Campbell Law Review

Volume 20
Issue 1 *Winter 1997*

Article 4

January 1997

North Carolina Hospitals' Dilemma: The Inherent Conflict between Carolina ACCESS and the Emergency Medical Treatment and Active Labor Act

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NORTH CAROLINA HOSPITALS' DILEMMA: THE INHERENT CONFLICT BETWEEN CAROLINA ACCESS AND THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

Hospitals across North Carolina are now facing a dilemma. Carolina ACCESS, North Carolina's managed care strategy designed to govern Medicaid patients, has established a stringent Emergency Room Policy. This policy, enacted in July of 1993, denies Medicaid payment for hospital charges of non-emergent conditions except for a twenty-two dollar initial examination fee. Therefore, the policy leaves hospitals with two costs. They are first responsible for any costs of their initial examination over Carolina ACCESS' limited payment. Second, they must pay for any treatment they give without first contacting Carolina ACCESS for permission. At the same time, the Emergency Medical Treatment and Active Labor Act ("EMTALA") governs the majority of North Carolina's hospitals.[1] This Federal statute requires hospitals to provide an "appropriate medical screening examination" for every patient that demands one.[2]

The North Carolina hospitals' dilemma is that the Emergency Room Policy and the EMTALA are inconsistent. The EMTALA requires a hospital to conduct an "appropriate screening examination" and imposes severe penalties for failure to do so. However, Carolina ACCESS' Emergency Room Policy will only pay twenty-two dollars for such an examination when the condition is not deemed an emergency. While twenty-two dollars may be sufficient for some routine examinations, it certainly is not adequate to cover costs for most examinations deemed "appropriate". Hospitals are probably going to be unwilling to violate the EMTALA and as a result they will lose money. Therefore, hospitals will have to raise revenue from other departments in order to make up for these losses. Unfortunately, this will ultimately supersede the goals of Carolina ACCESS: improving cost-control, access and quality.[3]

1. 42 U.S.C. § 1395dd (1994).

2. § 1395dd.

3. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 1. (All Medicaid Bulletins cited in this comment are on file in the Law Review Office.).

This comment will show that Carolina ACCESS' Emergency Room Policy forces hospitals into a difficult situation. On one hand, the EMTALA binds emergency departments to appropriately screen all persons who enter its doors. On the other hand, Carolina ACCESS tells a hospital that it will pay for only certain services leaving the hospital to make a choice: lower its exam standards thus risking liability under EMTALA, or conduct an appropriate exam and then suffer the economic loss when the patient's condition is deemed non-emergent.

Part I of this article will introduce Carolina ACCESS and its history. Part I will also discuss in detail the Emergency Room Policy which states that a hospital will only receive twenty-two dollars for conducting an initial medical screening. Part II will discuss the EMTALA and explain the Congressional basis for this Act. Part III will show the inherent conflict between Carolina ACCESS' Emergency Room Policy and the EMTALA. It will also examine possible solutions for this problem and why none of these solutions are satisfactory for hospitals or patients.[4] The only effective solution is to abolish the current Emergency Room Policy.

I. CAROLINA ACCESS

Carolina ACCESS is North Carolina's Medicaid managed care strategy.[5] The North Carolina Department of Human Resources Division of Medical Assistance (DMA) governs it.[6] The DMA

4. Managed care is becoming more a part of American's lives. States have offered Medicaid services in the form of managed care for years. However, only recently in such states as Tennessee have they made it mandatory. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 2.

5. *Id.* This bulletin included a letter from the Secretary of the Department of Health and Human Resources H. David Bruton. In this letter, Secretary Bruton commits the State to remaining "responsible for maintaining a system of quality care for its Medicaid population." *Id.*

6. North Carolina Department of Health and Human Services, (visited Oct. 28, 1997) <http://www.state.nc.us/DHR/docs/divinfo/dma.htm> (on file in Law Review Office). In the September 1993 MEDICAID BULLETIN, DMA listed its goals for Carolina ACCESS: "(1) Improve access to primary care for Medicaid recipients. (2) Establish comprehensive patient/physician relationships. (3) Reduce inappropriate use of emergency room services. (4) Promote the preventive aspects of health care. (5) Optimize the state and counties' investment in health care for recipients." MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

began this program in five counties on April 1, 1991,[7] partially in response to the enormous operation costs of the Medicaid system.[8] DMA also designed Carolina ACCESS in order to encourage more efficient arrangements in both the delivery and coordination of recipient care.[9]

The process of implementing Carolina ACCESS into a county begins with DMA's attempt to contract with primary care physicians ("PCP") in the area to deliver and coordinate recipient health care.[10] Once a sufficient number of PCPs agree to participate, the DMA will institute Carolina ACCESS in that county. Each eligible Medicaid recipient of Carolina ACCESS will then select the participating physician of his choice.[11] DMA considers the chosen physician as the patient's primary care provider.[12] As the name indicates, a PCP must provide primary care services and also coordinate ACCESS to hospitals as needed.[13] Once an eligible patient has chosen an acceptable PCP, Carolina ACCESS enrolls the patient into the Carolina ACCESS program.[14] As of

7. These counties included Durham, Edgecombe, Henderson, Moore and Wilson. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina) March 1991, Number 153, at 7.

