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A CALL TO MOVE FORWARD: PUSHING PAST THE UNWORKABLE STANDARD THAT GOVERNS UNDOCUMENTED IMMIGRANTS’ ACCESS TO HEALTH CARE UNDER MEDICAID

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In an ideal world, every citizen from every country would have access to health care coverage regardless of international boundaries. But, we do not live in an ideal world. The financial burden of providing health care to undocumented immigrants is simply too much for most countries to bear. As a result, law-making bodies must walk the fine line between financial responsibility and humane treatment in determining the extent to which undocumented immigrants are covered under public health care plans.

Here, in the United States, Congress enacted Title XIX of the Social Security Act, 42 U.S.C. § 1396b(v), to govern undocumented immigrants’ access to health care coverage under the federal Medicaid Assistance Program.\(^1\) Specifically, § 1396b(v) provides that undocumented immigrants only qualify for coverage under Medicaid if they suffer from an “emergency medical condition.”\(^2\) The exact meaning of this key phrase, however, is ambiguous within the explicit provisions of the statute. This ambiguity means that many undocumented immigrants who suffer from emergency conditions may be wrongfully denied treatment under Medicaid by hospital personnel who are unable to predict what the phrase “emergency medical condition” actually includes.

As a result, our federal judicial system has attempted to shed some light on the ambiguity inherent in § 1396b(v). In Greenery Rehabilitation Group, Inc. v. Copyright © 2007 by Michael J. McKeeffery.

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2. Id. § 1396b(v)(2)(A).
Hammon, the United States Court of Appeals for the Second Circuit interpreted the statutory language contained in § 1396b(v) and constructed a legal standard to govern undocumented immigrants’ access to health care coverage under Medicaid. Ultimately, the Second Circuit held that an “emergency medical condition,” for the purposes of § 1396b(v), is a “sudden bodily alteration such as is likely to require ‘immediate medical attention.’”

The Greenery test is too vague, however, to serve as an effective guide for judicial analysis. The test essentially erodes the general rule stated in the statute, since reviewing courts have used the Greenery standard to reach vastly different conclusions. As a result, some in the legal community now argue that it has become virtually impossible to predict whether an undocumented immigrant is legally covered by the Medicaid program. Nevertheless, Chief Judge William J. Sullivan of the Supreme Court of Connecticut has recently proposed a workable solution to this concern. In a recent dissent, Judge Sullivan advocated that a bright-line test based upon § 1396b(v)’s genealogy and its relationship to other federal acts is needed to create a legally consistent and precise definition of “emergency medical condition.”

This article establishes that the Second Circuit’s Greenery test is entirely unworkable when applied to real-life situations. As a result, the judiciary should adopt the alternative approach proposed by Judge Sullivan for fairness and consistency purposes. Part I of this work provides a general overview of the growing debate in this country regarding undocumented immigrants’ access to health care services. Part II discusses the mechanisms through which

3. 150 F.3d 226, 231-33 (2d Cir. 1998).
4. Id. at 231-32.
7. See Szewczyk, 881 A.2d at 287-88 (Sullivan, C.J., dissenting). The coverage line is one that is important to draw, because if hospitals cannot predict which undocumented immigrants are legally covered under Medicaid, they may have grounds to deny health care services to all undocumented immigrants with potentially emergency-type medical conditions.
8. Id. at 284, 289.
9. See id. at 275.
undocumented immigrants may receive necessary medical care and explains why it is so important that Medicaid’s application to undocumented immigrants is governed by a clear and decisive standard. Part III introduces the reader to Title XIX of the Social Security Act, 42 U.S.C. § 1396b(v), the federal statute that applies the Medicaid program to undocumented immigrants. This part also discusses the concern presented by the statute’s ambiguous language regarding what health conditions actually constitute “emergency medical conditions.” Part IV provides a summary of the Greenery decision and an overview of the subjective test formulated by the Second Circuit. Part V documents the unworkable nature of the Greenery test by evaluating the inconsistent results that reviewing courts have produced while applying this test to similar circumstances. Finally, Part VI discusses the primary problems associated with the Greenery standard and analyzes the nature and the likely impact of Judge Sullivan’s alternative proposal.

Ultimately, this article suggests that the judiciary should employ Judge Sullivan’s alternative bright-line standard of analysis to establish fairness and consistency in this area of the law. This action would ensure that hospitals do not have an incentive to wrongfully deny health care services to undocumented immigrants who genuinely require care for emergency conditions. In addition, judicial adoption of this proposal would create a powerful incentive for the legislature to finally clarify how undocumented immigrants are covered under the Medicaid program. Thus, such action would represent a call to the legislature to move forward.

I. THE TOPIC OF UNDOCUMENTED IMMIGRANTS’ ACCESS TO HEALTH CARE IN THE UNITED STATES IS AN ISSUE OF GROWING CONCERN

The issue of undocumented immigrants’ access to health care services has become a hotly debated topic in the United States. In 2002, there were more than 9.3 million undocumented immigrants residing in this country. Due to rapid increases in the country’s undocumented immigrant population over the past few years, undocumented immigrants now make up more than forty percent of the foreign-born population in ten states. This continuous flow of unauthorized


11. Dana Deravin Carr, Implications for Case Management: Ensuring Access and Delivery of Quality Health Care to Undocumented Immigrant Populations, 11 LIPPINCOTT’S CASE MGMT. 195, 196 (2006). This number is twenty-six percent of the total foreign-born population residing in the United States. Id. Mexicans make up more than half of the undocumented immigrants. Id. Other illegal immigrants are natives of Latin America, Asia, Europe, and Canada. Id. Approximately two-thirds, or sixty-five percent, of undocumented immigrants residing in the United States live in California, Texas, New York, Florida, Illinois, and New Jersey. Id.

12. Id. at 196-97.
immigrants into the United States has been so prevalent that it has captured the attention of the nation’s government, media, and citizenry.  

Generally, illegal immigrants flock to the United States in search of a better life for themselves and their families. This influx is due in part to the fact that the United States has been targeted as a favored destination for immigrants. However, this country has been quite unsuccessful in forcing new arrivals to comply with existing immigration laws. As a result, the debate surrounding whether undocumented immigrants should be afforded access to essential services, including health care services, has been pushed to the forefront.

For the purposes of this debate, "undocumented immigrants" or "illegal immigrants" are those individuals who are residing illegally in the United States. A person illegally resides in this country when that individual enters the country illegally, or when that individual enters the country in a legal manner but violates the explicit terms of his or her immigration status. As a whole, undocumented immigrants are much less likely to have health insurance than native-born citizens for several reasons. First, more than a quarter of the undocumented immigrants in the United States over the age of sixteen are part-time employees, seasonal workers, or are unemployed altogether. Normally, part-time and seasonal workers do not receive employment-based health care coverage. Second, undocumented immigrants are usually barred from government insurance programs and often lack the financial resources to obtain private insurance.

For these reasons, the issue of whether undocumented immigrants should have access to health care coverage in the United States has become an area of considerable debate. Some participants in the debate argue that cost considerations justify excluding undocumented immigrants from coverage. They

16. Id.
17. Carr, supra note 11, at 196. This article also uses the terms “illegal immigrants” and “undocumented immigrants” to refer to individuals who are residing illegally in the United States.
18. Id.; see also Loue, supra note 10, at 272. Illegal entry into the United States includes the following situations: entry without inspection, entry based on fraud, or entry based on misrepresentation. Id. Immigrants violate the terms of their legal immigration status by remaining in the United States after their legal authorization has expired. Id. at 272-73.
20. Id. at 195-96.
21. Id. at 196.
22. Id.
24. See Jones et al., supra note 10, at 679; Lopez, supra note 23, at 652.
contend that tax-supported services, like federal health care plans, cannot sustain the increase in demand that would result if undocumented immigrants were included in public health care programs. They also argue that immigrants who reside illegally in the United States do not deserve to receive the benefits of health care coverage, because undocumented immigrants do not usually pay taxes to support federal programs. Another argument against granting undocumented immigrants’ access to health care services focuses on the fact that a denial of coverage would likely create a disincentive for individuals to enter the United States illegally. According to this point of view, such a disincentive is problematic because undocumented immigrants threaten national security, the economy, the prevalence of the English language, American culture, and American jobs.

