

**UNINSURED, ILLEGAL, AND IN NEED OF LONG-TERM
CARE: THE REPATRIATION OF UNDOCUMENTED
IMMIGRANTS BY U.S. HOSPITALS**

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I. INTRODUCTION

Illegal immigration and healthcare costs both continue to rise and cause healthcare providers to resort to increasingly desperate measures to control uncompensated care costs. This Comment focuses on the newest cost-shifting tactic—hospitals transporting uninsured, undocumented immigrants to their native countries. The story of Luis Alberto Jiménez dramatizes this new form of hospital cost containment. Jiménez, an illegal immigrant residing in Florida, was transported to Guatemala by Martin Memorial Medical Center, which had cared for him for years at a cost of \$1.5 million.¹ Jiménez had suffered devastating injuries in a car crash with a drunken Floridian, and Martin Memorial saved his life.² While Jiménez was in poor physical condition, the hospital facilitated a guardianship for him.³ Jiménez was then transferred to a nursing home in Stuart, Florida, which likely accepted him because it believed that an insurance payout was likely.⁴ Unfortunately for Jiménez and his healthcare providers, the driver was uninsured and judgment proof.⁵

The nursing home transferred Jiménez back to Martin Memorial in terrible condition, which required the hospital and its physicians to once again save his life.⁶ Jiménez was “emaciated and suffer[ed] from ulcerous bedsores so deep that the tendons behind his knees

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¹ Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

were exposed.”⁷ Once these issues were addressed, Jiménez needed traumatic brain-injury rehabilitation and long-term care, not the kind of acute care that hospitals typically provide.⁸

Transferring Jiménez to an appropriate setting was not easy. The rules governing Martin Memorial’s participation in the Medicare program prohibited it from discharging patients without a medically appropriate treatment plan, which meant transfer or referral to “appropriate” post-hospital care for Jiménez.⁹ Hospital discharge planners tried to find a nursing home for Jiménez to no avail.¹⁰ Further complicating the discharge, Jiménez’s guardian and Martin Memorial disagreed over who should be responsible for Jiménez’s rehabilitation—Martin Memorial or Guatemala.¹¹ The guardian contended that it was the hospital’s responsibility even if it meant that the hospital would pay a rehabilitation center because that would be more cost effective, arguing that it would have been more cost-effective for the hospital than keeping him in acute care, but the hospital refused to subsidize the patient’s long-term care.¹² Martin Memorial made extensive efforts to involve the Guatemalan government and impressed upon it how expensive Jiménez’s care was becoming. Jiménez’s guardian, however, believing the Guatemalan healthcare system to be grossly inadequate, rejected the option of having Guatemala care for Jiménez.¹³

Unable to resolve the disagreement over who should pay for Jiménez’s rehabilitative care—Martin Memorial or the Guatemalan government—the parties resorted to judicial intervention.¹⁴ Martin Memorial brought Jiménez’s guardian to court to compel the guardian to comply with its repatriation plan for Jiménez.¹⁵ The judge ruled for the hospital and allowed it to discharge Jiménez and transport him to Guatemala.¹⁶ While a motion for a stay was pending in Florida state court, Martin Memorial commissioned an air ambulance at a cost of \$30,000 and flew Jiménez back to Guatemala in July

⁷ Sontag, *supra* note 1.

⁸ *Id.*

⁹ *Id.* 42 U.S.C. § 1395x(ee) (2006) and 42 C.F.R. § 482.43 (2009) both govern the discharge-planning process and impose various requirements on hospitals.

¹⁰ Sontag, *supra* note 1.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Sontag, *supra* note 1.

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2003.¹⁷ In May 2004, the Florida Fourth District Court of Appeal reversed the lower court's ruling, but it came too late for Jiménez.¹⁸ Overall, the hospital bill for Jiménez's care totaled about \$1.5 million dollars, but the hospital only received \$80,000 from Medicaid for the emergency care.¹⁹

This story represents an increasing practice by cash-strapped hospitals caring for uninsured, undocumented immigrants.²⁰ Three different laws dictate hospitals' obligations to severely ill or injured patients who come to the emergency room. First, the federal Emergency Medical Treatment and Active Labor Act (EMTALA)²¹ mandates that hospitals' emergency rooms stabilize²² individuals with emergency medical conditions²³ irrespective of their legal status or ability to pay.²⁴ Another law, Medicaid, governs reimbursement for

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ The Immigration and Nationality Act of 1952 defines the term alien as "any person not a citizen or national of the United States." 8 U.S.C. § 1101(a)(3) (2006). An alien who has not been "admitted" is unlawfully in the country and is an illegal alien. *Cf.* § 1101(a)(13)(A). Illegal aliens are sometimes referred to as "undocumented immigrants."

²¹ 42 U.S.C. § 1395dd (2006).

²² Under EMTALA, "to stabilize" an emergency medical condition means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

§ 1395dd(e)(3)(A).

²³ An "emergency medical condition" means

(A) 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

§ 1395dd(e)(1).

²⁴ *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 797 (10th Cir. 2001) ("The underlying principle behind [EMTALA] is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent attention.").

emergency medical care rendered by hospitals.²⁵ Finally, the Medicare Conditions of Participation²⁶ prohibit hospitals from discharging patients without an appropriate post-hospital care plan.²⁷ Federal law, however, neither requires receiving facilities, such as nursing homes, to accept the patients nor does it provide funds for the long-term care needs of undocumented immigrants.²⁸ While EMTALA mandates hospitals' obligations to patients, the corresponding funding mechanisms are inadequate to cover the costs of providing treatment.²⁹ Furthermore, there are no federal guidelines that clarify hospitals' obligations to provide post-stabilization (or long-term) care.

Whereas immigrant advocates see Martin Memorial Hospital's actions as international patient dumping, hospital administrators see few other options to remain financially viable.³⁰ The patchwork of federal legislation actually incentivizes hospitals to transport undocumented patients by imposing what are essentially unfunded mandates of care. The practice of hospital repatriation of undocumented immigrants is neither supervised nor regulated by federal or state law. In fact, the government has not addressed this issue at all. And yet, hospitals must balance their ethical and legal obligations to their patients with their fiduciary duties to responsibly manage their assets and survive.

This Comment concludes that the federal government must adequately fund emergency medical care rendered by hospitals to uninsured patients, including undocumented immigrants. Currently,

²⁵ See 42 U.S.C. § 1396b (2006). Emergency Medicaid allows aliens who are ineligible for Medicaid to receive emergency medical services and provides reimbursement to hospitals for rendering treatment to individuals in need of such care. See, e.g., §1396b(v)(2)(A) (providing emergency exception for "aliens not lawfully admitted for permanent residence").

²⁶ 42 C.F.R. § 482 (2009).

²⁷ The Centers for Medicare and Medicaid Services, part of the Department of Health and Human Services, promulgates various regulations. Hospitals that participate in Medicare must meet certain requirements as specified in 42 C.F.R. § 482 (2009), which covers various aspects of healthcare such as patients' rights, nursing services, discharge planning, and emergency services. All Medicare-participating hospitals must comply with the requirements set out in the statute in addition to any requirements that the Secretary of the Department of Health and Human Services finds "necessary in the interest of the health and safety of the individuals who are furnished services in hospitals." *Id.* § 482.1(a)(ii).

²⁸ Undocumented immigrants are ineligible for federally funded health services except for emergency medical care. See *infra* Part III.B.

²⁹ See Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANN. HEALTH L. 175, 183 (2008).

³⁰ See Sontag, *supra* note 1.

federal law mandates that hospitals provide emergency medical care for all, irrespective of legal status, but fails to provide the funding necessary to meet this obligation. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) explicitly eliminated federal funds for hospitals that provide medical care to undocumented immigrants.³¹ While the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) allocated \$250 million per year for five years to help offset uncompensated care costs,³² these funds are insufficient to offset the total expenses incurred,³³ which leaves hospitals with greater uncompensated care costs.

The convergence of EMTALA and discharge-planning obligations, reduced uncompensated care funding, and the failure of the U.S. immigration policy has led to the practice of hospitals repatriating patients who require expensive continued care. Hospitals are conducting repatriations without any guidelines, which are needed to prevent abuse and unethical conduct. Federal intervention is necessary, and it should not be left to the judiciary to prescribe repatriation guidelines. The phenomenon will undoubtedly become more prevalent as the number of uninsured rises and federal and state governments continue widespread cost containment efforts. In addition, the recently passed healthcare bill will not reduce or eliminate the phenomenon because undocumented immigrants are ineligible for insurance subsidies.³⁴ Therefore, the government must clarify hospitals' obligation to provide long-term care to uninsured, undocumented immigrants and must either make these patients eligible for Medicaid or have an accepted policy of repatriation with federal guidance and regulations.

Part II of this Comment surveys the plight of immigration and healthcare in the United States as a backdrop to the phenomenon of hospital repatriations of undocumented immigrants. Part III offers

³¹ Compare 8 U.S.C. § 1611(a) (2006) (applying to federal public benefits), with *id.* § 1621 (applying to states and local public benefits).

³² Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 1011, 117 Stat. 2066, 2432.