8. In 1995 over $150,000,000,000 was spent on Medicaid payments. *Welcome to HCFA, the Medicare and Medicaid Agency* (visited Nov. 7, 1997) <http://www.hcfa.gov./medicaid/mcdsta95.htm> (on file in Law Review Office).

9. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), March 1991, Number 153, at 7. It is another argument as to whether this plan has worked. Medicaid spending grew at a rate of 17% in 1996. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 1.

10. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), March 1991, Number 153, at 7. "Primary Care physicians may include general practitioners, family practitioners, pediatricians, obstetricians, and general internists. In addition, centers (including Community Health Centers, Rural Health Centers, Physician Group Practices, Health Department Primary Care Clinics, and Hospital Outpatient Clinics) may be enrolled as long as the center has at least one full-time physician or nurse practitioner/physicians' assistant working thirty hours a week." *Id.*

11. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

12. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), March 1991, Number 153, at 7. The primary care provider must be able to provide most primary care services and to coordinate access to other needed medical services including after hours care. *Id.*

13. *Id.*

14. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), July 1991, Number 157, at 5. Eligible Medicaid recipients include those categorized in Aid to Families with Dependent Children; Medicaid Indigent

May 1997, Carolina ACCESS included 47 counties and 300,000 people.[15] DMA's current goal is to expand the program into all one hundred of North Carolina's counties by 1999.[16]

Carolina ACCESS may have made life easier for its primary physicians and patients, but the same is probably not true for hospitals. On July 1, 1993, Carolina ACCESS put into effect a new emergency room policy for all its patients.[17] Carolina ACCESS announced that it would cover treatment in the Emergency Department only in the case of a "true emergency".[18] Carolina ACCESS' policy requires that the Emergency Department staff determine whether a "true emergency" exists prior to treatment.[19] Once the staff determines that a "true emergency" does exist it may then treat the patient.[20] However, if the staff determines that the patient's condition is not a true emergency, Carolina ACCESS will not pay for any treatment of that patient in the Emergency Department.[21] In these cases, the hospital must first refer the patient to his PCP for treatment.[22] If the patient suffers

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Children; Aged; Blind; and Disabled. Carolina ACCESS does exclude some groups from participation in this program. These include individuals in mental hospitals, nursing facilities, personal care homes, foster care or subsidized adoption, domiciliary care facilities, and refugees. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), March 1991, Number 153, at 7.

15. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 2.

16. *Id.*

17. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

18. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), June 1994, Number 4, at 2. Carolina ACCESS sent out a list of all diagnoses that constitute a "true emergency" in June 1993. It supplemented this list with additional diagnoses in the November 1993 MEDICAID BULLETIN.

19. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), July 1993, Number 7, at 8.

20. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), June 1994, Number 4, at 2. Carolina ACCESS will pay for treatment of true emergencies. *Id.*

21. *Id.* Between 8:00 a.m. and 6:00 p.m. a PCP may not authorize treatment of a non-emergent condition in the Emergency Room. Between 6:00 p.m. and 8:00 a.m. claims should also be referred to the PCP. However, "if it is clear that treatment cannot be delayed, the PCP may authorize the ED to treat a non-emergent condition after hours." *Id.*

22. *Id.* If the hospital chooses to treat the patient, it must first inform him that he will not be treated as a Medicaid patient. It must inform him that it will treat him as a private patient. Essentially, this means that the patient is going to be responsible for the costs of services administered. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), June 1996, Number 6, at 4.

from a non-emergent condition, the hospital may only bill Carolina ACCESS a twenty-two dollar assessment fee.[23] This is the maximum a hospital may charge, regardless of whatever measures or expenses the hospital incurred in determining the patient's condition.[24]

Carolina ACCESS cites two purposes for this policy: (1) it is attempting to cure inappropriate use of the emergency room by Medicaid participants[25] and (2) it wants to ensure that hospitals will redirect patients to the PCP.[26] Carolina ACCESS also stresses these points with its participating patients. Almost all the literature it distributes reminds the patient of this policy.[27] According to H. David Bruton these objectives will help Carolina ACCESS meet the ultimate goals of improved cost control, access and quality.[28]

II. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

North Carolina's hospitals are governed by the EMTALA which requires hospitals to screen patients regardless of their ability to pay for services. In all likelihood, the federal requirements for screening will require much more than a mere twenty-two dollar fee.

A. Affected Provision

For the purposes of this comment, the Emergency Department policy of Carolina ACCESS affects one provision of the EMTALA. The affected provision of the EMTALA states that:

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23. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), June 1994, Number 4, at 2.

