

# RETURN TO SENDER: EVALUATING THE MEDICAL REPATRIATIONS OF UNINSURED IMMIGRANTS

## I. INTRODUCTION

In 2000, Luis Alberto Jimenez, an undocumented and uninsured immigrant, sustained traumatic brain injuries in a car accident with an intoxicated Floridian driver.<sup>1</sup> After the accident, he was hospitalized at Martin Memorial Medical Center, a private community hospital in Stuart, Florida.<sup>2</sup> Because Jimenez, who remained incapacitated, required ongoing care but lacked medical insurance, Martin Memorial was unable to find a rehabilitation facility willing to accept him.<sup>3</sup> Instead, Jimenez remained as a ward of the hospital for several years at a cost exceeding \$1.5 million.<sup>4</sup> Of this \$1.5 million, Martin Memorial collected only \$80,000 from Medicaid for the emergency services rendered to Jimenez; the hospital absorbed the remaining costs associated with his care.<sup>5</sup> Faced with both Jimenez's continuing medical needs and the financial costs borne of this care, Martin Memorial secured a state court order to authorize the hospital to transport Jimenez to a medical facility in Guatemala, his country of origin.<sup>6</sup> Acting under this court order, which was later deemed invalid on appeal,<sup>7</sup> the hospital leased an air ambulance at its expense and forcibly transported Jimenez back to Guatemala.<sup>8</sup>

Martin Memorial's actions in returning Jimenez to his country of origin do not represent an isolated incident.<sup>9</sup> Instead, through a practice known as

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1. Deborah Sontag, *Deported, by U.S. Hospitals: Immigrants, Spurned on Rehabilitation, Are Forced Out*, N.Y. TIMES, Aug. 3, 2008, at A1.

2. *Id.*

3. *Id.* (noting that "[m]any American hospitals are taking it upon themselves to repatriate seriously injured or ill immigrants because they cannot find nursing homes willing to accept them without insurance").

4. *Id.*

5. Bruce Patsner, *Repatriation of Uninsured Immigrants by U.S. Hospitals: The Jimenez Case*, HEALTH L. PERSP., Dec. 16, 2008, at 1, [http://www.law.uh.edu/healthlaw/perspectives/2008/\(BP\)%20deport.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(BP)%20deport.pdf).

6. *Id.*

7. *See* *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004) (holding that the trial court lacked subject matter jurisdiction to authorize Jimenez's transportation to Guatemala).

8. Sontag, *supra* note 1. Jimenez's cousin, Montejó Gaspar Montejó, was appointed as his legal guardian. *Id.* Despite Montejó's opposition to Martin Memorial's request to return Jimenez to Guatemala, after a hearing in June 2003, a Florida Circuit Court authorized Jimenez's relocation. *Id.*

9. *Id.* (noting that the Guatemalan foreign ministry reported fifty-three repatriations conducted

medical repatriation, some hospitals return indigent immigrant patients who are ineligible for long-term Medicaid to their countries of origin to reduce the financial burdens associated with their uncompensated care.<sup>10</sup> Indeed, international medical repatriations have emerged as a creative response to the financial conundrum imposed upon hospitals<sup>11</sup> by virtue of immigration and health care policies. Collectively, these policies restrict immigrants' access to long-term Medicaid,<sup>12</sup> obligate certain hospitals to render emergency medical services without regard for the patient's ability to pay,<sup>13</sup> and require hospitals to secure appropriate follow-up care for patients in accordance with federal discharge regulations.<sup>14</sup> While hospitals may recoup some costs through Emergency Medicaid—which covers the treatment of emergency medical conditions without regard for immigration status<sup>15</sup>—the scope of Emergency Medicaid, as demonstrated in Jimenez's case, may not fully compensate hospitals for the treatment of uninsured, indigent patients.<sup>16</sup> Consequently, medical repatriations provide an alternative method of cost reduction.<sup>17</sup>

Even if they provide a creative solution, medical repatriations—which have been criticized as international patient dumping and as de facto deportations<sup>18</sup>—implicate significant concerns for both hospitals and

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by American hospitals within the last five years and describing repatriations as a “little-known but apparently widespread practice”).

10. *Id.* For example, newly arrived and undocumented immigrants are ineligible for long-term care under Medicaid. *Id.* However, as a condition of Medicaid and Medicare participation, upon which many hospitals depend for funding, hospitals are obligated by federal regulations to establish an adequate discharge plan, including post-hospital care, for patients who require such services. *Id.*; see also 42 C.F.R. § 482.43(d) (2009) (requiring hospitals to transfer patients to “appropriate facilities . . . as needed, for follow-up or ancillary care”). Thus, when hospitals cannot find nursing homes willing to accept uninsured patients who require ongoing care, the hospital may be forced to absorb the costs of continued treatment. Sontag, *supra* note 1.

11. Sontag, *supra* note 1.

12. See *infra* Part II.B (describing immigrants' narrowed access to Medicaid after 1996).

13. See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006). Pursuant to EMTALA, hospitals must provide both screening and stabilizing care to “any individual (whether or not eligible for benefits under this subchapter)” who presents at the hospital's emergency room with an “emergency medical condition.” *Id.* § 1395dd(a), (b)(1).

14. 42 C.F.R. § 482.43(d).

15. See 42 U.S.C. § 1396b(v)(2)(A) (2006).

16. Sontag, *supra* note 1 (commenting that hospitals “say that emergency Medicaid covers only a small fraction” of the expenses incurred through the screening and stabilization of immigrant patients who are ineligible for long-term Medicaid).

17. *Id.*

18. See Judith Graham & Deane Williams-Harris, *Fighting to Keep Comatose Man in U.S.*, CHI. TRIB., Aug. 20, 2008, Zone NW, at 1 (quoting an attorney representing an immigrant involved in a medical repatriation dispute, who stated that “[i]t's important to make sure that hospitals aren't permitted to dump patients on an international level when they can't do it on a local level”); Sontag, *supra* note 1 (remarking that immigrants' advocates view repatriations “as a kind of international

immigrants alike. Foremost, although Martin Memorial sought a court order before initiating Jimenez's removal to Guatemala, the majority of medical repatriations are undertaken without legislative authorization or judicial oversight.<sup>19</sup> In the medical context, the permissibility of international medical repatriations remains tenuous: in November 2009, the American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA) issued a report, advising against involuntary repatriations.<sup>20</sup> Thus, because the legality of forcibly transporting immigrant patients to medical facilities outside the United States remains uncertain, hospitals may incur liability through medical repatriations.<sup>21</sup>

Because repatriations implicate potentially serious consequences for both immigrant patients and hospitals, this Note places medical repatriations under the microscope by examining the legal causes of action arising from forcible repatriations. Part II discusses the history of immigrant access to Medicaid and immigrant eligibility for emergency Medicaid.<sup>22</sup> In addition, this Part considers the circumstances in which

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patient dumping, with ambulances taking patients in the wrong direction, away from first-world hospitals to less-adequate care, if any").

19. Sontag, *supra* note 1 (describing the Florida District Court of Appeals' decision in *Montejo* as "a case of first impression on the issue of hospital repatriations"); see also Tim Vanderpool, *Extraordinary Deportations: Hospitals Ship Immigrants to Their Home Countries—and Often to an Uncertain Future*, TUCSON WEEKLY, Aug. 14, 2008, available at <http://www.tucsonweekly.com/gbase/Currents/Content?oid=oid%3A114107> (stating that medical repatriations "are occurring in a legal twilight, with little or no governmental oversight"). In Jimenez's case, Martin Memorial sought a court order after Jimenez's guardian refused to consent to the hospital's proposed repatriation plan. See Sontag, *supra* note 1.

20. DUDLEY M. STEWART, JR., AMER. MED. ASS'N, CEJA REPORT 2-I-09, PHYSICIAN RESPONSIBILITIES FOR SAFE PATIENT DISCHARGE 5 (2009) [hereinafter CEJA REPORT], available at <http://www.ama-assn.org/ama1/pub/upload/mm/interim-2009/i-09-council-reports.pdf>. For a discussion of the AMA's position on repatriation, see Part III.A.2. Comprised of "seven practicing physicians, a resident or fellow, and a medical student," the CEJA "develops ethics policy for the AMA" by preparing "reports that analyze and address timely ethical issues that confront physicians and the medical profession." American Medical Association, Council on Ethical and Judicial Affairs, <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs.shtml> (last visited May 13, 2010).

21. See, e.g., Sontag, *supra* note 1. In light of the Florida District Court of Appeals' holding in Jimenez's case, "John DeLeon, a lawyer who advises the consulates of Mexico, Honduras and Guatemala in Miami, said he now referred to [the *Montejo* case] when he received calls from hospitals looking to discharge seriously injured or ill immigrants." *Id.* When advising hospitals, DeLeon cautions hospitals not "to dump this individual because [you'll] be risking legal action." *Id.*

22. Pursuant to 42 U.S.C. § 1396b(v)(2)(A) (2006), immigrants who, but for their immigration status, are otherwise qualified for Medicaid are eligible for medical care that is "necessary for the treatment of an emergency medical condition of the alien." However, as explained in a House Conference Report, "[t]he allowance for emergency medical services under Medicaid is very narrow" and applies only to medical care "that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit." H.R. REP. NO. 104-725, at 380 (1996) (Conf. Rep.), reprinted in 1996 U.S.C.C.A.N. 2649, 2768.

hospitals must provide treatment to uninsured, indigent immigrants, and the financial burdens arising from this care. In view of this backdrop, Part III evaluates the scope and consequences arising from medical repatriations. With reference to the benchmark case of *Montejo v. Martin Memorial Medical Center*,<sup>23</sup> Part IV considers the potential legal consequences of repatriation, including the violation of federal patient discharge requirements<sup>24</sup> and tort liability for false imprisonment.<sup>25</sup> Furthermore, because the federal government exercises plenary authority over immigration,<sup>26</sup> this Part evaluates whether immigrants may challenge repatriations by public or private hospitals under the Due Process Clause of the Fourteenth Amendment. While a comprehensive solution to the thorny issue of repatriation exceeds the scope of the Note, hospitals should, as a starting point, seek meaningful consent from patients or their guardians before repatriation. Doing so will shield the hospital from liability, while apprising immigrant patients of the collateral effects of repatriation.

## II. HOSPITALS' OBLIGATIONS TO TREAT UNINSURED IMMIGRANTS

Immigrants in the United States, for several reasons, often possess limited access to private or public health insurance.<sup>27</sup> Indeed, of the estimated 37.9 million noncitizen immigrants within the United States in 2006, over 12.8 million (33.8%) lacked any health insurance.<sup>28</sup> In the

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23. 935 So. 2d 1266, 1268–71 (Fla. Dist. Ct. App. 2006) (holding that Martin Memorial was not entitled to absolute or qualified immunity from the guardian's false imprisonment claim for repatriating Jimenez in reliance upon a court order that was issued without subject matter jurisdiction); 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004) (holding that the trial court lacked subject matter jurisdiction to authorize the repatriation of Jimenez to Guatemala).