By contrast, other scholars have argued that undocumented immigrants must have access to basic human rights, such as education, employment, and health care. According to this point of view, undocumented immigrants are human beings and, as such, it is their moral right to have access to services that are essential to sustaining life. Proponents of this perspective further assert that coverage is a moral necessity because some undocumented immigrants are children who have had no choice but to follow their parents abroad. These scholars also contend that health care coverage for undocumented immigrants is justified because undocumented immigrants have been found to pay more in taxes than they collect in benefits, and because many undocumented immigrants reside in the United States for substantial periods of time and contribute much to their local communities.

Based on the intensity of this debate, it is very important that the legislature clearly establish whether undocumented immigrants are covered by health care services under federal health care initiatives. The following part discusses the various mechanisms in place to provide immigrants with access to health care services in the United States, and explains why most of these mechanisms are not

25. See Jones et al., supra note 10, at 679-80.
27. See Jones et al., supra note 10, at 679, 681 ("[D]emands for better border control and tighter accountability for landed aliens who have evaded immigration laws have been loud and clear,” and that "[m]edical treatment for illegal immigrants is a growing problem complicated and inflated by elements of jingoism, fear, and cultural identity.").
28. See id. at 679.
29. Id.
30. See id. at 679-80.
31. Loue, supra note 10, at 320.
32. See id. at 320 (citing Robert Reinhold, Taxes Aliens Pay to Texas Found to Top Benefits, N.Y. TIMES, Nov. 15, 1983, at A17).
33. Id.
realistic means through which undocumented immigrants can receive health care coverage.

II. THE MEDICAID ASSISTANCE PROGRAM IS THE MOST REALISTIC MEANS THROUGH WHICH UNDOCUMENTED IMMIGRANTS MAY ATTAIN HEALTH CARE COVERAGE

Because the topic of illegal immigrants' access to health care has become a hotly debated issue, it is important to note the current mechanisms through which immigrants may obtain access to health care services in the United States. Once in the United States, immigrants may be eligible to receive health care services through three possible sources: the Hill-Burton Act, the Medicare Assistance Program, and the Medicaid Assistance Program. This part discusses each of these three programs in detail and evaluates whether each is a realistic means through which undocumented immigrants may attain health care coverage.

First, while residing illegally in the United States, undocumented immigrants may be able to receive health care services through certain provisions of the Hill-Burton Act. Under this Act, the federal government assists participating public and nonprofit hospitals in carrying out construction and modernization programs. In exchange for this federal assistance, each participating facility must provide "a reasonable volume of free or reduced cost care to individuals unable to pay and to render services available to all individuals who [reside] . . . in the facility's general service area, without discrimination." Thus, undocumented immigrants may be able to receive free or reduced cost health care services from facilities participating in the Hill-Burton program.

Nevertheless, despite the Act's uncompensated care and community service requirements, it is quite difficult for an undocumented immigrant to obtain health

34. Id. at 281-89. In addition, undocumented immigrants may also have access to health care services under the common law. See id. at 278-81. Generally, the common law holds that a hospital may deny treatment to a non-emergency patient, unless such a denial is racially discriminatory. Id. at 278-79. However, a hospital is obligated to treat any patients that it begins to treat. Id. at 279. In addition, a hospital may also be "obligated . . . to provide emergency care when: (1) an 'unmistakable emergency' exists; (2) the hospital has a 'well-established' custom of providing emergency care; and, (3) the patient relies on the hospital's usual practice of providing emergency care." Id. (internal citations omitted). Thus, undocumented immigrants may be able to attain emergency health care services under the common law, as long as they satisfy the above requirements. See id. at 278-79. Nonetheless, the common law has been significantly limited by certain legislative acts, such as the Hill-Burton Act. See id. at 281.

35. Id. at 281-86; 42 U.S.C. § 291c(e) (2000). Over one-half of the hospitals in the United States have received funds pursuant to the Hill-Burton Act. Loue, supra note 10, at 281.

36. Loue, supra note 10, at 281.

37. Id.

38. See id. at 281, 285-86.
care services under the Hill-Burton Act. A participating facility’s obligation to provide free or reduced cost care runs for twenty years after construction is finished, or until loan repayment is completed. As a result, many participating facilities are no longer obligated to provide the free or reduced cost services mandated by the Act. In addition, although the Act requires that participating facilities provide posted notice of the availability of free or reduced cost services, there is no provision in the Act requiring that the notice be in a language other than English. Thus, it is unlikely that undocumented immigrants are aware that certain facilities actually offer free or reduced cost health care services, since many undocumented immigrants simply cannot read English.

Moreover, the nature of eligibility determinations under the Hill-Burton Act tends to bar undocumented immigrants from attaining health care services. Regulations require that “aliens must have resided in the United States for at least three months to establish eligibility.” In addition, these regulations provide that participating facilities may require “any information that is reasonably necessary to establish eligibility” as a condition to providing uncompensated care. Undocumented immigrants are often unable to provide this required documentation, because many undocumented immigrants receive cash payments as income. As a result, no evidence exists regarding their terms of residency or their actual income levels. For these reasons, the Hill-Burton Act is not a realistic means of attaining health care services for many undocumented immigrants residing in the United States.

The second way that some immigrants residing in the United States may receive health care coverage is through the Medicare Assistance Program. Medicare is a federal program that provides health insurance to individuals who are elderly or disabled. Medicare offers medical insurance to cover physician care and provides hospital insurance to cover the costs of hospitalization and related

39. Id. at 283.
40. Id. (citing 42 C.F.R. § 124.501 (2006)).
41. Id.
42. Id.
43. Id.
44. Id.
45. Id. (citing DEP’T OF HEALTH & HUMAN SERVS., PROGRAM POLICY NOTICE NO. 89-5 (1989)).
46. Id. (citing 42 C.F.R. § 124.507(b)(2)(A) (1991)). Facilities may also require that prospective patients apply for benefits from third-party insurers or governmental programs. Id. at 283-84 (citing 42 C.F.R. § 124.507(b)(2)(B) (1991)).
47. Id. at 284.
48. Id.
49. See id. at 283-84.
50. See id. at 278, 286-87.
51. Id. at 286 (citing Social Security Act, tit. XVIII, 42 U.S.C. §§ 1395-1395ccc (2000)).
Thus, immigrants who are elderly or disabled may be eligible to receive health care benefits through the Medicare program. Nevertheless, it is nearly impossible for undocumented immigrants to attain health care coverage under Medicare. Unlike coverage under the Hill-Burton Act, coverage under Medicare does not depend upon financial need. Instead, to attain health care coverage under Medicare, an individual must have been employed under a valid social security number. To attain a valid social security number, one must demonstrate both a legal residence in the United States as well as authorization to work. Naturally, undocumented immigrants are unable to satisfy either of these requirements. Many illegal immigrants also work in employment sectors that are not included in the Medicare program. Thus, Medicare is also not a realistic means through which undocumented immigrants can receive coverage for health care services.

The third way that immigrants residing illegally in the United States may attain health care coverage is through the Medicaid Assistance Program. The Medicaid program is a national healthcare coverage initiative constructed by the federal government. Individual states may elect to participate in this federal program, but are not mandated to do so. Once a state chooses to participate in the Medicaid program, however, that state must comply with the federal statutes that define coverage under the program. The primary purpose of the Medicaid program is to “furnish medical assistance to persons whose income and resources are insufficient to meet the costs of necessary medical care and services.” To further this purpose, undocumented immigrants are covered under the Medicaid program for “emergency medical conditions.”

