

**A Matter of Life & Death:
Advocates in New York Respond to Medical Repatriation**

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On the afternoon of February 28, 2000, Luis Alberto Jiménez was returning home from work when he was hit by a drunk driver in a stolen van near Palm Beach Gardens, Florida.² Mr. Jiménez was rushed to Martin Memorial Hospital Center (“Martin Memorial”), where he was stabilized, but only after suffering severe brain damage and significant physical injuries.³ According to his cousin and eventual guardian, Montejo Gaspar Montejo, “He was no longer Luis He didn’t talk. He didn’t understand anything. He stayed curled up in a ball. But he was alive.”⁴ Around the same time, on the opposite coast of Florida, a young woman named Terri Schiavo remained in a persistent vegetative state after suffering cardiac and respiratory arrest. Her situation and Mr. Jiménez’s sparked a several-years-long legal, political, and media maelstrom about who should live and who can die in the modern American medical system. In the Schiavo case, the loudest public voices were demanding life, even though, absent a “true miracle,” Ms. Schiavo would “always remain in an unconscious, reflexive state, totally dependent upon others to feed her and care for her most private needs.”⁵ Meanwhile, when it came to Mr. Jiménez, the loudest voices seemed comfortable with death. Though Mr. Jiménez eventually came out of his vegetative state, many supported Martin Memorial’s decision to “repatriate” him back to his home country of Guatemala, where access to appropriate long-term care was so uncertain even physicians from the country argued that repatriation virtually assured

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² Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1, available at <http://www.nytimes.com/2008/08/03/us/03deport.html> [hereinafter Sontag, *Immigrants*].

³ *Montejo v. Martin Memorial Hospital*, 935 So. 2d 1266, 1267 (Fla. Dist. Ct. App. 2006).

⁴ Sontag, *Immigrants*, *supra* note 2.

⁵ *In re Guardianship of Schiavo*, 780 So.2d 176, 177 (Fla. Dist. Ct. App. 2001); see also Dale H. Cowan, *United States Laws and the Rights of the Terminally Ill*, 28 MED. & L. 519, 524–25 (2009).

that Luis Jiménez was “going to die.”⁶ That Mr. Jiménez was an undocumented immigrant seemed to be a crucial factor in the public’s moral calculus. As one Florida resident put it, “A huge part of this downward spiral [in the U.S.] is because we have been taking care of people—financially, medically and every other way—who have no business being here.”⁷

This article is about the response of one group of advocates to the practice of medical repatriation, also referred to as medical deportation, in which hospitals choose to send non-citizen patients, usually those in need of long-term care, back to their home countries for treatment without engaging the federal immigration process.⁸ Medical repatriation has emerged as one of the most controversial and complicated issues in health policy—a dramatic example of the desperation created for both patients and providers due to the expanding fissures in the U.S. healthcare and immigration systems. Mr. Jiménez’s case is, in many ways, typical: under federal law, Martin Memorial was required to engage in a discharge planning process for Mr. Jiménez to locate the appropriate post-hospital services.⁹ However, patients without insurance or the ability to pay out of pocket are difficult to place into long-term care. Low-wage, undocumented workers such as Mr. Jiménez are not eligible for public benefits programs such as Medicaid,¹⁰ typically do not receive health insurance through their employers, and do not earn enough to pay for services themselves.¹¹ Not surprisingly, Martin Memorial was unable to find a long-term care facility that would receive Mr. Jiménez. The hospital’s proposed alternative was to “discharge” Mr. Jiménez back to his home country of Guatemala, above the objections of his guardian.

The litigation that ensued, which will be discussed in greater detail below, garnered national media attention and cast a spotlight on a practice that had been happening quietly for many years in hospitals across the country. Indeed, shortly after *The New York Times* published a lengthy cover story on Mr. Jiménez’s case in August 2008,¹² our New York-based office began receiving calls about undocumented patients in the New York City area who were at risk of being repatriated or who simply were not being accepted by hospices and nursing homes due to their immigration status. What we quickly discovered in attempting to handle these calls was how little we and others knew about the resources available, the scope of the problem, or the

⁶ Melissa E. Holsman, *Pathologist Testifies in Jimenez Case*, ST. LUCIE NEWS TRIBUNE, July 11, 2009, at B5 (quoting Dr. Miguel Garces).

⁷ Chris Gockman, Letter to the Editor, *Illegal Immigration: It’s Time to Stand Up, Put an End to This Crazy*, STUART NEWS, Mar. 2, 2009, at A6 (in response to news story about Mr. Jiménez’s case).

⁸ See Charlene Harrington et al., *Trends in the Supply of Long-Term-Care Facilities and Beds in the United States*, 24 J. OF APPLIED GERONTOLOGY 265, 265–66 (2005) (describing as long-term care services “those that are needed for long periods, such as more than 90 days. These are generally associated with limitations in activities of daily living as well as limitations in cognitive functioning and mental illness.”).

⁹ 42 U.S.C. § 1395x(ee) (2010).

¹⁰ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2261 (1996) (PRWORA).

¹¹ See Cory S. Bagby, *The Nexus Between Immigrant Eligibility and Access: An Analysis of the Economic, Social, and Linguistic Barriers to Health Care*, 17 ANNALS HEALTH L. 293, 294 (2008) (“Employer-based health insurance coverage is frequently unavailable to immigrants because they tend to work in low-wage jobs and in industries that do not traditionally offer health insurance to their employees. In 2003, the median annual salary for a full-time, non-citizen employee was \$23,140. Nearly 40% of this group had incomes below \$20,000 per year.”)

¹² Sontag, *Immigrants*, *supra* note 2.

strategies that could (or should) be used in response.

In an effort to better grapple with the problem, the Health Justice Program at New York Lawyers for the Public Interest (“NYLPI”) along with the New York Immigration Coalition (“NYIC”), and the New York Academy of Medicine (“NYAM”) decided to convene a statewide workgroup on medical repatriation and long-term care for undocumented immigrants. The workgroup consists of legal services providers from the fields of health law, immigration, and disability rights; concerned health care and other service providers; researchers; and representatives from government agencies, national advocacy groups and local community-based organizations.¹³ The goal of the workgroup is to better understand why hospitals engage in the practice of medical repatriation, how often they do so, and what should be done in response in both the short- and long-term.¹⁴

In this Article, we share our workgroup’s approach to understanding and addressing medical repatriation in the hope that some of what we have learned in New York will inform the advocacy of practitioners elsewhere. We should emphasize at the outset that our essay does not put forward any definitive solutions, legal or otherwise, to the practice of medical deportation. Rather, our focus is on describing the workgroup’s process and on outlining some of the tentative conclusions we have been able to draw from this process. Medical repatriation poses a veritable minefield of complications for advocates concerned with immigrant rights or health policy, and passions run high on both sides of the debate. A degree of deliberateness and caution in developing “answers” to the problem is warranted, and this is reflected in both the approach of our workgroup and in this Article.

Part I shares the findings of a series of structured interviews we conducted with health care providers, community advocates, and hospital social workers, which provide very preliminary data on the scope of the medical repatriation problem in New York and the reasons for its persistence. Part II discusses strategies that emerge out of the factual research we have conducted thus far. Part III concludes with a discussion of the recently enacted health care reform bill and the implications, if any, it may have for medical repatriation as well as with a discussion of the communications challenges that remain on the workgroup’s agenda if we are to make meaningful progress in providing care to some of the country’s most vulnerable patients.

¹³ At the time of writing, the entities represented in the workgroup are: Cabrini Center for Nursing and Rehabilitation, Center for Independence of the Disabled New York, Committee of Interns and Residents, Community Service Society of New York, Empire Justice Center, FRIA, HIV Law Project, Legal Aid Society, Long Term Care Community Coalition, Make the Road New York, National Health Law Program, National Immigration Law Center, New York City Department of Health, New York City Health and Hospitals Corporation, New York Legal Assistance Group, NYU Center for Immigrant Health, Vera Institute of Justice, and Visiting Nurse Service.

