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Northwestern University Law Review
Printed in U.S.A.
Vol. 104, No. 1

# Notes and Comments

## CRITICAL CONDITION: USING ASYLUM LAW TO CONTEST FORCED MEDICAL REPATRIATION OF UNDOCUMENTED IMMIGRANTS

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### INTRODUCTION

Luis Jimenez entered the United States without immigration papers in the 1990s.[1] In February 2000, Mr. Jimenez was hit by a drunk driver in a stolen van while returning home from work.[2] Mr. Jimenez was taken to

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[*] Juris Doctor, Northwestern University School of Law, 2010. I would like to thank Jessica Bluebond-Langner, Margaret McTigue, Rami Fakhouri, Scott Lerner, and Gautam Huded for their detailed and thoughtful comments; the production staff of the *Northwestern University Law Review* for their careful verification and revisions; Ilan Benshalom for his thoughts on the structure of the argument; James Lindgren for introducing me to probate and guardianship proceedings; Frank Melone, José Manuel Ventura, and the rest of the legal department at Centro Romero for all of their training and guidance; and Ryan Sniatecki for his careful reading of each draft. All mistakes are my own.

[1] Deborah Sontag, *Deported, by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1 [hereinafter Sontag, *Deported, by U.S. Hospitals*].

[2] *Id.*

Martin Memorial Hospital, where he received life-saving treatment and eventually reached a state of medical stability.[3]

That summer, Mr. Jimenez was transferred to a nursing home, where substandard care caused his condition to deteriorate dramatically, and the home returned him to Martin Memorial.[4] The hospital again saved Mr. Jimenez's life, but he remained in a vegetative state for fourteen months following treatment.[5] He eventually awoke, but demonstrated the cognitive function of a fourth-grade child.[6] The hospital determined that Mr. Jimenez no longer required acute care, but it could not find a nursing home willing to take him because of his lack of health insurance and inability to qualify for Medicaid due to his undocumented status.[7] With nowhere else to go, Mr. Jimenez continued living in the hospital despite having reached a "therapeutic plateau."[8] Martin Memorial estimated it incurred costs of 1.5 million dollars in caring for Mr. Jimenez during this period.[9]

Unable to secure long-term care in the United States for Mr. Jimenez, Martin Memorial redirected its efforts to engaging his home country of Guatemala in providing Mr. Jimenez with care.[10] The hospital eventually obtained an order from a probate court allowing it to carry out the repatriation, which it executed the next day.[11] The order was eventually reversed in the state court of appeals, but the decision came too late for Mr. Jimenez.[12]

Within weeks of his arrival at Guatemala's National Hospital for Orthopedics and Rehabilitation, Mr. Jimenez was discharged to a local public hospital "because [the rehabilitation hospital] needed the bed."[13] Mr. Jimenez's brother found him on a stretcher in the hallway of the second hospital, covered in his own excrement.[14] His brother took Mr. Jimenez to their mother's home, where he continues to live.[15] Mr. Jimenez is now cared for

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[3] *Id.*

[4] *Id.* The nursing home may have accepted Mr. Jimenez only because it anticipated an insurance settlement from the accident. The family's legal efforts were unsuccessful and there were no settlement funds to cover the costs of his care. *Id.*

[5] *Id.*

[6] *Id.*

[7] *Id.* Undocumented immigrants, along with many other categories of immigrants in the United States, do not qualify for Medicaid funds. *See* Part I.A.2 for a discussion of the Medicaid laws relating to noncitizens.

[8] Martin Mem'l Med. Ctr., Inc. v. Gaspar Montejo, No. 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Prob. Div. June 27, 2003) (on file with author).

[9] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[10] *Id.*

[11] *Id.*

[12] Montejo v. Martin Mem'l Med. Ctr., Inc., 874 So. 2d 654, 657 (Fla. Dist. Ct.App. 2004).

[13] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[14] *Id.*

[15] Deborah Sontag, *Jury Rules for Hospital that Deported Patient*, N.Y. TIMES, July 28, 2009, at A1 [hereinafter Sontag, *Jury Rules for Hospital that Deported Patient*]. Mr. Jimenez's mother lives in a one-room house, which is inaccessible by car and located five hours north of Guatemala City, the site of the country's only rehabilitation hospital. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

exclusively by his seventy-two-year-old mother and has been without medication or medical attention since arriving at her house.[16] He regularly has violent seizures that result in vomiting blood and loss of consciousness.[17]

The discharge of immigrant patients like Mr. Jimenez from U.S. hospitals to facilities in their home countries is known as medical repatriation.[18] Repatriations are conducted without the involvement of federal immigration authorities, and there are no centralized records tracking their frequency.[19] Scattered numbers reported by hospitals and consulates, however, reveal that the practice is not uncommon.[20] While a spokesperson for the American Hospital Association estimates medical repatriations occur once or twice per month,[21] the limited figures from an August 2008 *New York Times* article reveal that the number of annual repatriations is at least in the hundreds.[22]

The article, by Deborah Sontag,[23] generated substantial interest in the topic of medical repatriations.[24] In addition to subsequent coverage by other

[16] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. His mother talks with him and cleans him, but is unable to lift him from his bed to his wheelchair. Mr. Jimenez is bedridden as a result. *Id.*

[17] *Id.* Doctors consulted for the *New York Times* story reported that patients suffering seizure disorders are at risk for self injury and increased brain damage resulting from seizures. *Id.*

[18] Documented immigrant patients may also face repatriation attempts because they are unable to qualify for Medicaid funding until they have forty qualifying quarters of payroll tax contributions. Because the focus of this Comment is potential asylum claims of those facing medical repatriation, and such claims would not be available to permanent residents, the discussion focuses on the situation of undocumented patients. The term "undocumented immigrants" describes those "who presently possess no proof of any right to be present in the United States." Beth Lyon, *When More "Security" Equals Less Workplace Safety: Reconsidering U.S. Laws that Disadvantage Unauthorized Workers*, 6 U. PA. J. LAB. & EMP. L. 571, 581 (2004). About one-third of undocumented immigrants in the United States entered the country legally but overstayed their visas, while the remainder of the group entered with false papers or "without presenting themselves for inspection." *Id.*

Also, in at least one case, a hospital has sought to deport a citizen infant whose parents were Mexican immigrants. Deborah Sontag, *Deported in Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1 [hereinafter Sontag, *Deported in Coma*].

[19] Sontag, *Deported in Coma*, *supra* note 18 (reporting the position articulated by an Immigrations and Customs Enforcement (ICE) spokeswoman that ICE does not get involved in medical repatriations).

[20] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1 ("A few hospitals and consulates offered statistics that provide snapshots of the phenomenon: some 96 immigrants a year repatriated by St. Joseph's Hospital in Phoenix; 6 to 8 patients a year flown to their homelands from Broward General Medical Center in Fort Lauderdale, Fla.; 10 returned to Honduras from Chicago hospitals since early 2007; some 87 medical cases involving Mexican immigrants—and 265 involving people injured crossing the border—handled by the Mexican consulate in San Diego last year, most but not all of which ended in repatriation."); Sontag, *Deported in Coma*, *supra* note 18 (noting that a representative of the Mexican consulate in Phoenix reported his office had worked with area hospitals in 80 medical repatriations in 2007).

[21] Jennifer Ludden, *Deportation Dilemmas Deepen for U.S. Hospitals*, NAT'L PUB. RADIO, July 31, 2009, http://www.npr.org/templates/story/story.php?storyId=111353362.

[22] *Supra* note 20. The disparity between these figures may reflect that many repatriations are not contested and therefore not publicized. Repatriations may occur unopposed for several reasons, including that family members do not feel comfortable challenging the hospital or are not present to advocate for the patient. Also, there are undoubtedly patients and families who welcome repatriation.

[23] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

news outlets, the piece also caught the attention of the medical community.[25] The legality of medical repatriations, however, has only been tested in the case of Mr. Jimenez, and no legal scholarship has been published on the topic.[26] Medical repatriations lie at the intersection of health care and immigration policy, two of the highest profile and most contentious domestic policy issues within the United States.

An examination of the legal implications of repatriation and the options available to a patient opposed to repatriation could serve as a useful tool for patient advocates. In particular, some patients facing medical repatriation may have viable asylum claims. A successful asylum application would block the repatriation, alleviate the hospital's funding concerns, and secure more appropriate care for the patient. Further, a discussion of the interrelation between health care and asylum law will encourage lawmakers to develop policies to address their overlap.