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52. Id.
53. See id. at 287.
54. Id.
55. Id.
56. Id.
57. Id.
58. Id.
59. Id.
60. See id. at 278, 287-89.
61. See Pharm. Research & Mfrs. of Am. v. Meadows, 304 F.3d 1197, 1199 (11th Cir. 2002).
64. Loue, supra note 10, at 287 (quoting DeJesus v. Perales, 770 F.2d 316, 318 (2d Cir. 1985)).
65. Id. at 289 (citing 42 U.S.C. § 1396b(v)(2) (1988)). To supplement this coverage under Medicaid, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals may not transfer any unstable patients, including unstable illegal immigrant patients, for purely economic reasons. See 42 U.S.C. § 1395dd(c)(1) (2000). EMTALA requires an emergency department to provide an appropriate medical screening examination for any individual who comes to an emergency
Thus, although health care coverage under Medicaid for undocumented immigrants is limited, undocumented immigrants are still able to receive coverage for emergency care under the Medicaid program. As a result, the Medicaid program arguably represents the most realistic legal means through which undocumented immigrants may receive coverage for necessary health care services. Consequently, it is very important that a clear and decisive standard governs undocumented immigrants’ access to health care coverage under Medicaid. The following part discusses Medicaid’s application to undocumented immigrants in more detail.

III. TITLE XIX OF THE SOCIAL SECURITY ACT, 42 U.S.C. § 1396b(v), GOVERNS MEDICAID’S APPLICATION TO UNDOCUMENTED IMMIGRANTS

42 U.S.C. § 1396b(v) is the federal statute that governs Medicaid’s application to undocumented immigrants. This statute provides that “no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.” Nonetheless, there is a significant exception to this general rule. Section 1396b(v)(2)(A) limits care and services provided to undocumented immigrants that will be covered under Medicaid to instances when an undocumented immigrant requires treatment for an “emergency medical condition.” Thus, the issue in applying this statute becomes which conditions qualify as emergency medical conditions.

Section 1396b(v)(3) provides a starting point for an analysis of how to construe this ambiguous phrase. This section states that

‘[E]mergency medical condition’ means a medical condition . . . manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in—(A) placing the patient’s health in serious department and for whom a request is made for an examination of or treatment for a medical condition. ld. § 1395dd(a) (2000). Under EMTALA, the definition of an “emergency medical condition” is essentially the same as the definition included in the Medicaid statute. See id. § 1395dd(e)(1) (2000); § 1396b(v)(3) (2000). Thus, Medicaid and EMTALA were intended to work together to ensure that undocumented immigrants who genuinely suffer from “emergency medical conditions” receive necessary medical care. See infra Part VI.B.1.

68. Id. § 1396b(v)(1) (2000).
69. Id. § 1396b(v)(2)(A) (2000). This treatment must also satisfy two additional requirements. See id. § 1396b(v)(2) (2000). The care and services must be provided to an undocumented immigrant who is otherwise eligible for Medicaid coverage, and cannot be related to an organ transplant procedure. Id. § 1396b(v)(2)(B)-(C) (2000).
70. Id. § 1396b(v)(3) (2000).
jeopardy, (B) serious impairment to bodily functions, or (C) serious
dysfunction of any bodily organ or part.\footnote{71}

The precise meaning of “emergency medical condition” is still largely unclear, however, when applied to the phrase \textit{chronic, debilitating medical conditions}.\footnote{72} In other words, the line between acute conditions covered by the statute and chronic conditions excluded by the statute is blurred when patient stabilization is achieved, but ongoing medical treatment is still necessary to sustain the life of the patient.\footnote{73}

Thus, the issue arises as to whether this particular situation nevertheless constitutes an “emergency medical condition,” despite the fact that the patient is not suffering from “acute symptoms.”\footnote{74}

Recently, courts have considered this particular issue in depth.\footnote{75} The Second Circuit’s analysis in \textit{Greenery Rehabilitation Group, Inc. v. Hammon} is a notable examination of whether an “emergency medical condition” exists when patient stabilization has been successfully achieved.\footnote{76} The following part discusses the facts of this case and provides a brief overview of the test formulated by the Second Circuit to govern this area of the law.

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\item \footnote{71} Id.
\item \footnote{72} Szewczyk v. Dep’t. of Soc. Servs., 881 A.2d 259, 277 (Conn. 2005) (Sullivan, C.J., dissenting). Notably, the regulations that define an “emergency medical condition” do not touch upon whether chronic, debilitating conditions are covered under Medicaid. See 42 C.F.R. § 440.255 (2006). In fact, the definition for “emergency medical condition” contained in the relevant regulations promulgated by the Centers for Medicare & Medicaid Services simply mirrors the definition included in 42 U.S.C. § 1396b(v). See id. § 440.255(b) (2006); 42 U.S.C. § 1396b(v)(3) (2000). Additionally, definitions of “medical emergencies” developed by professional organizations have not specifically addressed whether chronic, debilitating conditions should be considered “emergency medical conditions” under the statute. See Loue, \textit{supra} note 10, at 280 n.57. For instance, the American Hospital Association has defined a medical emergency as “any condition that, in the opinion of the patient, the patient’s family, or whoever assumes the responsibility of bringing the patient to the hospital, requires immediate attention.” \textit{Id.} (citing AM. HOSP. ASS’N, \textsc{Emergency Services} 5-8 (1982)). However, this definition is simply too broad to strike a workable balance between humane treatment and financial responsibility. Other definitions promulgated by professional organizations suffer from the same deficiency. \textit{See id.} (citing American College of Emergency Physicians, \textit{Definition of Emergency Medicine}, 10 \textsc{Annals Emergency Med.} 385, 385-88 (1981)) (discussing the definition of “medical emergency” promulgated by the American College of Emergency Physicians).
\item \footnote{73} Szewczyk, 881 A.2d at 277.
\item \footnote{74} \textit{Id.}
\item \footnote{75} \textit{See}, e.g., Greenery Rehab. Group, Inc. v. Hammon, 150 F.3d 226, 231-33 (2d Cir. 1998) (examining the Medicaid eligibility of undocumented immigrants suffering from chronic, debilitating medical conditions under \S 1396b(v)); Szewczyk, 881 A.2d at 267-74 (analyzing the application of \S 1396b(v) to an undocumented immigrant suffering from a chronic condition that necessitated long-term treatment).
\item \footnote{76} \textit{See} Greenery, 150 F.3d at 227.
\end{itemize}
IV. IN GREENERY REHABILITATION GROUP, INC. V. HAMMON, THE SECOND CIRCUIT CONSTRUCTED A VAGUE, SUBJECTIVE TEST TO GOVERN UNDOCUMENTED IMMIGRANTS’ ACCESS TO HEALTH CARE COVERAGE UNDER MEDICAID

In Greenery Rehabilitation Group, Inc. v. Hammon, the United States Court of Appeals for the Second Circuit attempted to construct a workable definition of “emergency medical condition.” The rule formulated in this case is the current standard used by reviewing state courts to interpret the application of the Medicaid program to undocumented immigrants under § 1396b(v).

The plaintiff, Greenery Rehabilitation Group, Inc. (GRG), operated nursing homes and specialized rehabilitation centers in several states for individuals suffering from severe brain injuries. GRG entered into various agreements with the New York City Human Resources Administration (NYCHRA) to admit patients into GRG’s specialized brain injury care programs via the Medicaid Assistance Program. In this instance, GRG admitted two patients into its programs who, according to NYCHRA, did not qualify for Medicaid coverage because they were both undocumented immigrants residing illegally in the United States. As a result, NYCHRA refused payment to GRG to cover the hospitalization and the medication costs incurred by these two patients.

Each of the patients at issue suffered from sudden and serious head injuries that “necessitated immediate treatment, and [that] ultimately left the patients with long-term debilitating conditions requiring ongoing care and daily attention.” Nonetheless, these patients also had been previously stabilized and transferred by hospital personnel, so that the acute symptoms of their respective conditions had been effectively treated.