¹⁴ Members of the group meet quarterly to set goals and uniform priorities. Because the group cuts across multiple disciplines, practitioners have subdivided based on their areas of expertise. Sub-committees have formed to address legal, policy, communications, data, financial, and availability of services issues. Each subgroup conducts research and develops project models and plans that inform the direction of the larger working group.

Part I: The Problem

No reliable data exist on the frequency with which medical repatriations take place,¹⁵ making systemic policy advocacy difficult. In order to get a better sense of the extent to which New York hospitals engaged in the practice, staff from NYLPI and the NYIC conducted two dozen structured interviews over the course of six months with advocates, health care providers, and hospital social workers throughout the New York metropolitan area to find out whether hospitals in the state were repatriating patients to their home countries, how often, and why.¹⁶ The interviews fulfilled two goals: (1) to collect data and anecdotal information from practitioners on the frontlines of health advocacy and delivery and (2) to conduct outreach and inform practitioners about the efforts of the working group and to recruit new participants. Our results revealed some interesting patterns with respect to both the scope and source of the problem in New York. Most notably, we found that health care providers admitted to repatriating uninsured immigrant patients, but they said they did so only if the patients or their representatives agreed to such a discharge—an unexpected finding given highly-publicized cases such as Mr. Jiménez’s, where repatriation took place despite the guardian’s objections. In addition, we heard from many health care providers that the practice of medical repatriation is rooted in deep structural and financial problems within the health care delivery system, but we also discovered some low hanging fruit: cases in which mere compliance with existing patients’ rights laws could have (and did) prevent repatriations from occurring. The trends revealed in our survey, some counter-intuitive and others not, provide the critical data to guide our advocacy in both the short- and long-term.

a. *Scope of the Problem*

Of the interviews we conducted, almost half were with health care providers and hospital social workers, and these interviewees reported that they saw between two and four cases per year in which an undocumented patient was faced with potential or actual repatriation. The practice thus seems to be employed consistently if not frequently. More notably, the hospital-based interviewees we spoke with said they would not repatriate an immigrant patient against her wishes, and they tended to provide anecdotal information about “voluntary” medical repatriations only—that is, cases in which patients or their representatives provided some form of

¹⁵ Compare Sontag, *Immigrants*, *supra* note 2 (“Medical repatriations are happening with varying frequency, and varying degrees of patient consent, from state to state and hospital to hospital. No government agency or advocacy group keeps track of these cases, and it is difficult to quantify them.”), with Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009) (“No state or federal government agencies track medical repatriations, so it is difficult to gauge their frequency nationwide . . .”).

¹⁶ Throughout this section, the names and affiliations of interviewees were omitted to protect confidentiality. All notes and records of these interviews are on file with the authors. It is worth noting that our most informative interviews were with hospital social workers, who straddle the line between hospital employee and patient advocate and are frequently in charge of crucial aspects of discharge planning such as billing, finding family, researching post-acute facilities, and contacting consulates and health care facilities in other countries. Advocates in other areas looking to conduct similar surveys of medical repatriation practices in their areas would be well-advised to focus their research on hospital social workers.

consent. The two cases of involuntary repatriation that were reported during our survey both came from staff at an advocacy organization.

This emphasis on voluntary repatriation may be an accurate reflection of the frequency with which patients are choosing to be returned to their home country instead of being forced to do so, or it could indicate a flaw in our survey methodology, in that hospital staff may be uncomfortable revealing that they have repatriated an individual against his or her will to surveyors from immigrant advocacy organizations. More research would certainly need to be done to better understand and refine these results, but the fact that so-called voluntary repatriations are being pursued with regularity suggests that the nature of consent provided in these cases also requires exploration.

As one commentator has noted, groups like the California Medical Association (“CMA”) and the American Medical Association (“AMA”) “have focused on ‘forced’ repatriations without defining the word ‘forced.’”¹⁷ In practice, it is unclear whether patients are advised about the immigration or even the full medical consequences of their agreeing to be sent back home, raising questions about the meaningfulness of the consent provided in these cases.¹⁸ A host of consent issues also arise in cases where the patient is in a coma or has a severe mental disability and a guardian has been appointed. For example, in a case with which our office was briefly involved, Kong Fong Yu, an elderly, undocumented man from China, suffered a stroke and found himself in a New York hospital for almost two years before the hospital began considering repatriation.¹⁹ The temporary guardian who was appointed for Mr. Yu opposed the hospital’s proposed plan to return him to China. However, during the course of our limited involvement with the case, questions arose about whether Mr. Yu himself had expressed a desire to return to China as well as the extent of the guardian’s power.²⁰ The need to ensure that Mr. Yu had access to appropriate medical care and a reasonable discharge option rubbed up against concerns that

¹⁷ Wolpin, *supra* note 15, at 153.

¹⁸ It has been proposed that to ensure consent in medical repatriation cases is informed and valid, hospitals could be required to inform patients about the possible immigration consequences of being returned to their home country, much the same way non-citizen defendants in criminal court are protected by statutes requiring them to be notified of the collateral consequences of a guilty plea. *See id.* at 154. A member of our workgroup has emphasized that patients should also be informed about the medical consequences of being sent to their home country before they are asked to consent to such a move.

¹⁹ *See* Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1, available at <http://www.nytimes.com/2008/11/09/us/09deport.html> (referencing the case of Kong Fong Yu).

²⁰ In a similar vein, in the Jiménez case, Martin Memorial’s lawyers made much of the fact that, after a period of time spent in the hospital, Mr. Jiménez frequently expressed a desire to return to Guatemala. Daphne Duret, *Hospital’s Motives Questioned in Lawsuit*, PALM BEACH POST, July 8, 2009, at B1 (“By the summer of 2003, Martin Memorial Medical Center patient Luis Alberto Jimenez spent his days lounging by the nurse’s station on the fourth floor, eager to talk to passers-by and tell them how he missed the wife, kids and family he had back in Guatemala. He refused to go to the bathroom on his own, saying he would only do so when he went back to Guatemala. He told nurses he was sad and wanted to go home It was for these reasons, Martin Memorial attorney Scott Michaud told a jury Tuesday, that hospital officials devised a plan to send the undocumented immigrant back to his homeland . . .”). Did this constitute “consent”? What about the fact that a guardian had been appointed for Mr. Jiménez who remained opposed to the repatriation and argued that he was not sufficiently informed about the hospital’s plans? *Id.* Whose consent should prevail in such instances: Mr. Jiménez’s expressed desire to return to Guatemala, or his guardian’s refusal based on his assessment of what awaits Mr. Jiménez there?

his autonomy as a person with disabilities be respected.²¹ An extensive system of guardianship law exists in New York and throughout the country to navigate these tensions,²² but cases of medical repatriation have yet to be addressed within this context.²³

These and a number of other thorny problems regarding consent must be addressed in the emerging advocacy and scholarship on medical repatriation if, as our survey results indicate, the majority of patients returned to their home countries do so by “choice.” Though voluntary repatriations may seem morally and ethically more palatable than involuntary ones, the distinction is somewhat meaningless until the nature of the consent needed in these cases is better understood and defined.

b. Sources of the Problem

In addition to interviewing hospital staff and advocates about the frequency with which they had to deal with medical repatriation, we also asked them about the reasons why repatriations were pursued. The responses we received fell into two broad categories: (1) problems with the health care delivery system as a whole and (2) problems with systems and practices at individual hospitals. The first category of issues may require long-term policy solutions, but the latter set of concerns are easier to address and may, therefore, provide the basis for short-term improvements for non-citizen patients facing repatriation.

i. Gaps in the Health Care Delivery System

Not surprisingly, we heard from many of those surveyed—and, in particular, from health care providers themselves—that there is a lack of appropriate and affordable long-term care options for the undocumented individuals who are uninsured, which consequently forces hospitals to consider repatriation as a discharge option of last resort. In New York City, the Coler-Goldwater facility of the Health and Hospitals Corporation (“HHC”), the city’s public hospital system, is the only nursing home that has charity care beds. A staff member from the finance department at Coler-Goldwater whom we interviewed estimated that the facility accepts between 10 and 20 undocumented immigrants in need of long-term care per year, but now that Coler-Goldwater is operating at full capacity it is becoming a less viable option for hospitals seeking to discharge their uninsurable patients.²⁴ Where public institutions are unable to

²¹ See, e.g., Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 U. COLO. L. REV. 157, 157 (2010) (arguing that, “in most cases, it would be preferable to support decision making rather than supplant it through guardianship”).