Part I provides an overview of the Medicare and Medicaid programs, describes the appellate court holding in *Montejo v. Martin Memorial*, and surveys asylum law particularly relevant to the medical repatriation context. Part II asserts that state courts do not have jurisdiction to issue orders allowing for repatriation, and Part III analyzes the potential for certain undocumented disabled patients to assert an asylum claim based on the particular social group of "persons with disabilities." Part IV addresses policy concerns relating to health care and immigration, in particular federal funding of health care for undocumented immigrants. Part V concludes.

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[24] *See, e.g.*, Judith Graham & Deanese Williams-Harris, *Undocumented Immigrant in Coma Set to Be Returned to Mexico*, CHI. TRIB., Aug. 20, 2008, *available at* http://archives.chicagotribune.com/2008/aug/20/local/chi-patient-deportaug20; Dave Parks, *Ailing Non-Citizens Fear a Forced Deportation*, BIRMINGHAM NEWS, Nov. 16, 2008, at 6A, *available at* http://www.al.com/news/birminghamnews/metro.ssf?/base/news/1226827008175590.xml&coll=2. Sontag's *New York Times* piece was not the first article to address medical repatriations. *See, e.g.*, Marcus Barham, *Uninsured Immigrant Patients Sent Home for Care Against Their Will*, ABC NEWS, May 22, 2008, http://abcnews.go.com/Health/Story?id=4903138&page=1. However, Sontag's piece generated substantial national attention, particularly within the medical community, and is therefore cited more prominently within this Comment than prior articles.

[25] The article prompted the California Medical Association to adopt a resolution in October 2008 opposing forced repatriations. The American Medical Association subsequently voted to undertake a study of such repatriations. Editorial, *Doctors Study Repatriation of Uninsured*, N.Y. TIMES, Nov. 11, 2008, at A18.

[26] For examples of medical literature addressing the issue, see Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152 (2009), which provides an overview of the medical repatriation issue suggesting some avenues for future analysis, and Adrianne Ortega, Comment, *. . . And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Ca*re, 35 AM. J.L. & MED. 185 (2009), which provides a broad discussion of immigrant health care issues, including a mention of medical repatriation.

# I. BACKGROUND

## *A. The Medicare and Medicaid Programs*

The circumstances giving rise to medical repatriations cannot be understood without a general overview of both the Medicare and Medicaid programs, particularly the coverage disjunction between the two as it affects disabled, undocumented immigrants.

*1. Medicare Reimbursement and Antidumping Laws.*—Medicare is a federal health insurance program created in 1965 that insures medical care for people sixty-five and over as well as for people under sixty-five who are entitled to disability benefits.[27] Most hospitals receive Medicare payments.[28] The program is funded through payroll taxes levied on all workers and matched by their employers.[29] Medicare does not pay for nursing home care unless the patient requires skilled nursing care for the treatment of an acute medical problem.[30]

Under federal law, hospitals that receive Medicare funding and have emergency treatment facilities must treat all patients who have emergency medical conditions and who present themselves in the emergency department, regardless of the patients' insurance status.[31] The law further specifies that the hospital must provide these patients with either treatment required to "stabilize the medical condition" or transfer to another facility under specified circumstances.[32] Hospitals that fail to comply with these so-called "anti-dumping" laws[33] are subject to civil monetary penalties for each violation.[34] In addition to paying fines, hospitals risk losing their status as Medicare providers if they fail to comply with the obligation to treat all emergency patients.[35] Because most hospitals are dependent on Medicare funds, they comply with the emergency treatment rules.[36]

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27 MARSHALL W. RAFFEL & CAMILLE K. BARSUKIEWICZ, THE U.S. HEALTH SYSTEM: ORIGINS AND FUNCTIONS 32 (5th ed. 2002).

28 Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

29 DONALD A. BARR, INTRODUCTION TO U.S. HEALTH POLICY: THE ORGANIZATION, FINANCING, AND DELIVERY OF HEALTH CARE IN AMERICA 116 (2d ed. 2007). These tax revenues are deposited into a Medicare trust fund. Hospitals that treat Medicare recipients are paid by private companies who have contracted with the government. These companies are subsequently paid from the Medicare trust fund. *Id.*

30 *Id.*. If a patient no longer qualifies for skilled nursing care but still needs assistance with activities of daily living such that nursing home care is required, that care is not funded by Medicare. *Id.*

31 42 U.S.C. §§ 1395cc(a)(1)(I), 1395dd(b)(1)(A) (2006).

32 42 U.S.C. § 1395dd(b)(1)(A)–(B).

33 RAFFEL & BARSUKIEWICZ, *supra* note 27, at 113.

34 42 U.S.C. § 1395dd(d)(1)(A). Penalties can be assessed up to $50,000 per incident or, in a hospital with fewer than 100 beds, $25,000 per incident.

35 42 U.S.C. § 1395dd(d)(3).

36 *See* Sontag, *Deported, by U.S. Hospitals*, *supra* note 1 ("About 45 percent of Martin Memorial's net operating revenues came from Medicare and Medicaid last year.").

The majority of patients who visit emergency rooms receive care and return home the same day.[37] A patient requiring additional care will be admitted to an in-patient center at the hospital or referred to another facility.[38] Such care will continue until a physician determines that the patient is able to return home or the hospital arranges a transfer to an appropriate facility.[39] In order to transfer a patient, the hospital must find a facility that is capable of providing the appropriate medical treatment and agrees to accept the patient.[40]

After admission to in-patient care, a patient may become stable to the point of no longer requiring acute hospital care, but still be unable to return home due to long-term care needs.[41] In such cases, the hospital must develop a discharge plan that addresses how the patient's needs will be met.[42]

If a patient's discharge plan requires continuing care for which the hospital can make no provision, both the hospital and the patient are left in limbo. Due to their ineligibility for Medicaid, discussed in subsection 2, this is often the situation facing seriously injured undocumented immigrants in acute care facilities. The hospital cannot discharge the patient without violating the Medicare rules it has agreed to follow, and the patient remains in the hospital but without receiving the type of treatment doctors have deemed medically appropriate.[43] The hospital continues to incur the costs of housing and caring for the patient at a much higher daily rate than that associated with long-term care.[44]

*2. Medicaid Ineligibility and the Impossibility of Discharge.*— Medicaid, created by the federal government in 1965, is a program that provides health care to the poor.[45] While Medicare is administered entirely by the federal government, Medicaid is administered by the states and funded

[37] RAFFEL & BARSUKIEWICZ, *supra* note 27, at 113.

[38] *Id.* In the case of a traumatic injury, such as the accident suffered by Mr. Jimenez, in-patient care will be required.

[39] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[40] 42 U.S.C. § 1395dd(c)(2).

[41] *But see* Sontag, *Deported in Coma*, *supra* note 18 (noting that some patients are repatriated "during 'a window of time' when they are stable but 'still acute'" because Mexican hospitals did not want them during the "'down the phase of recovery'"). In at least one such case, a patient was transferred when his white blood cell count was still too high to meet his physician's initial conditions of transfer. *Id.*

[42] 42 U.S.C. § 1395x(ee)(2)(D). In Mr. Jimenez's case, doctors determined that he required post-hospitalization traumatic brain injury rehabilitation. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[43] *See, e.g.*, Barham, *supra* note 24; Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[44] *See, e.g.*, Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. Martin Memorial claimed it chose not to underwrite the costs of Mr. Jimenez's nursing home care because there would be no end in sight to that expense. *Id.* This explanation does not address why the hospital would choose to incur greater costs housing the patient itself—rather than paying for a stay in a nursing facility—during the period preceding repatriation.

[45] BARR, *supra* note 29, at 145.

through a combination of state and federal funds.[46] The Medicaid statute specifies three groups whose members are eligible for Medicaid—low-income families with children, elderly people who meet certain income requirements, and disabled people who meet certain income requirements—as well as some general requirements that beneficiaries must meet.[47] In order for a state to receive federal reimbursement, all members of the specified groups within the state must be eligible for Medicaid under the state's eligibility criteria.[48] In contrast to Medicare's universal coverage for acute care to those over sixty-five, Medicaid does not provide automatic coverage to everyone below the federal poverty line.[49] Each state designs its own program of payment and coverage.[50]

The general Medicaid requirements specify that, in most cases, recipients must be U.S. citizens, although certain noncitizen legal immigrants are entitled to Medicaid.[51] Immigrants who receive a grant of asylum are among those entitled to receive Medicaid funds.[52] For such individuals, the statute limits the receipt of Medicaid funds to a period of seven years after asylum is granted.[53] Each state has the option of covering individuals who are not in one of the three specified groups, but whose income falls below a state-specified level.[54]

Unlike Medicare, Medicaid provides for long-term care costs in subacute facilities such as nursing homes, so long as the patient meets the income and other qualifications of his state's Medicaid program.[55] In fact, of the total expenditures for nursing home care in the United States in 2002, 49.3% of costs were paid by Medicaid.[56] Of the total Medicaid expendi-

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[46] *Id.*

[47] 42 U.S.C. § 1396 (2006); *see also* BARR, *supra* note 29, at 146–48.