Izeta Ugljanin, an undocumented immigrant from Macedonia, needed immediate care for serious head trauma. After being successfully stabilized by the GRG staff, she became a bedridden quadriplegic who required “a feeding tube, continual monitoring, and extensive nursing care.” Leon Casimir, a thirty-eight

77. See id. at 232-33.
79. Greenery, 150 F.3d at 228.
80. Id.
81. Id. This case also concerned GRG’s admission of a third patient, Yik Kan, into one of GRG’s specialized brain injury care programs. Id. However, the court’s analysis concerning Kan is not directly relevant to this discussion because Kan had been granted legal residency in the United States and simply had not yet met the residency requirements to qualify for Medicaid. See id.
82. Id.
83. Id.
84. Id. at 228-29.
85. Id. at 228.
86. Id.
year-old undocumented immigrant from Trinidad, suffered brain damage resulting from a gunshot wound to the head.\(^\text{87}\) After initial stabilization, he was transferred to one of GRG's facilities.\(^\text{88}\) Nonetheless, Casimir was left completely unable to walk, and he required constant monitoring and medication for seizures related to his condition.\(^\text{89}\) In addition, Casimir needed assistance to perform daily life tasks, such as bathing, dressing, eating, and using the toilet.\(^\text{90}\) These two patients would have been eligible for healthcare coverage through the Medicaid program but for the fact that they were undocumented immigrants residing illegally in the United States.\(^\text{91}\)

GRG admitted Ugljanin and Casimir into their specialized programs for head trauma under the mistaken belief that they were eligible beneficiaries under the Medicaid program in New York State.\(^\text{92}\) Thus, when NYCHRA denied Medicaid coverage to these patients, GRG instituted a legal action to attain suitable compensation for the services rendered.\(^\text{93}\) In its complaint, GRG argued that Ugljanin and Casimir were covered by Medicaid through the exception carved out in 42 U.S.C. § 1396b(v).\(^\text{94}\) GRG contended, in other words, that the phrase “emergency medical condition” should be construed by courts to include chronic, debilitating conditions.\(^\text{95}\) On appeal, the issue became simply “whether chronic debilitating conditions that result from sudden and serious injuries . . . are ‘emergency medical conditions’ as provided under § 1396b(v)(3).”\(^\text{96}\)

Before examining the specific circumstances at hand, the Second Circuit adopted a standard of analysis under which an “emergency medical condition” refers to any “sudden bodily alteration such as is likely to require ‘immediate medical attention.’”\(^\text{97}\) According to the court, the emphasis should be on the “severity, temporality and urgency” of the particular medical condition at issue.\(^\text{98}\) Thus, the Second Circuit concluded that conditions defined by acute symptoms are covered under the Medicaid program because they necessitate immediate medical attention.\(^\text{99}\) The court defined an acute symptom in this context as a symptom
“characterized by sharpness or severity . . . having a sudden onset, sharp rise, and short course.”

By applying this “immediate medical attention” standard to the events that occurred at GRG, the court found that Ugljanin and Casimir were not eligible for Medicaid coverage under the exception carved out in § 1396b(v)(2)(A). The two patients’ initial sudden and severe head injuries constituted “emergency medical conditions” under the statute, but once the patients were effectively stabilized they no longer suffered from conditions defined by acute symptoms. Since their conditions could no longer be considered acute in nature, the patients did not suffer from “emergency medical conditions.” As a result, the court concluded that these patients were not eligible for health care coverage under Medicaid for any ongoing treatment after stabilization.

This holding essentially conveys the notion that a patient does not suffer from an “emergency medical condition” under the definition provided in § 1396b(v)(3) if that patient’s condition has been sufficiently stabilized by hospital personnel. However, this decision still does not shed light on situations where the cessation of treatment for chronic symptoms would immediately result in the patient’s death, or in a significant impairment of the patient’s bodily functions. The lack of clarity with respect to this issue has led to inconsistent application of the Greenery test, causing it to become a completely unworkable guideline. The following section provides a brief overview of the inconsistencies produced by the Greenery standard.

V. REVIEWING COURTS EMPLOYING THE GREENERY STANDARD HAVE PRODUCED INCONSISTENT RESULTS BASED UPON SIMILAR FACTUAL CIRCUMSTANCES

In Greenery, the Second Circuit determined that a particular condition may be considered an “emergency medical condition” as long as that condition requires “immediate medical attention.” The court did not, however, provide reviewing courts with any further guidance as to how to appropriately apply this broad and

100. *Id.* (quoting WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 23 (3d ed. 1981)).
101. *Id.* at 232-33.
102. *Id.* at 232. Ugljanin and Casimir required ongoing care and general maintenance, but there was some doubt as to whether their health would be significantly at risk without immediate medical treatment. *Id.* at 231, 233.
103. *Id.* at 233.
104. *Id.*
105. *See id.*
106. *See cases cited supra note 6.*
107. Greenery, 150 F.3d at 232.
subjective standard. Specifically, the court never defined the exact contours of what “immediate medical attention” entails. Thus, the test is susceptible to the personal opinions and experiences of the reviewing court, so that decisions may, ultimately, have little to do with the actual merits of the case at bar. As a result, the application of the Greenery test to medical conditions suffered by undocumented immigrants has yielded vastly inconsistent results.

Generally, reviewing state courts have arrived at one of two conflicting conclusions regarding the proper construction of § 1396b(v). Some courts have applied the Greenery test and concluded that chronic conditions are not covered under the statutory definition of “emergency medical condition.” Other courts have used the Greenery standard to conclude that “emergency medical condition,” under § 1396b(v)(3), may include chronic, debilitating conditions. Subpart A, below, discusses cases holding that the definition of “emergency medical condition” does not include chronic conditions. In contrast, Subpart B reviews cases holding that chronic, debilitating conditions may be considered “emergency medical conditions.” These subparts provide examples of the two conflicting lines of case law and emphasize the inconsistencies that the Greenery standard has caused in this area of the law.

108. See Szewczyk v. Dep’t of Soc. Servs., 881 A.2d 259, 287-88 (Conn. 2005) (Sullivan, C.J., dissenting) (stating that the Greenery test is unworkable because it is “impossible to implement in any principled way”).

109. See id. at 288 nn.29-30 (Sullivan, C.J., dissenting) (criticizing the majority’s reasoning in defining “immediate medical attention”).

110. See id. at 288 n.30 (Sullivan, C.J., dissenting) (“[T]he majority does not follow its own holding that the ‘determination of the existence of an emergency medical condition should largely be informed by the expertise of health care providers . . . .”’).

111. See cases cited supra note 6.

112. See sources cited infra notes 117 and 140.

113. See Quiceno v. Dep’t of Soc. Servs., 728 A.2d 553, 555-56 (Conn. Super. Ct. 1999) (holding that treatment provided to an undocumented immigrant for end-stage renal failure due to systemic lupus erythematosus was not treatment for an “emergency medical condition” and, thus, could not be covered under the Medicaid program); Diaz v. Div. of Soc. Servs., 628 S.E.2d 1, 5 (N.C. 2006) (holding that treatment for acute lymphocytic leukemia is not covered under Medicaid).