24. *Id.*

25. *Id.* Academic sources reveal that traditional Medicaid programs actually encourage emergency room visits. French, Bettina, The Urgent Care Crunch, *Hospitals and Health Networks*, February 20, 1995, p. 34.

26. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), June 1994, Number 4, at 2. The idea of linking one certain physician with a patient is also part of the attempt to curb emergency room use. According to the program, the PCP is supposed to make himself available for daytime and after hours medical advice. This, in theory, will keep Carolina ACCESS patients out of the Emergency Room when it is not necessary. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

27. *See* Carolina ACCESS Brochure (on file in Law Review Office).

28. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 1.

> 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 including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.[29]

A failure to abide by this provision could lead to substantial liability for a hospital or an emergency department physician.[30] Specifically, EMTALA calls for both public and private enforcement of its requirements.[31] Under the EMTALA, the Secretary of Health and Human Services may seek civil monetary penalties against hospitals and physicians who violate the provisions of the EMTALA.[32] The statute also grants a private cause of action for those who obtain injuries as a result of an EMTALA violation.[33] However, a private citizen's claim lies only against a hospital and not against a physician.[34]

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29. 42 U.S.C. § 1395dd(a).

30. § 1395dd(d)

31. Lane v. Calhoun-Liberty County Hosp. Ass'n Inc., 846 F. Supp. 1543, 1547 (N.D. Fla. 1994).

32. 42 U.S.C. § 1395dd(d)(1)(A). The statute limits the amount of damages that a public action may obtain at $50,000 (or $25,000 if the hospital has less than 100 beds) for a civil monetary penalty. It also limits the damages recoverable from a physician liable under this section to $50,000. § 1395dd(d)(1)(B).

33. 42 U.S.C. § 1395dd(d)(2)(A) (1994) states as follows:

> any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

34. Baber v. Hospital Corp. of Am., 977 F.2d 872, 877 (4th Cir. 1992). Many people have claimed that a private cause of action extends to physicians as well as hospitals. However, courts are uniform in finding that a private cause of action does not extend against a physician for violation of this statute. *See* Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995). The legislative history behind this amendment which added the second action, "clarifies that actions for damages may be brought only against the hospital which has violated the requirements. . . ." H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 3 at 6-7, *reprinted in* 1986 U.S.C.C.A.N. 728.

B. *History and Purpose of the Act*

President Reagan signed EMTALA as a part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA).[35] Both health costs and the numbers of uninsured patients increased dramatically in the 1980s.[36] Congress became concerned "about the increasing number of reports that hospital emergency rooms were refusing to accept or treat patients with emergency medical conditions if the patient did not have medical insurance."[37] It felt that hospitals were abandoning their traditional role of providing emergency care to all as a cost-cutting measure.[38] As a result, Congress enacted this statute to deal with what is referred to as patient dumping, "the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized."[39] Congress wrote the Act to ensure that a hospital gives each emergency room patient the same level of treatment regularly provided to patients in the same medical circumstances.[40]

C. *To Whom Does the EMTALA Apply?*

Congress has conditioned the Act's effectiveness on hospitals with two characteristics. First, a hospital must have an emergency department.[41] Second, and more importantly, Congress conditioned a hospital's continued participation in the Federal Medicare program on acceptance of the duties that the new law imposed.[42] The Medicare requirement gives great incentive for a

35. Brodersen v. Sioux Valley Mem'l Hosp., 902 F. Supp. 931, 938 (N.D. Iowa 1995).

36. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991).

37. H.R. Rep. No. 99-241 (1986), at 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605.

38. Brooks v. Maryland Gen. Hosp., Inc., 996 F.2d 708, 710 (4th Cir. 1993).

39. Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994). The act was to ensure "an adequate first response to medical crisis" and "send a clear signal to the hospital community . . . that all Americans regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." 131 Cong. Rec. S13904 (1985) (Statement of Senator Durrenberger).

40. Gatewood , 933 F.2d at 1047.

41. § 1395dd(a) applies the regulations only to hospitals with emergency departments.

42. Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995), *cert. denied*, 116 S.Ct. 1423 (1996). Section 1395dd(e)(2) defines participating hospital

hospital to comply with the statute, because it is a source of "lucrative revenue" for those institutions.[43] Few hospitals can afford to turn away Medicare benefits. Thus, this statute's effect is extensive.

D. The Affirmative Duties and the Appropriate Medical Screening Examination

The EMTALA requires a hospital to do two things. It first requires that if an individual seeks treatment at a hospital's emergency room, "the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition exists."[44] If the screening examination reveals an emergency condition, the hospital must then "stabilize the medical condition" before transferring or discharging the patient.[45] The Act thus imposes a "limited duty on hospitals to provide emergency care to all individuals who come there."[46]

The Statute does not define the term "appropriate medical screening" other than to declare that its purpose is to identify an emergency medical condition.[47] The Act also provides that the

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to mean the hospital "has entered into a provider agreement under section 1395cc of this title." Section 1395cc addresses Medicare agreements.