24. See *Montejo*, 874 So. 2d at 658 (finding no "competent substantial evidence" to support the "transportation (deportation) of Jimenez to Guatemala"). When advising hospitals, attorney DeLeon counsels that "hospitals can't dump immigrant patients without securing appropriate after-care" and that "[i]f somebody has a serious illness and needs continuing care, a hospital can't simply discharge them onto the street, much less put them on a plane." Sontag, *supra* note 1.

25. See *Montejo*, 935 So. 2d at 1268 (permitting Jimenez's guardian to advance a false imprisonment claim against Martin Memorial for the hospital's forcible confinement of Jimenez in an ambulance and airplane).

26. See *infra* Part IV.C.2.

27. LEIGHTON KU & SHANNON BLANEY, CTR. ON BUDGET & POLICY PRIORITIES, HEALTH COVERAGE FOR LEGAL IMMIGRANT CHILDREN: NEW CENSUS DATA HIGHLIGHT IMPORTANCE OF RESTORING MEDICAID AND SCHIP COVERAGE 11 (2000), <http://www.cbpp.org/10-4-00health.pdf> (noting that "the proportion of low-income immigrant parents with employer-based coverage is considerably lower than the proportion of low-income native-born parents with such coverage").

28. CEJA REPORT, *supra* note 20, at 4. These figures include both lawful and undocumented immigrants. See STEVEN A. CAMAROTA, CTR. FOR IMMIGRATION STUDIES, IMMIGRANTS IN THE

private insurance sector, many immigrants are employed in industries, such as agriculture and food services, that customarily do not provide employer-based health insurance to workers.<sup>29</sup> In the public sector, Congress—through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)<sup>30</sup>—constrained immigrants’ access to most forms of Medicaid, a program that is jointly funded by federal and state contributions and that provides health care to persons with insufficient resources to independently obtain insurance.<sup>31</sup> Beyond constraining health care options for immigrants, narrowed Medicaid access imposes burdens upon the hospitals charged with their care: where immigrants cannot independently pay for health services and do not qualify for nonemergency Medicaid, hospitals may shoulder the financial burden associated with their treatment.<sup>32</sup>

#### *A. Immigrants’ Access to Medicaid Before PRWORA*

Before 1996, immigrants who were lawful permanent residents (LPR) and immigrants who were “otherwise permanently residing in the United States under color of law” (PRUCOL) were eligible for Medicaid on the same basis as U.S. citizens.<sup>33</sup> Although Congress did not initially define PRUCOL’s boundaries, PRUCOL status often was construed broadly, thus affording immigrants with ambiguous immigration statuses an avenue to benefits eligibility.<sup>34</sup> In section 9406 of the Omnibus Budget

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UNITED STATES, 2007: A PROFILE OF AMERICA’S FOREIGN-BORN POPULATION 1 (2007), available at <http://www.cis.org/articles/2007/back1007.pdf>.

29. Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS HEALTH L. 175, 177–79 (2008).

30. 8 U.S.C. §§ 1601–46 (2006).

31. Calvo, *supra* note 29, at 178–79.

32. *Id.* at 183 (noting that, under EMTALA, hospitals must provide screening and stabilizing services to all individuals who present with emergency medical conditions, “causing hospitals to increasingly struggle with the costs of uncompensated care”).

33. *Id.* at 179. As originally enacted in 1965, the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., did not expressly address immigrants’ eligibility for Medicaid benefits. See *Coye v. U.S. Dep’t of Health & Human Servs.*, 973 F.2d 786, 787 (9th Cir. 1992). However, in 1973, the Secretary of the United States Department of Health and Human Services issued a regulation that required state Medicaid agencies to provide Medicaid to immigrants with LPR and PRUCOL status and that precluded federal Medicaid expenditures for the care of undocumented immigrants. *Id.*; see also 42 C.F.R. § 435.402(b) (1979).

34. Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-immigrant Provisions of the “Contract With America” Congress*, 90 KY. L.J. 1043, 1046 (2001–02). Through PRUCOL status, “an immigrant whose status was ambiguous, under consideration, or even clearly irregular, could be eligible for government-sponsored benefits.” *Id.* However, immigrants could not be under active pursuit for deportation by the Immigration and Naturalization Service (INS). *Id.* Moreover, “the majority of undocumented immigrants could not benefit from the PRUCOL doctrine because their lack

Reconciliation Act of 1986,<sup>35</sup> Congress affirmed this expansive interpretation, stating that PRUCOL should encompass “all of the categories recognized by immigration law, policy, and practice.”<sup>36</sup>

Although undocumented immigrants with indisputably irregular legal statuses were ineligible for public benefits via PRUCOL,<sup>37</sup> in the years before PRWORA, “publicly-funded health care providers and practitioners customarily provided necessary health services regardless of immigration status.”<sup>38</sup> Some legal scholars suggest that this extension of medical services to undocumented immigrants was partially influenced by the Supreme Court’s holding in *Plyler v. Doe*.<sup>39</sup> In *Plyler*, the Court applied intermediate scrutiny to hold that a Texas state law, which barred the children of undocumented immigrants from freely enrolling in the state’s public elementary and high schools, violated the Equal Protection Clause of the Fourteenth Amendment because the law advanced no substantial state interest.<sup>40</sup> While the majority emphasized the unfairness of penalizing the “innocent children” of undocumented immigrants,<sup>41</sup> “an important part of the Court’s opinion turned on federalism concerns and limits on states’ ability to regulate immigration matters, which is [sic] reserved for the federal government.”<sup>42</sup> Thus, while finding “no national policy that supports the State in denying these children an elementary education,” the

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of legal status was clear.” *Id.* The judiciary likewise endorsed a broad interpretation of PRUCOL status. *See, e.g.,* *Berger v. Heckler*, 771 F.2d 1556, 1574–75 (2d Cir. 1985) (“Based on our examination of the language of the provision and our review of its legislative history, we find that the phrase, ‘under color of law,’ is designed to be an open vessel—to be given substance by experience.”).

35. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 2057–58 (codified at 42 U.S.C. § 1396b(v)(3) (2006)).

36. H.R. REP. NO. 99-727, at 111 (1986); *see also* Calvo, *supra* note 29, at 180.

37. *See supra* note 34 and accompanying text. *But see* *Lewis v. Gross*, 663 F. Supp. 1164 (E.D.N.Y. 1986) (holding that 42 C.F.R. § 435.402 violated the Medicaid statute, which did not include an express alienage requirement). In 1986, Congress amended the Medicaid statute through § 9406(c) of the Omnibus Budget Reconciliation Act (OBRA) to exclude aliens without LPR or PRUCOL status from accessing the full scope of Medicaid. Jane Perkins, *Medicaid Coverage of Emergency Medical Conditions: An Update*, NAT’L HEALTH LAW PROGRAM, May 7, 2007, at 2 & n.10, <http://www.healthlaw.org/images/stories/issues/medicaidcoverage-emergencymedical.pdf>.

38. Costich, *supra* note 34, at 1047.

39. 457 U.S. 202 (1982); Brietta R. Clark, *The Immigrant Health Care Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 238 (2008) (describing *Plyler*’s effect as a “controversial limit on state autonomy”); *see also* Costich, *supra* note 34, at 1047 (stating that, in *Plyler*, “the Supreme Court required state and local governments to extend basic public benefits to residents regardless of immigration status. Until 1996, such benefits were presumed to include health care.”).

40. *Plyler*, 457 U.S. at 230.

41. *Id.*

42. *See* Clark, *supra* note 39, at 238; *see also* *Plyler*, 457 U.S. at 225 (stating that the states possess “no power with respect to the classification of aliens” because “this power is ‘committed to the political branches of the Federal Government’” (quoting *Mathews v. Diaz*, 426 U.S. 67, 81 (1976))).

Court noted that “[s]tates do have some authority to act with respect to illegal aliens, at least where such action mirrors federal objectives and furthers a legitimate state goal.”<sup>43</sup>

### *B. Immigrants’ Limited Medicaid Eligibility After PRWORA*

In 1996, Congress articulated such a federal policy by enacting PRWORA,<sup>44</sup> which broadened state authority to condition access to state and local public benefits on immigration status and thereby authorized “the kind of state restriction on benefits that were previously vulnerable to constitutional attack.”<sup>45</sup> Among its objectives, Congress sought to reduce the federal government’s social service expenditures.<sup>46</sup> To help effectuate this purpose, PRWORA overhauled the method by which immigrant eligibility for public benefits was assessed and curtailed Medicaid for documented and undocumented immigrants.<sup>47</sup>

Under PRWORA, public-benefits eligibility is limited to a narrowly defined subset of “qualified” immigrants.<sup>48</sup> All other immigrants—including undocumented immigrants and immigrants who were previously eligible through PRUCOL status—are deemed nonqualified, and thus ineligible for most forms of Medicaid.<sup>49</sup> A limited exception to PRWORA

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43. *Plyler*, 457 U.S. at 225; *id.* at 226. Additionally, the Court observed that “the courts must be attentive to congressional policy; the exercise of congressional power might well affect the State’s prerogatives to afford differential treatment to a particular class of aliens.” *Id.* at 224.

44. 8 U.S.C. §§ 1601–46 (2006).

45. Clark, *supra* note 39, at 239 (commenting that PRWORA “was widely understood as Congress’ attempt to answer *Plyler*’s federalism concerns”).

46. Costich, *supra* note 34, at 1048 n.25. Indeed, “the Congressional Budget Office estimated that the immigrant restrictions would generate roughly 40 percent of welfare reform’s overall savings of \$54 billion—despite the fact that in 1996 immigrants represented only 15 percent of all welfare recipients in the United States.” MICHAEL FIX & JEFFREY PASSEL, THE URBAN INSTITUTE, THE SCOPE AND IMPACT OF WELFARE REFORM’S IMMIGRANT PROVISIONS 5 (2002), available at [http://www.urban.org/Uploadedpdf/410412\\_discussion02-03.pdf](http://www.urban.org/Uploadedpdf/410412_discussion02-03.pdf) [hereinafter WELFARE REFORM’S IMMIGRANT PROVISIONS].

47. See 8 U.S.C. § 1611(a) (2006) (stating that, with the exception of emergency medical conditions, an “alien who is not a qualified alien . . . is not eligible for any Federal public benefit”); Perkins, *supra* note 37, at 3 (stating that PRWORA “denies full scope Medicaid benefits to most immigrants”).

48. See Clark, *supra* note 39, at 235 (noting that “PRWORA created a broad rule against access to certain federally-funded public benefits for legal permanent and temporary residents, with exceptions created for certain narrowly defined groups”). Pursuant to 8 U.S.C. § 1641(b)(1)-(7) (2006), qualified aliens for purposes of Medicaid eligibility are defined exhaustively as LPRs; refugees and asylees; certain Cuban, Haitian, and Amerasian immigrants; aliens paroled in the United States for a period of at least one year; aliens granted withholding of deportation by the INS; aliens granted conditional entry into the United States; and aliens subjected to domestic violence who are in the process of obtaining a status as qualified aliens.