²² Under New York’s guardianship law, it is recognized “that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable.” N.Y. MENTAL HYG. LAW § 81.01 (McKinney 2010).

²³ See Wolpin, *supra* note 15, at 153 (observing that “[t]he legal and ethical boundaries for proceeding with a medical repatriation for a patient unable to personally consent have not been fully resolved by either statutory or common law . . .”).

²⁴ Moreover, for many patients, a nursing home may not be the appropriate discharge option. Funneling these

accommodate enough patients, non-profit organizations sometimes try to fill the gap. One faith leader we interviewed noted that because of her reputation and networks within the provider community, she is often able to negotiate with physicians and facilities for affordable care. Another interviewee from a community-based organization said that they sometimes are able to find families to house patients in need of long-term care who do not have family of their own. Measures such as these are, however, ad hoc, unfunded, and rather unstable.

If the patient does not have anyone who can take care of her outside the hospital, such as family members, the default solution is to house her as an inpatient in the acute care facility, which is both medically sub-optimal and can cost as much as \$10,000 to \$15,000 per day—that is, \$3.65 million to \$5.47 million per year per patient.²⁵ In the case of indigent, undocumented immigrants, hospitals see very little direct reimbursement for this care. With a few important exceptions, which will be discussed below, undocumented immigrants in New York State are not eligible for Medicaid except in emergencies,²⁶ and the definition of “emergency medical condition” for Medicaid reimbursement purposes is quite narrow, making it unlikely that emergency Medicaid alone will compensate hospitals for prolonged care provided to undocumented patients.²⁷ The care that is not directly reimbursed is theoretically covered by the state’s bad debt and charity care pool,²⁸ but hospitals in New York operate at such tight margins—just over 1 percent in recent years—thus, providing uncompensated care nevertheless creates financial pressure.²⁹ Undocumented immigrants are hardly the only patients to whom high-cost charity care is provided, but given the hostile political climate around immigration these days, they serve as convenient scapegoats for larger problems within the healthcare system.³⁰ Indeed, in some of our interviews, the issue of providing care for undocumented immigrants with serious health conditions was framed in terms of the life of the hospital, not the patient. Without adequate reimbursement, the doors of the hospital might have to be closed altogether. Viewed in this way, hospital administrators may decide it is in their financial interest to send the patient back to his country of origin than to continue to care for him, even paying full price for the cost

patients from one form of institutional care to another does not necessarily “solve” the problem. *See, e.g., Samantha DiPolito, Olmstead v. L.C.—Deinstitutionalization and Community Integration: An Awakening of the Nation’s Conscience?*, 58 MERCER L. REV. 1381 (2007).

²⁵ Interview with Senior Assistant Vice President, Health and Hosps. Corp. (August 2009).

²⁶ N.Y. SOC. SERV. LAW § 122(1)(e) (McKinney 2010).

²⁷ *See* 42 U.S.C. § 1369b(v)(3) (2010) (defining “emergency medical condition” for the purposes of Medicaid reimbursement as “a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.”).

²⁸ N.Y. PUB. HEALTH LAW § 2807 (McKinney 2010).

²⁹ United Hospital Fund, *Trends through June 2009*, 19 HOSP. WATCH, 2 (2009), available at <http://www.uhfny.org/assets/762>.

³⁰ *See, e.g., Hospital Sends Undocumented, Uninsured Immigrant Home for Care, Wins Civil Suit*, HEALTHCARE RISK MGMT., Oct. 1, 2009, available at 2009 WLNR 19260298 [hereinafter *Immigrant Wins Civil Suit*] (noting that “the issues in the Jimenez case are neither unique nor limited to undocumented immigrants The South Florida case gained widespread media attention because of the heated debate over illegal immigration in general, and the costs of providing health care specifically”).

of an air ambulance or procuring private donors and foundations to fund the patient's transport.³¹

ii. Gaps in Hospital Systems

In addition to the large-scale infrastructure and resource constraints described above, our structured survey also revealed a number of systems failures within individual hospitals that contribute to medical repatriation and that have far more tractable policy solutions. In particular, interviewees identified as factors the failure of hospital staff to understand immigrant eligibility for public benefits programs and their failure to follow pre-existing discharge planning and language access laws.

1. Immigrant Benefits Eligibility

Advocates we interviewed noted that health providers, particularly frontline staff like social workers, often lack sufficient knowledge about immigrant eligibility for programs such as Medicaid, with the result that providers may assume some patients have fewer domestic discharge options than they actually do. The confusion stems largely from the fact that, in New York, some non-citizen patients can qualify for Medicaid benefits if they are deemed to be “Permanently Residing Under Color of Law” (or, “PRUCOL”).³² The term refers to “an alien who is residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the U.S. such agency does not contemplate enforcing.”³³ Formerly a federal immigrant eligibility category as well, PRUCOL was eliminated by the 1996 federal welfare reform law and now only exists as a basis for benefits eligibility in a few states, including New York.³⁴

There are a number of ways that patients can establish PRUCOL status in order to secure Medicaid benefits in New York. For instance, one may use documentation acquired under the Freedom of Information Act indicating that an immigration application has been filed and has thus far received no response. An individual may also apply for deferred action status on humanitarian grounds, arguing that her medical condition is such that deportation could result in serious harm or death in transport or upon arrival.³⁵ If U.S. Customs and Immigration Services

³¹ Martin Memorial estimated that it cost approximately \$1.5 million to keep Luis Jiménez at their facility, making the \$30,000 they spent to send him back to Guatemala appear affordable in comparison. Sontag, *Immigrants*, *supra* note 2.

³² N.Y. COMP. CODES R. & REGS. tit.18, § 360-3.2(j)(2)(i)(a) (2010).

³³ N.Y. COMP. CODES R. & REGS. tit.18, § 360-3.2(j)(1)(ii) (2010).

³⁴ See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2261 (1996) (PRWORA); see also BARBARA WEINER, COMMUNITY, MIGRANT AND HOMELESS HEALTH CENTER HANDBOOK: IMMIGRANT ELIGIBILITY FOR PUBLICLY FUNDED HEALTH CARE BENEFITS 12–15 (2008), available at <http://www.empirejustice.org/assets/pdf/issue-areas/immigrant-rights/immigrant-eligibility.pdf>; see also CLAUDIA SCHLOSBERG, IMMIGRANT ACCESS TO HEALTH BENEFITS: A RESOURCE MANUAL, NAT'L HEALTH L. PROGRAM 32 (2000), available at http://www.accessproject.org/downloads/Immigrant_Access.pdf (listing other states that cover PRUCOL immigrants).

³⁵ It should be noted that dialysis is one of few conditions that immigration court judges will not grant deferred action on humanitarian grounds. Practitioners report that dialysis is available in most countries, even

(“USCIS”) does not respond in a timely manner, and the patient makes a status inquiry and still receives no response, she may apply for and receive Medicaid.³⁶ However, pursuing a deferred action is risky because it has the effect of notifying USCIS that an individual is present in the country illegally and therefore renders her vulnerable to a deportation action that may not have occurred without the deferred action application.