43. *Correa*, 69 F.3d at 1189.

44. Vickers v. Nash Gen. Hosp., 78 F.3d 139, 142 (4th Cir. 1996).

45. *Id.* (quoting § 1395dd(b)(1)). The provisions and requirements of appropriate stabilization and transfer of patients are beyond the scope of this article.

46. *Vickers*, 78 F.3d at 142. The First Circuit has instituted three elements to establish a cause of action. The plaintiff must show:

> (1) the hospital is a participating hospital, covered by the EMTALA, that operates an emergency department (or an equivalent treatment facility); (2) the patient arrived at the facility seeking treatment; and (3) the hospital either (a) did not afford the patient an appropriate screening in order to determine if she had an emergency medical condition or (b) bade farewell to the patient (whether by turning her away, discharging her, or improvidently transferring her) without first stabilizing the emergency medical condition.

Correa, 69 F.3d at 1190.

47. *Baber*, 977 F.2d at 879. The EMTALA defines an emergency medical condition as:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (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.

screening must take place within the capability of the emergency department, including all ancillary services available.[48] Given the lack of definition in the statute, courts have created their own definition of an appropriate medical screening examination. They have reached a fairly uniform test.

According to various federal courts, a hospital conducts an appropriate screening examination if it develops a screening procedure designed to identify critical medical conditions that exist in patients and then uniformly applies that screening procedure to all patients with similar complaints.[49] Thus, a proper screening is determined by examining a hospital's procedures and determining if it in fact followed them. The essence of this test is that a hospital must develop some type of standardized screening procedure and then apply it uniformly to all patients who come to the emergency room.[50]

Courts, though, have not interpreted the statute to require that hospitals develop one general procedure for all patients.[51] Emergency departments may tailor procedures to particular complaints or to particular symptoms.[52] In *Baber v. Hospital Corp. of America,* the court gives the example of having one procedure for people suffering a heart attack and a different procedure for women in labor.[53] These different procedures would not impose liability under the statute as long as people complaining of the same problem or having similar symptoms receive identical screening procedures.[54]

Courts have also been quick to decide that this statute does not establish a national standard of care.[55] Congress did not intend that the act establish a "federal remedy for misdiagnosis or medical negligence."[56] Federal courts have uniformly found that a new standard of care was not within the legislative intent of this

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§ 1395dd(e)(1)(A) (1994).

48. §1395dd(a) (1994).

49. *See Correa*, 69 F.3d at 1192; Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994); *Baber*, 977 F.2d at 879; *Gatewood*, 933 F.2d at 1047.

50. *Correa*, 69 F.3d at 1192.

51. *Baber*, 977 F.2d at 876 n.6.

52. *Id.*

53. *Id.*

54. *Id.*

55. *See* Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1137 (8th Cir. 1996); *Vickers*, 78 F.3d at 142; *Correa*, 69 F.3d at 1193; *Baber*, 977 F.2d at 872, 878; *Gatewood*, 933 F.2d at 1041.

56. *Vickers*, 78 F.3d at 142 (quoting *Power,* 42 F.3d at 856).

Act.[57] The EMTALA does not guarantee that emergency personnel will correctly diagnose an emergency condition.[58] The statute merely requires that a hospital apply uniform procedures to all patients, and thus applies only to disparate screenings, not faulty screenings.[59] The Statute leaves a remedy for failed or incorrect diagnosis to state negligence and malpractice law.[60]

E. Correa v. Hospital San Francisco[61]

Correa presents an excellent application of the requirement of the appropriate medical screening exam. The plaintiffs in this case were the surviving children of Carmen Gloria Gonzalez-Figueroa (Ms. Gonzalez), a sixty-five-year-old widow.[62] Ms. Gonzalez's son, Angel Correa, testified at trial that on the morning of September 6, 1991, his mother awoke feeling terrible, experiencing chills, dizziness, and chest pains.[63] Upon her request, Angel took her to the emergency room of the Hospital San Francisco.[64] According to Angel, they arrived around 1:00 p.m.[65] Upon arrival, the hospital assigned Ms. Gonzalez the number forty-seven and told her to bide her time.[66] Hospital personnel also checked her insurance card.[67]

Angel testified that they waited for approximately one hour.[68] At that point, Angel called his sister Esther to come and relieve him at the hospital.[69] She arrived at approximately 2:15 p.m., some fifteen minutes after his call.[70] Angel testified at trial that when she arrived the emergency department staff called for number twenty-seven.[71] Ms. Gonzalez and her daughter waited