49. Tanya Broder, *Overview of Immigrant Eligibility for Federal Programs*, LOW-INCOME

permits nonqualified immigrants to remain eligible for certain healthcare benefits, including the treatment of emergency medical conditions,<sup>50</sup> public health immunizations,<sup>51</sup> and the testing and treatment of symptoms of communicable diseases.<sup>52</sup> But, states may not use federal Medicaid funds for immunizations or for the testing and treatment of communicable diseases.<sup>53</sup>

Moreover, even qualified immigrants confront diminished access to public benefits under PRWORA—which imposes additional eligibility requirements<sup>54</sup>—and under the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA).<sup>55</sup> For example, with limited exceptions,<sup>56</sup> PRWORA differentiates qualified immigrants on the basis of their date of immigration.<sup>57</sup> Otherwise qualified recent immigrants, defined as those who entered the United States on or after the date of the PRWORA’s enactment in 1996, cannot access “[f]ederal means-tested public benefit[s],” including Medicaid, for the first five years of their

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IMMIGRANT RTS. CONF. (Nat’l Immigration Law Ctr., Los Angeles, Cal.), Dec. 2007, at 4.2, *available at* [http://www.lb9.uscourts.gov/webcites/09documents/Mendoza\\_overview.pdf](http://www.lb9.uscourts.gov/webcites/09documents/Mendoza_overview.pdf).

50. 8 U.S.C. § 1611(b)(1)(A).

51. *Id.* § 1611(b)(1)(C).

52. *Id.*

53. NAT’L CONFERENCE OF STATE LEGISLATURES, THE IMMIGRANT POLICY PROJECT: MEDICAL ASSISTANCE & HEALTH BENEFITS (1997), <http://ecom.ncsl.org/programs/immig/MedIB.htm> (“States may not use Medicaid funds for public health immunizations or for testing and treatment of symptoms of communicable diseases . . . for ‘not qualified’ aliens.”).

54. Perkins, *supra* note 37, at 3.

55. To prevent immigrants from becoming public charges, “PRWORA and IIRIRA substantially changed the rules regarding affidavits of support and sponsor deeming of income,” thereby “impos[ing] greater legal liability on sponsors and [making] it more difficult for new immigrants to qualify for public benefits even after they have lived in the United States for five years.” CLAUDIA SCHLOSBERG, NAT’L HEALTH LAW PROGRAM, IMMIGRANT ACCESS TO HEALTH BENEFITS: A RESOURCE MANUAL 35 (1999–2000), *available at* [http://www.accessproject.org/downloads/Immigrant\\_Access.pdf](http://www.accessproject.org/downloads/Immigrant_Access.pdf). As defined by PRWORA and IIRIRA, an affidavit of support “is a *legally enforceable* agreement between the sponsor and the government whereby the sponsor agrees to provide sufficient support to maintain an immigrant at 125 percent of the [federal poverty line].” *Id.* For a description of affidavit of support requirements, see 8 U.S.C. § 1183a (2006).

56. These exceptions include the following: asylees, refugees, and “active-duty members or veterans of the U.S. Armed Forces.” See KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, 1 (2006), <http://www.kff.org/medicaid/upload/7492.pdf> [hereinafter KAISER COMM’N REPORT].

57. See 8 U.S.C. § 1613(a) (2006) (imposing a five-year bar on Medicaid eligibility for those qualified aliens who enter the United States “on or after August 22, 1996”); see also Perkins, *supra* note 37, at 3 (describing the manner in which qualified aliens are classified into two groups on the basis of their date of entry into the United States). However, refugees, asylees, persons granted withholding of deportation or removal, victims of trafficking, and Cuban, Haitian, and Amerasian immigrants are exempt from the five-year eligibility bar. BRODER, *supra* note 49, at 4.4. Veterans and active duty military personnel, as well as their spouses and children, are similarly exempt. *Id.*



residency.<sup>58</sup> Even beyond PRWORA's five-year limitations, immigrants who are required under IIRIRA to obtain an Affidavit of Support by a U.S. citizen or LPR sponsor when applying for permanent residence may confront Medicaid benefits restrictions lasting ten years.<sup>59</sup> In the Affidavit, the sponsor provides a legally binding guarantee that the immigrant "will not become a public charge for ten years following admission to the U.S."<sup>60</sup> In addition, states may further restrict access to Medicaid beyond the five-year bar by limiting eligibility to immigrants who have worked continuously for forty quarters or who have become naturalized citizens.<sup>61</sup>

By permitting states to restrict or expand public-benefits eligibility for immigrants beyond even federal limitations, PRWORA nominally purported to broaden state authority in the immigration arena.<sup>62</sup> However, by narrowing the availability of federal funding for immigrants' Medicaid eligibility, PRWORA, in practical effect, has resulted in a substantial cost shifting from the federal to the state level and thus has weighed heavily against any state or local expansion of benefits for immigrants.<sup>63</sup> As a

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58. 8 U.S.C. § 1613(a). Federal means-tested public benefits include Medicaid (with the exception of emergency care), SCHIP, TANF, Food Stamps, and Supplemental Security Income. BRODER, *supra* note 49, at 4.4. The five-year bar to public-benefits eligibility advanced several Congressional objectives: (1) to "alter immigration flows by discouraging immigrants likely to seek public benefits from entering the United States," (2) to "shift responsibility for the support of immigrants away from the government and onto newcomers' sponsors," and (3) to "realize . . . cost savings." See WELFARE REFORM'S IMMIGRANT PROVISIONS, *supra* note 46, at 5.

59. See 8 C.F.R. § 213a.2 (2009). For example, family-based immigrants must provide an Affidavit of Support. *Id.* § 213a.2(a)(2)(i)(B). The sponsor's support obligations last until the immigrant becomes a U.S. citizen or has worked "40 qualifying quarters" without having received "any Federal means-tested public benefit." § 213a.2(e)(2)(i)(B).

60. Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 154 (2009). The Affidavit "creates a contract between the sponsor and the U.S. Government for the benefit of the sponsored immigrant, and of any Federal, State, or local governmental agency or private entity that administers any means-tested public benefits program." 8 C.F.R. § 213a.2(d). Consequently, "any Federal, State, or local governmental agency or private entity that provides any means-tested public benefit to the sponsored immigrant after the sponsored immigrant acquires permanent resident status, may seek enforcement of the sponsor's obligations through an appropriate civil action." *Id.*

61. See 8 U.S.C. § 1612(b)(1); KAISER COMM'N REPORT, *supra* note 56, at 2. As with the five-year bar, humanitarian immigrants, including refugees and asylees, may not be further barred through more restrictive state measures. KAISER COMM'N REPORT, *supra* note 56, at 2.

62. Clark, *supra* note 39, at 239. The so-called expansion of state discretion under PRWORA permits states to enact more restrictive measures than the federal default position but has made it more difficult for states to broaden immigrants' access to public benefits. *Id.*; see also Candice Hoke, *State Discretion Under New Federal Welfare Legislation: Illusion, Reality and a Federalism-Based Constitutional Challenge*, 9 STAN. L. & POL'Y REV. 115, 118 (1998). Characterizing the latitude granted to states as "uni-directional flexibility," Hoke contends that "where the Act awards states greater flexibility, it typically permits them to move only in a direction consistent with embedded, hard-nosed federal norms." *Id.*

63. See Costich, *supra* note 34, at 1057 ("Where states have elected to fund these benefits themselves, costs have been transferred from the federal government to the states."). In addition, state

further disincentive, it also erected procedural barriers to providing Medicaid to non-qualified immigrants.<sup>64</sup> Thus, nonqualified immigrants may become eligible for non-emergency health care benefits only through the enactment of a state law expressly authorizing such access.<sup>65</sup>

Despite the procedural constraints imposed by PRWORA, twenty-two states and the District of Columbia have extended varying degrees of Medicaid coverage to some nonqualified immigrants.<sup>66</sup> Yet, other state and local governments, particularly those with large populations of undocumented immigrants, have mirrored federal trends by restricting immigrant health care benefits.<sup>67</sup> In Texas, the state Attorney General stated that Houston-area, public-health agencies were “not authorized by state or federal law to provide outpatient services to allegedly ineligible immigrants.”<sup>68</sup> Therefore, where states elect not to expand Medicaid access to non-qualified immigrants, the costs of providing care have further devolved to local safety nets: financially strained hospitals and health care clinics.<sup>69</sup>

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legislation purporting to broaden immigrants’ eligibility for Medicaid “could be very difficult and politically unpopular in light of the surge in anti-immigrant sentiment.” Clark, *supra* note 39, at 240.

64. Clark, *supra* note 39, at 239.

65. Pursuant to 8 U.S.C. § 1621(d), “[a] state may provide that an alien who is not lawfully present in the United States is eligible for any State or local public benefit . . . only through the enactment of a State law.” Such procedural requirements “create political hurdles that make it difficult for state governments to provide these benefits.” Hoke, *supra* note 62, at 119.

66. KAISER COMM’N REPORT, *supra* note 56. For example, fourteen states have extended Medicaid coverage to legal immigrant children deemed otherwise ineligible. Likewise, Washington offers “full Medicaid benefits to low-income, post-PRWORA immigrants” who have resided “in the state for more than one year,” and “California provides coverage to all legal immigrants” via Medi-Cal. Costich, *supra* note 34, at 1056. In 2007, Medi-Cal spent approximately \$20 million on the care of 460 uninsured immigrants last year. Deborah Sontag, *Deported in 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>. Massachusetts accords “full Medicaid benefits to persons who were receiving long-term care at the time of enactment and a reduced benefit package to PRUCOL and post-PRWORA immigrants.” Costich, *supra* note 34, at 1056.

67. Clark, *supra* note 39, at 233.

68. Costich, *supra* note 34, at 1056; see also Op. Tex. Att’y Gen. No. JC-0394 (July 10, 2001), available at <http://www.org.state.tx.us/opinions/opinions/49cornyn/op/2001/hm/jc0394.htm>.

69. Costich, *supra* note 34, at 1057 (noting that “[e]ligibility restrictions under the PRWORA have had the intended effect of shifting costs away from the federal government, generally bringing the financial burden closer to the place where care is delivered” and that “[w]here state-funded benefits for ineligible immigrants are not available, costs have shifted to the municipal funders of safety net providers such as public hospitals and clinics”).

### C. Health Care Services Available to Non-Qualified Immigrants

Despite the narrowing effects of PRWORA,<sup>70</sup> nonqualified immigrants are entitled to limited health care benefits and services.<sup>71</sup> First, under EMTALA,<sup>72</sup> virtually all hospitals with emergency rooms are required to screen and stabilize emergency medical conditions without regard for the patient's Medicaid eligibility, immigration status, or independent ability to pay.<sup>73</sup> Second, nonqualified immigrants who, but for their immigration status, would otherwise qualify for Medicaid are eligible to receive coverage under Emergency Medicaid for the treatment of emergency medical conditions.<sup>74</sup>

#### I. EMTALA

Introduced in 1986, EMTALA was enacted to address the "critical problem of hospital emergency department dumping of the medically uninsured," a practice by which hospitals refuse to treat or inappropriately transfer patients who are unable to pay for medical care.<sup>75</sup> Codifying the belief that all individuals are entitled to receive emergency medical care regardless of immigration status or financial means,<sup>76</sup> EMTALA requires

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70. See generally Calvo, *supra* note 29, at 179–182 (discussing the effects of PRWORA on immigrants' access to Medicaid benefits).

71. See, e.g., Perkins, *supra* note 37, at 3.

72. 42 U.S.C. § 1395dd (2006).

