments are time limited and do not guarantee continued relief.

The Balanced Budget Act of 1997 first acknowledged the disproportionate amount of emergency care that some states are providing to noncitizens. The legislation provided for distribution of additional federal funding of $25 million, for each fiscal year 1998 through 2001, among the twelve states having the greatest number of undocumented aliens.[65] States could use these funds toward the emergency expenses of any undocumented aliens, but the majority of states reported using their entire payment to recover a portion of what the state had already paid for undocumented aliens as emergency Medicaid.[66]

Similarly, the recent Medicare drug coverage legislation includes funding for providers who serve undocumented aliens who are unable to pay for EMTALA-required care.[67] The Act

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[61] 150 F.3d 226 (2d Cir. 1998), *rev'g*, 893 F. Supp. 1196 (N.D. N.Y. 1995).

[62] *See, e.g., Scottsdate Healthcare*, 75 P.2d at 95, n.9 (describing *Greenery*).

[63] 150 F.3d at 232.

[64] *Id.*

[65] *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4723, 111 Stat. 251, 515. *See also* 63 Fed. Reg. 10400 (Mar.3, 1998) (announcing the state federal fiscal year allotments). The qualifying states were California, Texas, New York, Florida, Illinois, New Jersey, Arizona, Massachusetts, Virginia, Washington, Colorado, and Maryland.

[66] *See* U.S. General Accounting Office, *Undocumented Aliens, supra* n. 1, at 14.

[67] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432. *See also, e.g.*, 69 Fed. Reg. 13045 (Mar. 19, 2004) (Notice) (announcing a March 29, 2004 "open door listening session" to receive comments on methods and procedures for implementing § 1011).

provides $250 million per year for fiscal years 2005 through 2008 for payments to eligible providers for emergency health services to undocumented aliens. Two-thirds of the funds will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented aliens. The amount of money set aside for each state will be paid directly to eligible hospitals, physicians and ambulance providers. Payment amounts will be the lesser of (1) the amount the provider shows was incurred for emergency services or (2) amounts determined using a methodology developed by the Secretary of Health and Human Services.

Conclusion

Medicaid coverage of most noncitizens is limited to emergency medical conditions. Given the demand for this coverage, it is not surprising that disputes arise as to whether a given treatment is for an emergency. While there have been various statements of the legal standard, the application that tracks the Medicaid Act results in a two-step process: It must, first, be determined whether the presenting condition (including labor and delivery) initially manifests itself by "acute symptoms (including severe pain)" and, if so, then Medicaid must cover services for treatment of that medical condition so long as absence of immediate treatment of that condition could reasonably be expected to result in placing the patients' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. In applying the test, it is important for decision makers to assess the individual facts of each case and to give great deference to the statements of the treating health care providers.