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Emergency?

How the Federal Focus on Emergency Care Shifts the Cost of Immigrant Healthcare to Public Hospitals

*Introduction by Angela Epolito**

I. INTRODUCTION

Mr. Robert Earley, Senior Vice President of John Peter Smith Health Network (“JPS”), enlightened guests at the Beazley Institute’s First Annual Symposium on Access to Health Care by sharing his first hand experiences with challenges faced by a public hospital treating a large number of undocumented immigrants. At JPS, Mr. Earley oversees the departments of Government Affairs, Strategic Planning, Volunteer Services, Public Relations, and Health Promotions. Mr. Earley’s experience as an aide on Capital Hill, along with the ten years he spent as an elected official in the Texas House of Representatives, make him very familiar with the highly politicized debate over immigration.

In his presentation, Mr. Earley spoke of his experience at JPS Health Network, a large public hospital in Tarrant County, Texas. In Tarrant County, the immigration debate that so often colors the national news translates into a day-to-day reality for healthcare providers striving to care for those in need. At the same time, these providers are forced to deal with limited federal funding and political pressure to restrict the social services available to undocumented immigrants. Mr. Earley noted that hospitals and healthcare systems in Tarrant County are faced with a dramatic influx of undocumented immigrant patients, many of whom do not have private health insurance and are largely ineligible for government sponsored health care due to their legal status.

The JPS Health Network offers a charity care program, JPS Connection, to U.S. Citizens and Tarrant County residents who have an income below 250 percent of the federal poverty level and lack primary health insurance.

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In 2007, Mr. Earley spearheaded an aggressive evaluation of the citizenship requirements of JPS' charity care program. Mr. Earley described the process JPS went through to explore the option of opening the program to non-citizens and explained the health system's ultimate determination that the cost would simply be too much for the institution to bear. Mr. Earley's presentation at the Symposium provided insight into one hospital's approach to balancing a large undocumented population, strong political pressure, and limited federal aid. This introduction describes how the federal government's funding of only emergency medical care for undocumented adult immigrants has left local and state taxpayers, and the public hospitals they support, with the ultimate decision of whether to extend non-emergency care to undocumented immigrants.

II. THE FEDERAL FOCUS ON EMERGENCY CARE

A. EMTALA

Federal law imposes an affirmative duty on hospitals to provide emergency care to patients suffering from an emergency medical condition, regardless of the patient's ability to pay.¹ Under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), immigrants, regardless of their legal status, are entitled to this emergency care, but hospitals are not required to provide any treatment beyond the stabilization of an emergency condition.² Yet, while mandating emergency care, this law does not provide for preventative or routine medical care for immigrants.³

EMTALA was enacted to ensure public access to emergency care by prohibiting hospitals from denying emergency medical care to patients or transferring them because of their inability to pay for treatment.⁴ Under EMTALA, hospitals are only required to screen emergency room patients and then provide either stabilizing treatment or an appropriate transfer for patients with emergency medical conditions, including active labor.⁵

For some public hospitals, EMTALA is the source of significant financial burdens. The existence of EMTALA positions the emergency room as a safety net for those in need of health care who may not otherwise be able to seek or pay for treatment.⁶ An unintended consequence of

1. 42 U.S.C. § 1395dd (2000).

2. *Id.*

3. *Id.*; Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 475 (2007).

4. 42 U.S.C. § 1395dd (2000).

5. *Id.*

6. John Blum, Pieter Carstens & Norchaya Talib, *The Impact of Immigration on Health*

EMTALA is that uninsured patients not only use the emergency room for true emergency care, but also for minor illnesses, since they will be guaranteed treatment in the emergency room.⁷ In 2000, Texas border counties spent an estimated seventy-four million dollars to provide emergency health care for undocumented residents.⁸ Thus, even though EMTALA has expanded immigrants' right to access emergency care, not all of the emergency conditions treated are federally reimbursable, and the burden has fallen on the states and counties to finance this care.