Though PRUCOL, eligibility offers a crucial avenue to benefits for non-citizen immigrants, hospital staff, and social workers, especially in private hospitals, lack the training to recognize PRUCOL eligible patients. In one case that we learned about through our survey, an elderly patient was admitted to an emergency room with back problems, but the doctors discovered stage four breast cancer instead. After the initial operation and radiation treatment, the patient was denied emergency Medicaid for further care. The hospital reached out to a public benefits attorney in the area to determine if the patient was eligible for Medicaid. While the attorney was investigating the possibility of PRUCOL, however, the hospital became impatient to discharge the patient and devised a plan to return her to her home country of St. Lucia. Luckily, the PRUCOL status was established before the hospital could proceed too far with its repatriation plans, and now the patient is receiving care in a nursing home near her daughter’s home in New York.

According to our interviewees, cases such as these are not uncommon and could be reduced with better training of hospital staff regarding the intricacies of benefits eligibility or through better relationships between providers and advocates skilled in immigrant benefits work, such as in the case described above. In fact, it is not only in the best interest of the patient if hospitals are more sensitive to the relationship between immigration status and benefits eligibility. Hospitals also stand to see a direct benefit by being able to tap into a stream of financial reimbursement that they may have thought unavailable to them and by improving the ease with which they can discharge undocumented patients once the need for hospital-based care has ended.³⁷ From the perspective of the health care system as a whole, it is far more efficient to obtain health insurance coverage for non-citizen patients and transition them into a domestic, non-acute facility than it is to house the patients for months, sometimes years, and then spend tens of thousands of dollars to send them to their home country. While PRUCOL is not a basis for Medicaid eligibility in most states, the fact that in New York it provides a relatively easy “fix” in these cases has broader policy ramifications: expanding public health insurance eligibility to more immigrants, rather than less, can save health care institutions money that they can put to use elsewhere.

underdeveloped countries, and as such patients receiving dialysis are less likely to receive deferred action.

³⁶ N.Y. COMP. CODES R. & REGS. tit.18 § 360-3.2(j)(1)(ii)(i) (2010).

³⁷ For instance, one advocate told us about the case of a severely burned man who had been in the hospital for over a year, with the hospital assuming he was undocumented and only eligible for emergency Medicaid. Eventually, hospital staff contacted the advocate, who spoke with the man and learned that he had political asylum and was therefore eligible for public health benefits. The hospital could have saved itself hundreds of thousands of dollars had staff established his eligibility sooner, and the patient could have been discharged to a more appropriate facility rather than receiving care in the institutionalized setting of the hospital.

2. *Language Barriers in Discharge Planning*

Advocates we interviewed also noted that language creates a barrier for many non-citizen patients in terms of their ability to understand their rights during the discharge process and to challenge discharges that might be inappropriate or unwelcome.³⁸ Under New York state law, all hospitals must use a standardized notice that informs the patient that she is to be discharged and explains the reasons why.³⁹ The hospital must develop an “appropriate” discharge plan for the patient and provide it to her in writing.⁴⁰ And the hospital must inform the patient that she has the right to request a discharge review.⁴¹ Unfortunately, according to advocates with whom we spoke, non-citizen patients do not consistently receive these protections, particularly if they are limited English proficient (“LEP”) and the hospital fails to provide them with language assistance services.⁴² The result is that patients “consent” to repatriation because they do not realize they can appeal the discharge determination and plan, or they are unable to appeal effectively due to the language barrier.

In a case that several members of our workgroup handled, an undocumented immigrant patient was put at risk of repatriation due to the interplay of language barriers and the hospital’s flawed discharge process. “Mr. S.” had been receiving care at a hospital in Brooklyn for a severe head injury when hospital administrators decided that he needed to be discharged. The man’s wife (“Mrs. S.”), who was serving as his representative, spoke Spanish and very limited English, but was not given an interpreter during the discharge process despite repeated requests for one. Hospital staff nevertheless kept pressuring Mrs. S. to take her husband to Mexico for care because the hospital would not be able to find a facility for him in the U.S. given his immigration status. Mrs. S. felt that her husband was not ready to leave the hospital, and certainly was not in a position to be transported to Mexico for care. Due to the language barrier, however, she felt constrained in her ability to challenge the hospital’s discharge determination and turned to a local community-based organization for help. With the assistance of an advocate from this group, Mrs. S. was able to locate her husband’s treating physician, who said he had recommended against discharge since Mr. S. still had fluid in his brain and was too unstable to be moved. Mrs. S. and the advocate were able to work with the treating physician to prevent Mr. S.’s discharge, which hospital administrators seemed to be pursuing for non-medical reasons. In this case, the hospital’s failure to comply with existing language access and discharge planning laws betrayed

³⁸ One advocate reported that she spent several hours a week explaining discharge rights and post-hospital care to the Spanish-speaking community members with whom she works. Another advocate at an organization serving the Haitian community in New York said that language barriers prevent many of her clients from understanding that a discharge policy even exists.

³⁹ N.Y. PUB. HEALTH LAW § 2803-i(1) (McKinney 2010). Note that this section of the Public Health Law only applies to patients who are *not* beneficiaries of Medicare. As patients at risk of medical deportation are not likely to have Medicare benefits, they are presumably covered by this section.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Under state and federal law, health care providers must make free interpreter services and translations of vital documents available to LEP patients. See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7 (2010).

a broader impatience on the part of hospital administrators to dispose of an inconvenient patient, regardless of the impact that discharge would have on his life or well-being. The intervention of an advocate, who was able to help Mrs. S. bridge the language divide and navigate the discharge process, helped lead to a better outcome, but her importance in the process raises troubling questions about what happens to patients who are unable to access the same kind of assistance and whether hospitals might “take advantage” of undocumented patients’ many layers of vulnerability in the pursuit of economic efficiency.

c. Summary

From the start, the goal of our structured survey was to identify patterns related to the practice of medical repatriation that could inform advocacy and, perhaps, more formal research in the future. While our survey is by no means comprehensive, what has emerged from this effort is a clearer picture of the circumstances of patients facing medical repatriation. Already the victims of a medical calamity, they are confronted with exceedingly restricted “choices” about post-hospital care due to a health care system that interacts in toxic ways with immigration policy. What is more, undocumented patients are often denied the procedural protections and supportive services necessary to make the best of a terrible situation. In the next Part, we turn to the question of what may be done to assist patients like Mr. Jiménez and Mr. S and what role legal advocates in particular can play.

Part II: Developing Solutions

As the scope and nature of the medical repatriation problem in New York became clearer to our workgroup, we began to formulate some initial strategies to identify and assist patients in need. Our efforts in this regard have been focused on two areas: (1) the formation of a “rapid response team” to provide emergency intervention for individual patients facing medical repatriation and (2) research into legal theories that could be used to challenge the lawfulness of medical repatriation overall. Each of these approaches is discussed below. We present them in the hope of engaging with practitioners and scholars elsewhere who can help us refine our thinking or offer new ideas.

a. Rapid Response Team

As revealed in our survey, intervention by advocates at the point when a patient was imminently threatened with repatriation could dramatically alter the outcome of her case. Moreover, these interventions did not require extensive litigation or expenditure of resources, but simply an ability to navigate the public benefits and health care regulatory structure. The legal sub-committee of our workgroup thus began developing a “rapid response team” that would be responsible for intervening when individual cases involving repatriation arise—a strategy recommended by a number of the individuals we interviewed in our survey as well.