³³ Robert Pear, *U.S. is Linking Status of Aliens to Hospital Aid*, N.Y. TIMES, Aug. 10, 2004, at A1. Some public hospitals estimated that the federal allocation would only cover ten to fifteen percent of costs incurred in providing emergency medical care to undocumented immigrants. *Id.*

³⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1412, 124 Stat. 119, 231-33 (2010). The statute provides that “[n]othing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.” § 1412(d), 124 Stat. at 233.

the statutory framework that facilitates immigrants' access to health-care and the funding available to hospitals. Part IV explores the repatriation phenomenon and critiques the Florida court's decision in *Montejo v. Martin Memorial Medical Center, Inc.*,³⁵ which is the first and only case to specifically address repatriation by a U.S. hospital. This Part also proposes that either the federal government must make undocumented immigrants eligible for nonemergency Medicaid and thereby allow hospitals to be reimbursed for the long-term care that they provide and remove the economic incentive for repatriations, or the federal government must regulate repatriations and allow hospitals to transport uninsured, undocumented immigrants in compliance with federally prescribed guidelines.

II. ILLEGAL IMMIGRATION AND HEALTHCARE IN THE UNITED STATES

Especially in the border and port states that have the largest number of illegal immigrants, healthcare is the new front in the heated and perpetually unresolved immigration battle in the United States.³⁶ As illegal immigration to the United States continues to increase, hospitals feel the financial pressure of providing medical care to a segment of the population that often lacks health insurance (or is underinsured) and the ability to pay the costs of its own care. Repatriations are a creative solution that results from hospital efforts to ease economic pressures that threaten their financial viability.

A 2005 survey estimates that about eleven million undocumented immigrants are in the United States.³⁷ Nearly two thirds of the undocumented-immigrant population is concentrated in eight states³⁸—California, Texas, Florida, New York, Arizona, Illinois, Geor-

³⁵ 874 So. 2d 654 (Fla. Dist. Ct. App. 2004).

³⁶ The MMA allocations are based on the percentage of undocumented immigrants in a state's population. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011(b)(2), 117 Stat. 2066, 2433. The states receiving the greatest amount of federal funds are generally border and port states. See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH & HUMAN SERVS., FY 2008 STATE ALLOCATIONS FOR SECTION 1011 OF THE MEDICARE MODERNIZATION ACT, FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS (2008), available at http://www.cms.hhs.gov/UndocAliens/downloads/fy08_state_alloc.pdf.

³⁷ PEW HISPANIC CTR., FACT SHEET, ESTIMATES OF THE UNAUTHORIZED MIGRANT POPULATION FOR STATES BASED ON THE MARCH 2005 CPS 1 (2006), available at <http://pewhispanic.org/files/factsheets/17.pdf>. The states are listed above in descending order of their undocumented immigrant population, with California having the largest undocumented immigrant population in the United States. *Id.*

³⁸ See *id.*; ANDREA B. STAITI, ROBERT E. HURLEY & AARON KATZ, CTR. FOR STUDYING HEALTH SYS. CHANGE, STRETCHING THE SAFETY NET TO SERVE UNDOCUMENTED

gia, and New Jersey.³⁹ “In 2007, almost 60 percent of [adult undocumented immigrants] had no health insurance, more than double the proportion of uninsured adults among legal immigrants and four times the share among U.S.-born adults”⁴⁰ Low-income undocumented immigrants use hospitals and clinics for their medical-care needs.⁴¹ When undocumented immigrants cannot pay their medical bills, healthcare providers look to the federal government and charities for funds and also raise their fees on other patients to cover the uncompensated care costs.⁴²

The U.S. healthcare system largely rests on employer-based health insurance. As a result, undocumented immigrants typically lack health insurance for two reasons. First, they tend to work in industries that do not generally provide healthcare coverage for their employees,⁴³ such as agriculture, construction, and the service industry.⁴⁴ Second, supplemental government programs often have citizenship requirements for eligibility. For example, undocumented immigrants do not have access to public healthcare programs such as Medicaid and the Child Health Insurance Program (CHIP) because federal legislation restricts many immigrants from qualifying for coverage under these programs.⁴⁵

Uninsured, undocumented immigrants, however, may rely on emergency room care available through EMTALA obligations and emergency Medicaid.⁴⁶ The costs associated with providing emergency medical treatment are substantial and have risen over the years.

IMMIGRANTS: COMMUNITY RESPONSES TO HEALTH NEEDS 1 (2006), *available at* <http://www.hschange.org/CONTENT/818/818.pdf>.

³⁹ PEW HISPANIC CTR., *supra* note 37, at 1.

⁴⁰ Jennifer Evans, *How Health Reform Bills Would—And Wouldn't—Affect Illegal Immigrants*, KAISER HEALTH NEWS, Oct. 23, 2009, <http://www.kaiserhealthnews.org/Stories/2009/October/23/illegal-immigrants-health-explainer.aspx>.

⁴¹ *Id.*

⁴² *Id.*

⁴³ KARYN SCHWARTZ & SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID AND THE UNINSURED: HEALTH INSURANCE COVERAGE AND ACCESS TO CARE FOR LOW-INCOME NON-CITIZEN ADULTS 3 (2007), *available at* <http://kff.org/uninsured/upload/7651.pdf>.

⁴⁴ SCHWARTZ & ARTIGA, *supra* note 43, at 3. Of the total working population of illegal immigrants, twenty-four percent work in farming, seventeen percent in cleaning, fourteen percent in construction, and twelve percent in food preparation. JEFFREY S. PASSEL, PEW HISPANIC CTR., THE SIZE AND CHARACTERISTICS OF THE UNAUTHORIZED MIGRANT POPULATION IN THE U.S., ESTIMATES BASED ON THE MARCH 2005 CURRENT POPULATION SURVEY, at ii (2006), *available at* <http://pewhispanic.org/files/reports/61.pdf>.

⁴⁵ Evans, *supra* note 40.

⁴⁶ *See id.*; *infra* Part III.A–B.

From 2001 to 2004, North Carolina experienced a twenty-eight percent increase in spending for emergency Medicaid for undocumented immigrants.⁴⁷ “In California, emergency Medicaid spending for uninsured immigrants in fiscal year 2007 exceeded \$941 million”⁴⁸ Not every state, however, relies solely on federal dollars; states like New York, Illinois, and Washington use state tax dollars to cover undocumented-immigrant children.⁴⁹

Efforts to expand healthcare coverage to undocumented immigrants meet stiff public resistance. Opponents of expanded healthcare for undocumented immigrants see it “as a benefit that illegal immigrants don’t deserve—and that taxpayers can’t afford.”⁵⁰ Some state legislators “do not believe that state general fund revenues should be invested in people who are here illegally.”⁵¹ Fierce opposition to expanded healthcare coverage or increased funding makes backing either option politically perilous for elected officials.

III. UNDOCUMENTED IMMIGRANTS’ ACCESS TO HEALTHCARE AND THE FUNDING MECHANISMS FOR HOSPITALS PROVIDING CARE

A variety of federal laws govern hospitals’ responsibilities and duties to provide medical care to uninsured, undocumented immigrants. No neat overlap exists between legislation that mandates care and legislation that provides reimbursement to hospitals, which results in hospitals having legal obligations to administer medical care to all (under certain circumstances) but remaining uncompensated for these obligations. Federal legislation in this area is a “patchwork of programs and benefits designed and administered at the state and county levels, and characterized by immense variation in eligibility requirements, programmatic goals and outcomes, and timelines

⁴⁷ Richard Wolf, *Rising Health Care Costs Puts Focus on Migrants: Tension over Uninsured Sparks Curb on Benefits*, U.S.A. TODAY, Jan. 22, 2008, at 1A.

⁴⁸ Susan Okie, *Immigrants and Health Care—At the Intersection of Two Broken Systems*, 357 NEW ENG. J. MED. 525, 527 (2007).

⁴⁹ Wolf, *supra* note 47; see also NAT’L CONFERENCE OF STATE LEGISLATURES, CHILDREN’S HEALTH REFORM, STATE LAWS, <http://www.ncsl.org/programs/health/kidsins.htm> (last visited Apr. 21, 2010); U.S. GEN. ACCOUNTING OFFICE, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 9 (2004), available at <http://www.gao.gov/new.items/d04472.pdf> (“Medicaid provides some coverage for eligible undocumented aliens, such as low-income children and pregnant women.”).

⁵⁰ Wolf, *supra* note 47.

⁵¹ Okie, *supra* note 48, at 528 (internal quotations omitted).

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available for services and assistance.”⁵² Medicaid, EMTALA, PRWORA, and the MMA impose obligations and offer reimbursement schemes that do not provide hospitals with sufficient money to cover their costs, which results in substantial uncompensated expenses.

A. *Medicaid*

Medicaid, established by Title XIX of the Social Security Act, is a federal-state partnership program designed to provide healthcare services to low-income families with children, the elderly, and blind or disabled individuals.⁵³ Under 42 U.S.C. § 1396b, Congress denied Medicaid payments to states that provide healthcare services to undocumented immigrants except for treatment of an emergency medical condition,⁵⁴ which means that the federal government will not reimburse hospitals for nonemergency care provided to undocumented immigrants. Section 1396b(v) specifies that “no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.”⁵⁵ The only exception to this general prohibition of payment is known as the “emergency Medicaid” provision, which permits payment for the treatment of an “emergency medical condition,”⁵⁶ which is defined 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 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.⁵⁷

Much confusion and controversy has arisen as to what qualifies as treatment for an emergency medical condition because the physician’s medical opinion may not correspond to the judiciary’s inter-

⁵² John Fredriksson, *Bridging the Gap Between Rights and Responsibilities: Policy Changes Affecting Refugees and Immigrants in the United States Since 1996*, 14 GEO. IMMIGR. L.J. 757, 758 (2000).