B. Medicare Modernization Act, Section 1011 Funds

In an effort to alleviate some of the financial strain on hospitals caused by EMTALA, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") set aside federal funds to reimburse providers for EMTALA care to undocumented immigrants. Section 1011 of the MMA provides \$250 million per year of federal funds directly to healthcare providers for reimbursement of uncompensated emergency health services provided to undocumented immigrants.⁹ Two-thirds of the funding is allocated across all fifty states and the District of Columbia based on their relative percentages of undocumented aliens.¹⁰ The last third is divided between the six states that apprehend the largest number of undocumented aliens.¹¹ In 2008, the six states are Arizona, California, Florida, New Mexico, New York, and Texas.¹² In total, Texas will receive \$44,444,534 of this funding.¹³

Systems: A Legal Analysis from a Three-Country Perspective, 24 *MED. & L.* 323, 334-35 (2005).

7. Texas Medical Association, *Section 1011 Payment Under EMTALA*, Dec. 6, 2006, <http://www.texmed.org/Template.aspx?id=3730>.

8. THE UNITED STATES/MEXICO BORDER COUNTIES COALITION, *MEDICAL EMERGENCY: COSTS OF UNCOMPENSATED CARE IN SOUTHWEST BORDER COUNTIES* 74-88 (2002), <http://www.bordercounties.org/vertical/Sites/%7BB4A0F1FF-7823-4C95-8D7A-F5E400063C73%7D/uploads/%7BFAC57FA3-B310-4418-B2E7-B68A89976DC1%7D.pdf>.

9. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432 (2003) (codified as amended in scattered sections of 42 U.S.C.).

10. *Id.*

11. *Id.* at 2433.

12. CTRES. FOR MEDICARE & MEDICAID, FY 2008 STATE ALLOCATIONS FOR SECTION 1011 OF THE MEDICARE MODERNIZATION ACT: FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES TO UNDOCUMENTED ALIENS 1, 2008, http://www.cms.hhs.gov/UndocAliens/downloads/fy08_state_alloc.pdf.

13. *Id.*

However, many providers are slow to access these MMA funds. For example, in 2005, \$192 million of funds were left unclaimed.¹⁴ While the MMA does not require that physicians ask patients directly about their citizenship or immigration status, the required payment form does ask the provider to indicate whether the patient is undocumented if the information is known.¹⁵ The New York City public health network decided to forgo this federal money altogether to preserve patient confidentiality.¹⁶ In addition, providers have cited other reasons for declining the funds including laborious paperwork requirements and an unwillingness to deter immigrants from seeking care by probing into their legal status.¹⁷

If claimed, MMA funds may help hospitals balance the cost of providing emergency medical care to undocumented immigrants as mandated under EMTALA. The funds however, are limited, and may not be applied to routine care or continuing care after the stabilization of an emergency condition.¹⁸ If an undocumented individual presents himself at a hospital with an emergency condition, the hospital can use the funds made available by the MMA to cover only the costs of treating the patient until the patient is stabilized.¹⁹ If the patient remains at the hospital for some time after stabilization or requires continuing care, either the hospital or the individual has to shoulder the cost of that care.²⁰ The availability of funding under the MMA reflects the federal government's unwillingness to cover any treatment for undocumented immigrants that is not related to a medical emergency. It is only available to provide medical treatment to undocumented immigrants in emergency situations and cannot be used for routine health care coverage. Due to the limited scope of treatments that can be reimbursed, these funds may only marginally aid providers in treating undocumented aliens.

C. Medicaid

Public hospitals that treat uninsured, undocumented aliens cannot rely on the traditional federal financing that hospitals receive for treating other

14. WILLIAM A. DOLAN, AM. MED. ASS'N, REPORT OF THE COUNCIL ON MEDICAL SERVICE: FINANCIAL IMPACT OF IMMIGRATION ON THE AMERICAN HEALTH SYSTEM 3 (2007), <http://www.ama-assn.org/ama1/pub/upload/mm/372/a07cms3.pdf>.

15. *Id.*

16. Stephen Franklin & Bruce Jaspen, *No Rush to Claim Cash for ER Bills*, CHI. TRIB., Sept. 17, 2006, at B1.

17. *Id.*

18. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., EMERGENCY CLEARANCE: PUBLIC INFORMATION COLLECTION REQUIREMENTS SUBMITTED TO THE OFFICE OF MANAGEMENT AND BUDGET (OMB) 21 (2005), <http://www.cms.hhs.gov/UndocAliens/Downloads/cms10130.pdf>.