Although we are still in the process of creating the model for our rapid response team, the structure we are starting with will involve volunteers from various public interest legal organizations who have expertise in different issue areas, such as immigration, public benefits, and health law. When a case arises, the team may write letters to or negotiate with hospital administrators personally to discourage hasty repatriation. The team would also advise the patient and/or his family or guardian regarding patients' rights during the discharge process and assist in appealing discharge determinations or plans that are objectionable. Ideally, members of the team would be able to screen patients regarding public insurance eligibility when hospital personnel may have failed to do so properly. In cases where a hospital insists on repatriation, the team could pursue temporary restraining orders ("TRO") and injunctions using template motion papers and petitions that have been adapted to individual cases.⁴³ In the process of advocating for the client, the team may address other ancillary legal issues that arise from a patient's case. These issues may include immigration services, advocacy with city and federal agencies, and referrals to other social services.

In addition to the legal component, the workgroup contemplates incorporating physicians and other social service providers into the rapid response team. These non-legal members of the response team could advise patients on the medical consequences of being repatriated back to their home country, and their evaluations in this regard could also be used to challenge the appropriateness of particular discharge plans. Put another way, the medical arm of the legal response team would offer a "second opinion" for patients facing voluntary or involuntary repatriation and would help ensure that both patients and providers make more thoughtful decisions about the most appropriate discharge plan. The cases the rapid response team works on would add to the larger workgroup's knowledge of how and why medical repatriation cases arise, information that will hopefully influence future policy recommendations.

Once the rapid response team is established, members of the workgroup will conduct outreach into immigrant communities to educate patients and their families about their rights and about the availability of the team's services. Collectively, the agencies represented in the workgroup have relationships with hundreds of community-based organizations serving immigrant New Yorkers and extensive experience providing know-your-rights trainings and similar education workshops to low-income, undocumented, and limited English proficient immigrant groups, among others. We anticipate that the educational workshops that will be conducted will focus, broadly, on patients' discharge rights rather than on the specific issue of medical repatriation. The reason for this is based on feedback we received from community-based advocates when the Jiménez case broke in the media: the story of hospitals engaging in

⁴³ In federal practice, a TRO is filed to maintain the status quo until the court rules on an accompanying demand for a preliminary injunction. The preliminary injunction preserves the status quo for the rest of the lawsuit. MICHAEL C. SILBERBERG, EDWARD M. SPIRO, & JUDITH L. MOGUL, 1 CIVIL PRACTICE IN THE SOUTHERN DISTRICT OF NEW YORK § 12.2 (2d ed. rev. ed. 2010), *available at* 1 SDNYCIVP 12:2 (Westlaw) (discussing differences between TROs and preliminary injunctions in terms of duration, procedural requirements, and appealability). In New York State, a TRO is sought as a precursor to a preliminary injunction. David D. Siegel, NEW YORK PRACTICE § 330 (4th ed. 2009). Courts will issue a TRO pending a hearing for a preliminary injunction "where it appears that immediate and irreparable injury, loss or damage will result unless the defendant is restrained before the hearing can be had". N.Y. C.P.L.R. 6301 (McKinney 2010); *see* N.Y. C.P.L.R. 6313 (McKinney 2010). For the substantive claims that would provide the basis for the TRO application, please see Part(II)(b), *infra*, and accompanying notes.

“deportations” provoked fear among many immigrant community members, who became hesitant to seek health care services when needed. We certainly do not want our trainings to stoke these fears further. By framing our education workshops on discharge generally, we will hopefully be able to reach our intended audience without creating the impression that immigrants are being rampantly targeted for negative or hostile treatment by health care institutions. Recognizing that not all immigrants who are at risk for medical repatriation have families or community support networks to assist them, we will also continue to build relationships with the hospital social workers we interviewed as part of our survey so they feel comfortable reaching out to our workgroup for assistance and resources well before a patient is threatened with a return to his or her home country.

b. Challenging the Legality of Medical Repatriation

The rapid response team is designed to intervene in individual cases relatively early on and work within the existing legal and regulatory structure to prevent or at least delay repatriation if that is what the patient wants. The work of the team would not, however, involve challenging the lawfulness or validity of medical repatriation as a practice. This is a far murkier area that the Jiménez case brought into full view, and that the legal sub-committee of our workgroup has also begun to evaluate in the event that we decide to pursue litigation contesting the use of medical repatriation in New York. In this section, we present a brief discussion of some of the federal legal theories that we have considered as a basis for challenging medical repatriation, including patient anti-dumping laws and federal discharge laws.⁴⁴

We frame the analysis presented in this section against the backdrop of the Jiménez case that, during the course of its eight year history, managed to raise a number of the major legal claims that seem applicable in these circumstances. The tortured procedural and factual history of the case also speaks to the challenges inherent in litigating an issue that is so novel and controversial: the Jiménez litigation began in November 2001, when Martin Memorial Hospital intervened in Mr. Jiménez’s guardianship proceeding and filed a petition for judicial review, arguing that his guardian, Montejo Gaspar Montejo, was not acting in Mr. Jiménez’s best interest by objecting to his repatriation to Guatemala.⁴⁵ The ensuing legal dispute (hereinafter, “*Montejo I*”) centered on the question of whether repatriation to a Guatemalan health care facility would be considered “appropriate” under federal discharge laws and the hospital’s own discharge policy.⁴⁶ The trial court found in favor of the hospital and issued an order authorizing Mr. Jiménez’s transport to Guatemala.⁴⁷ While the appeal was pending, however, hospital administrators placed

⁴⁴ We feel compelled to reiterate the same warning that we have issued throughout this Article: practitioners reading this should not rely upon the research we have provided here, but should rather treat it as an invitation to share ideas and feedback. Also, since we presume that many of the practitioners reading this Article will be located in states other than New York, we have restricted the analysis presented here to federal claims. Advocates working in New York should contact us to discuss analogous claims under state law, which in many cases provide similar or even stronger protection than federal law.

⁴⁵ *Montejo v. Martin Mem’l Med. Ctr.*, 935 So. 2d 1266, 1267 (Fla. Dist. Ct. App. 2006).

⁴⁶ *Id.*

⁴⁷ *Montejo v. Martin Mem’l Med. Ctr.*, 874 So.2d 656 (Fla. Dist. Ct. App. 2004).

Mr. Jiménez in an air ambulance and whisked him off to Guatemala.⁴⁸ The appeals court later declared the trial court's order in *Montejo I* invalid,⁴⁹ which led to a second lawsuit (hereinafter, "*Montejo II*") seeking damages for false imprisonment. The final jury verdict in the false imprisonment action came out in favor of Martin Memorial Hospital.⁵⁰

As the Jiménez litigation bounced up and down the Florida courts, it lurched immigrant advocates between hope and despondency. The outcome of the case was, of course, tragic: Mr. Jiménez now resides in his mother's mountain home in Guatemala with virtually nothing in the form of health care or other support services.⁵¹ And, as the discussion below will make clear, the legal arguments against medical repatriation are by no means strong. But much of the law that was decided in both *Montejo I* and *Montejo II* was quite positive and could create an opening for advocates interested in using the courts to place restraints on the practice of medical repatriation.

1. Patient Anti-Dumping Law

One of the reasons Luis Jiménez was able to get emergency care at Martin Memorial, despite his immigration status and indigence, is because federal and state patient anti-dumping laws exist to prevent hospitals from either refusing to provide emergency medical treatment to patients who are unable to pay or transferring them before their emergency conditions are stabilized. The federal anti-dumping law, known as the Emergency Medical Treatment and Active Labor Act ("EMTALA"),⁵² was enacted in 1986 "to address the increasing number of reports that hospital emergency rooms [were] refusing to accept or treat patients with emergency conditions if the patient [did] not have medical insurance."⁵³ It requires, inter alia, that "[i]f any individual . . . comes to a hospital and the hospital determines that the individual has an *emergency medical condition*, the hospital must provide" either (1) such medical examination and treatment required to stabilize the medical condition or (2) transfer of the individual to another medical facility, in accordance with certain restrictions laid out in the statute.⁵⁴

⁴⁸ *Id.* at 656; see also Sontag, *Immigrants*, *supra* note 2.

⁴⁹ *Id.* at 658.