73. EMTALA, codified at 42 U.S.C. § 1395dd, applies to "any individual (whether or not eligible for benefits under this subchapter)." *Id.* § 1395dd(a); see also Svetlana Lebedinski, Note, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden It Places on Hospitals*, 7 J.L. Soc'y 146, 147 (2005) (noting that "EMTALA creates a duty to provide care to all individuals, regardless of the availability of health insurance coverage or eligibility for federally sponsored programs, such as Medicare and Medicaid"). Because hospitals typically must accept federal and state-sponsored health insurance in order to maintain financial solvency, EMTALA's obligations, in practical effect, apply to all hospitals with an emergency room. Morgan Greenspon, *The Emergency Medical Treatment and Active Labor Act and Sources of Funding*, 17 ANNALS HEALTH L. 309, 311–12 (2008).

74. 42 U.S.C. § 1396b(v)(2)(A) (2006); see also *id.* § 1396b(v)(3)(A)–(C) (defining the term, emergency medical condition). "However, if the patient does not qualify for Emergency Medicaid, then a hospital may go completely uncompensated." Greenspon, *supra* note 73, at 313.

75. 131 CONG. REC. S13,904 (daily ed. Oct. 23, 1985) (statement of Sen. Heinz). Senator Heinz remarked that Cook County Hospital in Chicago, a public facility, "receives over 500 patients per month transferred directly from other emergency departments" because such patients lack health insurance to pay for private medical care. *Id.* at S13,905; see also *Marshall v. E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) (citing cases identifying the prevention of patient dumping as the purpose of EMTALA); Calvo, *supra* note 29, at 182 ("Congress passed the Emergency Medical Treatment Act . . . to guarantee emergency health care to every individual and to prevent patient dumping by hospitals and providers.").

76. See, e.g., 131 CONG. REC. 228,568 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)

all participating hospitals to provide an “appropriate medical screening examination” to any individual seeking treatment for an “emergency medical condition.”<sup>77</sup> For purposes of EMTALA, a participating hospital is one with both an emergency department and a federal Medicare contract.<sup>78</sup> Yet, EMTALA provides no mechanism to compensate hospitals for the costs associated with the screening and stabilization of emergency medical conditions.<sup>79</sup>

Adopting the definition set forth in the Emergency Medicaid statute, EMTALA defines an emergency medical condition as one “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” any of the following adverse consequences: “placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”<sup>80</sup> Where an individual manifests these acute symptoms, the hospital cannot transfer or discharge the individual before screening the patient and providing stabilizing treatment adequate to reasonably ensure “that no material deterioration of the condition is likely to result from or occur during the transfer.”<sup>81</sup> Moreover, all patient transfers must be “appropriate,” meaning that they are effectuated by qualified personnel and transportation equipment; that the receiving hospital has available space and qualified medical staff; that the hospital has agreed to accept the transfer and can provide treatment to minimize medical risks; and that the patient’s medical records are provided to the receiving hospital.<sup>82</sup>

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(“The purpose of this amendment is to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”).

77. 42 U.S.C. § 1395dd(a).

78. Calvo, *supra* note 29, at 182; *see also* 42 C.F.R. § 489.24 (stating the “[s]pecial responsibilities of Medicare hospitals in emergency cases”).

79. *See* Sean Elliott, *Staying Within the Lines: The Question of Post-stabilization Treatment for Illegal Immigrants Under Emergency Medicaid*, 24 J. CONTEMP. HEALTH L. & POL’Y 149, 173 (2007) (noting that EMTALA does not provide for federal reimbursement of the services it requires and, accordingly, may obligate hospitals “to treat patients from whom they can expect to receive no payment whatsoever, either from the patient or the federal government”).

80. 42 U.S.C. § 1396b(v)(3)(A)–(C) (2006); *see also* Elliott, *supra* note 79, at 151–52 (noting that although the definition of emergency medical condition appears to set forth a bright-line standard, its scope has, in practice, proven ambiguous).

81. 42 U.S.C. § 1395dd(b)(1)(A), (e)(3)(A). A hospital may transfer a patient who has not been stabilized only if the patient requests a transfer in writing or if a physician or qualified medical personnel certifies that the expected benefits of treatment at another facility outweigh the risks of transfer. *See id.* § 1395dd(c)(1)(A)(i)–(iii).

82. *Id.* § 1395dd(c)(2)(A)–(D).

EMTALA violations implicate potentially serious penalties. The Office of the Inspector General (OIG) may levee up to \$50,000 in civil penalties per violation upon hospitals that negligently breach EMTALA's requirements.<sup>83</sup> In addition, the statute accords individuals who suffer personal harm arising from the hospital's EMTALA violation a civil cause of action to obtain damages or equitable relief against the hospital.<sup>84</sup> Finally, albeit an infrequent consequence, the Centers for Medicare and Medicaid Services (CMS) may bar noncompliant hospitals from Medicare participation.<sup>85</sup>

Because EMTALA does not reimburse hospitals for the treatment it requires,<sup>86</sup> the statute is widely regarded as a financial burden to hospitals, particularly among those serving a large population of indigent, uninsured patients.<sup>87</sup> The hospital may seek compensation from the patient; however, physicians may not delay screening or treatment to inquire about an individual's "method of payment or insurance status."<sup>88</sup> Consequently, if a patient is not eligible for Emergency Medicaid or if funding through Emergency Medicaid does not fully reimburse the hospital for services rendered under EMTALA, hospitals may go uncompensated.<sup>89</sup>

In recognition of the burdens imposed on hospitals by virtue of EMTALA's obligation to treat undocumented, indigent immigrants, Congress enacted section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,<sup>90</sup> "[i]n an effort to assist hospitals and other providers with their uncompensated care costs."<sup>91</sup> Appropriating \$250 million per fiscal years 2005 through 2008 to compensate hospitals for emergency medical care provided to undocumented, indigent patients, section 1011 offered coverage from the

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83. *Id.* § 1395dd(d)(1).

84. *Id.* § 1395dd(d)(2). Although EMTALA creates a private cause of action against the hospital, the statute does not entitle the patient to initiate a lawsuit against the treating physician. *Id.*

85. *Id.* § 1395dd(d)(1).

86. Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 702 (2006) (characterizing EMTALA as an "unfunded mandate").

87. Lebedinski, *supra* note 73, at 154–55 (noting that EMTALA imposes a "great financial burden" on hospitals and "disproportionately" burdens "inner-city, rural and public hospitals"). In addition, "EMTALA creates a financial anomaly in which hospitals can only seek federal reimbursement for medical emergencies, and not reimbursement for less expensive preventative care." Greenspon, *supra* note 73, at 312.

88. 42 U.S.C. § 1395dd(h).

89. Greenspon, *supra* note 73, at 314.

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

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

time a patient presents at the hospital emergency department until the point of stabilization.<sup>92</sup> However, section 1011 expired in October 2008, with no immediate plans for renewal.<sup>93</sup>

## 2. *Emergency Medicaid*

Whereas EMTALA affirmatively obligates hospitals to screen and stabilize emergency medical conditions without regard for immigration status or ability to pay, Emergency Medicaid is the instrument through which hospitals may seek compensation for the emergency services tendered to nonqualified immigrants.<sup>94</sup> Emergency Medicaid, codified at 42 U.S.C. § 1396b(v)(3), was enacted within the Omnibus Budget Reconciliation Act of 1986, in which Congress generally sought to reduce government expenditures.<sup>95</sup> To effectuate this purpose and to clarify uncertainties surrounding immigrants' eligibility for Medicaid, Congress "barred medicaid assistance to aliens not residing in the United States under color of law unless the alien suffered from an emergency medical condition."<sup>96</sup> Pursuant to § 1396b(v), Medicaid payments "shall be made," provided that several requirements are met: the care is necessary for the treatment of an immigrant's emergency medical condition, the immigrant "otherwise meets eligibility requirements for medical assistance" under the state-approved plan, and the care does not relate to an organ transplant procedure.<sup>97</sup>

Although both EMTALA and Emergency Medicaid adopt the same definition of an emergency medical condition,<sup>98</sup> the scope of an emergency

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92. *Id.*

93. Although it failed to pass the 110th Congress, the Border Health Care Relief Act of 2008 was introduced in the House on June 26, 2008 and proposed to "amend the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to extend Federal reimbursement of emergency health services furnished to undocumented aliens" through fiscal year 2012. H.R. 6394, 110th Cong. (2008).

94. *See, e.g., Szewczyk v. Dep't of Soc. Servs.*, 881 A.2d 259, 286 (Conn. 2005) (Sullivan, C.J., dissenting) ("EMTALA is the only law mandating the treatment of an illegal alien's emergency medical condition. [Emergency Medicaid] merely authorizes payment to the states for the treatment of an emergency medical condition after it has been provided." (emphasis in original)); Greenspon, *supra* note 73, at 313–14.

95. *See Szewczyk*, 881 A.2d at 278 (Sullivan, C.J., dissenting).

96. *Id.* (stating that the Medicaid provision was enacted in 1986 "in response to a ruling by the United States District Court for the Eastern District of New York," wherein the court held that "federal medicaid law placed no restriction on alien eligibility for medicaid assistance"). For a case history of this decision, see *Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001), and for a description of the effect of *Lewis*, see Perkins, *supra* note 37, at 2.

97. 42 U.S.C. § 1396b(v)(2)(A)–(C) (2006).

98. *See supra* note 80 and accompanying text. In 1990, the Department of Health and Human Services (HHS) "expressly recognized the relationship" between Emergency Medicaid and EMTALA

for purposes of immigrants' Emergency Medicaid coverage has troubled health care providers and courts alike.<sup>99</sup> As reflected in the explanatory language issued by the Department of Health and Human Services in 1990, the term "emergency medical condition" initially received a "broad definition" in order to permit states to "interpret and further define the services available to aliens" in a manner "supported by professional medical judgment."<sup>100</sup> But, in the years after PRWORA, courts have diverged in construing the contours of Emergency Medicaid.<sup>101</sup>

Advancing a broad interpretation, in *Mercy Healthcare Arizona, Inc. v. Arizona Health Care Cost Containment System*,<sup>102</sup> Arizona's intermediate appellate court addressed the meaning of an emergency medical condition in the context of a catastrophic automobile accident that rendered the victim—an undocumented immigrant—comatose, paralyzed, and reliant upon a gastrointestinal feeding tube.<sup>103</sup> The court held that Emergency Medicaid encompasses treatment for medical conditions that manifest by an acute symptom, "so long as absence of immediate treatment for that condition 'could reasonably be expected to result in' one of the adverse consequences contemplated in 42 U.S.C. § 1396b(v)."<sup>104</sup> Thus, Emergency Medicaid coverage does not terminate immediately upon the resolution of the acute symptom that prompted the initial need for medical treatment.<sup>105</sup>

At a federal level, the Second Circuit has narrowly construed the boundaries of emergency medical conditions by distinguishing chronic and acute symptoms. In *Greenery Rehabilitation Group, Inc. v. Hammon*,<sup>106</sup> the patients at issue were undocumented immigrants who suffered catastrophic head injuries and who, after receiving stabilizing in-

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when it revised the implementing regulation, 42 C.F.R. § 440.255(c)(1), to "make the definition of emergency services consistent with" EMTALA's interpretation. *Szewczyk*, 881 A.2d at 279.