19. *Id.*

20. *See id.* at 26.

uninsured populations. Across the United States, hospitals and providers that treat low income and uninsured populations depend on the Medicaid Program as a major source of financing.²¹ In 2004, Medicaid provided thirty-five percent of the net revenues of public hospitals nationally.²²

However, legal immigrants that have been in the country for less than five years and all undocumented immigrants are generally not eligible for Medicaid, unless seeking care for an emergency medical condition.²³ Due to these restrictions, hospitals treating large numbers of low-income, uninsured immigrants cannot access federal Medicaid money to finance the care they provide to that population, even when their patients would qualify for Medicaid if not for their immigration status.²⁴ For example, in Harris County, Texas, insurance and Medicaid reimbursements together in 2001 only covered ten percent of the \$67 million the public hospital spent in treating immigrants who did not qualify for Medicaid.²⁵

In general, Medicaid provides health insurance coverage to certain low income, non-elderly people including children, their parents, pregnant women, and individuals with disabilities.²⁶ Both federal and state governments provide funds to finance Medicaid, with the states' Medicaid administrations subject to the federal government's general guidelines.²⁷ Federal guidelines require that recipients of Medicaid be U.S. citizens, nationals, or qualified aliens.²⁸ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") narrowly defines the term "qualified alien" to exclude undocumented aliens from Medicaid and other federally funded social services.²⁹ The federal statute that governs Medicaid allows for an exception whereby undocumented immigrants can receive coverage for treatment of an emergency

21. CATHERINE HOFFMAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED: A PRIMER 11 (Oct. 2007), <http://www.kff.org/uninsured/upload/7451-03.pdf>.

22. *Id.*

23. SARA ROSENBAUM & JANE HIRSH, KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID ELIGIBILITY AND CITIZENSHIP STATUS: POLICY IMPLICATIONS FOR IMMIGRANT POPULATIONS 5 (2000), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/getfile/cfm&PageID=14046>.

24. *Id.* at 7.

25. Kristalee Guerra, *The Policy and Politics of Illegal Immigrant Health Care in Texas*, 3 HOUS. J. HEALTH L. & POL'Y 113, 142 (2002).

26. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AT-A-GLANCE 2005: A MEDICAID INFORMATION SOURCE 1, <http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf>.

27. *Id.*

28. Jacob Press, *Poor Law: The Deficit Reduction Act's Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. PA. J. CONST. L. 1003, 1037 (2006).

29. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 431, 110 Stat. 2105, 2274 (1996) (codified as amended in scattered sections of 42 U.S.C.); Mahmoudzadeh, *supra* note 3, at 471.

condition.³⁰ Emergency Medicaid is available to undocumented aliens who experience an emergency medical condition and would otherwise qualify for Medicaid absent their immigration status.³¹

Defining “emergency condition” to determine what treatments for immigrants will be reimbursed by Medicaid has proved to be difficult, resulting in many emergency treatments not being reimbursed by Medicaid.³² There is a lack of consensus among the courts as to whether chronic conditions requiring continual care are covered by Emergency Medicaid.³³ While Medicaid may reimburse treatment for conditions requiring emergency medical attention, it is unclear whether Medicaid will cover long-term treatments such as dialysis. Even when the cessation of a treatment for chronic symptoms would result in a patient’s death, under emergency Medicaid, the patient’s condition may not qualify for coverage.

In *Greenery Rehabilitation Group, Inc. v. Hammon*, the Second Circuit interpreted the limits of the term “emergency medical condition.” The *Greenery* court construed the emergency medical condition requirement to mean “sudden, severe and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm.”³⁴ The Second Circuit held that severe head injuries did constitute emergency medical conditions but the debilitating, chronic conditions the patients suffered as a result did not.³⁵ The court’s ruling limits the ability of hospitals to use Medicaid to fund treatments for undocumented immigrant patients that require feeding tubes or extensive nursing care to carry out basic daily functions after they have experienced a trauma.³⁶

In addition to some courts restrictively interpreting the scope of the emergency medical condition exception, federal administrative guidelines seem to also be constricting the category of treatments for undocumented immigrants that may be reimbursed under Medicaid in emergencies. Recently, federal officials from the Center for Medicaid and State Operations concluded an audit of New York’s Medicaid program and informed state administrators that chemotherapy would not qualify as emergency medical care.³⁷ As a result of this decision, providers cannot

30. Michael J. McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard that Governs Undocumented Immigrants Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL’Y 391, 399 (2007).

31. See generally *id.*

32. Blum, Carstens & Talib, *supra* note 6, at 335.

33. See McKeefery, *supra* note 30, at 391.

34. *Greenery Rehab. Group, Inc. v. Hammon*, 150 F.3d 226, 232 (2d Cir. 1998).