⁵⁰ Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES, July 28, 2009, at A10, available at <http://www.nytimes.com/2009/07/28/us/28deport.html>.

⁵¹ Sontag, *Immigrants*, *supra* note 2 (noting that since Mr. Jiménez arrived at his elderly mother's home he "received no medical care or medication—just Alka-Seltzer and prayer").

⁵² 42 U.S.C. § 1395dd(d) (2010).

⁵³ *St. Anthony Hosp. v. U.S. Dep't of Health & Human Servs.*, 309 F.3d 680, 692 (10th Cir. 2002); see also Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medical Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 146–151 (2004) (describing the history of EMTALA and the reasons for its enactment). The statute applies to hospitals who have entered into provider agreements under which they will accept payments from the Centers for Medicare and Medicaid Services ("CMS") through the Medicare program, which in practice includes virtually all hospitals. 42 U.S.C. § 1395dd(e)(2) (2010).

⁵⁴ 42 U.S.C. § 1395dd(b) (2010). An "*emergency medical condition*" is defined 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." 42 U.S.C. § 1395dd(e)(1) (2010).

The regulations define "sufficient severity" to also include psychiatric disturbances. 42 C.F.R. § 489.24(b)

Unfortunately, given the way courts have interpreted EMTALA, it may be difficult to extend its protections to cases such as Mr. Jiménez's, where the hospital seeks to "dump" a patient who has been languishing in the hospital for years into an inadequate foreign long-term care facility. It might, however, provide a limited avenue for advocacy for individuals such as Mr. S., discussed above, who may not have been adequately stabilized before the hospital began considering repatriation.⁵⁵

Under the EMTALA statute, "[t]o stabilize" an emergency medical condition involves determining "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"⁵⁶ Courts have noted that the statute's definition of stability is not the same as the medical term, "stable condition."⁵⁷ Instead, it is possible for a patient to be in critical condition and still be "stabilized" under EMTALA.⁵⁸ A determination that a patient is or is not stabilized is a factual one, and requires a "flexible standard of reasonableness that depends on the circumstances."⁵⁹ For example, a patient with a life-threatening injury to the abdominal aorta was considered unstable for EMTALA purposes when the patient would not have survived an ambulance trip to another hospital.⁶⁰ By contrast, another case concluded that a stroke victim was stabilized pursuant to EMTALA after she spent 21 days in the hospital, including time spent in the Intensive Care Unit and as a regular in-patient, even though her condition substantially deteriorated after discharge from the hospital.⁶¹

Furthermore, courts have very narrowly construed the scope of a hospital's duty to stabilize patients, finding that the duty only extends to the "immediate aftermath" of an emergency requiring treatment and to the interim period while the hospital considers whether to undertake longer-term full treatment or transfer the patient⁶²—a position that was adopted in EMTALA regulations promulgated in 2003.⁶³ Though it is difficult to discern in the abstract, it

(2010). In most of the cases we have seen in which medical repatriation arises, the presence of an emergency medical condition tends not to be in question, so we do not discuss it extensively here. Before pursuing this cause of action, advocates would be advised to research the relevant case law on how "emergency medical condition" is defined. Determining which illnesses fall within this category is a highly fact-specific determination.

⁵⁵ The EMTALA statute explicitly provides for a private right of action. See 42 U.S.C. §1395dd(d)(2) (2010) ("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"). In addition, CMS may terminate a hospital's provider agreement through Medicare if it fails to meet the requirements of EMTALA's regulatory scheme. See 42 U.S.C. § 1395cc(b)(2) (2010); 42 C.F.R. § 489.24(g) (2010).

⁵⁶ 42 U.S.C. § 1395dd(e)(3)(A) (2010).

⁵⁷ *St. Anthony Hosp.*, 309 F.3d at 694.

⁵⁸ *Id.*

⁵⁹ *Cherukuri v. Shalala*, 175 F.3d 446, 454 (6th Cir. 1999)

⁶⁰ *St. Anthony Hosp.*, 309 F.3d at 695.

⁶¹ *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990)

⁶² *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996)

⁶³ 42 C.F.R. § 489.24(d)(2) (2010) ("If a hospital has screened an individual . . . and found . . . [an] emergency medical condition, and admits the individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section . . ."). See also *CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPS. MANUAL, INTERPRETATIVE GUIDELINES: RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPS. IN EMERGENCY CASES* (2004).

is possible that individuals like Mr. S., who still had fluid in his brain and whose treating physician felt he was too fragile to move, would not be considered “stabilized” for the purposes of EMTALA.⁶⁴ However, given that Mr. S. and other patients in a similar position are usually admitted as inpatients—indeed, it is their admission and subsequent discharge that is at the heart of the medical repatriation problem—it is also quite possible that a court would find that the hospital’s duty to stabilize was met.

Only after the patient is able to overcome the hurdle of showing that he had an emergency medical condition that was not stabilized can he potentially move to challenge the transfer to the international facility itself.⁶⁵ The analysis here would turn to a factual question of whether (1) the patient requested the transfer in writing or a physician or other qualified medical person certified that the benefits of transfer outweighed the risks and (2) the transfer was appropriate.⁶⁶ Under the EMTALA statute, an appropriate transfer merely requires that the transferring hospital provide “the medical treatment within its capacity which minimizes the risks to the individual’s health” and sends the receiving hospital relevant patient records. In addition, the receiving hospital must have available space and qualified personnel to treat the patient, while also agreeing to accept the transfer and provide appropriate medical treatment so long as the transfer is conducted with qualified personnel and transportation equipment (including life support measures).⁶⁷ Interestingly, in the Jiménez case, Martin Memorial satisfied all of these requirements, hiring a private air ambulance to transport Mr. Jiménez to Guatemala and allowing a nurse from the hospital to travel with him and personally deliver him to the National Hospital for Orthopedics and Rehabilitation in Guatemala City.⁶⁸ Hospitals may therefore be able to insulate themselves from liability under EMTALA in medical repatriation cases simply by following the required transfer procedures.

In the case of a transfer to a domestic facility, it is possible that compliance with the procedural requirements of EMTALA is sufficient to ensure that uninsured patients are not passed around like hot potatoes, since all facilities in the country are covered by the same set of laws and there are even provisions within EMTALA that allow receiving hospitals to seek claims against facilities that have inappropriately transferred patients to them. But when the transfer is to an international facility, the receiving hospital is not bound by our patient dumping and discharge planning laws and there is nothing to stop the facility from doing as they did with Mr.

⁶⁴ See, e.g., *Roberts v. Galen of Va.*, 111 F.3d 405, 410 (6th Cir. 1997) (genuine issue of fact existed regarding whether truck accident victim was stabilized enough, after 6-week stay, to be transferred to nursing home), *rev’d on other grounds*, 525 U.S. 249 (1999), *on remand at* 112 F. Supp. 2d 638, 641 (2000).

⁶⁵ Courts have tended to view the proper transfer requirement of EMTALA as being tied to the stabilization requirement. See, e.g., *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 883 (4th Cir. 1992) (articulating the elements of an improper transfer claim under EMTALA as: (1) the patient had an emergency medical condition; (2) the hospital actually knew of that condition; (3) the patient was not stabilized before being transferred; and (4) prior to transfer of the unstable patient, the transferring hospital did not obtain the proper consent or follow the appropriate certification and transfer procedures) (citing *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990)). See also *Lopez Morales v. Hosp. Hermanos Melendez*, 245 F. Supp. 2d 374, 378–79 (D.P.R. 2003); *Scott v. Hutchinson Hosp.*, 959 F. Supp. 1351, 1358–1361 (Dist. Ct. Kan. 1997).

⁶⁶ 42 U.S.C. § 1395dd(c)(1) (2010)

⁶⁷ 42 U.S.C. § 1395dd(c)(2)(A)–(D) 2010)

⁶⁸ Sontag, *Immigrants*, *supra* note 2.