99. See Elliott, *supra* 79, at 152 (noting that "[i]n cases brought by individuals and health care providers, the courts have come up with somewhat conflicting interpretations of this term, leaving open to question the exact scope of Medicaid coverage for illegal immigrants."); *Szewczyk*, 881 A.2d at 286–87 (Sullivan, C.J., dissenting) (declining to construe Emergency Medicaid in the broad manner advanced by certain state courts).

100. Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36, 816 (Sept. 7, 1990) (codified at 42 C.F.R. pts. 435, 436, 440).

101. See generally Calvo, *supra* note 29, at 184–89.

102. 887 P.2d 625 (Ariz. Ct. App. 1994).

103. *Id.* at 627; see also *Gaddam v. Rowe*, 684 A.2d 286 (Conn. Super. Ct. 1995) (concluding that outpatient dialysis for an undocumented immigrant suffering end-stage renal disease satisfied that statutory definition of an emergency medical condition and thus warranted coverage under Emergency Medicaid).

104. *Mercy Healthcare*, 887 P.2d at 628–29.

105. *Id.* at 629.

106. 150 F.3d 226 (2d Cir. 1998).

hospital treatment, were transferred to rehabilitation facilities.<sup>107</sup> Reversing the district court,<sup>108</sup> the Second Circuit concluded that the hospital's stabilizing treatment resolved the patients' respective emergency medical conditions.<sup>109</sup> Following stabilization, the patients suffered chronic conditions<sup>110</sup> that exceeded the statutory scope of Emergency Medicaid, even though the condition arose through initially emergent circumstances.<sup>111</sup>

#### *D. Burdens on Hospitals*

The foregoing provisions have posed an economic quandary for hospitals by mandating treatment for certain immigrants who do not qualify for public benefits and who cannot independently afford medical treatment.<sup>112</sup> While Emergency Medicaid provides one avenue to compensate hospitals, its reimbursement potential is limited by several factors.<sup>113</sup> First, only those immigrants who, but for their migration status, "otherwise qualify" for Medicaid under the state-approved plan are entitled to receive Emergency Medicaid.<sup>114</sup> Accordingly, hospitals cannot seek Emergency Medicaid reimbursements for the care of nonqualified immigrants who fail to satisfy the income and residency conditions required for Medicaid.<sup>115</sup>

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107. *Id.* at 228–29. The first patient, who suffered "severe brain damage" following an automobile accident, was quadriplegic and required "continual monitoring and extensive nursing care." *Id.* at 228. Likewise, following a gunshot wound that resulted in brain damage, the second patient remained unable to walk, prone to seizures, and reliant upon assistance for daily tasks "such as bathing, dressing, eating, and toileting." *Id.* at 229.

108. *Id.* at 233. Crediting the treating physicians' testimonies, the district court determined that the patients were treated for emergency medical conditions in their respective rehabilitation facilities because the absence of this care would seriously imperil the patients' health and bodily functions. *Id.* at 230–31. For example, the district court determined that the patient who suffered a gunshot wound was receiving emergency medical care, the absence of which would render him "without food, in his own waste, [and] unable to move." *Id.* at 231 (quoting Greenway Rehabilitation Group, Inc. v. Hammon, 893 F. Supp. 1195, 1206 (N.D.N.Y. 1995)).

109. *Id.* at 233.

110. *Id.* at 232. While the Second Circuit concluded that chronic rehabilitative treatment exceeded the statutory definition of an emergency, the court observed that an emergency could arise in the course of chronic care. For example, "if one of these patients suffered a sudden heart attack, treatment to stabilize the patient would be covered by Medicaid pursuant to § 1396b(v)(3)." *Id.* at 233.

111. *Id.* at 233. The Second Circuit further observed that several treating physicians described the patients' conditions as chronic. *Id.* at 232.

112. Greenspon, *supra* note 73, at 314.

113. *Id.* at 313–14 (citing instances in which Emergency Medicaid fails to compensate hospitals for the treatment of undocumented immigrants).

114. *Id.* at 313.

115. Perkins, *supra* note 37, at 4 (explaining that states have "denied Medicaid coverage for emergency medical conditions citing the residency provisions"). For Medicaid eligibility among



Second, because the line between emergent and chronic symptoms is ill-defined, hospitals “must confront whether government officials will agree with their assessment of what constitutes appropriate treatment of an emergency medical condition” in seeking reimbursement through emergency Medicaid.<sup>116</sup> In accordance with EMTALA, a hospital may render what it believes to be stabilizing care to a nonqualified, indigent immigrant who presents with an emergency medical condition.<sup>117</sup> Yet, if the government or a reviewing court instead defines the condition as chronic, the hospital may go uncompensated.<sup>118</sup> Thus, health care providers face a Hobson’s choice: the hospital can offer treatment for a perceived emergency, which may prove financially undesirable if reimbursement is denied,<sup>119</sup> or it can withhold treatment, possibly in derogation from EMTALA’s requirements.

Third, as a condition of Medicare participation, federal regulations mandate the implementation of adequate discharge plans for patients, obligating hospitals to “transfer or refer patients, along with necessary medical information, to *appropriate* facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.”<sup>120</sup> Likewise, the Joint

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individuals age twenty-one and over, the state of residence is defined as “the State where the individual is . . . [l]iving with the intention to remain there permanently or for an indefinite period.” 42 C.F.R. § 435.403(i)(1)(i) (2006). Thus, if the immigrant has not manifested a sufficient intent to remain, Medicaid coverage for emergency medical conditions may be denied. *See Perkins, supra* note 37, at 4. For example, in *Okale v. North Carolina Department of Health and Human Services*, 570 S.E.2d 741, 744 (N.C. Ct. App. 2002), the court affirmed the Medicaid agency’s denial of coverage for Ms. Okale, who possessed an unexpired nonimmigrant tourist visa. Although she had entered a lease, procured a driver’s license, and opened a bank account, the court determined that her “unexpired tourist temporary visa creates the verification to doubt Okale’s asserted intent to remain in the state. To hold otherwise, we must presume that Okale will violate the law and attempt to illegally stay beyond her latest declared date of departure from this state and country.” *Id.* at 742, 745; *see also Perkins, supra* note 37, at 4–5 (describing *Okale* and stating that “[c]ourts have generally affirmed states’ refusals to cover emergency conditions based on the non-resident status of the noncitizen”).

116. *Calvo, supra* note 29, at 190. In addition, the disbursement of Emergency Medicaid funds may raise disputes between federal and state authorities. *Id.* While state-level Medicaid programs determine reimbursement to hospitals within the state, these state programs, “particularly those with significant immigrant populations, face federal rejection of their determinations, subjecting them to loss of federal dollars for reimbursement of Medicaid expenses.” *Id.* For example, “from 2001 to 2006, the federal government denied [New York] state about \$11 million in matching funds for the cancer treatment” provided to uninsured immigrants. *See Sarah Kershaw, New York, Faulting U.S., Says It Will Pay for Cancer Care for Illegal Immigrants*, N.Y. TIMES, Sept. 26, 2007, at B3.

117. *Calvo, supra* note 29, at 190.

118. *Id.*

119. *See generally Creativity is the Key in Discharge Planning for Undocumented Immigrants*, 14 HOSP. CASE MGMT. 97, 97–100 (2006) (noting that, in 2000, “hospitals in just 24 counties along the Mexican border spent more than \$200 million on emergency health care and transportation for undocumented immigrants,” according to a Border Counties Coalition study) [hereinafter “*Creativity is the Key in Discharge Planning*”].

120. 42 C.F.R. § 482.43(d) (2008) (emphasis added); *see also Alfred J. Chiplin, Jr., Breathing Life*

Commission on Accreditation of Hospitals (Joint Commission) provides that accredited hospitals “must have in place a mechanism to ensure that . . . admission, transfer, and discharge practices are conducted in an ethical manner.”<sup>121</sup> Accordingly, inappropriate discharge may constitute patient abandonment,<sup>122</sup> even when appropriate post-acute treatment for non-qualified, indigent immigrants is difficult, if not impossible, to find.<sup>123</sup> Thus, when long-term care facilities refuse uninsured, indigent patients, hospitals are left to shoulder the cost.<sup>124</sup>

### III. MEDICAL REPATRIATIONS

As Part II illustrates, the confluence of federal immigration laws and health care laws situate indigent immigrant patients who do not qualify for Medicaid as a unique financial threat to hospitals.<sup>125</sup> On one hand, PRWORA restricts access to nonemergency Medicaid for nonqualified immigrants and for otherwise qualified immigrants who have not satisfied a five-year residency requirement.<sup>126</sup> On the other hand, irrespective of the patient’s immigration status or ability to pay, hospitals are obligated to provide stabilizing treatment through EMTALA and must adhere to federal discharge requirements, which require the hospital to secure appropriate ancillary care for patients who require post-acute treatment.<sup>127</sup> Consequently, from this quagmire, medical repatriations of immigrant patients have emerged as a vigilante response to the burden of uncompensated care.

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*into Discharge Planning*, 13 ELDER L.J. 1, 27 (2005). CMS has described “appropriate facilities” as “those with the appropriate capabilities to handle the patient’s condition.” SURVEY & CERTIFICATION GROUP, CTRS. FOR MEDICARE & MEDICAID SERVS., PROVISION OF EMERGENCY SERVICES—IMPORTANT REQUIREMENTS FOR HOSPITALS 3 (2007), available at <http://www.cms.hhs.gov/survey/certificationgeninfo/downloads/scletter07-19.pdf>.

121. Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB POL’Y 245, 287 (2000) (internal quotation omitted).

122. Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provides Obligations to Treat Patients*, 3 HEALTH MATRIX 31 (1993).

123. See *Creativity is the Key in Discharge Planning*, *supra* note 119, at 97 (observing that hospital discharge planners must use “ingenuity to find a discharge destination for undocumented workers who need post-acute care” and must “tap[] into whatever community resources are available” in order to do so).

124. See *supra* note 16 and accompanying text.

125. See *supra* Part II.D.

126. See *supra* Part II.B.

127. For a discussion of EMTALA, Emergency Medicaid, and federal discharge requirements, see *supra* Part II.C.1–2 and Part II.D.

### A. *The Scope of Medical Repatriations*

Medical repatriation occurs when hospitals transport uninsured and indigent immigrants to medical facilities outside the United States.<sup>128</sup> Repatriations are usually conducted at the transporting hospital's expense, and, depending on the destination, may be effectuated by ambulance, plane, or through a contract with a private repatriation company.<sup>129</sup> Often undertaken without governmental or judicial oversight,<sup>130</sup> repatriations constitute a limited, but consistent, practice at some public and private hospitals, particularly those that treat a substantial population of immigrants.<sup>131</sup> For example, St. Joseph's Hospital in Phoenix, Arizona, repatriates approximately ninety-six immigrants per year.<sup>132</sup> Repatriations are typically initiated when hospitals, after providing stabilizing treatment to an immigrant within the mandates of EMTALA, are unable to find a rehabilitative facility or nursing home willing to accept an uninsured, indigent immigrant who requires long-term care.<sup>133</sup> Thus, medical repatriations have evolved as a creative last resort to reduce the financial burdens placed upon over-extended hospitals for the long-term care of indigent, nonqualified immigrants.<sup>134</sup>

Though motivated by common financial concerns, repatriation practices vary along two dimensions: (1) the patient's immigration status and (2) the degree of force applied.