⁵³ 42 U.S.C. § 1396 (2006).

⁵⁴ *Id.* § 1396b(v)(1)–(2).

⁵⁵ § 1396b(v)(1).

⁵⁶ § 1396b(v)(2).

⁵⁷ § 1396b(v)(3).

pretation of the statutory term as employed by Medicaid.⁵⁸ The Medicaid definition of “emergency medical condition” parallels the EMTALA definition of “antidumping.”⁵⁹ But “judicial interpretation of what constitutes ‘emergency medical care’ in the context of Medicaid reimbursement is, however, significantly limited and highly dependent on the factual basis of each claim.”⁶⁰ Courts are divided on whether long-term medical care falls within the statutory definition of emergency medical condition.⁶¹ The state Medicaid agency and its medical advisors determine whether treatment qualifies as emergency medical care, and therefore, within federal guidelines, services covered under Emergency Medicaid vary from state to state.⁶²

The scope of the emergency-medical-care definition affects reimbursement for medical treatment provided by hospitals. Hospitals have legal and ethical obligations to provide necessary medical care but are then reliant on government officials who ultimately determine whether their treatment was appropriate treatment of an emergency medical condition and thus reimbursable by emergency Medicaid.⁶³ The retrospective determinations sometimes mean that the hospital remains unreimbursed.

Medicaid directly addresses the acute-care needs of those who are in the United States illegally by mandating emergency medical

⁵⁸ See generally Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANN. HEALTH L. 175, 184 (2008) (discussing the conflicting judicial interpretations of the definition of “emergency medical condition” and the conflict between state and federal authorities related to defining the term).

⁵⁹ Lynnette Doan Wiggins, *Application of the Definition of “Emergency Medical Condition” to the Provision of Long-Term Care*, 1 DEPAUL J. HEALTH CARE L. 55, 58 (1996).

⁶⁰ *Id.* at 59.

⁶¹ See *Greenery Rehab. Group, Inc. v. Hammon*, 150 F.3d 226, 233 (2d Cir. 1998) (holding that ongoing care of chronic conditions suffered by undocumented aliens did not qualify as treatment of an “emergency medical condition” so as to warrant Medicaid coverage); *Diaz v. Div. of Soc. Servs.*, 628 S.E.2d 1, 5 (N.C. 2006) (holding that chemotherapy for an illegal alien was not treatment of an “emergency medical condition” and denying Medicaid reimbursement to the hospital). But see *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259, 261 (Conn. 2005) (holding that an illegal alien with leukemia suffered from an “emergency medical condition” for which Medicaid benefits should have been awarded).

⁶² U.S. GEN. ACCOUNTING OFFICE, *supra* note 49, at 13.

⁶³ *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 93 (Ariz. 2003) (seeking judicial review of Arizona Health Care Cost Containment System (AHCCCS) decisions denying Medicaid payment for portion of claims for hospital treatment of undocumented aliens); see also Sarah Kershaw, *U.S. Rule Limits Emergency Care for Immigrants*, N.Y. TIMES, Sept. 22, 2007, at A1 (discussing the federal government’s disqualification of coverage for chemotherapy for illegal immigrants under emergency Medicaid in New York).

treatment. Medicaid indirectly speaks to patient long-term-care obligations through its discharge requirements, which oblige hospitals to secure “appropriate” post-hospital care for patients as a condition of Medicare participation.⁶⁴ Medicare does not provide funding for the long-term care of undocumented immigrants, however, which leaves hospitals in a bind—forced to provide stabilizing care but unable to discharge patients once stabilized without securing “appropriate” post-hospital care.

B. EMTALA

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA), which included an amendment to Medicare and Medicaid known as EMTALA,⁶⁵ commonly referred to as the “Patient Anti-Dumping Act.”⁶⁶ Congress enacted EMTALA to ensure public access to emergency medical services regardless of a patient’s ability to pay.⁶⁷ EMTALA applies to *all* individuals and is not limited to the uninsured, the indigent, or citizens.⁶⁸ Prior to the enactment of EMTALA, the common-law doctrine of “no duty” essentially permitted hospitals to turn away patients or transfer them to another hospital because of their inability to pay.⁶⁹ In *Wilmington General Hospital v. Manlove*, the court held that “a private hospital owes the public no duty to accept any patient not desired by it.”⁷⁰ EMTALA abrogated this common-law doctrine and transformed hos-

⁶⁴ “Hospitals participating in Medicare must meet certain specified requirements” 42 C.F.R. § 482.1(a)(i) (2009). *See also id.* § 482.43 (stating that hospitals participating in Medicare must meet discharge-planning requirements).

⁶⁵ RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 65 (1997).

⁶⁶ *Arrington v. Wong*, 237 F.3d 1066, 1069 (9th Cir. 2001). “The act of patient dumping occurs when patients presenting in the emergency department are denied emergency medical care or stabilizing treatment based on economic or non-economic grounds, such as the patient’s race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease.” Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 175–76 (2002).

⁶⁷ *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014, 1020 (D. Colo. 2004) (“The purpose of . . . EMTALA is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent attention.”).

⁶⁸ *See Arrington*, 237 F.3d at 1070.

⁶⁹ *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 138 (Del. 1961).

⁷⁰ *Id.*

pitals' duties by forbidding hospitals from turning away patients or denying individuals treatment in an effort to cut costs.⁷¹

EMTALA has been called "the safety net of the safety net."⁷² It applies to all "Medicare-participating hospitals that offer emergency services."⁷³ Because most hospitals with an emergency department are Medicare-participating hospitals, the statute therefore applies to virtually all emergency departments.⁷⁴ EMTALA imposes two duties on participating hospitals: (1) a medical-screening examination and (2) stabilizing treatment for an emergency medical condition.⁷⁵ An emergency medical condition is

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

- (i) placing the health of individual . . . in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.⁷⁶

If a hospital determines that an emergency medical condition does not exist after conducting a medical-screening examination, then its EMTALA duty is satisfied and no further action is required.

Upon finding that an emergency medical condition exists, the hospital must stabilize the patient's medical condition⁷⁷ or transfer him to another medical facility in accordance with further statutory requirements.⁷⁸ "To stabilize" an emergency medical condition means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility."⁷⁹ Once the

⁷¹ *Emergency Physicians Integrated Care v. Salt Lake County*, 167 P.3d 1080, 1086 (Utah 2007) ("EMTALA requires hospital emergency departments to treat individuals who have emergency medical conditions without regard for their ability to pay.").

⁷² Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 698 (2006) (internal quotation marks omitted).

⁷³ Ctrs. for Medicare & Medicaid Servs., EMTALA Overview, <http://www.cms.gov/EMTALA/> (last visited Apr. 20, 2010).

⁷⁴ Hermer, *supra* note 72, at 695.

⁷⁵ 42 U.S.C. § 1395dd(a)–(b) (2006).

⁷⁶ § 1395dd(e) (1).

⁷⁷ § 1395dd(b) (A).

⁷⁸ § 1395dd(b) (B).

⁷⁹ § 1395dd(e) (3) (A).

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hospital stabilizes the patient, EMTALA no longer applies.⁸⁰ The primary point of EMTALA is to stabilize the patient in an emergency rather than to cure the underlying injury or illness.

EMTALA has been referred to as an “unfunded mandate”⁸¹ because hospitals must render medical treatment without direct government reimbursement. As a result, hospitals commonly provide uncompensated medical care to the uninsured. “Medicare and Medicaid provide a small amount of compensation to help offset losses incurred through . . . providing emergency medical care to illegal immigrants, but the compensation is partial and indirect, and goes only to hospitals rather than to physicians or other individual providers.”⁸² Currently, states and local healthcare providers bear the burden of funding the majority of unreimbursed emergency medical care for undocumented immigrants.⁸³ Hospitals “contend that EMTALA has contributed to an increase in uncompensated care in emergency departments.”⁸⁴ The costs of providing federally mandated emergency healthcare fall disproportionately on states with large undocumented immigrant populations, which must bear the financial, social, and political costs of compliance with EMTALA. Through EMTALA, these uninsured, undocumented immigrants have access to emergency healthcare, and hospitals are reimbursed for the care that they provide through emergency Medicaid, but these funds may be insufficient to cover the hospitals’ costs.

The federal government must adequately reimburse states and hospitals for medical services that they are federally mandated to provide to undocumented immigrants. Currently, U.S. hospitals bear the brunt of federal legislation that imposes obligations onto hospitals without providing the corresponding funds to pay for those obligations. Hospitals are at least partially reimbursed for emergency medical care provided to undocumented immigrants, but they must bear the costs of the patient’s inpatient hospital stay.⁸⁵ Historically, the federal government has paid about fifty-seven percent (weighted

⁸⁰ See Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186, 1207 (1986).

⁸¹ See, e.g., Dean M. Harris, *Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals*, 60 WASH. & LEE L. REV. 1251, 1279 (2003).

⁸² Hermer, *supra* note 72, at 723.

⁸³ Wiggins, *supra* note 59, at 68.

⁸⁴ U.S. GEN. ACCOUNTING OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 12 (2001), available at <http://www.gao.gov/new.items/d01747.pdf>.