35. *Id.*

36. *Id.* at 233.

37. Sarah Kershaw, *U.S. Rule Limits Emergency Care for Immigrants*, N.Y. TIMES, Sept. 22, 2007, at A1.

collect federal Medicaid funds for treating cancer patients with chemotherapy when the patient is undocumented, even when failure to administer chemotherapy would lead to death.³⁸ Prior to this decision, New York billed Medicaid for emergencies defined as “any condition that could become an emergency or lead to death without treatment” and relied on Medicaid to reimburse providers for chemotherapy treatments rendered to undocumented immigrants.³⁹ In response to the federal government’s strict construction of the emergency condition exception for immigrants, New York made the decision to solely fund chemotherapy treatment for undocumented immigrants.⁴⁰ With such limited Medicaid coverage available for undocumented immigrants under the emergency care exception, states like New York have been forced to bear the burden of providing care for those individuals. At least seventeen states have taken it upon themselves to provide fully state-funded coverage to cover at least some immigrants who are not eligible for Medicaid because of the eligibility restrictions.⁴¹

While EMTALA may improve immigrants’ access to emergency care, restrictions on Medicaid eligibility significantly limit access to care for all immigrants. This shifts the ultimate decision of whether to provide medical care beyond the emergency room to local and state taxpayers and the public community hospitals.⁴²

III. CONCLUSION

It remains uncertain whether hospitals will be reimbursed when they provide required emergency care under EMTALA. Providing emergency care to low-income undocumented aliens is especially problematic because foreign-born adults are more likely to be uninsured than citizens, and low-income non-citizen adults who have been in the United States for less than five years are the least likely to have health insurance with 67% being uninsured.⁴³ In addition, unless an undocumented alien presents an “emergency medical conditions,” the hospital will not be entitled to Medicaid reimbursement, but nonetheless must screen and stabilize the condition. Factors such as strict construction of the term “emergency

38. *See id.*

39. *Id.*

40. Sarah Kershaw, *New York, Faulting U.S., Says It Will Pay for Cancer Care for Illegal Immigrants*, N.Y. TIMES, Sept. 26, 2007, at B3.

41. KARYN SCHWARTZ & SAMANTHA ARTIGA, KAISER COMM’N ON MEDICAID & THE UNINSURED., HEALTH INSURANCE COVERAGE AND ACCESS TO CARE FOR LOW-INCOME NON-CITIZEN ADULTS 3 (June 2007), <http://www.kff.org/uninsured/upload/7651.pdf>.

42. *See* ROSENBAUM & HIRSH, *supra* note 23, at 5.

43. SCHWARTZ & ARTIGA, *supra* note 41, at 2.

medical condition” have caused difficulty for providers when determining whether an immigrant qualifies for Medicaid coverage. This ambiguity has inevitably resulted in uncompensated emergency treatments and post-stabilization care.⁴⁴

The existence of a large patient group that is low-income, uninsured, and ineligible for Medicaid can leave a large hole in a hospital’s balance sheet.⁴⁵ In 2000, hospitals in the Mexican-American border region reported losses of over \$200 million as a result of uncompensated care provided to uninsured, undocumented immigrants.⁴⁶ The federal government’s focus on emergency care is not likely to provide reliable, adequate, or sustainable funding to public hospitals treating undocumented immigrant populations. The lack of federal funding is a major factor that prevents public hospitals, like JPS, from extending charity care programs to undocumented immigrants for routine or preventative care beyond the emergency room. Ultimately, the prohibition on federal public benefits for immigrants with only a narrow exception for emergency healthcare shifts the burden of financing immigrant healthcare in public hospitals to local and state governments, leaving local taxpayers and the community hospitals they support with the ultimate decision of whether to extend non-emergency care to undocumented immigrants.

In the transcript that follows, Mr. Earley describes the various factors that influenced JPS’s decision not to extend charity care for non-emergencies to undocumented immigrants and other non-citizens. Mr. Earley specifically cites the concerns of local and state taxpayers, political pressure and an extensive empirical study of the costs associated with caring for the undocumented in Tarrant County, as the leading factors that shaped JPS’ policy on immigrant health care.

44. Blum, Carstens & Talib, *supra* note 6, at 335.

45. *Id.*

46. *Id.*