Jiménez, which is to immediately discharge the patient to family members ill-equipped to provide the necessary care. The transferring hospital thus washes its hands of the problem, as does the receiving hospital, and it is the patient who falls through the loophole.

1. Federal Discharge Law

Perhaps because of the associated challenges, no EMTALA claims were raised in the Jiménez case. Instead, the focus of *Montejo I* was on federal discharge law. The federal Medicare statute provides that, as a condition of participation in the Medicare program, hospitals must, among other things, provide discharge planning evaluation for patients “on a timely basis to ensure that *appropriate* arrangements for post-hospital care will be made before discharge”⁶⁹ In *Montejo I*, both sides proffered evidence regarding the appropriateness of the discharge to a Guatemalan facility: the hospital presented a letter from the Vice Minister of Public Health in Guatemala and Mr. Montejo offered the testimony of a Guatemalan physician who was an expert in the country’s public health system.⁷⁰ Based on this evidence, the trial court issued its order authorizing Martin Memorial to transport Mr. Jiménez to Guatemala over the objections of his guardian.⁷¹ Mr. Montejo, the guardian, appealed, but literally hours before the hospital was due to submit its papers in response to the appeal, hospital administrators placed Mr. Jiménez on a plane to Guatemala.⁷² The appeals court later found that the letter from the Guatemalan health minister—the only evidence Martin Memorial offered to support its claim—was hearsay and not specific enough to satisfy the federal discharge requirements, which rendered the lower court’s transfer order invalid.⁷³ By this point, however, Mr. Jiménez had already been discharged from the hospital in Guatemala to which he had been transferred to his

⁶⁹ 42 U.S.C. § 1395x(ee)(2)(C) (2010) (emphasis added). The requirement to have a discharge planning process is a condition of hospitals’ participation in the Medicare program, but it applies to all patients at the hospital regardless of whether they are insured through Medicare or not. See 42 C.F.R. § 482.43.

⁷⁰ *Montejo v. Martin Mem’l Med. Ctr.*, 874 So. 2d 654, 657-58 (Fla. Dist. Ct. App. 2004).

⁷¹ *Id.* at 656.

⁷² *Id.*, see also Sontag, *Immigrants*, *supra* note 2.

⁷³ *Id.* at 658. The court also held that the trial court did not have subject matter jurisdiction to issue the discharge order because it was preempted from doing so by federal immigration law. *Id.* Some scholars have suggested that similar preemption claims can be raised with respect to the hospitals that are engaging in the medical repatriation practice. See Kit Johnson, *Patients Without Borders: Extralegal Deportations By Hospitals*, 78 U. CINCINNATI L. REV. 657, 660 (2009). We are still researching this theory more fully, but remain unconvinced by Johnson’s argument that hospitals may be construed as state actors for the purposes of the preemption analysis. More importantly, we are troubled by some of the policy recommendations that Johnson presents in the article based on the preemption analysis, especially her proposal for a “new administrative process whereby hospitals can call upon the Department of Homeland Security to initiate the expedited removal and transfer of medically needy undocumented migrants.” From a public health standpoint, such a policy could be disastrous because it would deter immigrants from seeking out health care even in emergencies. This is precisely what happened in New York City several years ago, when an employee of the public hospital system reported an undocumented immigrant to the authorities. To manage the problem, the city hospitals issued an open letter to immigrant residents reassuring them that a trip to the hospital will not result in immigration authorities being called and instituting a new policy that employees could be subject to termination if they violated the hospital system’s confidentiality policy with respect to immigration status. See *Open Letter to Immigrant New Yorkers*, New York City Health and Hosp. Corp., <http://www.nyc.gov/html/hhc/html/community/letter-to-immigrants.shtml>.

indigent, elderly mother's home.⁷⁴

One of the notable aspects of this phase of the Jiménez litigation was the fact that the appeals court agreed to hear the Medicare discharge claim at all. The Medicare discharge planning statute does not expressly provide for a private right of action the way that EMTALA does.⁷⁵ In order for a patient to bring a lawsuit alleging violations of the Medicare discharge rules, a court has to imply a private right to enforce the statute.⁷⁶ In *Montejo I*, the court simply assumed that there was a private right of action and, to our knowledge, Martin Memorial did not raise any objection. Other recent circuit court decisions have similarly presumed that a private right of action exists under the federal discharge statute.⁷⁷ Advocates could take advantage of this incipient trend in the case law and use the Medicare discharge law to bring challenges to medical repatriation, particularly since there is good reason to believe that a private right of action could be implied in the statute even if the issue were considered explicitly by a court.⁷⁸

Another notable feature of *Montejo I* was the evidence offered to establish whether the discharge was “appropriate” for the purposes of the Medicare discharge statute. On its face, the Medicare discharge statute, like EMTALA, seems to impose requirements that are largely procedural in nature. For example, the hospital must (1) establish a discharge planning process,⁷⁹ (2) identify, at an early stage of the hospitalization, those patients who would likely require discharge planning⁸⁰ and (3) provide a discharge planning evaluation to all patients identified as needing one.⁸¹ However, a strong reading of the statute suggests that discharge plans might also have to meet certain substantive requirements, such as including “an evaluation of a patient’s likely need for *appropriate* post-hospital services . . . and the *availability* of those services”⁸² as well as placing the evaluation in “the patient’s medical record for use in establishing an *appropriate* discharge plan.”⁸³ In *Montejo I*, the trial and the appeals court considered evidence about the quality and availability of necessary health services for Mr. Jiménez in Guatemala—that is, about the substantive appropriateness of the post-discharge care, not simply the process by which it was obtained. Martin Memorial’s actions while appeal was pending rendered the issue moot, but the appeals court’s findings that the hospital offered evidence “not nearly specific enough to satisfy either the federal regulations or the hospital’s discharge procedures” cracks open the door for advocates seeking to use the Medicare discharge statute to challenge

⁷⁴ Sontag, *Immigrants*, *supra* note 2.

⁷⁵ See *Montejo v. Martin Mem’l Med. Ctr.*, 874 So.2d 656 (Fla. Dist. Ct. App. 2004)..

⁷⁶ A statute can only give rise to a cause of action if it contains an explicit or implicit authorization to bring a claim. It is not enough that a statute is violated and a person harmed. *Cannon v. Univ. of Chi.*, 441 U.S. 677, 688 (1979).

⁷⁷ See *Harris v. Bd. of Supervisors*, 366 F.3d 754, 765-66 (9th Cir. 2004) (hearing, at a preliminary stage, patients’ claim that spending cutbacks would result in violations of their federal discharge planning rights).

⁷⁸ The Supreme Court’s standards for determining an implied private right have evolved over time, and a complete discussion of this jurisprudence and its application to the Medicare discharge context is beyond the scope of this Article. Advocates who would like to pursue this issue further are invited to contact us directly for additional research our workgroup has conducted on this question.

⁷⁹ 42 U.S.C. § 1395x(ee)(1) (2010).

⁸⁰ 42 U.S.C. § 1395x(ee)(2)(A) (2010).

⁸¹ 42 U.S.C. § 1395x(ee)(2)(B) (2010).

⁸² 42 U.S.C. § 1395x(ee)(2)(D) (2010) (emphasis added).

⁸³ 42 U.S.C. § 1395x(ee)(2)(E) (2010) (emphasis added).

similar discharges in the future.⁸⁴

This note of optimism may be surprising given the eventual outcome of the Jiménez litigation in *Montejo II*. However, even in that phase of the litigation, the critical legal issue was decided in favor of the patient. In deciding the motion to dismiss, a Florida appeals court found that three out of the four elements for false imprisonment—(1) the unlawful detention and deprivation of liberty, (2) against that person’s will, and (3) without legal authority or “color of authority”—had been established as a matter of law.⁸⁵ All that remained to be decided was whether the hospital’s actions were “unwarranted and unreasonable” under the circumstances, and the case was remanded to trial for that purpose.⁸⁶ Jury selection proved difficult in the case, as a pool of 155 was whittled down to only 23 because many potential jurors expressed hostile attitudes toward undocumented immigrants.⁸⁷ Though the jury that was eventually impaneled found in favor of the hospital, the law was decided in favor of Mr. Jiménez and his guardian.