⁸⁵ Bruce Japsen, *Unpaid Bills Squeeze U.S. Hospitals’ Resources*, CHI. TRIB., Oct. 22, 2006, at C1.

average) of all Medicaid costs.⁸⁶ Federal assistance to states, localities, and hospitals is insufficient; the programs established by the federal government to provide additional funds do not offset the full costs of providing services.⁸⁷ Adequate reimbursement for emergency medical care will reduce hospitals' uncompensated costs. The federal government should contribute additional funds to reimburse states, localities, and hospitals for expenses incurred in providing emergency medical care to undocumented immigrants. The costs of the federal government's failure to enforce its immigration policy should not be shifted to states, local governments, and healthcare providers—none of which have a direct role in formulating immigration policy. Therefore, the financial responsibility for providing undocumented immigrants with federally mandated emergency medical care should fall on the federal government.

C. PRWORA

Rising costs and public backlash against undocumented immigrants and the perceived strains that they impose led to the passage of PRWORA in 1996.⁸⁸ PRWORA reduced reimbursement for hospitals that provided medical care to undocumented immigrants by further restricting Medicaid eligibility.⁸⁹ PRWORA provided that "it is a compelling government interest to remove the incentive for undocumented immigration provided by the availability of public benefits."⁹⁰ Prior to 1996, legal permanent residents and aliens residing in the United States under color of law were fully eligible for Medicaid on the same basis as citizens.⁹¹ Although undocumented immigrants were not covered, the federal government did help offset EMTALA costs by providing funds for other immigrant groups that used emergency care services.⁹² After 1996, legal permanent residents and

⁸⁶ CONG. BUDGET OFFICE, THE IMPACT OF UNAUTHORIZED IMMIGRANTS ON THE BUDGETS OF STATE AND LOCAL GOVERNMENTS 11 (2007), available at <http://www.cbo.gov/ftpdocs/87xx/doc8711/12-6-Immigration.pdf>. Depending on the per capita income of the state, the actual percentage varies anywhere from fifty to eight-three percent. *Id.*

⁸⁷ *Id.* at 10.

⁸⁸ Mary J. Lopez, Comment, *Access to Healthcare for Legal and Undocumented Immigrants*, 21 IMMIGR. & NAT'LITY L. REV. 641, 654–55 (2000).

⁸⁹ 8 U.S.C. § 1611(a) (2006) denies federal public benefits to those who are not qualified aliens. Even qualified aliens are denied federal public-health benefits for five years. *Id.* § 1613(a).

⁹⁰ *Id.* § 1601(6). The government estimated cost savings of \$54 billion over the course of the six years since its enactment. Lopez, *supra* note 88, at 655.

⁹¹ Calvo, *supra* note 58, at 179.

⁹² *Id.* at 179–82.

aliens permanently residing under color of law were denied Medicaid eligibility.⁹³ Only qualified aliens were eligible for Medicaid,⁹⁴ but emergency Medicaid continued to be available for all.⁹⁵

PRWORA prohibits states from providing undocumented immigrants with any public benefits.⁹⁶ Those who are not qualified aliens are ineligible for any federal,⁹⁷ state, or local⁹⁸ public benefits. Some exceptions do exist, however, most notable of which is emergency Medicaid and EMTALA, both of which are specifically exempted so long as medical services are not related to organ transplants.⁹⁹

PRWORA merely restricts funds available to hospitals, but it does not constrain a hospital's obligations under EMTALA. PRWORA may arguably help to deter individuals from entering the United States illegally in the future, but it does nothing to address the healthcare issues that result from undocumented immigrants currently in the country. As a result of PRWORA, "states and localities bear the brunt of federal policies that attempt to promote immigration policy through programs designed to achieve public-health objectives."¹⁰⁰ By reducing the availability of federal funds, PRWORA merely shifts the financial burden of providing medical care to uninsured, undocumented immigrants to states, localities, and hospitals, but it does not reduce the costs.

⁹³ *Id.* at 180.

⁹⁴ *Id.* Qualified aliens include legal permanent residents, refugees, asylees, aliens granted withholding, conditional entrants, Cuban and Haitian entrants, aliens paroled into United States for at least one year, and certain abused spouses and children of U.S. citizens or legal permanent residents if a substantial connection exists between the abuse and need for Medicaid. 8 U.S.C. § 1641(b)–(c) (2006). Qualified aliens who became legal permanent residents after August 22, 1996, are barred from receiving nonemergency Medicaid for five years beginning on the date that they obtained their status. *Id.* § 1613(a). Prior to 1996, qualified aliens, which included legal permanent residents, did not have a five-year waiting period before becoming eligible for public benefits. *See id.*

⁹⁵ *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 115(f), 110 Stat. 2105, 2181 ("Nothing in this section shall be construed to deny . . . [e]mergency medical services under title XIX of the Social Security Act.")

⁹⁶ 8 U.S.C. § 1621(a) (2006).

⁹⁷ *Id.* § 1611(a).

⁹⁸ § 1621(a). The prohibition applies to federally funded programs and does not prohibit states from using their own funds to pay for programs. *Id.*

⁹⁹ § 1611(b)(1)(A). This section exempts organ transplants as a federal public benefit. *Id.* Section 1621 applies to states and localities and similarly prohibits coverage for services related to organ-transplant procedures. § 1621(b)(1).

¹⁰⁰ Calvo, *supra* note 58, at 179.

D. The MMA

Congress included a provision in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) to set aside money to help hospitals recoup some expenses of providing uncompensated emergency medical care to undocumented immigrants.¹⁰¹ For years, states and hospitals lobbied for additional federal money, arguing that the federal government is responsible for immigration policy and should therefore pay the expenses.¹⁰² In section 1011 of the MMA, Congress appropriated \$1 billion to hospitals,¹⁰³ with \$250 million available for each fiscal year from 2005 to 2008.¹⁰⁴ The funds are distributed in two ways: (1) \$167 million is to be distributed to all fifty states and the District of Columbia,¹⁰⁵ and (2) the remaining \$83 million will be distributed to the six states with the highest number of undocumented immigrants.¹⁰⁶ The largest total allocations are to California, \$73 million; Texas, \$45 million; Arizona, \$47 million; New York, \$12 million; Illinois, \$10 million; and Florida, \$9 million.¹⁰⁷ The federal government originally conditioned the \$1 billion dollars on hospitals asking patients about their immigration status,¹⁰⁸ but it later reversed its position after the public worried that this requirement would deter undocumented immigrants from seeking necessary medical care.¹⁰⁹

The MMA falls short of adequately reimbursing states, hospitals and healthcare providers for costs incurred in providing emergency medical care. The federal aid, although promising, is paltry compared to the costs of providing medical care. For example, in 2000, counties along the Mexico border expended more than \$800 million

¹⁰¹ Press Release, Ctrs. for Medicare & Medicaid Servs., Fact Sheets: Emergency Health Services for Undocumented Aliens: Section 1011 of the Medicare Modernization Act (May 9, 2005), <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=1452>.

¹⁰² Pear, *supra* note 33.

¹⁰³ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011(a), 117 Stat. 2066, 2432 (2003). In addition to hospitals, the Secretary must also directly pay certain physicians and ambulance providers. Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 101.

¹⁰⁴ § 1011(a), 117 Stat. at 2432.

¹⁰⁵ § 1011(b)(1)(A), 117 Stat. at 2432.

¹⁰⁶ § 1011(b)(2)(A), 117 Stat. at 2433.

¹⁰⁷ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 36. These figures are estimates and have been rounded.

¹⁰⁸ Pear, *supra* note 33.

¹⁰⁹ Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB), 69 Fed. Reg. 53,924 (Sept. 3, 2004).

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in healthcare services for which they were not compensated.¹¹⁰ About twenty-five percent of that went to care for undocumented immigrants.¹¹¹ Although additional federal funding presents a step in the right direction, it still leaves hospitals bearing the overwhelming cost. Some public hospital administrators estimate that the “federal money will cover only ten to fifteen percent of the costs [that] they incur providing emergency care to undocumented immigrants.”¹¹² In the words of one healthcare analyst, the \$1 billion allocation “is just a ‘drop in the bucket.’”¹¹³

The MMA is a superficial solution to the problem. First, it falls short of providing hospitals with sufficient money to cover their costs. Second, the MMA fails to address the lack of federal funding for long-term care. Finally, because the allotted funds ceased in 2008, absent an extension, the limited federal reimbursement that the MMA provided is not a long-term solution to the financial pressures hospitals face. In sum, the MMA is a band-aid approach to the illegal immigration and healthcare problem.

E. Federal Discharge-Planning Requirements

Federal discharge-planning requirements prevent hospitals from discharging patients without securing appropriate post-hospital care. Medicare-certified hospitals must comply with discharge-planning requirements contained in Medicare¹¹⁴ and the *Code of Federal Regulations*.¹¹⁵ “Discharge planning” refers to “a service provided by a hospital or skilled nursing facility to assist patients in arranging care following a hospital stay.”¹¹⁶ Hospitals must have a written discharge-planning process in place that applies to all patients,¹¹⁷ and they must identify and evaluate persons who may need discharge-planning assistance.¹¹⁸ The discharge planner, typically a registered nurse or social worker, develops the discharge-planning evaluation,¹¹⁹ in which the

¹¹⁰ Wolf, *supra* note 47.

¹¹¹ *Id.*

¹¹² Pear, *supra* note 33.

¹¹³ Laurie Cunningham, *Illegal, Uninsured and Under Scrutiny*, DAILY BUS. REV. (Miami), May 28, 2004, available at <http://www.law.com/jsp/article.jsp?id=1085626340974>.

¹¹⁴ See 42 U.S.C. § 1395x(ee) (2006).

¹¹⁵ See 42 C.F.R. § 482.43 (2009).