#### 1. *Immigration Status*

Because they are ineligible for nonemergency Medicaid, undocumented and indigent immigrants are the primary subjects of medical repatriations. Some medical professionals maintain that when immigrants have irregular legal statuses, the immigrant's country of origin ought to assume financial responsibility for the medical needs of its

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128. Sontag, *supra* note 1.

129. *Id.* MexCare is one such repatriation company, which describes itself as “[a]n alternative choice for the care of the unfunded Latin American National.” Mexcare, <http://mexcare.com> (last visited May 13, 2010). Mexcare advertises that it “offer[s] a significant reduction in the cost of unpaid services.” Mexcare Services, [http://mexcare.com/services\\_MexCare.html](http://mexcare.com/services_MexCare.html) (last visited May 13, 2010).

130. Vanderpool, *supra* note 19 (stating that medical repatriations “are occurring in a legal twilight, with little or no governmental oversight”); *see also* Patsner, *supra* note 5 (“For all intents and purposes, the practice of repatriation by U.S. hospitals is essentially unregulated.”).

131. Sontag, *supra* note 1.

132. *Id.*

133. *Id.*

134. Sontag, *supra* note 66.

citizens.<sup>135</sup> Others contend that the federal government should legislatively address the burdens associated with the uncompensated care of immigrants who are ineligible for long-term Medicaid.<sup>136</sup>

Yet, even if this argument reflects a rational allocation of limited resources, it does not present a complete picture of repatriations: LPRs who are barred by Medicaid's five-year residency requirement have also been subjected to repatriation.<sup>137</sup> In June 2008, Antonio Torres, a nineteen-year-old LPR from Mexico, suffered catastrophic injuries in a car accident, which rendered him comatose and reliant upon a ventilator at St. Joseph's Hospital in Arizona.<sup>138</sup> Over his parents' objections, St. Joseph's Hospital transported Torres across the border to a public hospital emergency room in Mexicali.<sup>139</sup> With the assistance of his family's church, Torres was transported back to the United States to El Centro Regional Medical Center in California, which provided care until he was discharged.<sup>140</sup>

Even beyond efforts to repatriate LPRs, one hospital attempted to "repatriate" a full-fledged American citizen.<sup>141</sup> In March 2007, Elliott Bustamante was born with Down's syndrome and a heart defect to a Mexican immigrant in Arizona at Tucson's University Medical Center (UMC).<sup>142</sup> Notwithstanding the fact that Bustamante was an American citizen by virtue of his birth in the United States, UMC stated that the hospital's policy is to transfer patients to their "community of residence" and prepared for the infant's removal to a Mexican hospital.<sup>143</sup> Bustamante's repatriation was halted only after the Mexican consulate

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135. *Id.* (quoting the vice president of Scottsdale Health in Arizona, who stated, "Then, it's like, 'Mexican government, take responsibility for your own citizens!'").

136. Wolpin, *supra* note 60, at 154 (quoting a hospital administrator); *see also* Sontag, *supra* note 1.

137. Sontag, *supra* note 66 (discussing the case of Antonio Torres, an LPR who was repatriated to Mexico); *see also* Daniel Gonzalez, *For Some Ill Migrants, Free Care Has a Price*, ARIZ. REPUBLIC, Aug. 3, 2008, <http://www.azcentral.com/arizonarepublic/news/articles/2008/08/03/20080803hospitals0803.htmh?&wired> ("Not all patients who are sent back are undocumented immigrants. The hospital also is sending back legal immigrants who don't qualify for long-term Medicaid. Hospital officials attribute the practice to stricter laws and tighter controls at the state and federal levels that have made it harder for immigrants to obtain non-emergency Medicaid care.").

138. Sontag, *supra* note 66. Torres, who had resided in the United States for less than five years, was ineligible for Medicaid because of the five-year bar imposed upon newly arrived LPRs. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.* The circumstances surrounding Bustamante's repatriation are contested: UMC claimed that the infant's mother initially consented to the transfer and later "equivocated." *Id.* In contrast, Bustamante's mother stated that she was pressured by UMC and was told that the infant would be transferred with or without her. *Id.*

provided an attorney to the infant's parents and after the police were summoned.<sup>144</sup> When the Arizona Medicaid system approved Bustamante's care and reimbursed the hospital, UMC abandoned its efforts to repatriate the infant.<sup>145</sup>

## 2. Degree of Force Applied

Just as the patients targeted for repatriation may vary, hospitals apply differing degrees of force when repatriating patients. While some hospitals require consent from the patient or the patient's guardian before authorizing repatriation,<sup>146</sup> other hospitals conduct forcible repatriations. In the latter cases, the hospital transfers the patient outside the United States against the wishes of the patient or the patient's legal guardian.<sup>147</sup> For example, UMC would "not confirm whether all past transfers were consensual" and noted that "sometimes we don't [require consent]."<sup>148</sup>

In other cases, either the hospital authorizing repatriation or the company effectuating the removal requires informed consent before transferring the patient outside the United States.<sup>149</sup> Although consensual repatriations arguably afford a greater degree of protection to immigrant patients, the meaning of consent remains uncertain in this context.<sup>150</sup> If the patient or the patient's guardians are undocumented and fear that a failure to comply with the hospital's directives will result in disclosure of their presence to federal immigration authorities, the sincerity of consent is questionable.<sup>151</sup> Similarly, the value of consent diminishes if the hospital does not apprise the patient of the possible immigration consequences that may attach to leaving the country.<sup>152</sup>

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144. *Id.* Upon Bustamante's return to Tucson, UMC sought a judicial order to compel the parents to consent to the infant's transfer and argued that, given the family's failure to transfer the child or pay the \$28,000 in medical expenses, the baby was trespassing on hospital property. *Id.*

145. *Id.*

146. *Id.* ("And, just as some [hospitals] forcibly repatriate patients, others do so only with consent . . ."). On its website, MexCare explicitly notes that all transfers "have been done with a signed consent of the patient and their Legal Guardian and with extensive communication with the family." Press Release, MexCare, *The New York Times Gets It Wrong!* (Aug. 15, 2008), [http://www.mexcare.com/pressRelease\\_Mexcare.html](http://www.mexcare.com/pressRelease_Mexcare.html) (follow "Sunday, August 15th, 2008" hyperlink under "2008").

147. *See infra* Part IV.B.

148. Gonzalez, *supra* note 137 (quoting UMC's attorney).

149. Wolpin, *supra* note 60, at 153–54.

150. *Id.*

151. Sontag, *supra* note 66 ("[C]onsent is a murky concept when patients are told they have no alternative.").

152. Wolpin, *supra* note 60, at 155 n.17 ("Among the many possible immigration consequences that could follow a medical repatriation, permanent residents might find themselves unable to re-enter the U.S. after leaving its borders under certain circumstances.").

Although repatriations have only recently attracted national attention and have not been addressed by Congress, the medical community has expressed disapproval of forcible repatriations.<sup>153</sup> In October 2008, the California Medical Association passed Resolution 105a-08, stating that it “oppose[s] forced deportation of patients.”<sup>154</sup> In November 2009, the AMA CEJA issued recommendations on repatriations.<sup>155</sup> While the report acknowledged that physicians should “use health care resources responsibly and can ethically consider compelling arguments . . . to discharge a patient whose continued hospitalization is likely to compromise the care of other patients,” it affirmed that physicians’ “primary ethical obligation” is to ensure safe patient discharge, “without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations.”<sup>156</sup> Thus, physicians should “[r]efrain from signing a discharge order that would result in involuntary discharge of a patient who is not a U.S. citizen to his/her country of origin.”<sup>157</sup>

### *B. Consequences of Repatriation*

Medical repatriations raise significant health, immigration, and personal concerns for immigrant patients. Where patients are repatriated to countries lacking adequate medical facilities to address their health care needs, serious adverse health consequences may result.<sup>158</sup> Since his return to Guatemala, Mr. Jimenez has received no medical care and has experienced “violent seizures,” marked by convulsions, vomiting, and unconsciousness.<sup>159</sup> In addition, repatriations may have detrimental immigration consequences.<sup>160</sup> For LPRs seeking eventual U.S. citizenship, repatriation may impede the naturalization process by disrupting their continuous U.S. residence, a requirement of naturalization.<sup>161</sup> Likewise, an

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153. *Id.* at 153 (noting that the medical community has yet to adopt a definition for “forced” repatriations).

154. *Id.* (quoting Resolution 105a-08).

155. CEJA REPORT, *supra* note 20.

156. *Id.* at 6.

157. *Id.*

158. *See* *Montejo v. Martin Mem’l Med. Ctr., Inc.*, 874 So. 2d 654, 657–58 (Fla. Dist. Ct. App. 2004) (holding that Martin Memorial violated federal discharge requirements when it transferred a patient who suffered traumatic brain injuries to a medical center in Guatemala that lacked facilities offering traumatic brain injury rehabilitation).

159. Sontag, *supra* note 1.

160. Wolpin, *supra* note 60, at 155 n.17.

161. 8 C.F.R. § 316.2 (2009) sets forth the eligibility requirements for naturalization. Among them, the immigrant must establish that he or she “[h]as resided continuously within the United States . . . for a period of at least five years after having been lawfully admitted for permanent residence[.]”

LPR whose repatriation results in a continuous absence exceeding 180 days will be regarded as seeking admission upon his return to the United States,<sup>162</sup> and thus will be subject to stringent inadmissibility grounds.<sup>163</sup> Equally significant are the potential collateral effects arising from repatriations: separation from family and community and the loss of livelihood.<sup>164</sup> Finally, where repatriations are conducted forcibly, they are tantamount to deportation, a notably severe consequence.<sup>165</sup>

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*Id.* § 316.2(a)(3). In addition, the immigrant must have been “physically present in the United States for at least 30 months of the five years preceding the date of filing the application” and must have “resided continuously within the United States from the date of application for naturalization up to the time of admission to citizenship[.]” *Id.* § 316.2(a)(4), (a)(6). Pursuant to § 316.5(c)(1)(i), an absence from the United States for a continuous period of between six months and one year “shall disrupt the continuity of such residence for purposes of this part unless the applicant can establish otherwise to the satisfaction of the Service.” The immigrant may submit various types of documentation to show that his or her extended absence did not disrupt the continuity of residence. *Id.* § 316.5(c)(1)(i)(A)–(D). An absence from the United States for continuous period of one year or more “shall disrupt the continuity of the applicant’s residence,” with no opportunity to present evidence otherwise. *Id.* § 316.5(c)(1)(ii). Thus, if repatriation of an LPR results in an extended absence, it may interfere with the immigrant’s residency requirements for naturalization.

162. 8 U.S.C. § 1101(a)(13)(C)(ii) (2006). In addition to the grounds set forth in § 1101(a)(13)(C), there is some academic debate concerning the circumstances in which an immigrant is seeking admission. The Board of Immigration Appeals has held that a returning LPR who falls within the categories described in § 1101(a)(13)(C) will be regarded as seeking admission. *See In re Collado-Munoz*, 21 B.I.A. 1061 (1998). Yet, other courts have considered, in addition to these categories, whether the absence “meaningfully interrupted the person’s permanent residence in the United States.” STEPHEN H. LEGOMSKY, *IMMIGRATION AND REFUGEE LAW AND POLICY* 524 (4th ed. 2005) (citing *Richardson v. Reno*, 994 F. Supp. 1466 (S.D. Fla. 1998)).