[48] BARR, *supra* note 29, at 148.

[49] *Id.* at 144.

[50] *Id.* at 144–45. There are some basic services Medicaid must cover for all recipients, including hospital care, nursing home care, physician services, laboratory and x-ray services, immunizations and other preventative medicine for children, and family planning services. *Id.*

[51] 8 U.S.C. § 1612(a)(2)(A) (2006) (asylees eligible for Medicaid); 8 U.S.C. § 1612(a)(2)(B) (legal permanent residents of the United States who have worked for forty qualifying quarters of coverage may receive Medicaid).

[52] 8 U.S.C. § 1612(a)(2)(A).

[53] *Id.*

[54] BARR, *supra* note 29, at 148–49 ("There is a wide range of eligibility levels among the states. . . . Poor people who are eligible for care in one state are often ineligible in another.").

[55] *Id.* at 214 ("This is our country's final safety net to ensure that no elderly or disabled person who needs custodial nursing care will be denied that care because he or she is unable to pay for it.").

[56] *Id.* at 213 (noting also that many individuals who enter custodial care facilities initially pay for care from their own funds). Once individuals' savings have been "spent down," or exhausted, to a specified point below the poverty level, they will qualify for Medicaid funding of their care. Because the costs of continuing care cause many elderly people to become impoverished, Medicaid frequently provides some of the funding. Sixty percent of nursing home residents in the United States are covered by Medicaid. *Id.*

tures in 2003, 69% were paid toward care of elderly and disabled individuals.[57]

Because Medicaid pays for the cost of long-term care, an unfunded or underfunded citizen who is hospitalized after a traumatic injury and later requires sub-acute care can be transferred to a nursing home or rehabilitation facility because he will qualify for Medicaid.[58] This safety net allows hospitals to move stabilized citizen patients to long-term facilities regardless of their economic status. Nursing homes, however, recognize that Medicaid funding will not be available for undocumented immigrants and, therefore, generally refuse to accept them.[59] Faced with the prospect of providing potentially lifelong care for an unfunded immigrant patient who cannot be discharged to a nursing home, some hospitals turn to the possibility of repatriating the patient.[60]

Repatriation involves using private medical transport services to fly the unfunded immigrant patient back to his home country, where he will be admitted to a local care facility or entrusted to his family for care.[61] Hospitals generally must work with the consulate of the patient's home country to secure travel documents for the patient.[62] Hospitals may also use the consulate to help locate a care facility that will treat the patient upon repatriation.[63] In other cases, private providers facilitate contact between the discharging hospital and the receiving facility.[64] Hospitals also have different standards regarding patient and family consent prior to repatriation. Some hospitals have repatriated patients without the consent of the patient or family.[65]

### B. *Court Treatment of Medical Repatriations:* Montejo v. Martin Memorial *and State Court Jurisdiction*

The federal funding system explains why hospitals engage in repatriation, but the legality of the practice is questionable. Mr. Jimenez's case represents the only time a court has addressed the issue.

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[57] *Id.* at 150.

[58] *See id.* at 148.

[59] Martin Memorial staff tried to locate an appropriate care facility for Mr. Jimenez but was unsuccessful due to his lack of insurance and ineligibility for Medicaid. Martin Mem'l Med. Ctr., Inc. v. Gaspar Montejo, No. 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Prob. Div. June 27, 2003) (on file with author); Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[60] *See, e.g.*, Barham, *supra* note 24.

[61] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[62] Sontag, *Deported in Coma*, *supra* note 18.

[63] *Id.*

[64] One private company that specializes in medical repatriations, MexCare, maintains a network of private hospitals in Mexico to which patients may be discharged. *See* MexCare, http://mexcare.com/services_MexCare.html (last visited Mar. 30, 2010).

[65] Mr. Jimenez is one such example. *See* Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. The article quotes an administrator from a Phoenix hospital, saying "[w]e don't require consent from the family." *Id.*

After his accident, Mr. Jimenez was deemed incompetent by the courts, and his cousin's husband, Montejo Gaspar Montejo, was appointed guardian of Mr. Jimenez's person and property.[66] Once the improbability of a domestic discharge became apparent, Mr. Jimenez's guardian and the hospital disagreed about the next appropriate step.[67] The guardian insisted that the hospital should pay for Mr. Jimenez's care in a long-term nursing facility; the hospital refused.[68] The hospital, which had experience with repatriations of unfunded immigrants, established contact with the Guatemalan consulate. Eventually Guatemala's Vice Minister of Public Health wrote to Martin Memorial to assure the hospital that were Mr. Jimenez returned to Guatemala, the country's only rehabilitation hospital would provide him with care at no cost.[69]

The guardian doubted the ability of the Guatemalan health care system to provide Mr. Jimenez with adequate care and did not accede to the transfer. The hospital sought an answer to the impasse in probate court, where it asked the judge to order the guardian to consent to and cooperate in the repatriation plan.[70]

Mr. Jimenez's guardian argued that the hospital was looking for a court to sanction "patient dumping."[71] He also presented a deposition from a prominent Guatemalan physician asserting that serious rehabilitation was almost nonexistent in Guatemala and predicting that Mr. Jimenez would be released from the rehabilitation hospital within weeks of his return to Guatemala.[72]

The probate court acknowledged the case to be a difficult matter of first impression, but found that the hospital was unable to provide for Mr. Jimenez's long-term therapy needs.[73] Pairing these findings with the guardian's objection to repatriation, the court determined that the guardian was not acting in Mr. Jimenez's best interests and allowed the repatriation to go forward.[74] The guardian voiced his intention to appeal and requested a stay

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[66] Petition for Appointment of Plenary Guardian of Person and Property at 1–2, *In re* Guardianship of Luis Alberto Jimenez, No. 00-344CP (Fla. Cir. Ct. June 8, 2000) (on file with author).

[67] Martin Mem'l Med. Ctr., Inc. v. Gaspar Montejo, No. 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Prob. Div. June 27, 2003) (on file with author).

[68] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. Although the hospital's refusal is understandable given its fear of writing a blank check to the long-term care facility, the fact that long-term care is significantly cheaper than acute care may have made such a transfer—subject to some time limit—a more economical choice.

[69] *Martin Mem'l*, No. 00-344CP, slip op. at 530–31. The letter did not specify any limitations for how long Mr. Jimenez could receive care in Guatemala, but one expert questioned the validity of the promise due to scant resources. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1; *see infra* text accompanying note 72.

[70] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[71] *Id.*

[72] *Id.*

[73] *Martin Mem'l*, No. 00-344-CP, slip op. at 531 (Fla. Cir. Ct. Prob. Div. June 27, 2003) (on file with author).

[74] *Id.* at 535.

of the court's order.[75] The judge requested that the hospital file a response to the request for a stay before making his ruling, but the hospital instead repatriated Mr. Jimenez before the ruling could be made.[76]

The Florida Court of Appeals ruled on the legality of the lower court's order despite the fact that Mr. Jimenez was no longer in the United States.[77] The appellate court dismissed the hospital's assertion of mootness because the matter was deemed an important issue that was likely to recur.[78] Further, the court emphasized that the mootness argument, which focused on Mr. Jimenez's immigration status, only highlighted the legal precariousness of the repatriation.[79] Deportations, the appellate court stated, are the realm of the federal government and not a matter within the discretion of state courts.[80]

The bulk of the court's opinion, however, was dedicated to a discussion of the inadequacy of Martin Memorial's discharge plan under the Medicare regulations.[81] Ultimately, the appeals court overturned the trial court's order on the grounds that "(1) there was no competent substantial evidence to support Jimenez's discharge from the hospital, and (2) the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala."[82] Part II presents a further analysis of the legal and normative issues presented by the decision.

### C. *Overview of U.S. Asylum Law*

Some patients facing medical repatriations are likely to have strong asylum claims. Because asylees are eligible for Medicaid, a successful asylum claim could benefit both the patient and the hospital. This section summarizes areas of asylum law particularly relevant to these claims and then examines three cases in which medical-based social groups were recognized by federal courts of appeals.