57. *Brooks*, 996 F.2d at 714-715; *Eberhardt*, 62 F.3d at 1258. *See also* Cleland v. Bronson Health Care Group Inc., 917 F.2d 266, 272 (6th Cir. 1990); *Gatewood*, 933 F.2d at 1041.
58. *Baber*, 977 F.2d at 879.
59. *Correa*, 69 F.3d at 1192.
60. *Vickers*, 78 F.3d at 142.
61. *Correa*, 69 F.3d 1184.
62. *Id.* at 1188.
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.*
68. *Correa*, 69 F.3d at 1188-1189.
69. *Id.* at 1189.
70. *Id.*
71. *Id.*

for an additional forty-five minutes.[72] At that point, they left and drove to the office of Dr. Acacia Rojas Davis (Dr. Rojas) at Hospmed.[73] Dr. Rojas testified that she received a call earlier that day that Ms. Gonzalez would be coming to her office for treatment.[74] Upon arrival, Ms. Gonzalez informed Dr. Rojas of her symptoms and that she had taken a double dose of her high blood pressure medication.[75] Dr. Rojas immediately began treating Ms. Gonzalez.[76] At one point, she had to resuscitate her.[77] Ultimately, Ms. Gonzalez passed away before Dr. Rojas could transfer her to the hospital.[78]

In its analysis, the *Correa* court discussed Hospital San Francisco's internal screening procedures.[79] Hospital San Francisco's standard procedures required the emergency room staff to promptly take the vital signs of every patient who visited the facility.[80] It also required the staff to make a written record of all such visits.[81] Hospital procedures required personnel to treat patients with chest pains as critical and immediately refer them to an in-house physician.[82] The First Circuit Court of Appeals concluded that the jury could have inferred that the hospital did not comply with its own screening procedures.[83] Hospital San Francisco presented no records, nor did it present evidence that any staff member took Ms. Gonzalez's vital signs.[84] Further, the hospital did not refer Ms. Gonzalez to an in-house physician as was their standard practice with people complaining of chest pains.[85] Therefore, the First Circuit concluded that Hospital San Francisco violated the EMTALA because it did not treat patients with the same symptoms in the same fashion.[86]

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72. *Id.*
73. *Id.*
74. *Id.*
75. *Correa*, 69 F.3d at 1189.
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.* at 1193.
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.*
85. *Correa*, 69 F.3d at 1189.
86. *Id.* The hospital had to pay substantial damages. The trial court awarded each of Ms.Gonzalez's three children $100,000. It also awarded $50,000 to each

F. *The Split in Authority Over the Requirement of Economic Motive*

Federal courts throughout the country have differed on whether a patient must show that the hospital varied its procedures because of the patient's inability to pay.[87] On one side of this debate is the Sixth Circuit's ruling in *Cleland v. Brown Health Care Group*.[88] The *Cleland* court recognized that Congress's intent to eliminate patient dumping was the major force behind the EMTALA.[89] In its analysis, it considered the "appropriateness" requirement and concluded that "appropriate must more correctly be interpreted to refer to the motives with which the hospital acts."[90] It thus imposed a requirement of improper motive on an EMTALA action.

Conversely, other courts side with the D.C. Circuit's decision in *Gatewood v. Washington*.[91] In *Gatewood*, the D.C. Circuit flatly rejected any requirement of economic motive for an EMTALA claim.[92] The court recognized that the Act's legislative history reflected an "unmistakable concern with the treatment of uninsured patients."[93] However, the statute's overwhelmingly clear language precluded it from finding an economic motive.[94] Thus, the court chose to apply the clear meaning of the statute's provision of "any individual."[95] It reasoned that statutory language bound it since such language was clear and not manifestly inconsistent with legislative intent.[96]

The Fourth Circuit has chosen to follow the example of the *Gatewood* court.[97] In *Power v. Arlington Hospital Ass'n*, the court found three legitimate reasons for refusing to impose a motive

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of her four grandchildren. Finally, it assessed damages in the amount of $200,000 for pain and suffering. This totaled $700,000. *Id.* at 1189.

87. *See* Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990).

88. *Cleland*, 917 F.2d 266.

89. *Id.* at 271.

90. *Id.* at 272.

91. *Gatewood*, 933 F.2d at 1040.

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Power*, 42 F.3d at 857. The Eastern District of North Carolina has also rejected any improper motive requirement in Jones v. Wake County Hosp. Sys., Inc., 786 F. Supp. 538, 544 (E.D.N.C. 1991).

requirement.[98] First, the statute contains no language about indigency, inability to pay or any other improper motive.[99] Second, it found that the motive requirement in *Cleland* was so expansive that it amounted to no limit at all.[100] Finally, the problem of proving an improper motive most troubled the court. The court concluded that such a requirement would make a civil EMTALA claim essentially impossible.[101]

III. Is the Emergency Room Policy Consistent with the Appropriate Medical Screening Examination?

The practical effect of the Emergency Department policy is that it is inconsistent with an appropriate medical screening as required by EMTALA. While twenty-two dollars may be sufficient to conduct an appropriate screening for some conditions, it certainly will not cover the costs of the majority of such examinations. The Emergency Department procedure appears not only to contravene the goals of the EMTALA, but it also defeats many of the legitimate goals of Carolina ACCESS. Primarily, this policy hinders the goal of optimizing the state's investment in health care and improving access to primary care for its patients.[102] Thus, before the Department of Human Resources institutes Carolina ACCESS into all of North Carolina's one hundred counties, the options which Carolina ACCESS leaves to North Carolina's hospitals deserve some reflection.