163. For example, “[a] single crime of moral turpitude committed at any time may trigger inadmissibility whereas it must have been committed within 5 years of lawful admission for it to trigger deportability.” LEGAL ACTION CTR., *PRACTICE ADVISORY: § 211(H) ELIGIBILITY: CASE LAW AND POTENTIAL ARGUMENTS* 7 (Feb. 19, 2008), available at <http://www.legalactioncenter.org/sites/default/files/212elig.pdf> (comparing INA § 212(a)(2)(A)(i)(1) with INA § 237(a)(2)(A)(i)(1)). The following scenario illustrates one problem posed by repatriation. Imagine that a family-sponsored immigrant was admitted to the United States as an LPR in 2000. In 2004, having not yet met the five-year residency requirement for Medicaid, the uninsured immigrant was seriously injured in an automobile accident and required ongoing care, which no long-term facility would provide. Thus, the hospital repatriated the LPR to his country of origin in 2004. The immigrant remained in his country for two years, but after recovering, was re-admitted in 2006. In 2008, the immigrant was convicted of falsifying his tax return, a crime involving moral turpitude with a possible punishment exceeding one year. Because the immigrant, whose repatriation resulted in a lengthy absence, would be regarded as seeking admission in 2006, his crime involving moral turpitude would have occurred within five years of this second admission, thus triggering deportability under INA § 237. Had he remained continuously within the United States, his crime involving moral turpitude would not trigger deportation in this instance, as it occurred more than five years after his first admission in 2000. For an extensive discussion of issues relating to immigrant entry and admission, see LEGOMSKY, *supra* note 162, at 519–25.

164. Stephen H. Legomsky, *The New Path of Immigration Law: Asymmetric Incorporation of Criminal Justice Norms*, 64 WASH. & LEE L. REV. 469, 512–13 (2007); *see also* *Ng Fung Ho v. White*, 259 U.S. 276, 284 (1922) (remarking that deportation “may result also in loss of both property and life; or of all that makes life worth living”).

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

#### IV. CAUSES OF ACTION ARISING FROM FORCIBLE REPATRIATIONS

While immigrants subject to repatriation may confront a variety of adverse health and immigration consequences, repatriation also may be disadvantageous from the hospital's perspective.<sup>166</sup> In particular, despite their intended goal of reducing medical expenses, repatriations may breach federal discharge requirements<sup>167</sup> and may expose hospitals to tort liability.<sup>168</sup> More significantly, by intruding into the realm of immigration, a field occupied by federal law, public and private hospitals alike risk violating the Due Process Clause of the Fourteenth Amendment.<sup>169</sup>

Before evaluating these causes of action, it is necessary to define the scope of hospital liability. First, only forcible repatriations should be subject to liability. Thus, requiring informed consent by the patient or the patient's guardians should shield the hospital from liability. Yet in some cases, the authenticity of a nominal consent may be challenged, particularly if the patient is not aware of the collateral immigration consequences resulting from repatriation. Second, to seek redress in a federal or state court of the United States, the repatriation must be challenged before the patient is transported outside the United States.<sup>170</sup>

##### *A. Breach of Federal Discharge Requirements*

Although medical repatriations have remained largely outside the purview of the courts or immigration authorities,<sup>171</sup> in *Montejo*, the

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(describing the repatriation of Jimenez as "the transportation (deportation) of Jimenez to Guatemala"); see also LEGOMSKY, *supra* note 162, at 499 (characterizing deportation as "a harsh sanction" and describing the economic and familial hardships that may arise from deportation).

166. See *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006) (holding that *Montejo* could sue and seek punitive damages from Martin Memorial for the false imprisonment of Jimenez in the course of Jimenez's repatriation).

167. See *Montejo*, 874 So. 2d at 657–58 (finding that the hospital, as a Medicare provider, "was required to comply with federal discharge requirements," and that "there was no competent substantial evidence" to support the discharge of an immigrant with traumatic brain injuries to a Guatemalan hospital that lacked traumatic brain injury rehabilitation facilities).

168. See *supra* note 165 and accompanying text.

169. See Graham & Williams-Harris, *supra* note 18 (quoting Sonal Ambegaokar, a health policy attorney, who notes that where hospitals act as immigration agents by deporting patients, "immigrants may be denied due process").

170. See Wolpin, *supra* note 60, at 154 (observing that "pre-repatriation protection is particularly important for non-citizen patients because once outside the country, they will face significant logistical obstacles to obtaining legal remedies in U.S. courts and will be unable to challenge any part of their repatriation").

171. See Sontag, *supra* note 1 (remarking that "the hospitals are operating in a void, without governmental assistance or oversight, leaving ample room for legal and ethical transgressions on both sides of the border").



benchmark case described in Part I, the District Court of Appeal of Florida, Fourth District, decided that medical repatriations may breach federal patient-discharge requirements.<sup>172</sup> In reversing the decision of the Circuit Court for Martin County, which granted Martin Memorial's requested order to authorize Jimenez's transfer to Guatemala,<sup>173</sup> the appellate court first observed that "federal immigration law preempts deportation";<sup>174</sup> consequently, the state trial court "lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala."<sup>175</sup> Second, because the medical facility in Guatemala lacked facilities providing rehabilitation for traumatic brain injuries, the court found insufficient "competent substantial evidence to support Jimenez's discharge,"<sup>176</sup> which "was required to comply with federal discharge requirements."<sup>177</sup> Pursuant to the court's holding in *Montejo*, the repatriation of immigrants may violate federal discharge requirements if the patient is not transferred to an "appropriate facility," defined "as one which can meet the patient's medical needs."<sup>178</sup> Thus, "[i]f other courts follow this precedent, then Medicaid-participating hospitals will need to be particularly careful in investigating the quality and capacity of foreign medical facilities before repatriating patients to them."<sup>179</sup>

### *B. Tort Liability for False Imprisonment*

Beyond patient discharge violations, the appellate court in *Montejo* determined that an immigrant subject to forcible repatriation may sue the hospital in tort for false imprisonment.<sup>180</sup> In Florida, a plaintiff must

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172. *Montejo*, 874 So. 2d at 658.

173. *Id.* Although Jimenez had already been repatriated at the time of the appeal, the appellate court determined that the appeal "was not moot because similar situations involving extended medical care of undocumented immigrants were likely to recur." Patsner, *supra* note 5.

174. *Montejo*, 874 So. 2d at 656.

175. *Id.* at 658.

176. *Id.*

177. *Id.* at 657. These federal discharge requirements are codified at 42 U.S.C. § 1395X(ee) (2006) and 42 C.F.R. § 482.43 (2008). Notably, these federal discharge requirements apply to all Medicare and Medicaid participating hospitals, regardless of whether the patient himself is eligible for Medicare or Medicaid benefits. See Connie A. Raffa, *Discharge Planning Issues in Hospitals: Steering to Preferred Certified Home Health Agencies and the Risks of Providing Free Discharge Planning Services to Hospitals*, ARTICLES & LEGAL UPDATES, May 30, 2008, at 1, [http://www.arentfox.com/pdf\\_notReady/Discharge%20Planning%20Issues%20in%20Hospitals.pdf](http://www.arentfox.com/pdf_notReady/Discharge%20Planning%20Issues%20in%20Hospitals.pdf).

178. *Montejo*, 874 So. 2d at 657.

179. Wolpin, *supra* note 60, at 154.

180. See *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 935 So. 2d at 1266, 1268 (Fla. Dist. Ct. App. 2006) (holding that Martin Memorial's reliance upon a court order, which was later determined to

establish four elements in order to maintain a successful false imprisonment claim: (1) the “unlawful detention and deprivation of liberty of a person”; (2) “against the person’s will”; (3) “without legal authority or ‘color of authority’”; (4) “which is unreasonable and unwarranted under the circumstances.”<sup>181</sup> Jimenez’s false imprisonment claim was premised upon his non-consensual confinement within an ambulance and airplane in the course of his transfer from Martin Memorial to Guatemala.<sup>182</sup> Although the trial court dismissed the false imprisonment suit with prejudice because the hospital acted under a then-valid court order authorizing his repatriation, the appellate court reversed, concluding that the hospital’s reliance upon a voided court order did not immunize the hospital from false imprisonment liability.<sup>183</sup> In remanding the case, the appellate court determined that Martin Memorial acted without legal authority as a matter of law, but that “the trier of fact must determine . . . whether Martin Memorial’s actions were unwarranted and unreasonable under the circumstances.”<sup>184</sup> In July 2009, on remand to the trial court, a jury found for Martin Memorial, concluding that the hospitals actions were not “unreasonable and unwarranted under the circumstances,” the fourth element of false imprisonment.<sup>185</sup>

Given that Jimenez ultimately did not prevail in his false imprisonment suit, the issue of hospital tort liability for medical repatriations remains unresolved. On one hand, immigrant patients may have difficulty convincing a jury that a hospital acted unreasonably in conducting a forcible repatriation, particularly when the hospital has unsuccessfully pursued alternative options, such as placement in a long-term rehabilitation facility. On the other hand, the appellate court in Jimenez’s case determined both that state courts lack jurisdiction to issue court orders authorizing repatriation and that hospitals cannot rely upon an

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have been granted without subject matter jurisdiction, did not entitle the hospital to immunity against Montejo’s false imprisonment claim).

181. *Id.*

182. *Id.* In response, Martin Memorial filed a motion to dismiss or, in the alternative, sought judgment on the pleadings on two bases: (1) Montejo lacked standing, and (2) because Martin Memorial acted pursuant to a then-valid court order, Montejo could not demonstrate an essential element of false imprisonment: that his detention was unreasonable and unwarranted. *Id.*

183. *Id.* Although Martin Memorial contended that “because it acted in reliance on the court order, it should be cloaked with qualified or quasi-judicial immunity to the same extent as that afforded to state agents executing the order of a trial court.” *Id.* at 1270. The appellate court rejected this argument, noting that the hospital sought to enforce “a purely private right.” *Id.* at 1271.

184. *Id.* at 1272.

185. Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES, July 28, 2009, at A10.

invalidated court order to avoid tort liability.<sup>186</sup> Consequently, while further cases may be needed to measure the success of similar tort lawsuits, Jimenez's case nevertheless signals that immigrants may pursue tort claims against hospitals that conduct forcible repatriations.