In establishing the statutory grounds for asylum by adopting the Refugee Act of 1980 (Refugee Act),[83] Congress sought to bring U.S. law into

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[75] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[76] After the repatriation, the family sued the hospital for false imprisonment. The jury found that the hospital had acted reasonably and was not liable for damages. Sontag, *Jury Rules for Hospital that Deported Patient*, *supra* note 15.

[77] Montejo v. Martin Mem'l Med. Ctr., Inc., 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004). Because Mr. Jimenez was undocumented, he would not be able to return regardless of the court's finding. *See* 8 U.S.C. § 1182(a)(9)(B)(i)(II) (2006) ("Any alien (other than an alien lawfully admitted for permanent residence) who . . . has been unlawfully present in the United States for one year or more, and who again seeks admission within 10 years of the date of such alien's departure or removal from the United States, is inadmissible.").

[78] *Montejo*, 874 So. 2d at 657.

[79] *Id.* at 656.

[80] *Id.*

[81] *Id.* at 657–58.

[82] *Id.* at 658.

[83] 8 U.S.C. § 1158 (2006).

compliance with the 1951 United Nations Convention Relating to the Status of Refugees (Convention)[84] and its modifications in the 1967 Protocol (Protocol).[85] In order to qualify for asylum in the United States, an applicant must show that he is a refugee within the meaning of the Immigration and Nationality Act (INA).[86]

The INA defines a refugee as a person outside the country of his nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution on account of (1) race, (2) religion, (3) nationality, (4) membership in a particular social group, or (5) political opinion.[87] The applicant must show he fits within one of the five protected categories and link the persecution to that status.[88] As judicial interpretation of the Refugee Act has evolved, the restrictions imposed by the five categories have "proved to be among the most substantial barriers to relief."[89]

Applications for asylum must be filed within one year of arrival into the United States unless the applicant can demonstrate that extraordinary circumstances beyond his control prevented him from filing or that a change in circumstances has affected his eligibility for asylum.[90] Disabled patients seeking asylum to avoid medical repatriation face three primary challenges: (1) overcoming the procedural hurdle presented by the one-year filing deadline, (2) asserting a protected status, and (3) demonstrating a well-founded fear of persecution based on that protected status.

*1. Exception to the One-Year Filing Deadline: Changed Circumstances.*—The grounds for exception to the one-year filing period are extraordinary circumstances beyond the applicant's control and changed circumstances affecting the applicant's eligibility for asylum.[91] The ex-

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[84] Convention and Protocol Relating to the Status of Refugees, Jan. 31, 1967, 19 U.S.T. 6223, 606 U.N.T.S. 267 [hereinafter Convention and Protocol].

[85] *Id.*; *see also* INS v. Stevic, 467 U.S. 407, 418 (1983) (explaining the purpose of the Refugee Act).

[86] 8 U.S.C. § 1158(b)(1)(B)(i) ("The burden of proof is on the applicant to establish that the applicant is a refugee . . . .").

[87] 8 U.S.C. § 1101(a)(42)(A) (2006). That definition of the term refugee was modified by the Refugee Act of 1980 to specifically track the language of the Protocol. *See* 13 AM. JUR. PROOF OF FACTS 665 § 2 (3d ed. 1991).

[88] Hincapie v. Gonzales, 494 F.3d 213, 217 (1st Cir. 2007) ("Another element of an asylum claim based on persecution involves the nexus requirement, that is, whether the harm, if otherwise sufficient, has occurred (or is anticipated to occur) 'on account of' one of the five statutorily protected grounds.").

[89] THE GROUNDS OF REFUGEE PROTECTION IN THE CONTEXT OF INTERNATIONAL HUMAN RIGHTS AND HUMANITARIAN LAW: CANADIAN AND UNITED STATES CASE LAW COMPARED 2 (Mark R. von Sternberg ed., 2002).

[90] 8 U.S.C. § 1158(a)(2)(B), (D).

[91] *Id.* § 1158(a)(2)(D).

traordinary circumstances exception is limited to circumstances within the year after arrival that prevented an applicant from applying for asylum.[92]

In contrast, the changed circumstances exception relates directly to the substance of the asylum claim. A significant change in conditions occurring more than a year after the applicant entered the United States could be the basis for an asylum claim if, due to the change, the applicant has developed a well-founded fear that he will suffer persecution if he is required to return to his homeland.[93]

The changed circumstances need not arise in the home country. Courts have recognized situations in which changes in the applicant's personal circumstances in the United States may form the basis of an asylum claim and thereby justify filing after the one-year bar. In *Guo v. Ashcroft*, for example, the Third Circuit held that a Chinese immigrant fearing forced abortion or sterilization if she returned to mainland China made a prima facie showing of asylum eligibility based on the fact that she became pregnant with a second child while living in the United States.[94]

*2. Membership in a Particular Social Group.*—An applicant who qualifies for the changed circumstances exception must then establish asylum eligibility based on one of the five protected categories. This Comment focuses on the category of "particular social group," the category an alien facing medical repatriation would most likely claim.[95]

The 1951 Convention adopted the five protected categories that are recognized in U.S. asylum law.[96] The category of "particular social group" was added near the end of the drafting period, and the motivation for its inclusion is unclear.[97] The United Nations *Handbook on Procedures and Criteria for Determining Refugee Status* (Handbook)[98] offers little information

[92] Such extraordinary circumstances include serious illness of significant duration, ineffective assistance of counsel, and legal disability. 8 C.F.R. § 208.4(a)(5) (2008). Except for procedural purposes, these extraordinary circumstances are independent of the asylum claim.

[93] For example, a military coup in the home country may make officials of the former government susceptible to persecution. A former government official residing in the United States may, upon the takeover, apply for asylum in spite of presence of more than one year in the United States due to the change in home country circumstances.

[94] 386 F.3d 556, 560 (3d Cir. 2004); *see also* Tun v. INS, 445 F.3d 554, 558, 570–71 (2d Cir. 2006) (applicant's political activism, which had begun six years after illegal overstay of his seaman's visa, could be basis of an asylum claim); Guan v. BIA, 345 F.3d 47, 49 (2d Cir. 2003) ("The government agrees that the definition of such 'changed circumstances' provided by 8 C.F.R. § 208.4(a)(4) . . . encompasses changed personal circumstances arising in the United States.").

[95] *See infra* Part III.B.

[96] Convention and Protocol, *supra* note 84; INS v. Stevic, 467 U.S. 407, 418 (1983).

[97] T. Alexander Aleinikoff, *Protected Characteristics and Social Perceptions: An Analysis of the Meaning of 'Membership of a Particular Social Group,' in* REFUGEE PROTECTION IN INTERNATIONAL LAW 263, 265–66 (Erika Feller et al. eds., 2003).

[98] See INS v. Cardoza-Fonseca, 480 U.S. 421, 438–39 (1987), for support of the proposition that the Handbook is a valid and useful tool in interpreting U.S. asylum law.

about the term's meaning, saying only that such a group "normally comprises persons of similar background, habits or social status."[99]

In the United States, the leading case interpreting the term is *Matter of Acosta*, from the Board of Immigration Appeals (BIA).[100] The BIA concluded that the members of a particular social group are individuals possessing fixed characteristics that are beyond their power to change or that are so fundamental to group members' identities or consciences that they should not be required to change.[101]

*3. Fear of Persecution.*—In addition to establishing that he fits into a protected category, an asylum applicant must also provide evidence that he has been persecuted or has a well-founded fear of being persecuted because of his membership in that protected group.[102] Despite hinging asylum eligibility on persecution, the statutes and regulations do not provide a definition of the term. The Handbook states that "there is no universally accepted definition of 'persecution,'" but explains that "it may be inferred that a threat to life or freedom on account of race, religion, nationality, political opinion or membership of a particular social group is always persecution."[103] U.S. courts have defined persecution as "oppression which is inflicted on groups or individuals because of a difference that the persecutor will not tolerate."[104]

Persecution need not be physical; economic deprivations, or restrictions so severe as to constitute a threat to life or freedom, may also constitute persecution.[105] However, generally harsh conditions that are widely shared by residents of the home country do not form a basis for a grant of asylum.[106] While an applicant from a country in which poverty is widespread may still assert a claim of persecution on the basis of deprivation so extreme as to threaten life or freedom, he must show that the deprivation exists because his home government has based the allocation of its limited

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[99] U.N. High Comm'r on Refugees, *Handbook on Procedures and Criteria for Determining Refugee Status Under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees*, U.N. Doc. HCR/IP/4/Eng/REV.1 (Jan. 1992) [hereinafter *Handbook*], *available at* http://www.unhcr.org/publ/PUBL/3d58e13b4.pdf.