115. See cases cited infra note 117.

116. See cases cited infra note 140.
A. Some Reviewing Courts Have Found That Undocumented Immigrants May Not Receive Health Care Coverage Under Medicaid for Chronic, Debilitating Conditions

In some instances, reviewing courts applying the Greenery test have reached conclusions in accordance with the Second Circuit's holding in Greenery.117 These courts have held that chronic conditions cannot be included within the definition of "emergency medical condition" laid out in § 1396b(v)(3).118

For instance, in Quiceno v. Department of Social Services, the Superior Court of Connecticut found that undocumented immigrants are not covered under Medicaid for the treatment of chronic, debilitating medical conditions.119 In that case, Astrid Quiceno was an undocumented immigrant residing illegally in the United States.120 She suffered from end-stage renal failure due to systemic lupus erythematosus and, as a result, required ongoing, life-sustaining kidney dialysis.121 From June 1996 until December 1996, Quiceno received treatment at a Connecticut hospital for her condition.122 The State of Connecticut Department of Social Services (SDSS) determined that kidney dialysis is not considered emergency medical treatment and therefore denied Medicaid payment for Quiceno's treatment.123 As a result, Quiceno instituted legal action against SDSS to obtain coverage under Medicaid for her treatment.124

While reviewing these facts, the Superior Court of Connecticut adopted the Greenery standard, asserting that "[t]he outcome of this case is dictated by the recent decision in Greenery Rehabilitation Group, Inc. v. Hammon."125 By applying the "immediate medical attention" standard, the court concluded that there was not an immediate urgency to Quiceno's condition and, thus, Quiceno did not suffer from acute symptoms.126 In coming to this result, the court stated that the patients in Greenery were in a more fragile condition than Quiceno and, since those individuals were denied coverage under § 1396b(v), Quiceno should also be denied such coverage.127 As a result, the court ultimately held that Quiceno was not

117. See Quiceno, 728 A.2d at 554-56 (applying the Greenery standard and concluding that chronic conditions cannot be covered under the Medicaid statute); Diaz, 628 S.E.2d at 5 (applying the Greenery test and holding that acute lymphocytic leukemia does not constitute an "emergency medical condition" under the statute).
118. See cases cited supra note 117.
119. 728 A.2d at 554-56.
120. Id. at 554.
121. Id.
122. Id.
123. Id.
124. See id.
125. Id. at 555.
126. See id.
127. See id.
eligible for coverage under Medicaid because her condition could not be considered an "emergency medical condition" for the purposes of § 1396b(v)(2)(A).

_Diaz v. Division of Social Services_ is another case in which a reviewing court employed the _Greenery_ test and found that a chronic, debilitating condition may not be considered an "emergency medical condition." In that case, the plaintiff, Hector Diaz, was an undocumented immigrant residing in the United States. In October 2000, Diaz began to suffer from a sore throat, severe nausea, vomiting, bleeding gums, and exhaustion. He was diagnosed with acute lymphocytic leukemia and received chemotherapy treatment for this condition until July 2002. During treatment, Diaz applied for health care coverage under Medicaid, but the State of North Carolina denied his request. As a result, Diaz brought legal action against the State.

In deciding this case, the Supreme Court of North Carolina adopted the _Greenery_ standard. The court concluded that "an emergency medical condition is one which manifests itself by acute symptoms at the time of treatment and requires immediate treatment to stabilize the condition, such that the absence of this treatment would reasonably be expected to cause any of the three results listed in 42 U.S.C. § 1396b(v)(3)(A), (B), or (C)." The court applied this definition to the condition at issue, finding that Diaz was not eligible for Medicaid coverage for his chemotherapy treatments because "[d]uring [Diaz's] chemotherapy treatments, his condition was stable and, therefore, he was no longer entitled to Medicaid coverage."

These cases illustrate that some reviewing courts have found that the achievement of stabilization pushes a medical condition outside the limits of the definition of an "emergency medical condition" as it is laid out in § 1396b(v)(3). However, as the following section notes, other courts have rejected this notion, and have instead held that treatment for chronic, debilitating conditions after the achievement of stabilization may be covered under Medicaid.

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128. _Id._ at 555-56.
129. 628 S.E.2d 1, 3-5 (N.C. 2006).
130. _Id._ at 2.
131. _Id._
132. _Id._
133. _Id._
134. _Id._
135. _Id._ at 4.
136. _Id._ at 5.
137. _Id._
138. _Id._
B. Other Courts Have Concluded That Undocumented Immigrants May Be Covered Under Medicaid for the Treatment of Chronic, Debilitating Conditions

Some courts applying the Greenery test under similar circumstances have concluded that a condition may still be considered an “emergency medical condition” despite effective stabilization.\textsuperscript{140} The most notable example from this line of cases is the recent decision handed down by the Supreme Court of Connecticut in Szewczyk v. Department of Social Services.\textsuperscript{141} In this case, Zbigniew Szewczyk, a native of Poland, remained in the United States illegally after his visa expired.\textsuperscript{142} In 1998, he sought medical treatment from his family physician for pain, nausea, and overall weakness “so severe that he could take only one to two steps before collapsing.”\textsuperscript{143} During this visit, Szewczyk’s doctor referred him to an oncologist at Stamford Hospital.\textsuperscript{144} Szewczyk was diagnosed with acute myelogenous leukemia, and was immediately admitted to the hospital.\textsuperscript{145} As an inpatient, Szewczyk received chemotherapy, surgery, and biopsies as treatment for his medical condition.\textsuperscript{146}

When Szewczyk applied for health care benefits from the State through Medicaid, his oncologist wrote a letter on his behalf, stating that acute myelogenous leukemia “is a rapidly fatal disease unless treated aggressively with chemotherapy.”\textsuperscript{147} The oncologist also wrote that without the therapy that was provided by the hospital, Szewczyk likely would have died.\textsuperscript{148} Nonetheless, despite a lack of contrasting medical evidence, the hearing officer for the State concluded that Szewczyk had not suffered from an “emergency medical condition.”\textsuperscript{149} The officer found that there was no emergency because, absent treatment, Szewczyk would not have died on the day that he was admitted to the hospital.\textsuperscript{150} After

\textsuperscript{140} See Szewczyk v. Dep’t. of Soc. Servs., 881 A.2d 259, 267-74 (Conn. 2005) (applying the Greenery standard and holding that treatment for the plaintiff’s acute myelogenous leukemia is covered by Medicaid as an “emergency medical condition”); Luna v. Div. of Soc. Servs., 589 S.E.2d 917, 922-25 (N.C. Ct. App. 2004) (applying the Greenery standard and concluding that Medicaid may cover the treatment provided for undocumented immigrant’s medullary non-Hodgkin’s lymphoma despite the achievement of stabilization); Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin., 75 P.3d 91, 95-99 (Ariz. 2003) (applying the Greenery test and remanding the case to determine whether an undocumented immigrant’s serious head and neck trauma was a “non-chronic condition presently manifesting itself by acute symptoms of sufficient severity,” so that the condition might be covered under the Medicaid program).

\textsuperscript{141} 881 A.2d 259 (Conn. 2005).

\textsuperscript{142} Id. at 262.

\textsuperscript{143} Id.

\textsuperscript{144} Id.

\textsuperscript{145} Id.

\textsuperscript{146} Id.

\textsuperscript{147} Id.

\textsuperscript{148} Id.

\textsuperscript{149} Id.

\textsuperscript{150} Id.
receiving this officer's decision, Szewczyk instituted a legal action to force the State to pay for his medical costs under the exception laid out in § 1396b(v)(2)(A). 151

The court applied the Greenery test in the context of Szewczyk's circumstances to determine whether Szewczyk suffered from an "emergency medical condition." 152 In adopting this standard, the court asserted that "[a]n 'emergency medical condition' must be manifested by acute, rather than chronic symptoms . . . . It must necessitate immediate medical treatment, without which the patient's physical well-being would likely be put in jeopardy or serious physical impairment or dysfunction would result." 153 The court found that immediate medical treatment was necessary to avoid placing Szewczyk's health in serious jeopardy. 154 Thus, the Supreme Court of Connecticut employed the Greenery standard and found that an "emergency medical condition" existed despite successful stabilization of Szewczyk once he was admitted to the hospital. 155 This outcome directly conflicts with the conclusions reached in Greenery, Quiceno, and Diaz, despite the fact that these courts all applied the same standard to similar factual circumstances. 156

Likewise, in Medina v. Division of Social Services, the Court of Appeals of North Carolina found that an "emergency medical condition" may still exist despite the achievement of stabilization. 157 In this instance, Elmer Medina was hospitalized and diagnosed with acute lymphoblastic leukemia. 158 As a result of his diagnosis, Medina was treated with chemotherapy and began to suffer from severe acute abdominal pains that were associated with his chemotherapy treatment. 159 Medina applied for Medicaid benefits to cover the costs of his ongoing chemotherapy, but the State of North Carolina rejected his request. 160 The State asserted that the ongoing treatment should not be covered under the statute because the condition was no longer an "emergency medical condition." 161 As a result, Medina brought a legal action against the State to obtain health care coverage for his ongoing chemotherapy treatments. 162

151. See id.
152. See id. at 267.
153. Id. (quoting Greenery Rehab. Group, Inc. v. Hammon, 150 F.3d 226, 233 (2d Cir. 1998)).
154. Id. at 273.
155. Id.
158. Id. at 708.
159. Id.
160. Id. at 709.
161. Id.
162. See id.
With these facts to consider, the Court of Appeals of North Carolina concluded that Medina's condition may constitute an "emergency medical condition" within the exception laid out in § 1396b(v)(2)(A).