¹¹⁶ Olga Cotera-Perez-Perez, *Discharge Planning in Acute Care and Long-Term Facilities*, 26 J. LEGAL MED. 85, 85 (2005).

¹¹⁷ § 482.43.

¹¹⁸ § 482.43(a).

¹¹⁹ § 482.43(b).

discharge planner assesses the likelihood that a patient will need post-hospital services and the availability of the services.¹²⁰ The discharge planner must complete the evaluation in a timely manner so that appropriate post-hospital care arrangements can be made before discharge.¹²¹ The results of the evaluation must be discussed with the patient or the patient's representative,¹²² and the discharge plan must include a list of facilities available to the patient, such as a home health agency, nursing home, or rehabilitative facility.¹²³ "The hospital must arrange for the initial implementation of the patient's discharge plan."¹²⁴ Discharge planning is becoming more important to hospitals when "a few days in a hospital translate into great financial losses for institutions in both the acute and long-term care sectors."¹²⁵ While EMTALA requires hospitals to admit and treat patients, the federal discharge requirements govern how and when hospitals can then discharge those patients.

VI. CONGRESS MUST DIRECTLY ADDRESS REPATRIATIONS AND NOT LEAVE IT TO THE JUDICIARY TO PRESCRIBE REGULATIONS

The repatriation of undocumented immigrants by U.S. hospitals is an increasingly widespread phenomenon that will likely proliferate. While not clearly illegal, transporting seriously injured or chronically ill undocumented immigrants to their native countries raises important legal and ethical questions. The issue involves the rights of undocumented immigrants to obtain long-term care and the rights of hospitals to transport uninsured, undocumented immigrants to their native countries. Undocumented immigrants have the right to emergency medical care,¹²⁶ but they are not clearly entitled to long-term care under current federal law. Hospitals may discharge patients without their consent so long as alternative arrangements have been

¹²⁰ § 482.43(b)(3).

¹²¹ § 482.43(b)(5).

¹²² § 482.43(c)(5).

¹²³ § 482.43(c)(6).

¹²⁴ § 482.43(c)(3).

¹²⁵ Cotera-Perez-Perez, *supra* note 116, at 94.

¹²⁶ EMTALA essentially guarantees individuals the right to receive emergency medical treatment without regard to their ability to pay or immigration status. *See Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1165 (9th Cir. 2002) ("Congress enacted EMTALA to ensure that individuals, regardless of their ability to pay, receive adequate emergency medical care." (citing *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001))).

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made.¹²⁷ Hospitals do not have an explicit legal right to transport undocumented immigrants to their native countries without their consent, but considering that hospitals have medically stabilized the patients and given them expensive care, what further legal obligations they have towards these patients is unclear.

This practice raises the issue of whether hospitals may legally transport uninsured, undocumented immigrants who refuse to consent to leave the hospital by obtaining a court order to discharge and transport the individual to his native country. Without insurance or Medicaid eligibility, the patients have nowhere else to go, and hospitals, which are required to treat them by EMTALA and are prohibited from discharging patients without arranging for “appropriate” post-hospital care, are put in a quandary. In the words of one hospital administrator, “it’s a real Catch-22.”¹²⁸

Hospitals currently operate in a gray area; no governmental regulation or oversight exists, which creates the potential for abuse. This Comment argues that repatriations will proliferate and Congress must confront the dilemma posed by uninsured, undocumented immigrants in need of long-term care. The federal government must either make undocumented immigrants eligible for Medicaid or permit repatriations and prescribe regulations that govern U.S. hospitals seeking to transport these patients in need of long-term care to their native countries.

A. *The Repatriation Phenomenon*

The practice of U.S. hospitals transporting undocumented immigrants to their native countries appears to be an increasingly widespread phenomenon. No definitive study on the prevalence of the practice has been conducted, but the House of Delegates of the American Medical Association (AMA) on November 10, 2008 recommended that a resolution that opposed forced repatriation be referred back to the Board of Trustees for a report of the practice.¹²⁹ Repatriations are effectively a cost-reduction tactic, and as the economy deteriorates and government spending is likely to be slashed (at least in some areas), repatriations will continue and undoubtedly in-

¹²⁷ Bruce Patsner, *Repatriation of Uninsured Immigrants by U.S. Hospitals: The Jimenez Case*, HEALTH L. PERSP., Dec. 16, 2008, [http://www.law.uh.edu/healthlaw/perspectives/2008/\(BP\)%20deport.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(BP)%20deport.pdf).

¹²⁸ Wolf, *supra* note 47.

¹²⁹ AM. MED. ASSOC. HOUSE OF DELEGATES (I-08), REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS 13–14 (2008), <http://www.ama-assn.org/amal/pub/upload/mm/475/refcommconby.pdf>.

crease because of the combination of unpaid medical bills and decreased government funding, which will result in greater uncompensated care costs for hospitals.

Martin Memorial, seemingly undeterred by the court's ruling in *Montejo v. Martin Memorial Medical Center*,¹³⁰ has since transported another undocumented immigrant to his native country. The *New York Times* reported that in July 2008, Martin Memorial, with a court order authorizing its action, flew Neptali Díaz, a severely brain-injured patient, to Mexico.¹³¹ Díaz had stayed at Martin Memorial for 859 days at a cost of \$2 million dollars.¹³² Another Florida hospital, Broward General Medical Center in Fort Lauderdale, returns six to eight patients a year.¹³³ In Arizona, St. Joseph's Hospital in Phoenix repatriates some ninety-six immigrants a year.¹³⁴ New York, with its extremely diverse population, faces the prospect of repatriations to locations such as Africa and Asia.¹³⁵ New York Downtown Hospital has been the home to an uninsured Chinese patient for about a year.¹³⁶ The hospital has explored the possibility of transporting him to China¹³⁷ but has faced challenges similar to those Martin Memorial faced in Jiménez's case.¹³⁸ It initially planned to transfer the patient to a nursing home but later reneged when it balked at the costs of paying for the patient's lifetime care, including burial costs.¹³⁹

Hospitals usually work with consular offices in arranging to transport patients. The Mexican Consulate in San Diego, Califor-

¹³⁰ 874 So. 2d 654 (Fla. Dist. Ct. App. 2004) (holding that insufficient evidence existed to support the patient's discharge and the trial court did not possess subject matter jurisdiction to authorize transport to Guatemala).

¹³¹ Sontag, *supra* note 1.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ Deborah Sontag, *Deported in a Coma, Saved Back in the U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1.

¹³⁶ *Id.* The patient overstayed his visa in the U.S. and worked off the books for years. *Id.* The article did not state he was in the U.S. illegally but there is no indication he has the requisite immigration papers to live and work in the U.S.

¹³⁷ *Id.* No nursing home would admit the patient because he is uninsured and ineligible for Medicaid and because the patient has no relatives in the United States to whom the hospital could discharge him. *Id.* Furthermore, his family in China has indicated that it does not want him back because taking care of him would be burdensome. *Id.*

¹³⁸ Sontag, *supra* note 1.

¹³⁹ *Id.*

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nia¹⁴⁰ handled some eighty-seven medical cases involving its citizens, most of which ended in repatriation,¹⁴¹ while the Guatemalan foreign ministry knew of fifty-three repatriations by U.S. hospitals during a five-year period ending in June 2008.¹⁴² The University of North Carolina's four hospitals have worked with the Mexican Consulate to arrange transportation for undocumented immigrants.¹⁴³

Several hospitals in Illinois, which has the seventh largest undocumented-immigrant population,¹⁴⁴ have also repatriated a number of uninsured, undocumented immigrants. According to the *New York Times*, Chicago hospitals transported ten people to Honduras since early 2007.¹⁴⁵ The director of Mount Sinai Hospital in Chicago reported that the hospital has flown seriously injured and ill undocumented immigrants to Lithuania, Poland, Guatemala, and Mexico.¹⁴⁶ The director stated that the hospital flew only a few people back each year, but other hospitals have been much more aggressive.¹⁴⁷ For example, a Tucson hospital attempted to fly back a sick baby who was a U.S. citizen but whose parents were undocumented immigrants to Mexico, but the hospital was stopped by police who blocked the flight.¹⁴⁸ A Chicago hospital administrator acknowledged that undocumented immigrants were difficult to place,¹⁴⁹ which leaves hospitals to either fund their treatment or find a suitable alternative.

In a case that mimics Jiménez's story, Mount Sinai Hospital in Chicago repatriated an undocumented immigrant from Lithuania named Sergej Jakolev, who suffered severe head injuries in a car crash.¹⁵⁰ He had run up more than \$500,000 in bills, and the driver's insurance policy provided little relief because it capped bodily injury

¹⁴⁰ According to the MMA fund allocation chart, California is estimated to have over two-million undocumented immigrants, by the far the largest population of all the fifty states. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 36.

¹⁴¹ Sontag, *supra* note 1.

¹⁴² *Id.*

¹⁴³ Wolf, *supra* note 47.

¹⁴⁴ According to the MMA funding allocation chart, Illinois's undocumented immigrant population is estimated to be 432,000, making it fourth largest population in the United States. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 36.

¹⁴⁵ Sontag, *supra* note 1.

¹⁴⁶ Japsen, *supra* note 85.

¹⁴⁷ *Id.*

¹⁴⁸ Sontag, *supra* note 1.

¹⁴⁹ Japsen, *supra* note 85.