[100] 19 I. & N. Dec. 211 (BIA 1985).

[101] *Id.* at 233–34.

[102] *Id.* at 218–19.

[103] *Handbook*, *supra* note 99, at ¶ 51.

[104] *E.g.*, Hernandez-Ortiz v. INS, 777 F.2d 509, 516 (9th Cir. 1985).

[105] *See* Zhen Hua Li v. Att'y Gen. of the U.S., 400 F.3d 157, 168 (3d Cir. 2005); Eduard v. Ashcroft, 379 F.3d 182, 187 (5th Cir. 2004) ("The harm or suffering need not be physical, but may take other forms, such as the deliberate imposition of severe economic disadvantage or the deprivation of liberty, food, housing, employment or other essentials of life.").

[106] *In re* Mogharrabi, 19 I. & N. Dec. 439, 447 (BIA 1987) ("[A]liens fleeing general conditions of violence and upheaval in their countries, would not qualify for asylum. Such persons may have well-founded fears, but such fears would not be on account of their race, religion, nationality, membership in a particular social group, or political opinion.").

resources on the impermissible grounds of one of the five categories protected by U.S. asylum law.[107]

*4. Medical-Based Social Groups and Fear of Persecution.*—Some asylum applicants have asserted refugee status based on membership in a social group united, in whole or in part, by shared medical conditions.[108] Federal courts of appeals have recognized that medical conditions may form the basis of a particular social group, so long as the condition is fundamental to group members' identities and the group is closely affiliated.[109] Even when medical-based social groups have been recognized, success on the ultimate asylum claims has been limited due to insufficient linkage between the claimed persecution and the asserted group or a finding that the discrimination faced by the group did not rise to the level of persecution.

Three cases involving medical-based social group claims are detailed in subsections a and b. Of particular relevance to the medical repatriation scenario is *Tchoukhrova v. Gonzales*, in which the Ninth Circuit recognized disabled children and their parents as a protected social group.[110]

*a. Medical characteristics as the basis of a particular social group.*—In two recent cases, *Ramdane v. Mukasey*[111] and *Paredes v. U.S. Attorney General*,[112] federal courts of appeals found that a shared medical condition can form the basis of a particular social group. While the petitioners' asylum claims in both cases were ultimately unsuccessful, the courts' discussions of medical treatment in the petitioners' home countries implicitly acknowledged that medical care could be so substandard as to amount to persecution.

In *Ramdane v. Mukasey*, the petitioner sought asylum based on fear of persecution upon return to Mali as a result of his membership in the group HIV-positive individuals.[113] The BIA found those infected with HIV did constitute a particular social group.[114] However, the immigration courts found, and the Sixth Circuit affirmed, that Ramdane did not have a reasonable fear of persecution based on membership in that group.[115] While the Sixth Circuit acknowledged that the level of care available in Mali was not as good as what Ramdane could receive in the United States, it did not find the standard of care to be so low that Ramdane "would suffer deprivation of his life or freedom."[116] This was based largely on the Immigration Judge's

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[107] Tchoukhrova v. Gonzales, 404 F.3d 1181, 1194 (9th Cir. 2005).
[108] *See, e.g.*, *id.*
[109] *See id.* at 1188–89.
[110] *Id.* at 1184.
[111] 296 F. App'x 440, 446–47 (6th Cir. 2008).
[112] 219 F. App'x 879, 883, 886 (11th Cir. 2007).
[113] 296 F. App'x at 444.
[114] *Id.* at 445.
[115] *Id.* at 445–48.
[116] *Id.* at 447.

finding that there was no evidence Ramdane "would not be able to obtain necessary medical treatment" in his home country.[117] The court did not detail what would constitute a standard of care low enough to warrant an asylum claim, but the clear implication was that an asylum seeker might succeed if he demonstrated that he could not obtain needed care in his home country.

The Eleventh Circuit reached a similar conclusion in *Paredes v. U.S. Attorney General*.[118] Paredes claimed membership in the particular social group of homosexual men infected with HIV.[119] The court recognized this social group, which was based in part on Paredes's medical condition, but did not find that discrimination against the group rose to the level of persecution necessary for a grant of asylum.[120] Specifically, the court noted that "it is at least possible for HIV-infected homosexual men to obtain medications through means other than the Venezuelan government."[121]

*b. Disability as the basis of a particular social group.*—In *Tchoukhrova v. Gonzales*, the Ninth Circuit held that disabled children and their caretaker parents were eligible for asylum.[122] The court based its decision in part on a finding that medical care in Russia was withheld from the disabled on the prohibited basis of their membership in that particular social group.

*Tchoukhrova* involved a child named Evgueni who suffered from cerebral palsy caused by a botched delivery in a Russian hospital.[123] Evgueni's neck was broken while doctors attempted to extract him during birth, and, although he was still alive, he was thrown into a medical waste container that also contained abortion material.[124] Evgueni was eventually retrieved from the waste bin but was subsequently transferred to a state-run orphanage for children with birth defects despite his parents' refusal to consent to his institutionalization.[125]

Conditions of care in the orphanage were deplorable, and Evgueni's parents eventually secured his release.[126] Because he was classified as disabled and his parents refused institutionalization, Evgueni was banned from receiving any public medical support for his condition and was not allowed

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117 *Id.*

118 219 F. App'x 879, 887 (11th Cir. 2007).

119 *Id.* at 880.

120 *Id.* at 883, 887.

121 *Id.* at 888. The court noted that nongovernmental organizations operating in Venezuela offered medicine to HIV patients at no cost.

122 404 F.3d 1181, 1184 (9th Cir. 2005).

123 *Id.*

124 *Id.*

125 *Id.* at 1184–85.

126 *Id.* at 1185 ("The children were wrapped in old, wet, dirty linens and cried out from hunger. No one cleaned or otherwise took care of them. Some children writhed in pain but received no treatment.").

to enroll in school.[127] Authorities continued to pressure his parents to institutionalize him throughout the time the family lived in Russia.[128]

The Immigration Judge and the BIA both found that the family was part of a particular social group, but did not find that their treatment amounted to persecution.[129] The Ninth Circuit, in affirming the Immigration Judge's social group determination, stated that "persons with disabilities are precisely the kind of individuals that our asylum law contemplates by the words 'members of a particular social group.'"[130] Although disabilities are not always innate or inherent, they are, the court reasoned, usually "immutable."[131]

In support of its conclusion that individuals with disabilities constitute a particular social group, the court pointed to the Americans with Disabilities Act (ADA) as evidence that the U.S. government recognizes persons with disabilities as a social group.[132] The court emphasized that members of this social group would only be those persons whose disabilities were serious and long-lasting or permanent in nature.[133]

The court went on to find that the abuse Evgueni had suffered from government and private actors on account of his group membership rose to the level of persecution.[134] The court specifically addressed the fact that Evgueni had been denied access to medical care based on his disability, but noted that in general, "a country's failure to provide its citizens with a particular level of medical care or education due to economic constraints is not persecution."[135] However, the court emphasized that a foreign government's financial constraints cannot justify a selective deprivation of resources based on one of the five categories protected under U.S. asylum law.[136] Rather, when medical resources are to be limited, the allocation must be based on other determinations.[137]

A finding that a government has looked to one of the five protected categories in choosing how to allocate limited medical resources does not automatically indicate persecution.[138] Such an allocation is at least discrimination, but the severity of harm associated with the deprivation must be ex-

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[127] *Id.* at 1185, 1189.

[128] *Id.*

[129] The social group was disabled children and their parents who provide care for them. *Id.* at 1187.

[130] *Id.* at 1188–89.

[131] *Id.* at 1189.

[132] *Id.* at 1189. The relevant portion of the ADA states: "The Congress finds that . . . individuals with disabilities are a discrete and insular minority." 42 U.S.C. § 12101(a)(7) (2006).

[133] *Tchoukhrova*, 404 F.3d at 1189. The court did not explain how it would determine whether a disability was serious and long-lasting.

[134] *Id.* at 1194.

[135] *Id.*

[136] *Id.* ("Evgueni was never given any treatment for his cerebral palsy and had difficulty obtaining routine medical care afforded to other Russians as a matter of course.").