The court premised its holding on the possibility that Medina could sustain significant impairment of daily bodily functions or could die if hospital personnel withheld chemotherapy treatment. By remanding the case for further factual findings, this court, like the court in Szewczyk, implied that an emergency medical condition may persist after the patient has been successfully stabilized.

As illustrated above, courts applying the Greenery test have construed this standard in inconsistent ways. One line of cases interprets the Greenery test as a standard that precludes individuals who suffer from chronic, persistent conditions from attaining health care coverage under Medicaid. Alternatively, other cases construe the Greenery test to include ongoing treatment, such as kidney dialysis and chemotherapy, within the exception carved out in § 1396b(v)(2)(A). These inconsistent results from similar factual circumstances necessitate the institution of more precise guidelines to direct courts toward more consistent outcomes in future cases. The following part discusses the problems created by the current standard and offers a promising proposal for establishing a clear and decisive standard that governs Medicaid's application to undocumented immigrants.

VI. THE GREENERY TEST CREATES SERIOUS PROBLEMS THAT CAN BE ALLEVIATED BY THE ADOPTION OF A BRIGHT-LINE STANDARD

This part establishes both that the current test to evaluate Medicaid's application to undocumented immigrants is inappropriate, and that an alternative approach is necessary. Subpart A addresses the primary flaws associated with the Greenery test. Subpart B discusses a promising alternative standard based upon a renewed interpretation of what "emergency medical condition" actually entails.

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163. Id. at 710-11.
164. Id. at 711.
165. See id. at 710-711. The court concluded that the case must be remanded because the trial court did not make sufficient factual findings on the following issues: "whether [the plaintiff's] condition was manifesting itself by acute symptoms . . . whether the absence of immediate medical attention . . . could result in any of the consequences listed in the North Carolina rule (health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part)." Id at 711. Unlike the courts in Greenery, Quiceno, and Diaz, the court here left open the possibility that chronic, debilitating conditions may still be considered "emergency medical conditions." See id.
166. See cases cited supra note 6 (discussing the holdings of various courts applying the Greenery standard); Part V (detailing how reviewing courts employing the Greenery standard have produced inconsistent results based upon similar factual circumstances).
167. See supra Part V.A.
168. See supra Part V.B.
169. See infra Part VI.A.
under § 1396b(v). If adopted by the judiciary, this alternative standard would successfully address the major problems created by the Greenery test. Furthermore, judicial adoption of this alternative standard could motivate the legislature to finally clarify the ambiguities created by § 1396b(v).

A. The Problem: The Greenery Standard Promotes Inequity and Inconsistency

Based on the previously-discussed judicial holdings, the Greenery test has proven to be an unworkable standard of analysis for two primary reasons. First, this standard produces inequitable outcomes because it does not account for all of the medical conditions that could necessitate “immediate medical attention.” Arguably, many chronic medical conditions that would likely result in immediate, serious bodily impairment or death, if left untreated, would not be considered “emergency medical conditions” under the Greenery test. These conditions cannot be considered emergencies under Greenery because they necessitate ongoing care following stabilization and thus, cannot be resolved with a “finite course of treatment.” As a result, the Greenery standard ensures that some patients who genuinely require ongoing medical treatment for life-threatening conditions are precluded from attaining health care coverage, while other patients with similarly life-threatening conditions qualify for coverage under Medicaid.

To illustrate this problem, consider the holdings in Greenery and Quiceno. In these cases, the Second Circuit and the Superior Court of Connecticut, respectively, found that serious debilitating and life-threatening conditions, such as major brain damage and kidney failure, did not constitute “emergency medical conditions” under the “immediate medical attention” standard. However, cessation of treatment in those cases would have led to a “serious impairment to bodily functions” in apparent violation of the explicit provisions of § 1396b(v)(3)(B). In both cases, application of the Greenery test barred patients

170. See infra Part VI.B.
171. See cases cited supra note 6 (discussing the holdings of various courts applying the Greenery standard); Part V (discussing in detail how reviewing courts employing the Greenery standard have produced inconsistent results based on similar factual circumstances).
172. See Szewczyk v. Dep’t of Soc. Servs., 881 A.2d 259, 277 (Conn. 2005) (Sullivan, C.J., dissenting) (“[I]t is not clear whether the phrase [‘emergency medical condition’] was intended to encompass a condition . . . that presents with severe symptoms but requires longer term treatment and, therefore, reasonably may be characterized as chronic.”).
173. Id.
175. See cases cited supra note 6 (discussing the holdings of various courts applying the Greenery standard).
177. Greenery, 150 F.3d at 228-229, 233; Quiceno, 728 A.2d at 554-56.
with seriously debilitating medical conditions from attaining health care coverage. Nevertheless, the Greenery test ensures that patients suffering from serious debilitating conditions that present with “acute” symptoms qualify for coverage under Medicaid. If Medicaid coverage attaches to some life-threatening or seriously debilitating conditions, then it should attach to all medical conditions of this nature.

Second, the Greenery standard produces inconsistent results in state courts. These inconsistencies arise from the Greenery test’s distinction between “acute” medical conditions and “chronic” medical conditions. Under the court’s decision in Greenery, only acute medical symptoms can be considered as rising to the level of “emergency medical conditions” and, therefore, only the treatment of such symptoms is reimbursable under § 1396b(v)(2)(A). However, the line between “acute” and “chronic” in this context is too vague to serve as a functional legal guide. For example, when an individual suffers from a lingering, seriously debilitating injury, and the termination of medical treatment at any time would lead to death or serious bodily impairment, then the injury can be perceived as both acute and chronic in nature.

Thus, whether an individual’s health problems are classified as “emergency medical conditions” for purposes of reimbursement under § 1396b(v)(2)(A) will depend largely upon the subjective perception of the court and medical experts, unguided by anything except an ambiguously worded statute. The consequence of these subjective procedures has been that it is entirely impossible to predict whether undocumented immigrants who come to the hospital with emergency conditions are eligible for coverage under Medicaid. As an unfortunate result of such unpredictable outcomes, hospitals may begin to reject patients from ongoing treatment programs due to an inability to predict whether undocumented immigrants are legally covered under Medicaid.

179. Greenery, 150 F.3d at 232-33.
181. See cases cited supra note 6 (discussing the holdings of various courts applying the Greenery standard).
182. Greenery, 150 F.3d at 232.
183. Id. at 231-33. Section 1396b(v)(2) states, in part, that “Payment shall be made under this section for care and services that are furnished to an alien . . . only if—(A) such care and services are necessary for the treatment of an emergency medical condition of the alien . . . .” 42 U.S.C. § 1396b(v)(2)(A) (2000).
185. Id. at 288. Such an injury can be considered “acute in the sense that it was of sudden onset and is severe, and it is chronic in the sense that it cannot be resolved with a finite course of treatment.” Id.
186. Id.
187. See supra notes 171-186.
For these reasons, the *Greenery* test is an unworkable standard of analysis for determining the eligibility of undocumented immigrants for Medicaid coverage. The judiciary should instead employ a recently proposed alternative designed to maximize fairness and consistency. The following subpart discusses this promising alternative standard in detail.