One analysis in a health care risk management publication has noted: “risk managers [should] not . . . focus only on the outcome of the civil suit. Though the Florida hospital prevailed in that case, the federal court clearly indicated that the process by which the hospital transferred the patient was flawed.”⁸⁸ Indeed, with regard to the verdict in the civil suit, the jury foreman, William Phillips, noted that at the start of deliberations the vote among jurors was evenly split.⁸⁹ Only through further discussion was it decided that the hospital acted in the best interests of Mr. Jiménez⁹⁰—a theme that Martin Memorial’s lawyers carefully and effectively developed over the course of the trial.⁹¹ Advocates litigating cases such as these in the future thus have some openings, both in terms of the law and litigation strategy, to shape a different outcome, particularly if the facts and venue are slightly more favorable.

Part III: Conclusion

As we have repeated throughout this Article, the efforts of the New York State workgroup on medical repatriation and long-term care for undocumented immigrants are still tentative and incomplete. We continue to try and understand the nature and scope of medical

⁸⁴ *Montejo v. Martin Mem'l Med. Ctr.*, 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004).

⁸⁵ *Montejo v. Martin Mem'l Med. Ctr.*, 935 So. 2d 1266, 1268-72 (Fla. Dist. Ct. App. 2006).

⁸⁶ *Id.* at 1272.

⁸⁷ See Melissa E. Holsman, *Immigration Issues Dominate Jury Selection in Guatemalan’s Case Against Stuart Hospital*, TCPALM.COM, July 2, 2009, <http://www.tcpalm.com/news/2009/jul/02/immigration-issues-dominate-jury-selection-guatemala/>.

⁸⁸ *Immigrant Wins Civil Suit*, *supra* note 30. Note that it was a state appeals court, not a federal court, which found the discharge to be flawed.

⁸⁹ Daphne Duret, *Hospital Wins, But Care Still Clouded*, PALM BEACH POST, July 28, 2009, at A1.

⁹⁰ *Id.*

⁹¹ See *id.*; Wolpin, *supra* note 15; Melissa Holsman, *Opening Statements Begin in Lawsuit Against Martin Hospital*, ST. LUCIE NEWS TRIBUNE, July 8, 2009, at B5 (reporting that the “hospital considered it a ‘victory’ for Jimenez, who’d grown depressed and angry, and repeatedly expressed a desire to return to his homeland”); see also Melissa Holsman, *Jimenez Mental State Focus of Testimony*, ST. LUCIE NEWS TRIBUNE, July 14, 2009, at B3 (attorney for hospital “suggested the mounting cost of unpaid medical care wasn’t what motivated the hospital to extradite Jimenez. Their decision . . . was based on advice from his medical providers—that being in his own country and with his family would aid his recovery.”).

repatriation in New York, and especially the contours of the consent offered in “voluntary” repatriation cases. The rapid response team is still in formation, and we have not yet completed our research into a number of legal theories that could be raised to challenge medical repatriation, such as federal preemption, state criminal and tort liability, and international human rights instruments. We welcome collaboration with other advocates across the country as we grapple with this difficult problem and particularly as we all collectively craft long-term policy solutions to get at the root of why health care institutions resort to repatriation, even when doing so could be disastrous for their patients.

In our view, the recently enacted health care reform legislation will not be much of a game-changer as far as medical repatriation is concerned. Undocumented immigrants are wholly invisible in the reform package in that they remain ineligible for Medicaid and other public health insurance programs, they cannot receive subsidies to purchase affordable insurance on their own, and they are even prohibited from purchasing full-freight insurance on the exchange.⁹² They will also be unable to enjoy the benefits of the Community Living Assistance Services and Supports Act (“CLASS Act”), which was enacted as part of the health reform package and creates a national insurance program to pay for the costs of long-term care.⁹³ In other words, if a low-wage undocumented worker is hit by a drunk driver now and sent into a coma, he will not be in any better position to pay for his care than was Mr. Jiménez.

More disturbingly, the reason undocumented immigrants were excluded from health care reform is the same reason it was so difficult to seat a jury in the Jiménez case and the same reason why medical repatriation is, by and large, morally sanctioned by the American public: in this political moment, one’s citizenship status is a measure of one’s humanity.⁹⁴ Thus, a critical task for advocates concerned with medical repatriation and with immigrant health more generally is how we frame the issue. One strategy is to tackle the dollars and cents of the problem. As discussed above, significant resource and infrastructure constraints within the health care delivery system provide the backdrop against which medical repatriation occurs. To the extent that any of these constraints have been addressed by policymakers, the focus has tended to be on ensuring that hospitals are reimbursed for the care that they provide to undocumented immigrants.⁹⁵ However, such policy “solutions” take at face value hospitals’ arguments about the relationship between the cost of providing care to undocumented immigrants, their own

⁹² See Sonal Ambegaokar, *Immigrants Can Cheer and Jeer for Health Care Reform*, NEW AMERICAN MEDIA, Mar. 25, 2010, available at http://news.newamericamedia.org/news/view_article.html?article_id=897b3e1096551c398ec592d116bf9c66.

⁹³ Undocumented immigrants will not be able to benefit from CLASS because it operates as a payroll deduction for authorized workers. See Community Living Assistance Services and Supports Act, H.R. 3001, 110th Cong. § 3001(c)(1) (2007), available at <http://www.opencongress.org/bill/110-h3001/text>.

⁹⁴ Anti-immigrant sentiment swayed the health care reform debates from the earliest “town hall” protests across the country. See, e.g., *Send Them Home With a Bullet in the Head*, YOUTUBE (Aug. 11, 2009), <http://www.youtube.com/watch?v=G3xS2ad1GhQ> (video of anti-health reform protester shouting, “we don’t need illegals. Send ‘em all back. Send ‘em back with a bullet in the head the second time.”).

⁹⁵ In 2001, for instance, federal lawmakers introduced two pieces of legislation meant to ease the financial strain on hospitals in border states ostensibly resulting from care to undocumented immigrants. See Dana Canedy, *Hospitals Feeling Strain From Illegal Immigrants*, N.Y. TIMES, Aug. 25, 2002, at Section 1, 16, available at <http://www.nytimes.com/2002/08/25/us/hospitals-feeling-strain-from-illegal-immigrants.html>.

financial well-being, and the impetus to repatriate those patients who become too expensive. Undocumented immigrants are cast as a costly problem even though, to our knowledge, no independent analysis has been done actually linking care for this particular category of patients to the financially precarious position of health care institutions in New York or elsewhere.

An alternative strategy would be to confront directly the horror that medical repatriation represents: namely, that some lives are less valued than others in the American health care system, and that expense has become a moral justification for taking actions that may contribute to a human being's death. In this respect, health care reform may prove helpful. Much of the hostility that emerged in response to Mr. Jiménez's case in the local Florida press had an us-versus-them quality to it: undocumented immigrants "are taking advantage of everything this country has to offer" at the expense of American citizens.⁹⁶ In mean times, a zero-sum morality has appeal. With health care reform, however, all Americans have at least the hope of getting affordable insurance themselves. Will this change the nature of the public discourse, or at least create the opportunity to frame the discussion in a way that is less hostile? It is hard to tell, but as advocates, we must find a way to talk about medical repatriation in such a way that it does not pit the life of the individual against the life of the hospital, or the lives of some (citizens) against the lives of others (non-citizens). We must find a way to change the conversation.

⁹⁶ Gockman, *supra* note 7, at A6.