¹⁵⁰ *Id.*

coverage at \$25,000, which was insufficient to cover Jakolev's health-care costs.¹⁵¹ Hospital officials worked with the Lithuanian Embassy in the United States and his mother to transport him home and admit him to a healthcare facility there.¹⁵² In another case of repatriation to Eastern Europe, Advocate Illinois Masonic repatriated a Ukrainian construction worker who had undergone two neurological surgeries and had spent 103 days in the hospital.¹⁵³ The hospital arranged for a commercial flight back and sent an employee who spoke Ukrainian with the patient.¹⁵⁴

Hospitals conduct repatriations to reduce their uncompensated costs, but transporting individuals back to their native countries is still expensive. A hospital can commonly spend \$25,000 or more to fly undocumented immigrants back to their home countries in medically equipped planes.¹⁵⁵ The hospital may choose to send a healthcare worker with the patient, which adds another \$2,000 to the expenses incurred by hospitals.¹⁵⁶ Transporting the patients is expensive but much less costly than the alternatives—an indefinite stay in the hospital or nursing-home care subsidized by the hospital.

Documented accounts of hospital repatriations are probably just the tip of the iceberg, and the practice is likely much more widespread than the reported anecdotes suggest. The phenomenon has probably been occurring for some time but has evaded publicity because it is likely done quietly and because the undocumented immigrants may have little knowledge of any legal recourse¹⁵⁷ available to them. The practice has become common enough that at least one repatriation company has emerged—MexCare.¹⁵⁸

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ Japsen, *supra* note 85.

¹⁵⁶ *Id.*

¹⁵⁷ After the court's decision in *Montejo v. Martin Mem'l Med. Ctr.*, 874 So. 2d 654 (Fla. Dist. Ct. App. 2004), Jiménez's guardian, in another proceeding, successfully sued Martin Memorial Hospital in a personal-injury suit for false imprisonment. *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006).

¹⁵⁸ Sontag, *supra* note 1. The company's website states that it has a network of thirty hospitals, dialysis treatment centers, and physicians in Latin America that offer placement facilities closer to the patient's home at a significant reduction to the cost of unpaid services. MexCare, MexCare Services, http://www.mexcare.com/services_MexCare.html (last visited Apr. 21, 2010). The company offers air ambulance and placement services in Latin America to hospitals seeking to defray unreimbursed medical care costs. *Id.*

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An accurate assessment of the impact of undocumented immigrants on hospitals' uncompensated costs for medical care is elusive.¹⁵⁹ A report by the U.S. Government Accounting Office (GAO) ultimately concluded that it could not provide any clarification on the issue because hospitals generally do not collect information on the immigration status of patients.¹⁶⁰ The GAO report focused on ten states—Arizona, California, Florida, Georgia, Illinois, New Jersey, New York, New Mexico, North Carolina, and Texas¹⁶¹—because their total undocumented-immigrant population comprised seventy-eight percent of the undocumented-immigrant population in the United States in 2000.¹⁶² Despite the uncertainty in accurately ascertaining the uncompensated costs of providing medical care to undocumented immigrants, hospital officials in seven of the ten states expressed concern about the cost of medical treatment that continues beyond emergency care and is not covered by Medicaid.¹⁶³

Nevertheless, the cost of providing medical care to undocumented immigrants is substantial. Estimates for the nationwide cost of providing medical care to undocumented immigrants who do not have the means to pay are about \$2 billion per year.¹⁶⁴ In Harris County, Texas, a study reported that one fifth of the patients in its healthcare system were undocumented immigrants, with most hailing from Mexico.¹⁶⁵ The number of undocumented immigrants increased forty-four percent in three years, and their medical care cost the county \$97.3 million—about fourteen percent of the healthcare system's total operating costs.¹⁶⁶ According to federal government estimates, California, a border state with a large undocumented-immigrant population, spent \$1.02 billion in 2005 on healthcare for

¹⁵⁹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 49, at introductory comment.

¹⁶⁰ The GAO questionnaire garnered a low response rate/inadequate responses, which made estimating the costs difficult. *Id.* at 3.

¹⁶¹ *Id.* at 2.

¹⁶² *Id.*

¹⁶³ *Id.* at 12–13. Medicaid coverage for undocumented immigrants is limited to treatment for an emergency medical condition. *Id.* at 12. The cost of treatment post-emergency care is not covered by Medicaid, which leaves hospitals with uncompensated costs. *Id.* at 13.

¹⁶⁴ Alfonso Chardy, *Uninsured Patient in Stuart, Fla., Sent Home to Guatemala*, MIAMI HERALD, July 11, 2003, at 1A.

¹⁶⁵ Julia Preston, *Texas Hospitals' Separate Paths Reflect the Debate on Immigration*, N.Y. TIMES, July 18, 2006, at A1.

¹⁶⁶ *Id.*

undocumented immigrants but remains unreimbursed by federal or state programs.¹⁶⁷

A report commissioned by the U.S./Mexico Border Counties Coalition found that counties that share a border with Mexico incurred \$190 million in costs associated with providing healthcare to undocumented immigrants, which represented about one quarter of all uncompensated costs incurred by the counties in 2000.¹⁶⁸ Total expenditures for emergency medical care services are increasing, but they account for a small percentage of total spending by most state and local governments.¹⁶⁹ For example, in 2003, Oklahoma's expenditures on Medicaid services for undocumented immigrants comprised less than one percent of the total budget for Medicaid Services.¹⁷⁰ The proportion, though small, is growing in some states. For example, Georgia's emergency Medicaid expenditures increased by 349% from 2000 to 2002, eight times faster than its increases in Medicaid expenditures overall.¹⁷¹ The GAO reported that emergency Medicaid expenditures in the ten states surveyed increased.¹⁷² Perhaps the best indicator of the financial stress that undocumented immigrants place on hospitals such as Martin Memorial is the emerging practice of returning them to their native countries.

Currently, no federal oversight or regulation exists, which creates the potential for abuse, neglect, and unethical behavior by hospitals. Without formal regulations, "[t]he opportunity to turn your back is there."¹⁷³ In one case, a Phoenix hospital sent a comatose patient to a hospital in Mexicali despite the fact that he was a legal immigrant.¹⁷⁴ In another case, the hospital obtained the consent to the repatriation from a member of the patient's family, but the patient's sister and cousin protested and subsequently retained attor-

¹⁶⁷ *Id.*

¹⁶⁸ MGT OF AMERICA, MEDICAL EMERGENCY: COSTS OF UNCOMPENSATED CARE IN SOUTHWEST BORDER COUNTIES, at iii (September 2002), available at <http://www.bordercounties.org/vertical/Sites/%7BB4A0F1FF-7823-4C95-8D7A-F5E400063C73%7D/uploads/%7BFAC57FA3-B310-4418-B2E7-B68A89976DC1%7D.PDF>.

¹⁶⁹ CONG. BUDGET OFFICE, *supra* note 86, at 8.

¹⁷⁰ *Id.* at 9.

¹⁷¹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 49, at 11.

¹⁷² *Id.* at 11. Emergency Medicaid expenditures in the ten states accounted for less than three percent of each state's total Medicaid spending. *Id.* at 11.

¹⁷³ Sontag, *supra* note 135.

¹⁷⁴ *Id.*

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neys arguing that the hospital failed to follow legal procedures.¹⁷⁵ Hospital officials stated that they “did not know that was necessary” to transport the undocumented immigrant.¹⁷⁶ Clearly, guidance is necessary and both patients and hospitals would benefit from some clarity on the undocumented immigrants’ rights and hospitals’ obligations.

B. Montejo v. Martin Memorial Medical Center, Inc.

To date, *Montejo v. Martin Memorial Medical Center, Inc.* is the only reported case to deal directly with a U.S. hospital seeking to transport an uninsured, undocumented immigrant to his native country without the patient’s consent. The Florida Fourth District Court of Appeals reversed the lower court’s ruling.¹⁷⁷ In a relatively short opinion, the Fourth District Court of Appeals held that Martin Memorial improperly discharged Jiménez because the evidence was insufficient to establish compliance with federal discharge requirements.¹⁷⁸ The court further held that the trial court lacked the subject matter jurisdiction to authorize the transport of Jiménez to Guatemala because immigration is the prerogative of the federal government, not the courts.¹⁷⁹

On the discharge issue, the court noted that Martin Memorial, as a Medicare participating hospital, was required to comply with federal discharge requirements.¹⁸⁰ Martin Memorial needed to prove

¹⁷⁵ Judith Graham & Deanesse Williams-Harris, *Fighting to Keep Comatose Man in U.S.: UIC Officials Want to Send the Undocumented Immigrant Back to Mexico for Medical Care*, CHI. TRIB., Aug. 20, 2008, Metro, at 1.

¹⁷⁶ *Id.*

¹⁷⁷ *Montejo v. Martin Mem’l Med. Ctr.*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004). About four months after the court of appeals reversed, Montejo sued the hospital for monetary damages and alleged that Martin Memorial falsely imprisoned Jiménez under Florida law when it confined him in the ambulance and airplane to Mexico. *Montejo v. Martin Mem’l Med. Ctr.*, 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006). The court concluded that the hospital was not entitled either to absolute or qualified immunity and had acted without legal authority. *Id.* at 1270. The court remanded the matter to the jury to determine whether the hospital’s actions were unwarranted and unreasonable. *Id.* at 1272. On July 27, 2009, the jury ruled in favor of the hospital, signaling by implication that the hospital’s actions were not unreasonable and unwarranted under the circumstances and so did not result in monetary damages owed to Jimenez. See MoreLaw Lexapedia, *Montejo Gaspar as Guardian for Luis Jimenez v. Martin Memorial Medical Center*, <http://morelaw.com/verdicts/case.asp?n=4300CA000715&s=FL&d=40765> (last visited Mar. 28, 2010).