B. A Workable Solution: An Examination of § 1396b(v)’s Legislative History and its Relationship to Other Federal Statutes Reveals a Reasonable Alternative to the *Greenery* Standard

In his dissenting opinion in *Szewczyk*, Chief Judge William J. Sullivan of the Supreme Court of Connecticut presented a practicable alternative approach to the *Greenery* standard. This proposed alternative centers around a more precise and workable definition of “emergency medical condition.” Judge Sullivan constructed this definition from an analysis of § 1396b(v)’s legislative history and its relationship to other interconnected sections of federal legislation. This alternative is based upon the conclusion that Congress intended the language contained in § 1396b(v)(2)(A) to be construed consistently with equivalent language found in the Emergency Medical Treatment and Active Labor Act (EMTALA).

Generally, this subpart discusses Judge Sullivan’s alternative proposal and explains why this proposal is preferable to the *Greenery* standard. First, this subpart examines the genealogy of § 1396b(v) and its relationship to EMTALA, essentially explaining why § 1396b(v)(3) should be construed as having the same meaning as § 1395dd(e)(1) of EMTALA. This subpart then investigates the meaning of § 1395dd(e)(1) to clarify the definition of “emergency medical condition” contained in § 1396b(v)(3). This subpart then provides a brief overview of the bright-line standard envisioned by Judge Sullivan, and explains how this bright-line standard would address the primary problems created by the *Greenery* test. Ultimately, this subpart proposes that the judiciary should adopt Judge Sullivan’s alternative standard to create an incentive for the legislature to finally clarify this traditionally ambiguous area of the law.

188. See *Szewczyk*, 881 A.2d at 284 (Sullivan, C.J., dissenting).

189. *Id.*

190. *Id.*

191. *Id.* at 275, 277-284.


193. See infra Part VI.B.

194. See infra Part VI.B.1.

195. See infra Part VI.B.2.

196. See infra Part VI.B.3.

197. See infra Part VI.B.4.
1. Based on an Examination of Legislative History, the Legislature Intended That § 1396b(v) Would Mean the Same as § 1395dd(e)(1) in EMTALA

To determine the suitability of Judge Sullivan’s proposed alternative and to ascertain the manner in which Congress intended § 1396b(v) to be construed, it is necessary to conduct a thorough review of the statute’s genealogy, its legislative history, and its relationship to EMTALA. In 1986, Congress enacted EMTALA, codified at 42 U.S.C. § 1395dd, to amend the federal law governing the national Medicare Assistance Program. This statute requires hospitals participating in the Medicare program to screen and stabilize all patients with “emergency medical conditions” to the extent realistically possible. Legislative history indicates that the purpose of EMTALA is to address “inappropriate transfer[s] of ‘patients in life threatening situations’ from the emergency rooms of private hospitals to public hospitals ‘for economic reasons alone’.”

At the time of EMTALA’s enactment, the United States General Accounting Office conducted a study to determine whether a refinement of the federal Medicaid laws would also be necessary to effectively advance the purposes of § 1395dd. Six months after the ratification of EMTALA, Congress amended the federal Medicaid law by enacting § 1396b(v)(3). This amendment applied and defined “emergency medical condition,” a phrase originally included in § 1395dd(e)(1), in the context of the Medicaid program. As a result, the phrase

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198. Szewczyk v. Dep’t of Soc. Servs., 881 A.2d 259, 277-84 (Conn. 2005) (Sullivan, C.J., dissenting). Because the statute at issue contains ambiguous language, an analysis of the statute’s legislative history is appropriate. Id. at 277 (citing In re Venture Mortgage Fund, L.P., 282 F.3d 185, 188 (2d Cir. 2002)).

199. Id. at 279 (Sullivan, C.J., dissenting) (citing The Emergency Medical Treatment and Active Labor Act, or EMTALA, codified at 42 U.S.C. § 1395dd (2000)). EMTALA is also referred to as the “patient dumping act.” Id. EMTALA requires, in relevant part, that:

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department . . . to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 U.S.C. § 1395dd(a). The Act further provides that “If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual . . .” Id. § 1395dd(c)(1).

200. Id. § 1395dd(b).

201. Szewczyk, 881 A.2d at 279 (Sullivan, C.J., dissenting) (quoting 131 CONG. REC. 28,568 (1985)).

202. Id.

203. Id.; see also 42 U.S.C. § 1396b(v)(3).

204. Szewczyk, 881 A.2d at 279 (Sullivan, C.J., dissenting). Specifically, § 1395dd(e)(1) defines an “emergency medical condition” as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in—
"emergency medical condition" likely means the same in § 1396b(v)(3) as it does in § 1395dd(e)(1).

Furthermore, the United States Department of Health and Human Services (HHS) also recognized the relationship between § 1396b(v)(3) and § 1395dd(e)(1) when it revised 42 C.F.R. § 440.255(c)(1), the implementing regulation for § 1396b(v)(3). In modifying this section, HHS stated that "we have revised the definition of emergency services . . . [and] this change will make the definition of emergency services consistent with the definition already in use in the Omnibus Budget Reconciliation Act of 1985, [codified at 42 U.S.C. § 1395dd(e)(1)]." Based on this legislative history, Congress likely intended "emergency medical condition," as defined in §1396b(v)(3), to have the same meaning as it does in § 1395dd(e)(1) of EMTALA.

2. The Definition of "Emergency Medical Condition" in § 1395dd(e)(1) of EMTALA Only Includes Medical Conditions That Require Patient Stabilization

Since § 1396b(v)(3) likely mirrors § 1395dd(e)(1) of EMTALA, the remaining determination is to decide what § 1395dd(e)(1) actually means. To decipher the meaning of § 1395dd(e)(1), the relationship between § 1395dd(e)(1) and two related provisions in § 1395dd must be considered. These two related provisions are §§ 1395dd(a)(2) and 1395dd(c)(1). Section 1395dd(b)(1) provides that hospitals participating in the Medicare program must stabilize patients suffering from an "emergency medical condition." Additionally, once a medical condition has been effectively stabilized so that "no material deterioration of the condition is likely to result from" transferring the patient, the provisions of § 1395dd no longer apply.

Reading § 1395dd(e)(1) together with the definition of "stabilization" in § 1395dd(e)(3) creates a definition of "emergency medical condition" as "a condition that requires stabilizing treatment in order to assure, within reasonable medical

(i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.
probability, that no material deterioration of the condition is likely to result from or
occur during the transfer of the individual from a facility or his discharge.”213 Thus,
if stabilization is achieved, or if transfer or discharge of the patient is contemplated,
then any treatment received by a patient may not be considered treatment for an
“emergency medical condition” under § 1395dd(e)(1).214 In other words, under the
meaning of § 1395dd(e)(1), patients would not qualify for health care coverage for
any procedures or medication used to treat chronic, debilitating conditions. The
following section provides a discussion of how this definition of “emergency
medical condition” should be applied in the context of the Medicaid program.

3. Under Judge Sullivan’s Alternative Standard, Only Conditions That
Require Patient Stabilization Would Be Considered “Emergency Medical
Conditions” for the Purposes of § 1396b(v)

According to Judge Sullivan, the legislature amended § 1396b(v)(3) of
Medicaid with the expectation that reviewing courts would interpret this provision
as having the same meaning as the similar Medicare provision in § 1395dd(e)(1).215
As a result, Judge Sullivan’s proposed definition of “emergency medical condition”
under §1396b(v)(3) would only include medical conditions that require “stabilizing
treatment in order to assure, within reasonable medical probability, that no material
deterioration of the condition is likely to result from or occur during the transfer of
the individual from a facility or his discharge.”216 Any treatment beyond patient
stabilization would not be included within the definition of “emergency medical
condition” and thus, would not be covered by the Medicaid program.217 Under this
proposed alternative standard, any undocumented immigrants who suffer from
medical conditions that require patient stabilization would be able to obtain health
care coverage through the Medicaid program for “emergency medical
conditions.”218 However, the moment that patient stabilization is achieved,
undocumented immigrants would no longer be eligible for health care coverage
through Medicaid.219

Thus, under Judge Sullivan’s proposed standard of analysis, no
undocumented immigrant would be eligible for Medicaid coverage for any
treatment provided for chronic, debilitating conditions following patient
stabilization.220 The following section explains why this bright-line standard is
preferable to the Greenery test.