On their face, Carolina ACCESS and EMTALA requirements appear to be consistent with one another. In fact, the Health Care Financing Administration ("HCFA"), the federal agency that administers Medicaid and Medicare,[103] has determined that Carolina ACCESS' emergency room screening procedure does not put hospitals in the position of violating the EMTALA.[104] According to HCFA, a hospital meets the requirement of an appropriate medical screening by making an original assessment and a refer-

98. *Power*, 42 F.3d at 857.

99. *Id.*

100. *Id.*

101. *Id.* at 858.

102. Medicaid Bulletin, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

103. *Welcome to HCFA, the Medicare and Medicaid Agency* (visited Nov. 7, 1997) <http://www.hcfa.gov/> (on file in Law Review Office). Its other major duty is the regulation of laboratory testing throughout the United States.

104. Medicaid Bulletin, (Division of Medical Assistance, North Carolina), July 1993, Number 7, at 8.

ral to that patient's primary care provider.[105] However, even though Carolina ACCESS will allow a preliminary screening to determine whether an emergency condition exists, it will only pay twenty-two dollars for this test. The conflict between Carolina ACCESS and the EMTALA occurs because the overwhelming majority of tests that are necessary for an appropriate medical screening examination will cost the hospital a considerable amount more than twenty-two dollars.

What are the hospitals to do? If they continue to provide adequate appropriate tests, they risk the chance of incurring great losses in emergency department revenue. Practically, this will lead to service costs increasing and thus destroying the goal of the Emergency Room Policy. However, if they do not continue appropriately screening patients, they risk the possibility of overwhelming criminal and civil penalties under the EMTALA.[106] Carolina ACCESS' Emergency Department procedure is thus extremely problematic.

A. Hospital Options

1. Lower Screening Standards for the Initial Examination

The most obvious answer to the EMTALA/Carolina ACCESS dilemma is for a hospital to create a less expensive initial screening examination. However, the hospital would have to ensure that the in-house cost of its examination would be less than or equal to the twenty-two dollars that Carolina ACCESS is willing to pay for such a screening. If it does not ensure such a cost then a hospital is doomed to lose money and any change would not assist its financial needs. Thus, in order to protect itself from financial trouble, a hospital must develop a twenty-two dollar initial screening examination to determine if there is an emergency condition.

In order to create a cheaper screening examination, a hospital would have to lower its current standards of initial examination. Cost-saving measures would probably dictate the elimination of the use of any technology or machinery to determine an emergency. It is also almost certain that emergency department personnel would have to limit the amount of time they spend with a patient to a bare minimum. The likely result of such a practice

105. *Id.*

106. In *Correa*, Hospital San Francisco had to pay $700,000 in damages. *Correa*, 69 F.3d at 1189.

would be for a hospital to create one general test for every patient which would no longer distinguish between symptoms. A general test of this type would probably consist of a few questions and answers and a brief visual examination by an emergency department staff member.[107] While this option looks promising and in fact seems to coincide with what Carolina ACCESS recommends, many reasons exist to show why this option is not a practical or legal solution to a hospital's dilemma.

a. Conflict with EMTALA

The plaintiff in *Baber* argued that the hospital did not provide any medical screening to the patient.[108] The Fourth Circuit Court of Appeals disagreed with this contention but did agree that the EMTALA requires some medical screening to take place.[109] In its analysis, the court went on to discuss the term "appropriate" in the statute.[110] It noted that some commentators have expressed concern that hospitals could use this term to avoid liability by providing "cursory or substandard screenings."[111] The court declined to address this particular issue because it believed Ms. Baber had received some medical treatment by the hospital.[112] The court did not foreclose the possibility that a hospital's examination might be so low that it did not amount to an "appropriate medical screening."[113] However, the opinion firmly states that such a holding would not require that an emergency department render a correct diagnosis.[114] The *Baber* court has simply said that the possibility exists that a screening standard may be so low that it does not amount to an examination at all.

107. Whether a doctor has to conduct an appropriate medical screening under EMTALA is an issue upon which the courts have not yet made a final decision.

108. *Baber*, 977 F.2d at 879. Mrs. Baber's brother was the plaintiff in the action. *Id.* at 875. On the day in question he brought his sister to the hospital. *Id.* She was nauseated and agitated. *Id.* During her stay in the emergency room, she had a seizure and fell. *Id.* She injured her scalp which the doctors examined and sutured. *Id.* However, they did not order an X-ray. *Id.* at 876. She subsequently died because of a fractured skull and a right subdural hematoma. *Id.*

109. *Id.* at 878.

110. *Id.* at 879 n.7.

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.* at 879. As this comment has already pointed out in Part II, Subsection d, courts have uniformly held that EMTALA does not establish a national standard of care.