¹⁷⁸ *Montejo*, 874 So. 2d at 658.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 657.

that Jiménez would receive appropriate post-hospital care in Guatemala to discharge him.¹⁸¹ The court concluded that the evidence presented was insufficient, and thus, Martin Memorial could not discharge Jiménez to Guatemala's care.¹⁸² The court dismissed Martin Memorial's introduction of a letter from the Vice Minister of Public Health in Guatemala as inadmissible hearsay and concluded that the only other evidence supplied—testimony of an expert on the Guatemalan healthcare system—was not “competent substantial evidence to support Jimenez’s discharge from the hospital.”¹⁸³ In its ruling, the court looked to federal discharge requirements and the hospital's own discharge requirements to determine whether the evidence demonstrated that the Guatemalan facility would provide him with “appropriate medical care.”¹⁸⁴ The court ultimately concluded that no admissible substantial evidence showed that traumatic brain injury rehabilitation was available in Guatemala.¹⁸⁵

The court essentially focused on the adequacy of the facility to which Jiménez would be transferred and the level of care that he would receive in Guatemala when it concluded that the facility to which he would be transferred could not provide Jiménez with the type of care he needed.¹⁸⁶ In doing so, the court essentially applied U.S. standards to foreign hospitals and thus did not take into consideration that what qualifies as “appropriate” post-hospital care differs from country to country, depending on the sophistication of its healthcare system. Rather, “appropriate” post-hospital care should be judged in light of its location and that country's medical standards. Under the Florida state court's decision, presumably few foreign hospitals or healthcare facilities would qualify as being able to provide “appropriate medical care,” which thus makes repatriating patients to countries with inferior facilities as compared to the United States virtually impossible.¹⁸⁷ This effectively forces hospitals to either keep patients in acute care indefinitely without reimbursement or pay for the patients' long-term care in a nursing facility out of pocket. “Absent an accepted policy of repatriation, the end result will be an indefinite U.S. taxpayer subsidized stay for these individuals in U.S. acute care

¹⁸¹ *Id.* at 658.

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Montejo*, 874 So. 2d at 657–58.

¹⁸⁵ *Id.* at 658.

¹⁸⁶ *Id.* at 657.

¹⁸⁷ Patsner, *supra* note 127.

hospitals.”¹⁸⁸ Because undocumented immigrants are ineligible for Medicaid, the hospital could expect no reimbursement from either the state or federal government for post-emergency care provided.

The Florida state court’s decision has not been followed, and no other cases have been reported in which a hospital sought court authorization to discharge and transport an undocumented immigrant to the immigrant’s native country. If other courts follow the Florida state-court precedent, hospitals will surely protest because it would effectively force hospitals to subsidize care for these patients without any hope of reimbursement. By basically requiring hospitals to provide long-term care to this group through the use of federal discharge guidelines, the court circumvents the public debate about the public’s willingness to extend long-term medical care to undocumented immigrants and the government’s responsibility to pay for it.¹⁸⁹ The court’s decision effectively imposes another unfunded mandate of care onto hospitals.

On the issue of the court’s power to authorize the hospital to transport Jiménez, the court concluded that the state court could not authorize such an action “because federal immigration law preempts deportation.”¹⁹⁰ With patient consent, the power of hospitals to transport undocumented immigrants and the authority of the courts to sanction the transport is not an issue. Without patient consent, however, judicial authority becomes problematic. Federal intervention is necessary to avoid the jurisdictional issues. Therefore, the federal government must either make undocumented immigrants eligible for Medicaid so that the costs of their long-term care is covered or permit U.S. hospitals to transport uninsured, undocumented immigrants to their native countries and regulate the practice. If an accepted policy of repatriation existed, the courts’ authority to issue an order authorizing a hospital to discharge and transport the patient to his native country would not raise jurisdictional problems.

C. *Resolving the Repatriation Dilemma*

The practice of U.S. hospitals transporting uninsured, undocumented immigrants in need of long-term care to their native countries is neither clearly illegal nor explicitly sanctioned by the government. The repatriation phenomenon is a direct result of inadequate funding for public-health programs that serve undocumented immi-

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ *Montejo*, 874 So. 2d at 654.

grants, unfunded mandates of care like EMTALA, and the failure of the United State's immigration policies. Therefore, Congress must confront the repatriation dilemma rather than leave the courts to tackle the practice with a judicially crafted solution. Congress must address repatriation by clarifying hospitals' obligations to provide long-term care to undocumented immigrants who lack insurance and are ineligible for publicly funded health programs. If hospitals have no legal obligation to provide long-term care to undocumented immigrants, then the government must provide hospitals with a solution that does not force them to absorb the costs of care and that gives them a workable chart to guide hospitals on how to proceed.

Congress has three ways in which to confront the repatriation dilemma. None of the solutions is ideal, and all will undoubtedly fuel criticism from stakeholders. Maintaining the status quo is not an option, however, because it allows hospitals to conduct repatriations without any guidelines and thus creates the conditions for patient abuse.

The first potential solution is to require nursing homes to accept uninsured, undocumented immigrants as patients. This option is infeasible because it would be tantamount to mandating that nursing homes provide free long-term care without any hope for reimbursement from either the patient or the government. Moreover, it is another cost-shifting measure, not a solution, and may lead to patient abuse. This is an impracticable option that will not solve the repatriation dilemma.

The second solution is to extend Medicaid eligibility to uninsured, undocumented immigrants. This would allow hospitals to discharge patients to nursing homes, which are equipped to provide long-term and rehabilitative care, and these facilities would be paid by Medicaid. This option removes hospitals' economic incentives to repatriate undocumented immigrants by reducing their uncompensated care costs. The likelihood of this occurring is slim considering the public's lack of support for expanding public benefits to undocumented immigrants.¹⁹¹

This potential solution is problematic for a variety of reasons. First, expanding Medicaid eligibility so that undocumented immigrants can obtain long-term medical care squarely contradicts PRWORA, which makes undocumented immigrants ineligible for any

¹⁹¹ State politicians are drafting laws and ordinances that limit access to government services by undocumented immigrants in response to the perceived strain that they place on public finances. Miriam Jordan, *States and Towns Attempt to Draw the Line on Illegal Immigration*, WALL ST. J., July 14, 2006 at A-1.

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federal, state, or local aid programs. Therefore, this option would require legislation specifically overriding PROWRA. Moreover, the second option would result in undocumented immigrants receiving greater public benefits than legal residents. Under PRWORA, legal immigrants are denied public benefits, such as nonemergency medical care, for five years. Unless they have employer-provided health insurance or can pay for it out of pocket, they will be uninsured. If Medicaid eligibility were extended to undocumented immigrants, while legal residents continued to be excluded, inequities would result. Undocumented immigrants could be subject to a five-year waiting period before becoming eligible similar to legal residents, but accurately proving residency for individuals who live in the shadows and lack necessary documentation will be problematic.

Second, as long as a significant number of U.S. citizens remained uninsured and lack access to meaningful healthcare, there will be little widespread support for funding long-term medical care for undocumented immigrants. Furthermore, covering long-term care, while not giving individuals access to preventative care, which, in some cases, may reduce uncompensated care costs and the need for expensive long-term care, is not sensible. Additionally, any funds that would go to paying for the long-term-care needs of undocumented immigrants could ostensibly go to expanding Medicaid eligibility to other segments of the population, such as citizens and legal residents who lack healthcare coverage.

The healthcare needs of undocumented immigrants cannot be addressed in isolation from the larger picture of healthcare coverage in the United States. Some segments of the U.S. population still lack access to healthcare.¹⁹² For example, many of the working poor lack healthcare coverage.¹⁹³ This segment of the population earns too much to qualify for Medicaid, but not enough to purchase private

¹⁹² The uninsured in the United States number about 47 million as of 2006. Press Release, U.S. Census Bureau News, Household Income Rises, Poverty Rate Declines, Number of Uninsured Up (Aug. 28, 2007), http://www.census.gov/newsroom/releases/archives/income_wealth/cb07-120.html.

¹⁹³ JOCELYN GUYER & CINDY MANN, CTR. ON BUDGET AND POLICY PRIORITIES, EMPLOYED BUT NOT INSURED: A STATE-BY-STATE ANALYSIS OF THE NUMBER OF LOW-INCOME WORKING PARENTS WHO LACK HEALTH INSURANCE (1999), *available at* <http://www.cbpp.org/2-9-99mcaid.htm>. Although child health programs exist to provide healthcare coverage for uninsured children, the parents of these children remain uninsured. *Id.* In 1997, more than 5.4 million low-income working parents were uninsured. *Id.*

health insurance on its own.¹⁹⁴ The lack of insurance primarily affects working adults and children because almost all over the age of sixty five are covered by Medicare.¹⁹⁵ The second option would require amending Medicaid's citizenship restrictions to allow for coverage of undocumented immigrants in need of long-term care. Eliminating Medicaid's citizenship eligibility requirement without simultaneously amending the income-threshold requirements to expand coverage for the working poor would result in undocumented immigrants receiving better healthcare benefits than citizens and legal residents. Amending Medicaid's categorical requirements without looking at the sense and political wisdom in the other eligibility requirements is impossible.