### *C. Due Process Violations Arising Under the Fourteenth Amendment*

While *Montejo* suggests that forcible repatriations may expose hospitals to liability for federal patient discharge violations and for tort-based personal injury claims, a yet-untested inquiry is whether immigrants, such as Jimenez, who are subjected to forcible medical repatriations, may assert claims against the hospitals responsible for repatriation under 42 U.S.C. § 1983<sup>187</sup> for the deprivation of due process under the Fourteenth Amendment of the U.S. Constitution.<sup>188</sup> To advance a successful § 1983 claim, a plaintiff must prove two elements: that a person subjected the plaintiff to conduct under the color of state law, and that this conduct deprived the plaintiff of rights guaranteed under federal law or the U.S. Constitution.<sup>189</sup> Notably, both § 1983 and the Fourteenth Amendment—which protects “any person” from a state-based deprivation of life, liberty, and property—apply to all persons, not merely to U.S. citizens.<sup>190</sup> Thus, Fourteenth Amendment due process protections of the Constitution apply to all immigrants, whether documented or not, within the United States, and § 1983 permits these immigrants to seek damages for due process violations by state officers.<sup>191</sup>

#### *1. Section 1983 Claims Against Public Hospitals*

Where a public hospital seeks to forcibly repatriate an immigrant patient, this immigrant likely can establish a successful § 1983 claim. First, because “state employment is generally sufficient to render the defendant a state actor”<sup>192</sup> even where a public employee “abuses the

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186. *Montejo*, 935 So. 2d at 1268.

187. 42 U.S.C. § 1983 (2006) provides that “[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects . . . any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights . . . secured by the Constitution and laws, shall be liable to the party injured in an action at law.”

188. U.S. CONST. amend XIV, § 1 (providing, in pertinent part, that “nor shall any State deprive any person of life, liberty, or property, without due process of law”).

189. 42 U.S.C. § 1983 (2006); 15 AM. JUR. 2d *Civil Rights* § 148 (2000) (discussing the elements of a § 1983 claim).

190. See *supra* notes 188 and 189.

191. See *Bolanos v. Kiley*, 509 F.2d 1023, 1025–26 (2d Cir. 1975).

192. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 936 n.18 (1982).

position given to him by the State,” the employees of a public hospital are likely state actors who act under the color of state law when conducting official employment duties.<sup>193</sup> The Supreme Court has determined on several occasions that doctors constitute government actors when rendering medical care at hospitals operating under state contracts.<sup>194</sup> Second, because deportation results in a loss of liberty,<sup>195</sup> an immigrant is likely to prevail in demonstrating that forcible repatriation will deprive the immigrant of due process rights secured under the Fourteenth Amendment.

Indeed, “all noncitizens whom the government seeks to expel—even those who have not been lawfully admitted—are protected by . . . due process.”<sup>196</sup> In the context of deportation, due process generally entitles immigrants to certain procedural protections, including an administrative hearing before an immigration judge, the right to seek administrative review before the Board of Immigration Appeals, and, in certain cases, an opportunity for judicial review.<sup>197</sup> Thus, when a hospital—in an act approximating deportation—forcibly transports an immigrant patient outside the United States, and when this patient is not afforded prior notice or a hearing,<sup>198</sup> this action violates the immigrant’s due process rights, which are guaranteed by the U.S. Constitution. Consistent with this view,

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193. *West v. Atkins*, 487 U.S. 42, 49–50 (1988). In *West*, an incarcerated patient was treated for a torn Achilles tendon by a physician who provided orthopedic treatment to prisoners under a contract with the state of North Carolina. *Id.* at 43–44. When the physician allegedly “acknowledged that surgery would be necessary” but “refused to schedule it,” the prisoner filed suit, alleging that the physician “was deliberately indifferent to his serious medical needs” in violation of the Eighth Amendment right “to be free from cruel and unusual punishment.” *Id.* at 44–45. Reversing the Fourth Circuit, the Court held that a physician employed by the state to provide medical treatment to state prisoners, “acted under color of state law for purposes of § 1983 when undertaking his duties in treating [the prisoner’s] injury.” *Id.* at 54. Moreover, if the physician “misused his power by demonstrating deliberate indifference to West’s serious medical needs, the resultant deprivation was caused, in the sense relevant for state-action inquiry, by the State’s exercise of its right . . . to deny him a venue independent of the State to obtain needed medical care.” *Id.* at 55.

194. *See id.* at 54; *Estelle v. Gamble*, 429 U.S. 97 (1976). For a discussion of these cases, see ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 516 (3d ed. 2006). Moreover, “[t]he Court has made it clear that a government officer is acting under color of law, and is a state actor, if he or she is acting in an official capacity, even if the conduct is not authorized by state law.” *Id.* Thus, even if the public hospital employees who effect repatriations are not permitted to do so within the parameters of state law, they still may be considered state actors if patient repatriations are conducted within the scope of their public employment.

195. CHERMERINSKY, *supra* note 194, at 569 (discussing due process protections in the context of deportation and exclusion proceedings).

196. LEGOMSKY, *supra* note 162, at 663.

197. *Id.* at 635–43. For an extensive discussion of these procedural protections, see *id.* at 633–44.

198. Arguably, immigrants facing de facto deportations by hospitals should be entitled to the same procedural protections afforded to immigrants facing deportation by the federal government. For a description of these procedural safeguards, see *supra* note 197 and accompanying text.

the AMA CEJA has noted that “[f]orcing an immigrant to leave the U.S. is a prerogative of the federal government, and should only occur following due process, in which the immigrant’s legal options are exhausted.”<sup>199</sup>

## 2. Section 1983 Claims Against Private Hospitals

Given that medical repatriations also are effectuated by private hospitals, a related, but more complex question arises: whether immigrants may assert a § 1983 claim against the officials of private hospitals that are responsible for repatriations. In this case, because the Constitution generally does not protect against the violations of private rights by private actors,<sup>200</sup> a successful § 1983 claim will hinge upon a showing that the actions of private hospital administrators or physicians constituted state action.<sup>201</sup>

Although the state-action requirement imposes an additional hurdle for immigrants who seek relief against private hospitals under § 1983, it is not necessarily an insurmountable one.<sup>202</sup> Pursuant to the public-function exception to the state action doctrine, when a private actor fulfills a role that is traditionally performed exclusively by the government, the private actor may be subject to constitutional limitations.<sup>203</sup> In 1974, the Supreme Court articulated a modern formulation of the public-function exception in *Jackson v. Metropolitan Edison Corporation* when it stated that there is “state action present in the exercise by a private entity of powers traditionally exclusively reserved to the [s]tate.”<sup>204</sup> In the immigration

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199. CEJA REPORT, *supra* note 20, at 5.

200. See CHEMERINSKY, *supra* note 194, at 507 (“The Constitution’s protections of individual liberties and its requirements for equal protection apply only to the government. Private conduct generally does not have to comply with the Constitution.”).

201. For an analysis of the history and policy justifications substantiating the state action doctrine, see *id.* at 510–13. The requirement of state action as a prerequisite to constitutional liability serves several purposes. First, state action “preserves an area of individual freedom by limiting the reach of federal law and federal judicial power.” *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 936 (1982). Second, the state-action doctrine preserves state sovereignty by avoiding “the imposition of responsibility on a State for conduct it could not control.” *Nat’l Collegiate Athletic Ass’n v. Tarkanian*, 488 U.S. 179, 191 (1988).

202. See CHEMERINSKY, *supra* note 194, at 518–39 (discussing exceptions to the state action doctrine, including the public-function exception and the entanglement exception).

203. *Id.* at 518–19 (defining the public-function exception to the state action doctrine). For a discussion of three notable areas—including private property management, school regulation, and electoral process control—in which the Court has found a public function to exist, see *id.* at 518–26. For a student note arguing that, in the immigration context, the border enforcement activities of private border patrol groups along the U.S.-Mexico border constitute state action, see Justin A. McCarty, Note, *The Volunteer Border Patrol: The Inevitable Disaster of the Minuteman Project*, 92 IOWA L. REV. 1459 (2007).

204. 419 U.S. 345, 352 (1974). More recently, in *Brentwood Academy v. Tennessee Secondary*

context, notwithstanding academic debate concerning the constitutional underpinnings of the federal government's exclusive power to regulate immigration,<sup>205</sup> "it is settled law today that the power exists."<sup>206</sup> When private hospitals forcibly repatriate immigrant patients—an act that effectively results in deportation—this behavior reflects an exercise of powers "traditionally exclusively reserved to the [s]tate"<sup>207</sup> by intruding upon the federal government's exclusive power to regulate immigration. Thus, forcible repatriations arguably fall within the ambit of state action for the purpose of a § 1983 lawsuit.

## V. CONCLUSION

At the crossroads of troublesome immigration and health care policies, which restrict access to Medicaid while obligating hospitals to provide emergent care, medical repatriations have emerged as a last resort for hospitals.<sup>208</sup> Yet, as this Note discussed, the consequences of repatriation may be problematic for both parties involved.<sup>209</sup> If the medical facility outside the United States lacks the means to provide meaningful treatment, repatriations may expose immigrant patients to adverse health consequences.<sup>210</sup> Moreover, repatriations will not necessarily accomplish

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*School Athletic Association*, 531 U.S. 288, 302 (2001), the Court held that a private association regulating high school athletics was a state actor because of the government's "entwinement" with its activities. However, the entwinement language used in *Brentwood Academy* does not appear to disturb the public function test, as articulated in *Metropolitan Edison*, but instead signals a possible expansion of state action where factual circumstances reveal substantial government involvement. See CHEMERINSKY, *supra* note 194, at 526.

205. For a discussion of this debate, see LEGOMSKY, *supra* note 162, at 103–20. The federal government's power to regulate immigration has been premised on several constitutional provisions, including the Commerce Clause, the Naturalization Clause, the Migration or Importation Clause, and the War Clause. *Id.* at 104–07. Furthermore, structural theorists suggest that the structure of the Constitution confers upon the federal government a general power over foreign affairs, including the specific power to regulate immigration. *Id.* at 113. The Supreme Court has likewise affirmed the federal government's power to exclude non-citizens:

That the government of the United States, through the action of the legislative department, can exclude aliens from its territory is a proposition which we do not think open to controversy. Jurisdiction over its own territory to that extent is an incident of every independent nation. It is a part of its independence.

*Chae Chan Ping v. United States (The Chinese Exclusion Case)*, 130 U.S. 581, 603–04 (1889).

206. LEGOMSKY, *supra* note 162, at 120.

207. *Metro. Edison*, 419 U.S. at 352.

208. See Sontag, *supra* note 1 ("Many hospitals engage in repatriations of seriously injured and ill immigrants only as a last resort.")

209. For a discussion of the problems implicated by forcible repatriations, see Parts III.B and IV.

210. In his recent article on the case of Jimenez's repatriation to Guatemala, Patsner notes that, given the extensive medical resources available within U.S. hospitals as compared to those available in Latin and South American countries, "it is entirely possible that every state court in the U.S. could

the cost reduction desired by hospitals.<sup>211</sup> Instead, forcible repatriations may expose hospitals to liability for the breach of federal discharge requirements, for personal injury lawsuits, and, potentially, for § 1983 claims arising from due process violations.<sup>212</sup> While there is no easy answer to the question of repatriations, requiring a meaningful informed consent is a useful starting point,<sup>213</sup> which will shield hospitals from liability while safeguarding patients, by apprising them of the collateral effects of repatriation.

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determine that comparable medical facilities do not exist in the country of origin for any severely injured . . . undocumented immigrant hospitalized in the U.S.” See Patsner, *supra* note 5.

211. See *supra* Part IV (describing the various ways in which hospitals may incur liability through the practice of forcible repatriation).

212. See *supra* Part IV.

213. This suggestion is consistent with the view expressed by the AMA in November 2009. See *supra* note 20 and accompanying text.

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