Baber suggests that there is a line that no hospital may cross in the creation of its appropriate medical screening examinations. If a hospital lowered its examination to a standard of twenty-two dollars, it is certainly reasonable to assume that it might fall within the type of substandard examination that the *Baber* court discusses. The result of such a cost decrease would be a decrease of the amount of services that a patient receives. The twenty-two dollar economic limitation prevents an emergency department staff member from conducting a proper examination. A court could easily conclude that the hospital's procedure amounted to no examination at all and could subject it to the extreme penalties of the EMTALA.

Such a decrease might also hinder a determination of an emergency medical condition. According to EMTALA, the purpose of an "appropriate medical screening" is to determine whether an emergency medical condition exists. A hospital's examination could be so substandard that it was not in fact tailored to determine the existence of an emergency medical condition. Again the twenty-two dollar limitation may not allow a staff member to conduct a minimum level examination.

Of course, one must first accept that a more thorough examination requires more expenditures to conduct those exams. But, *Baber* has stated that hospitals may not go below a certain standard in their appropriate medical screening examinations. If a twenty-two dollar test is not an example of a screening that falls below that standard, it is difficult to conceive what would. Therefore, a hospital opens itself to the possibility under the statute if it elects to lower its standards for screenings.

Further, this type of policy seems to contravene the purpose of EMTALA. Legislative history shows that Congress' concern was with the inadequate treatment of poor patients.[115] A lowering of screening standards would result in an inadequate screening exam for all patients poor and rich alike. Congress wanted to guarantee that all persons would have some type of exam when they went to the emergency room. This offered at least some protection for the health of people who could not afford emergency room visits. However, if hospitals lower their standards for screening under the economic pressure of Carolina ACCESS, the constraints created by Carolina ACCESS have destroyed the stat-

115. H.R. Rep. No. 99-241 (1986), at 5, *reprinted in* 1986 U.S.C.C.A.N. 42, 726-27.

ute's protection. Both the public's well-being and its confidence in the health care industry would suffer as a result.

b. Conflict with State Negligence Law

Courts have consistently stated that EMTALA does not create a national standard of care.[116] However, they have also uniformly concluded that the statute does not preclude recovery under state malpractice or negligence law.[117] In North Carolina, a plaintiff in a medical malpractice action may proceed against a hospital under two distinct theories: respondeat superior and corporate negligence.[118] Thus, a hospital could be financially responsible beyond the statute's penalties.

This presents a realistic problem for a hospital which lowers its standards for an initial screening. An emergency department's examination could conceivably fall below a level of reasonable care for its patients. The lowering of standards will likely result in missed diagnoses, a failure to diagnose, and, quite possibly, serious injury to patients. A plaintiff would recover once he showed that a hospital did not practice care in accordance with standards of practice among other hospitals in the same or a similar community.[119] Thus, the possibility of civil liability is too great for a hospital to lower its standards.

c. Conflict with Fundamentals of Medicine

In enacting EMTALA, Congress expressed concern that hospitals were abandoning their traditional practice of providing emergency care to all.[120] The Ways and Means Committee reported that they wanted:

> to provide a strong assurance that pressures for greater hospital efficiency are not to be construed to ignore traditional responsibilities and loosen historic standards.[121]

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116. *Gatewood*, 933 F.2d at 1041.

117. *Id.* at 1039.

118. Respondeat superior - charging the hospital with vicarious liability for the negligence of its employees, servants, or agents. Corporate negligence - charging the hospital with liability for its employees' violations of duties owed directly from the hospital to the patient. Clark v. Perry, 114 N.C. App. 297, 311, 442 S.E.2d 57, 65 (1994). The details of North Carolina negligence law are beyond the scope of this article.

119. *Id.* at 312, 442 S.E.2d at 65.

120. *Brooks*, 996 F.2d at 710.

121. H.R. Rep. No. 99-241 (1986), at 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605.

Thus, Congress enacted the EMTALA recognizing the strong historic commitment of those in the health care industry to provide emergency care for their patients. Society has also recognized this tradition. Webster's New International Dictionary defines physician as "one who is skilled in the art of healing."[122] Hospitals and health care practitioners have over time created a perception that their primary function is to help heal others. Thus, the public has come to trust and expect treatment when it is in need.

If a hospital decreases its standards, then it is decreasing its level of care. The hospital's purpose changes from healing patients to saving money. Physicians then become something less than a healer and violate the purpose of their profession. Some medical schools still administer the Hippocratic oath to their graduates.[123] One part of the oath requires doctors to perform their profession for the benefit of the sick.[124] If hospitals limit their services because of financial considerations, they are certainly not acting for the benefit of those who are ill. It in effect acts for the almighty dollar.