Third, because Medicaid costs are ballooning and because the program is generally regarded as underfunded and draining of government reserves, expanding its coverage to undocumented immigrants, although unlikely, would be a great legislative feat. Expanding Medicaid benefits to uninsured, undocumented immigrants will increase healthcare expenditures in a time of severe economic downturn. Although emergency Medicaid expenditures have been relatively small in comparison to the total state budgets, they have been increasing. Given the current state of the economy and the number of uninsured that has swelled because of layoffs, it is not the best climate to push for expanded public benefits for undocumented immigrants.

Under the second option, the United States would be providing greater public-health benefits to undocumented immigrants than Europe. Western European countries, with their generous welfare benefits and strong social safety net, typically provide illegal immigrants only emergency care and treatment of infectious diseases that pose a

¹⁹⁴ See, e.g., Maine's Children Alliance, Child Health Care Access Project: Who Are the Uninsured in Maine, http://www.mainechildrensalliance.org/am/publish/article_67.shtml (last visited Apr. 21, 2010). The working poor "earn too little to purchase insurance for themselves and their children . . . and . . . are more likely to be without either Medicaid or private insurance." *Id.* An estimated eighty percent of the uninsured have at least one working family member but lack health insurance either because the employer does not provide it or they cannot afford it on their own. Julian Mincer, *Living and Working Without Healthcare*, CNNMONEY, Dec. 23, 2004, http://money.cnn.com/2004/12/22/news/economy/poverty_healthcare/index.htm.

¹⁹⁵ ELLEN O'BRIEN & JUDITH FEDER, KAISER COMM'N ON MEDICAID & THE INSURED, HOW WELL DOES THE EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM WORK FOR LOW-INCOME FAMILIES? (1998), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14792>.

public-health risk.¹⁹⁶ Their policy seems to be one of minimum accommodation whereby they provide those in their countries illegally with basic healthcare but will not extend full healthcare benefits for fear of this becoming a “pull factor.”¹⁹⁷ Whether European countries have permitted their hospitals to transport undocumented immigrants in need of long-term care to their native countries is unclear, but they certainly do not provide them with full public-health benefits. Instead, Western European countries typically offer undocumented immigrants the same healthcare coverage that the United States currently does.

The third solution is an accepted policy of repatriation, which would allow U.S. hospitals to transport uninsured, undocumented immigrants to their native countries to receive long-term care with federal oversight. Congress should enact regulations explicitly permitting repatriations that thereby sanction them and give courts the authority to intervene in disputes. This would also give hospitals leverage with foreign consular offices, which sometimes resist and refuse to accept their own citizens.¹⁹⁸ One hospital administrator described one consulate as “obstructionist,”¹⁹⁹ but the consular official disagreed with the depiction and maintained that it “worked collaboratively with hospitals” and that its “principal objective [was] to help its compatriots.”²⁰⁰ Because hospitals have little leverage to compel other countries to accept their own citizens, hospitals must negotiate with the individual consulates to transport the patient.

U.S. hospitals are already liaising with foreign consulates to return undocumented patients to their native countries and arrange for their post-hospital care there. Congressional authorization would validate their dealings, and hospitals would continue to coordinate the patients’ transfers with the consular offices to ensure their care in their native countries. Hospitals have knowledge of the patients’ medical conditions and needs while foreign consulates have information (or at least access to information) about medical facilities in the country as well as the patients’ families. Hospitals often need the consulate’s assistance in securing healthcare, finding relatives, and

¹⁹⁶ See Román Romero-Ortuño, *Access to Health Care for Illegal Immigrants in the EU: Should We Be Concerned?*, 11 EUR. J. HEALTH L. 245, 245 (2004). “It is clear that EU Member States are not willing to extend *full* health care coverage to [undocumented immigrants].” *Id.* at 250.

¹⁹⁷ *Id.* at 250.

¹⁹⁸ Chardy, *supra* note 164.

¹⁹⁹ Sontag, *supra* note 135.

²⁰⁰ *Id.*

obtaining travel documents.²⁰¹ Therefore, the two must collaborate to ensure appropriate transfer and treatment. A federal policy would legitimize the repatriation process and thus give hospitals leverage to coordinate with foreign consulates, and regulations would ensure that patients are not medically dumped in other countries.

Hospitals are in the best position to arrange repatriations in a medically appropriate and safe manner. They understand the patients' illness or injuries and can ensure that the medical transport is accomplished in a way that minimizes risks to the patients' health. Federal immigration agencies may be ill-equipped to transport seriously injured or ill undocumented immigrants back to their native countries and may not want to take on this responsibility. Furthermore, hospitals are likely to have knowledge of medical transport services because medical repatriations are performed as part of private health insurance.

Hospitals should still be required to comply with discharge guidelines similar to those promulgated in the Code of Federal Regulations, such that hospitals would be responsible for helping to find appropriate post-hospital care for the patient in the patient's native country. Because hospitals already have discharge planners, they could utilize them in preparing to discharge and transport the patients. The patients could only be transported when medically stabilized. The discharge planner would still need to develop a discharge-planning evaluation, which would include a list of facilities to which the patient could be transferred to receive "appropriate" post-hospital care. In contrast to the Florida court's approach, the receiving country's own standards would be used to determine whether a facility or hospital qualifies as "appropriate" post-hospital care. The results of the evaluation should be discussed with the patient, and he should be apprised of his rights. Family members or friends can serve as the patient's legal representative if necessary. Although the hospital cannot force a patient to enter a particular facility or discharge a patient without his consent, the patient cannot stay in the hospital indefinitely either.²⁰² Accepting a policy of repatriation would allow hospitals to discharge patients without their consent and transport them to their native countries for long-term care unless alternative arrangements could be made for care in the United States. For example, a charitable organization could offer to pay for the patient's nursing home care. Because transporting patients in medical-

²⁰¹ *Id.*

²⁰² Citizens for Better Care, Fact Sheet: Hospital Discharge Planning, http://www.cbcmi.org/publications/hospdsch_fs.htm (last visited Mar. 12, 2010).

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ly equipped planes or vehicles is costly, hospitals should be able to at least partially recoup the costs of repatriations from Medicaid.

Accepting a policy of repatriation does not mean that hospitals will be required to transport undocumented immigrants to their native countries. Hospitals that have made an internal policy choice that they will not repatriate any patients will remain free to continue providing long-term care or find a suitable alternative for the patient either by subsidizing the patients' care itself or finding a charitable organization that will cover the medical costs. In reality, this is unlikely to happen in the majority of cases because of the large financial cost to hospitals. Long-term care is simply too expensive. In a case such as Jiménez's, where he will not fully recover or be able to live independently, providing lifetime, long-term care is extremely expensive. If a policy of repatriation is adopted, critics will argue that the policy is unfair to undocumented immigrants and perhaps even exploitative. These individuals live and often work in the United States, and once some become seriously ill or injured and require expensive continued care, they are sent back to their native countries. Employment, however, does not guarantee an individual health insurance or public benefits. Uninsured U.S. citizens and legal residents face similar predicaments when they require long-term care but are unable to afford it. Ultimately, the repatriation dilemma involves challenging questions of how to best allocate limited resources and necessitates very difficult policy choices.

VI. CONCLUSION

No easy solution to the repatriation dilemma is available. None of the options will satisfy all parties involved, and inevitably, the option chosen will be contentious. Repatriation is "fraught with negative social intonation,"²⁰³ but this should not dissuade Congress from confronting the issues raised by repatriation. Rather, Congress must resolve the problems raised by unregulated repatriations by permitting U.S. hospitals to transport these patients to their native countries when subject to federal oversight. Congressional action to reform immigration by regularizing the legal status of undocumented immigrants in the United States and a universal healthcare system will not put an end to the repatriation dilemma. New undocumented immigrants will continue to come to the United States and will need medical care that they cannot afford. Unless full universal coverage is extended to all those in the United States, regardless of immigration

²⁰³ Patsner, *supra* note 127.

status, the same issues will occur. Even countries with universal healthcare systems have been forced to confront the repatriation dilemma. For example, a Ghanaian woman with cancer was repatriated by the United Kingdom after her visa had expired.²⁰⁴ The drug necessary to prolong her life was unavailable in Ghana, and she died of cancer shortly after being deported.²⁰⁵

A balance must be struck between humane treatment of undocumented immigrants and the economic realities of modern-day healthcare. Clearly, if uninsured, undocumented immigrants were returned to wealthier nations with better healthcare systems, the repatriation issue would not be nearly as controversial. An AMA Trustee, acknowledging the “conflicting concerns” of hospitals, stated, “On the one hand, patients shouldn’t be dumped. On the other, hospitals need to be solvent. After all, if the care of these patients were actually paid for by some entity, these repatriations would not be happening and this would not be an issue.”²⁰⁶ If done responsibly, an accepted policy of repatriation is a humane, practical, and financially sensible solution.

²⁰⁴ ‘No U-Turn’ in Cancer Woman Row, BBC NEWS, Jan. 15, 2008, available at http://news.bbc.co.uk/2/hi/uk_news/wales/7189137.stm.

²⁰⁵ *Removed Ghanaian Dies of Cancer*, BBC NEWS, Mar. 20, 2008, available at http://news.bbc.co.uk/2/hi/uk_news/wales/7305963.stm.

²⁰⁶ *Doctors Study Repatriation of Uninsured*, N.Y. TIMES, Nov. 10, 2008, at A18 (internal quotation marks omitted).