[137] *Id.*

[138] *Id.*

amined in order to determine whether it was persecutory.[139] The court explained that a finding of persecution is warranted "where the denial seriously jeopardizes the health or welfare of the affected individuals."[140]

## II. State Courts Lack Jurisdiction to Order Medical Repatriations

Building on the above discussion of asylum law in the context of the disabled, this Part returns to *Montejo v. Martin Memorial* by analyzing the jurisdictional aspect of the case from legal and normative perspectives. It concludes that state courts do not—and should not—have jurisdiction over medical repatriations. Even within Florida's Fourth Judicial Circuit the impact of the *Montejo* decision is unclear. The court's opinion discussed the evidence supporting the discharge plan at length, raising the question of whether a better-supported plan would have led the court to avoid its jurisdictional determination. This Part emphasizes that the adequacy of the discharge plan was irrelevant because jurisdictional objections alone should be sufficient to prevent state courts from ordering repatriation against the will of the patient or guardian.

The Supreme Court has long held that it is within the power of the U.S. Congress, not the state legislatures or state or federal courts, to make immigration policy.[141] Congress has assigned federal agencies the task of developing and enforcing immigration policy, and there are specialized administrative courts for hearing immigration cases.[142] Decisions to remove immigrants from the United States should not be made outside of that system.[143]

Further, for many practical reasons, probate courts in particular, which exist to administer estates of decedents and handle guardianship petitions,

[139] *Id.*

[140] *Id.*

[141] *See, e.g.*, Fong Yue Ting v. United States, 149 U.S. 698, 730 (1893) ("The question whether, and upon what conditions, these aliens shall be permitted to remain within the United States being one to be determined by the political departments of the government, the judicial department cannot properly express an opinion upon the wisdom, the policy, or the justice of the measures enacted by congress . . . ."); T. Alexander Aleinikoff, David A. Martin & Hiroshi Motomura, Immigration and Citizenship: Process and Policy 181 (5th ed. 2003) ("The federal government's power to conduct foreign affairs . . . has led the courts to invalidate *state* statutes that attempt to regulate immigration."). See Aleinkoff et al, *supra*, at 170–90, for a discussion of the sources of the Congress's plenary power over immigration, including a discussion of constitutional interpretations that support the Court's long-held stance that Congress has the power to regulate immigration.

[142] The main agencies, all housed within the Department of Homeland Security, are U.S. Citizenship and Immigration Services (USCIS), U.S. Immigration and Customs Enforcement (ICE), and U.S. Customs and Border Protection (CBP). 1 Charles Gordon et al., Immigration Law and Procedure § 3.01 (Matthew Bender, rev. ed. 2009). The Departments of State, Health and Human Services, and Labor also play roles in enforcing immigration laws. *Id.* See *id.* at § 3.05–06 for a description of immigration courts.

[143] Aleinikoff et al., *supra* note 141, at 238–39.

should not be allowed to render decisions that reach into immigration matters. The quality of legal analysis applied by probate courts is often questioned by scholars within the field of wills and estates, the alleged area of the courts' competence.[144] Some states do not require that probate judges have law degrees.[145] Allowing what amounts to deportation to be carried out by court order in a guardianship proceeding hands a federal power to a state judge who likely has no immigration experience and possibly no legal training.[146]

Even skilled probate judges are likely well outside their area of expertise in the repatriation setting, raising the possibility of serious error. Immigration law is complex,[147] and there are many avenues to legal status that a judge unfamiliar with the INA may not recognize.[148] It is possible that a probate judge could even unwittingly allow for deportation of an American citizen at the bidding of an insistent, well-represented hospital.[149] Further,

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[144] *See* DUKEMINIER, JOHANSON, LINDGREN & SITKOFF, WILLS, TRUSTS, & ESTATES 53 (7th ed. 2005) (describing traditional distrust of probate courts within the legal profession and observing that while probate courts have gained more respect in recent decades, most states still reject their findings of fact or law as determinative on appeal or in related suits); John H. Langbein, *Don't Die in Connecticut*, HARTFORD COURANT, Oct. 23, 2005, at C1 (America's leading Estates and Trusts professor describing Connecticut probate courts as incompetent and wasteful).

[145] DUKEMINIER, JOHANSON, LINDGREN & SITKOFF, *supra* note 144, at 53.

[146] *Id.* (providing example of a New Mexico teenager who was elected as a probate judge months after his high school graduation).

[147] *See, e.g.*, GORDON ET AL., *supra* note 142, at § 1.02[3] (explaining that multiple sources of law in the immigration context make the field complex); Tyche Hendricks, *Modesto Man's Citizenship Upheld, Deportation Dropped*, S.F. CHRON., May 21, 2009, at A1 (quoting a law professor's statement that citizenship is one of the most complex areas of law).

[148] In recent years, ICE, the federal agency responsible for carrying out deportations, has itself been criticized for its own difficulties in determining who is and is not a citizen, suggesting the complexity of these determinations and the danger of allowing those unversed in citizenship law to make repatriation decisions. *See, e.g.*, Andrew Becker & Patrick J. McDonnell, *U.S. Citizens Caught Up in Immigration Sweeps*, L.A. TIMES, Apr. 9, 2009, at A1, *available at* http://articles.latimes.com/2009/apr/09/nation/na-citizen9 (describing how citizens are placed in ICE custody due to mistaken beliefs about their citizenship status; stating that "[s]ome in custody *may even be unaware of their citizenship* or unable to prove it without a lawyer's help") (emphasis added); Kristin Collins, *N.C. Native Wrongly Deported to Mexico*, CHARLOTTE OBSERVER, Aug. 30, 2009, *available at* http://www.charlotteobserver.com/local/story/917007.html (describing case of natural-born U.S. citizen who was wrongly deported to Mexico by ICE and subsequently deported by Mexico to Honduras and then by Honduras to Guatemala, where a U.S. embassy officer finally helped him obtain proof of citizenship); Tyche Hendricks, *Citizens Wrongly Held by ICE Sue U.S.*, S.F. CHRON., July 28, 2009, at A1 (reporting that "[h]undreds of U.S. citizens have been detained and, in some cases, deported by U.S. Immigration and Customs Enforcement").

[149] Some individuals who gain citizenship derivatively through their parents' naturalization are unaware of their status. Were such an individual to be at the center of a repatriation fight, it is doubtful whether a probate judge unversed in immigration law would uncover the fact that the patient was a citizen. *Cf.* Becker & McDonnell, *supra* note 148 (describing the case of a man who, unaware that he had gained citizenship at fifteen when his mother naturalized, was wrongfully deported and subsequently arrested and jailed for trying to reenter the United States; only upon his release from custody did he discover that he had been a citizen all along); Hendricks, *supra* note 147 (describing the case of a Nicaraguan-born man who was detained by ICE for four months although a citizen by virtue of his father's

because probate judges are often elected, a judge making a repatriation decision might be more attuned to local political leanings than to the INA.[150] Finally, because the rules and procedures of probate courts vary from state to state, it is likely that the states would develop a fragmented jurisprudence related to repatriation, obstructing the federal government's plenary power over immigration matters.[151]

## III. APPLYING THE ASYLUM CRITERIA TO THE MEDICAL REPATRIATION SETTING

Even if the *Montejo* decision did not leave future repatriation cases to turn on the credibility of evidence supporting the hospital's discharge plan, and even if the decision was not limited in application to Florida's Fourth Judicial Circuit, it would still be unsatisfactory from the point of view of those advocating for the patients in these situations.

A prohibition on repatriations does not change the patient's medical needs or alleviate the strain on the hospital's budget caused by housing stabilized patients for long periods of time. A practitioner advocating for a patient in a position similar to that of Mr. Jimenez should consider all possible legal avenues not only to blocking the unwanted repatriation, but also to improving the patient's overall situation. One avenue that may be available to many patients who have experienced severely debilitating injuries is an asylum claim.

Some of the patients facing repatriation may be able to assert successful asylum claims in light of the change in circumstances that led to their hospitalization. If successful, the asylum claim would provide additional grounds on which to fight the repatriation effort. More notably, a hospital considering repatriation would likely change course if the patient were granted asylum, since asylees qualify for Medicaid for a period of seven years after the grant of asylum.[152] Once the patient qualifies for extended

naturalization). See 7 CHARLES GORDON ET AL., *supra* note 142, at § 98.03, for an overview of the law determining whether an individual gains citizenship through a parent's naturalization.

[150] At least some of these sentiments were exhibited during the jury trial in the tort suit against Martin Memorial brought by Mr. Jimenez's family. The courtroom was often packed with supporters of the hospital, and the case "elicited considerable anti-immigrant sentiment." Sontag, *Jury Rules for Hospital that Deported Patient*, *supra* note 15.