2. Raise Costs Elsewhere

The next logical step for a hospital is to acknowledge that it will lose some revenue from emergency department examinations. Therefore, if the hospital wants to compensate for this loss, it must find the revenue elsewhere. It seems that there are two ways that a hospital could perform this task. First, it could raise the prices for services to other patients. The hospital could increase the prices for tests, medicine, in-patient care, out-patient care, physical therapy, x-rays, and all other hospital activities to cover the lost revenue. Second, it could simply eliminate jobs. This would cut out the costs of salary and benefits for paid employees. While these solutions seem very logical, they also defeat the purposes of Carolina ACCESS.

a. Defeats the Primary Purpose of Carolina ACCESS.

In a Medicaid Bulletin from September of 1993, the Division of Medical Assistance states that one of the goals of Carolina

122. WEBSTER'S NEW INTERNATIONAL DICTIONARY 1707 (3d ed. 1971).

123. The Hippocratic Oath "is one of the earliest and most important statements on medical ethics." ENCYCLOPEDIA OF BIOETHICS 1731 (The Free Press Georgetown University) (Section I Appendix 1978).

124. *Id.*

ACCESS was to optimize the state and counties' investment in health care for recipients.[125] H. David Bruton's letter contained in the May 1997 Medicaid Bulletin states that his goal was to cut North Carolina's annual growth in Medicaid spending to eight percent.[126] The inference of these two goals is that the Division of Medical Assistance created Carolina ACCESS in order to save money for the taxpayers of North Carolina.

However, Carolina ACCESS' emergency room policy will not save the taxpayers' money. More than likely it will result in higher expenditures for them. If the policy forces hospitals to raise prices for their services then the taxpayers are still losing money. Hospitals simply obtain their revenue from other patients rather than from the government. In effect, the taxpayers are only delaying their payments for the disadvantaged citizens' health care. Further, the base of paying people has also been decreased. Instead of spreading the costs of a poor person's health case across the entire population, the only people covering the costs of indigent health care are those who become sick themselves.

Another possible result is that an increase in health care costs could make health care unaffordable for many citizens of North Carolina. This increase would force many of these people to obtain Medicaid benefits. This again would burden the taxpayers of North Carolina for increased expenditures.

b. Results in Poorer Quality of Care for Others

Carolina ACCESS also states that one of its goals is improving access to primary care for Medicaid Recipients.[127] Access to care involves a number of different factors. One primary factor is that qualified personnel exist to provide that care. Carolina ACCESS' Emergency Room policy may jeopardize a patient's access to personnel. Patients will certainly suffer if the policy forces hospitals to eliminate positions as a revenue-saving measure. Longer waits will follow as fewer people are working in the various departments of the hospitals. More importantly, the quality in care of the patient will also likely diminish. As fewer people

125. MEDICAID BULLETIN (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

126. MEDICAID SPECIAL BULLETIN, (Division of Medical Assistance, North Carolina), May 1997, Number III, at 1.

127. MEDICAID BULLETIN, (Division of Medical Assistance, North Carolina), September 1993, Number 9, at 4.

care for more patients, the tendency to become tired and rushed accelerates. This often results in mistakes and in the case of health care, these mistakes affect people's lives.

3. *Stop Accepting Medicare Payments*

EMTALA only applies to hospitals who receive Medicare benefits.[128] Thus, the easiest answer may be for hospitals to stop accepting Medicare payments. In effect, they would no longer be under any legal obligation to screen patients. They could merely accept only those people who could pay for their treatment.

This option is completely unrealistic. Medicare benefits generally account for a great amount of hospital revenue.[129] Further, an option like this one challenges the medical community's commitment to provide care to all. Medicare is a federal supplement for disadvantaged citizens. Hospitals would be opting out of treating these patients. This option would amount to letting the unfortunate go untreated while the rich would keep the luxury of health care.

B. The Proper Solution

One realistic answer to the conflict of Carolina ACCESS and the EMTALA is to eliminate Carolina ACCESS' Emergency Room Policy. If hospitals follow Carolina ACCESS' formula for screening then they risk being in violation of the EMTALA or state negligence law. If they find other ways to recover lost revenue, then they create various other social problems. Doctors, not the government or bureaucracy, need to make medical decisions. Federal law requires emergency room personnel to screen patients for emergencies. Carolina ACCESS should not hold doctors hostage as to what types of tests they should administer in order to ensure patient safety. The health of the patient and not financial considerations should be the primary concern of hospitals when they develop their procedures. Eliminating unnecessary emergency room use among Medicaid patients is a legitimate goal. However, North Carolina should not punish people that actually need treatment for other's misuse.

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128. § 1395dd(e)(2).
129. *Correa*, 69 F.3d at 1189.

IV. CONCLUSION

The Division of Medical Assistance wants to institute Carolina ACCESS in every county in North Carolina. Hospitals need to consider seriously the implication of lowering their initial screening examinations to make up for the limited fee that Carolina ACCESS provides. Lowering standards may result in a violation of EMTALA. Additionally, the Division of Medical Assistance needs to reconsider the implications of their Emergency Room Policy. This policy defeats the express purposes of Carolina ACCESS. Therefore, the Division of Medical Assistance should either eliminate the Emergency Room Policy altogether or remove the twenty-two dollar cap.

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