213. Id. at 281; 42 U.S.C. § 1395dd(e)(1), (3) (2000).
215. Id. at 279-80.
216. See id. at 281.
217. See id. at 279-81.
218. See id. at 284.
219. See id.
220. See id.
4. Judge Sullivan’s Proposed Standard of Analysis Addresses the Major Problems Created by the Greenery Test

Judge Sullivan’s bright-line test would successfully address the two primary problems associated with the Greenery standard: its tendency to produce inequitable results for patients, and its susceptibility to generating inconsistent outcomes among reviewing state courts. First, Judge Sullivan’s alternative proposal would address the problem of inequity by setting easily-understood guidelines for what conditions are included within the exception carved out in § 1396b(v)(2)(A). Treatment for a medical condition would only be covered under Medicaid if patient stabilization is necessary. As a result, under this proposal, it would no longer be the case that some patients would be able to attain coverage under Medicaid while other patients suffering from the same or similar conditions would be rejected coverage. Instead, it would be clear that all life-threatening or seriously debilitating medical conditions would be covered under Medicaid prior to stabilization, and that medical conditions would not be covered once stabilization is achieved.

Second, this proposal would address the problem of judicial inconsistency by making the applicable test an objective standard, rather than a subjective standard. Under the proposed alternative test, reviewing courts would only have to determine whether a patient has been stabilized. Stabilization represents a more reliable legal guide than “immediate medical attention,” because stabilization is a medical concept that is more readily discernable. Very simply, a patient is stabilized when the status of the patient will not deteriorate during transfer. Thus, under this standard, no subjective analyses would be necessary, and reviewing state courts would not likely produce inconsistent rulings. Consequently, this proposal would incentivize hospitals to treat undocumented immigrants who require immediate care, because hospital personnel would be better able to predict which patients qualify for Medicaid coverage.

In addition, Judge Sullivan’s proposed alternative balances the notions of humane treatment and financial responsibility in this area of the law. This alternative standard would ensure that undocumented immigrants who genuinely need emergency care would be afforded access to health care coverage under Medicaid. Simultaneously, this bright-line standard would also address the issue of

221. See supra Part VI.A.
222. Szewczyk, 881 A.2d at 284 (Sullivan, C.J., dissenting).
223. See supra Part VI.A.
224. Szewczyk, 881 A.2d at 284 (Sullivan, C.J., dissenting).
225. Id. at 289.
226. Under EMTALA, “the term ‘to stabilize’ means, with respect to an emergency medical condition . . . , that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . .” 42 U.S.C. § 1395dd(e)(3)(A) (2000).
financial responsibility by setting coverage limits based upon patient stabilization. This proposed standard represents a workable compromise in the context of undocumented immigrants' access to health care services in the United States.

Moreover, Judge Sullivan's proposed interpretation of § 1396b(v) conforms to general federal policy, and complies with the ultimate holding in Greenery. By basing Medicaid coverage for undocumented immigrants upon stabilization, this standard of analysis is consistent with federal law, which provides that undocumented immigrants should be ineligible for public benefits through state and local governments. In addition, by clarifying that chronic conditions may never be covered under Medicaid, this alternative standard is consistent with the Second Circuit's precedent-setting decision in Greenery that long-term treatment precludes Medicaid eligibility.

Most importantly, however, this alternative proposal would create a powerful incentive for the legislature to finally clarify what "emergency medical condition" actually entails under § 1396b(v). If the current legislature agrees that Medicaid cannot apply to undocumented immigrants with chronic, debilitating conditions, then this alternative proposal would supply the intended outcome. On the other hand, however, if the legislature deems this standard to be too harsh on undocumented immigrants, then the legislature would be strongly encouraged to revise § 1396b(v) to explicitly protect undocumented immigrants suffering from chronic, debilitating conditions. Thus, unlike the vague Greenery standard, this alternative proposal would represent a call to the legislature to clarify a traditionally ambiguous area of the law.

CONCLUSION

The federal statute governing Medicaid's application to undocumented immigrants, 42 U.S.C. § 1396b(v), contains ambiguous language. This statute generally states that medical treatment provided to an undocumented immigrant is only covered under Medicaid when an undocumented immigrant suffers from an "emergency medical condition." The phrase "emergency medical condition," however, is defined in a manner that leaves the following issue unresolved: is treatment received by an undocumented immigrant for chronic, debilitating

227. See Greenery Rehab. Group, Inc. v. Hammon, 150 F.3d 226, 233 (2d Cir. 1998) (holding that the statutory definition of "emergency medical condition" is plain in meaning).
229. See Greenery, 150 F.3d at 233.
231. Id. § 1396b(v)(2)(A).
conditions over an extended period of time nonetheless covered by the Medicaid Assistance Program? 232

The Second Circuit constructed a test in its Greenery decision to assist courts in determining the scope of the phrase “emergency medical condition.” 233 The court construed this phrase to mean that a medical condition is covered under the Medicaid program as long as the condition at issue necessitates “immediate medical attention.” 234 This standard, however, provides very little guidance to reviewing state courts. 235 As a result, state courts, aided only by a subjective standard and an ambiguously worded statute, have produced vastly inconsistent holdings as to whether treatment for chronic, debilitating conditions comes within the purview of § 1396b(v)(2)(A). 236 These inconsistencies have generated inequitable circumstances and unpredictability in this area of the law. 237 For these reasons, the Greenery test has proven to be ineffective and unworkable. 238 An alternative approach to analyzing this issue is needed. 239

An examination of the legislative history of § 1396b(v) and its relationship with other federal statutes reveals a promising solution to the problems created by the Greenery standard. 240 Legislative history indicates that the legislature intended for § 1396b(v)(3) and § 1395dd(e)(1) of EMTALA to have the same meaning. 241 As a result, the meaning of “emergency medical condition” under § 1396b(v) becomes clear. Because EMTALA’s provisions indicate that an “emergency medical condition” only occurs when stabilization is necessary, treatment for chronic conditions should not be covered by Medicaid under § 1396b(v). 242 Thus, under Medicaid, only treatment for medical conditions that necessitate patient stabilization should be covered.

233. Greenery, 150 F.3d at 231.
234. Id. at 232.
236. See, e.g., Quiceno v. Dep’t of Soc. Servs., 728 A.2d 553, 555-56 (Conn. Super. Ct. 1999) (concluding that a chronic condition that necessitates long-term care may not be included within the meaning of “emergency medical condition”). But see, e.g., Szewczyk, 881 A.2d at 272-74 (determining that a chronic condition may be included within the definition of “emergency medical condition”).
237. See supra Part V.
238. See Szewczyk, 881 A.2d at 287-88 (Sullivan, C.J., dissenting).
239. See id. at 274-75.
240. See id. at 275.
243. See id. at 284.
The judiciary should adopt this bright-line standard to clarify what conditions are actually covered under the exception provided by § 1396b(v)(2)(A). Unlike the Greenery standard's vague approach, this proposal would create identifiable boundaries regarding what medical conditions qualify undocumented immigrants for Medicaid coverage. As a result of such defined boundaries, this proposal would motivate hospital personnel to provide treatment to undocumented immigrants who genuinely need emergency care. In addition, this alternative standard would create a powerful incentive for the legislature to finally clarify Medicaid’s application to undocumented immigrants. Judicial adoption of Judge Sullivan’s proposed standard would represent a call to the legislature to move forward and provide clarification in this uncertain area of the law.