[151] Hospitals seeking to repatriate patients complain that federal immigration authorities provide no assistance in these situations. *See, e.g.*, *id.* (quoting a Martin Memorial administrator lamenting the failure of the federal government to legislatively address situations like that of Mr. Jimenez). However, this should be addressed by appeal to the national legislature rather than by using guardianship proceedings to circumvent federal law.

[152] It is possible that some long-term care facilities may not be interested in taking a patient who qualifies for Medicaid for only seven years. However, this Comment assumes that a facility with empty beds would be willing to take a patient who is likely to be funded for at least seven years. This assumption is based in part on the fact that the nursing home that accepted Mr. Jimenez soon after his accident may have done so because of the possibility of an unspecified payout on an insurance suit of questionable merit. *See* Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. This suggests that more definite fund-

Medicaid benefits, a hospital seeking long-term care for a patient, particularly rehabilitative care, should be able to locate a nursing home willing to accept the patient.[153]

Section A discusses how the changed circumstances exception may apply to these patients. Section B proposes that the particular social group of "disabled persons" would often apply in the repatriation setting. Finally, section C examines how a seriously disabled immigrant may establish a well-founded fear of persecution upon return to his home country based on his disabled status.

### *A. Changed Circumstances*

A serious accident or illness can be such a transformational event as to make one a member of a particular social group to which he did not previously belong.[154] In Mr. Jimenez's situation, the automobile accident resulted in dramatically reduced cognitive function and his inability to walk or move himself from bed to wheelchair.[155] As alluded to in *Tchoukhrova*, Mr. Jimenez acquired a severe disability.[156] As demonstrated by that case, a disability can form the basis of a cognizable social group.[157] The acquisition of a disability could therefore be a change in circumstances affecting one's eligibility for asylum. Therefore, immigrants suffering from a severe disability that was acquired more than one year after they entered the United States should qualify for a changed personal circumstances exception to the one-year filing bar based on the recently acquired disability status.

### *B. Particular Social Group*

Once an asylum applicant is granted a change in circumstances exception to the one-year filing period, he will still have to demonstrate membership in a particular social group and a well-founded fear of persecution on the basis of that membership.

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ing in the form of Medicaid, even if time-limited, would be enough for some nursing homes to take on patients like Mr. Jimenez.

[153] A patient who has been recommended for rehabilitative care may, upon receiving such care, improve to the point of no longer requiring in-patient care within the seven-year period of coverage. Antonio Torres, an immigrant who was repatriated by a U.S. hospital while comatose, had just such an experience. Following his repatriation, Mr. Torres's parents secured care for him in California. Back in the United States, he awoke from his coma, received rehabilitative care, and has since been discharged from a rehabilitation facility and is again able to walk and talk. Sontag, *Deported in Coma*, *supra* note 18.

[154] Tchoukhrova v. Gonzales, 404 F.3d 1181, 1189 (9th Cir. 2005) ("While not all disabilities are 'innate' or 'inherent,' in the sense that they may be acquired, they are usually, unfortunately, 'immutable.'").

[155] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

[156] *See supra* note 154 and accompanying explanatory parenthetical.

[157] *Tchoukhrova*, 404 F.3d at 1188–89.

This Comment assumes that most aliens facing medical repatriations who could seek relief through an asylum claim would need to do so based on a claim of membership in a particular social group.[158] For the purposes of this Comment, such persons will generally be referred to as "persons with disabilities" or "disabled persons."[159] Applicants should easily meet *Acosta*'s immutability standard if they are suffering from long-term disabilities from which doctors assert they will never fully recover.

In *Tchoukhrova*, the Ninth Circuit declined to say whether "disabled persons" qualify as a particular social group in countries other than Russia and the United States.[160] It is likely, however, that disabled persons will be recognized as a social group regardless of their home country. The United Nations has recognized people with disabilities as a particular group insofar as it has published a set of goals, known as the "Standard Rules," for promoting and advancing the rights of persons with disabilities.[161] The Standard Rules—which are not legally binding but are intended to represent a moral commitment of member nations—state that "in all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their societies."[162] The recognition of persons with disabilities as a group by the United Nations—the body that promulgated the five protected categories—certainly lends support to group membership claims based on disability, regardless of the home country.

### C. *Fear of Future Persecution*

Once the applicant has established membership in a particular social group covered by the INA, he still must assert a well-founded fear that he will suffer persecution based upon that membership.

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[158] While it is conceivable that an immigrant facing medical repatriation could also have a claim to fear of persecution based on one of the other four protected categories, it is critical that the feared persecution be at least in part connected to the category upon which one's claim rests. If a patient were to claim the persecution was related to one of the other categories, into which she presumably fit before the accident or illness giving rise to her disability, she may be barred by the one-year time limit on filing. This would not be true if certain groups received reduced medical services in the home country based on one of the other protected categories.

[159] The group description might be tailored depending on the case and home country circumstances to better reflect societal perceptions within that country or to highlight connectedness between group members. Other group designations related to this general category are "disabled children," the "mentally disabled," "paraplegics," and "disabled women." *See, e.g.*, Nora Ellen Groce, *People with Disabilities*, *in* SOCIAL INJUSTICE AND PUBLIC HEALTH 145, 149 (Barry S. Levy & Victor W. Sidel eds., 2006) ("To be female and disabled is frequently referred to as being doubly disabled. Survival itself is often at issue.").

[160] *Tchoukhrova*, 404 F.3d at 1189.

[161] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, G.A. Res. 48/96, U.N. Doc. A/RES/48/96 (Dec. 20, 1993).

[162] *Id.* at ¶¶ 14–15.

For a patient to claim he fears persecution in his home country based on inadequacy of medical treatment, the applicant must assert not just that disabled persons within the home country receive medical care that is below the standard they would receive within the United States, but also that such persons are discriminated against in the provision of care because of their disabilities.[163]

The court in *Ramdane*, while denying the applicant's assertion that he had a well-founded fear of persecution, suggested that the appropriate standard for analyzing medical-based persecution was whether the applicant "would suffer such a low standard of medical care in [the home country] that he would suffer deprivation of his life or freedom."[164]

One expert on migrant health, Dr. Steven Larson, has stated that repatriations undertaken by U.S. hospitals are, in some cases, "pretty much a death sentence."[165] If a patient can be kept alive and potentially treated to improvement within the United States, and there are medical opinions that repatriation to the home country's public hospital system is likely to result in the patient's death, the patient in question is clearly facing a threat to life or freedom that his government is unable or unwilling to control. As discussed above, this low standard of care would have to be tied to the patient's disabled status. That is, he would have to show that disabled persons receive reduced services as a result of their disabilities.

Mr. Jimenez's case would likely meet this standard. Not only was he not receiving the rehabilitative services doctors had found he needed, he was not even receiving the most basic levels of hygienic care.[166] Without medication or medical attention, Mr. Jimenez was at risk of death from a seizure-related accident or from infection.[167] It is important to note, howev-

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[163] Because the emphasis of Medicare discharge plans is on appropriate postdischarge care, this Comment focuses on the medical system within the home country as the source of persecution. However, it is possible that some disabled patients could assert fear of other forms of persecution routinely directed at the disabled in their home country, such as forced institutionalization or deprivation of generally available rights. For a discussion of the variety of societal challenges faced by persons with disabilities, see Groce, *supra* note 159, at 147–49 ("Hundreds of thousands [of people with disabilities] continue to be institutionalized against their will. . . . As adults, [people with disabilities] are [also] often forbidden to marry . . . and frequently are barred from taking oaths or giving testimony in court, which severely restricts their ability to call upon protection from the legal system . . . .").

[164] Ramdane v. Mukasey, 296 F. App'x 440, 447 (6th Cir. 2008).

[165] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. *See also* Groce, *supra* note 159, at 148–52 ("Where disability is stigmatized, a common corollary is that people with disabilities are deprived of the resources of that society. . . . Clinicians often refuse to provide basic vaccinations, reproductive health information, or chemotherapy to people with disabilities because they assume that people with disabilities do not have a need for these services or do not have the right to use scarce resources.").

[166] *See supra* text accompanying notes 13–14. It was the family's reaction to Mr. Jimenez's treatment in the public hospital that suggests he was receiving substandard care by local standards. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1 (describing Mr. Jimenez's brother's decision to place Mr. Jimenez in the care of their elderly mother, far from any cities, rather than leave him in the completely untended state in which he found him).

[167] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1.

er, that many patients will not be able to demonstrate such a low standard of care in the home country that they will be able to successfully claim a legitimate fear of persecution.[168] A standard of care that is merely lower than that available in the United States will not sustain a claim of a well-founded fear of persecution.[169]

## IV. POLICY CONSIDERATIONS

This Part addresses some of the primary policy concerns relating to the granting of asylum in the medical repatriation context: the application of asylum law to undocumented immigrants who did not have refugee status at the time of entry to the United States; the high costs of health care in the United States; and the unavailability of the asylum avenue to legal permanent residents.

### A. *Refugee Status Emerging Postdeparture*

The suggestion of granting asylum to undocumented immigrants who had no fear of persecution at the time of leaving their home countries may arouse feelings of discomfort. Some may think that granting asylum to such individuals represents a departure from the goal of protecting refugees who entered the United States to flee or avoid persecution in their home countries.[170]

One way to address this discomfort is to consider a variation of the *Tchoukhrova* case. While the parents in that case left Russia with the specific purpose of escaping the persecution of their disabled child, it is easy to imagine a variation in which a Russian family living in the United States on nonimmigrant visas[171] was involved in an accident resulting in the son acquiring disabilities similar to those caused to Evgueni at birth. Upon returning to Russia, a family in this situation would face the same discrimination that the Tchoukhrovas had fled. Nothing about the country in which the accident occurred would change the treatment of the social group of persons

[168] These patients also may not find contesting repatriation to be in their best interests. If adequate care is available to the patient in the home country, he may wish to accept the hospital's offer of repatriation, particularly if it entails reunification with family, treatment in his primary language, and the chance of eventual release to familiar settings. The thrust of this Comment is not to suggest that care in the United States is uniformly the best option, but rather to explore a manner in which a patient who is opposed to repatriation and legitimately fears death within his country's medical system can fight the repatriation and maximize his own opportunities for improvement.

[169] *Ramdane*, 296 F. App'x at 447.

[170] It bears emphasizing that the difference between the case proposed in this Comment and many "typical" asylum cases is not the applicant's undocumented status. Asylum applicants are often undocumented, either because they entered without papers or overstayed their visas. The actual difference is in the motivation for leaving the home country: the Tchoukhrovas, for example, left Russia to escape their son's persecution, while Mr. Jimenez left Guatemala only for economic reasons, with no fear of persecution.

[171] A nonimmigrant "is a noncitizen who seeks entry to the United States for a specific purpose to be accomplished during a temporary stay." ALEINIKOFF ET AL., *supra* note 141, at 392–94.

with disabilities in Russia; the child in question, now a member of that social group, would be just as threatened by a return as one who was born with or acquired the disability in Russia.

It is the intersection of persecution and membership in a particular social group that qualifies one for asylum. The Refugee Act's changed circumstances exception demonstrates Congress's recognition that an individual's eligibility for asylum may be affected by events that either place him into a particular social group of which he was not already a member or make him a target of persecution based on a category that had not been previously targeted in the home country. Further, as the government has acknowledged, such circumstances could occur in the home country or in the United States.[172] As such, in considering whether an asylum seeker is asserting a meritorious claim, the focus should be on whether the applicant is now a member of a particular social group that is targeted for persecution in the home country, rather than a backward-looking assessment of the circumstances under which the applicant entered the United States.

### *B. Medical Spending in the United States*

Another difficulty with medical-based asylum claims for undocumented immigrants is that the economic realities cited by administrators at the hospitals that engage in medical repatriations are not easily dismissed.[173] It is indisputable that the one-time expenditure for a medical repatriation, although significant, is cheaper than an extended stay in either an acute care facility or a nursing home.[174] However, as noted in Part II, private medical

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[172] *See supra* note 93 and accompanying text.

[173] BARR, *supra* note 29, at 7 ("Increased health care expenditures will be at the expense of other sectors of the economy, such as education and national infrastructure. We will have less money available for schools, for roads and other forms of transportation, and for investing in the capital and technology necessary for continued expansion of the economy."). But see PATRICIA F. WALKER & ELIZABETH D. BARNETT, IMMIGRANT MEDICINE 4–5 (2007), for a brief discussion of studies explaining that immigrant health care expenditures do not disproportionately burden the U.S. health system. These findings suggest that discussions of the cost of immigrant care may be a distraction from the overall problem of increased medical costs across the board. *Id.*

It is also somewhat imprecise to consider the costs incurred by the relatively small group of immigrant patients facing repatriation without acknowledging the overall economic impact of undocumented immigrants, which many scholars and commentators believe to be positive. *See, e.g.*, Francine J. Lipman, *Taxing Undocumented Immigrants: Separate, Unequal, and Without Representation*, 59 TAX. LAW. 813, 816 n.4 (2006) (supporting assertion that undocumented immigrants contribute more to the U.S. economy than they receive in resources); Eduardo Porter, *Illegal Immigrants Are Bolstering Social Security with Billions*, N.Y. TIMES, Apr. 5 2005, at A1, *available at* http://query.nytimes.com/gst/fullpage.html?res=9803EEDD1F3FF936A35757C0A9639C8B63&sec=&spon=&emc=eta1 (reporting that because many undocumented immigrants work under false social security numbers, they contribute payroll taxes to the Social Security and Medicare funds that they will likely never collect).

[174] BARR, *supra* note 29, at 214 (nursing home care costs estimated at $50,000 per year); Sontag, *Deported, by U.S. Hospitals*, *supra* note 1 (Martin Memorial spent $30,000 to lease the air ambulance that carried Mr. Jimenez to Guatemala City).

repatriations performed without the consent of the federal government are jurisdictionally suspect and subject to challenge. Had Martin Memorial awaited the ruling on the stay of the trial court's order, Mr. Jimenez's own repatriation would have been blocked, and the cost of care would have remained on the hospital's balance sheet; it would have been required to either allow Mr. Jimenez to continue residing in its facility or underwrite the cost of his nursing care.[175]

For this reason, once the legality of the repatriation is called into question as a jurisdictional matter, the issue becomes not how to avoid treating the patient, but rather how to treat him in the most cost-effective manner.[176] In terms of comparative costs, a grant of asylum and the concomitant eligibility for Medicaid would result in an overall reduction in care costs, since long-term care facilities, which have lower operating costs than hospitals,[177] will accept Medicaid-covered patients.

### *C. Differentiation Between Permanent Residents and Undocumented Aliens*

It is also noteworthy that while both undocumented immigrants and legal permanent residents (LPRs) may face medical repatriation, the asylum avenue would only be available to the undocumented patient.[178] While this differentiation between asylees and permanent residents exists across the board, it may seem particularly discordant in the context of disabled immigrants facing repatriation. The undocumented immigrant who qualifies for asylum may receive continuing care consistent with his discharge plan, while the permanent resident who resides in the country under the provisions of the INA could be left without any option for obtaining care.[179]

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[175] Further, the $30,000 cost of repatriating Mr. Jimenez does not include the money Martin Memorial spent in legal costs defending its position. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. These costs go beyond the initial battle to block the repatriation plan, as the family brought a civil suit asserting that the hospital engaged in false imprisonment of Mr. Jimenez. While the hospital was not found liable, the costs it incurred in defending the suit should be taken into account. Further, the fact that the suit survived summary judgment suggests that further suits involving contested repatriations may result in significant liability for damages. Sontag, *Jury Rules for Hospital that Deported Patient*, *supra* note 15.

[176] Cost effectiveness would be the calculation performed by a hospital previously willing to repatriate the patient. It is also of particular importance that placement in a long-term care facility is also in the best interests of the patient who has reached a therapeutic plateau in the hospital setting.

[177] PETER REID KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 144 (5th ed. 2007) ("[T]he cost for a bed-day in a subacute facility is much less than it is in an acute care hospital.").

[178] Permanent residents have permission to remain in the United States for life and therefore do not need asylum. An LPR who is repatriated by a hospital can technically reenter the United States, although the severity of the medical conditions involved would generally prevent reentry without significant assistance. *See* Sontag, *Deported in Coma*, *supra* note 18 (describing case of an LPR who was repatriated by a Phoenix hospital and returned to the United States by ambulance).

[179] Assuming that the repatriation of such an immigrant could be successfully fought on jurisdictional grounds alone, the hospital might choose to underwrite the cost of nursing home care for the LPR under the logic that it would benefit financially by filling the acute-care bed with a funded patient. Also,

This Comment recognizes that medical repatriations may be carried out against all categories of immigrant patients, and argues that unconsented repatriation by hospitals of any patient, whether an undocumented immigrant, an LPR, or otherwise, is illegal.[180] It also recognizes that the legal avenue of asylum may be available to a particular subset of immigrant patients, the undocumented. While acknowledging that not every patient facing repatriation could pursue asylum, the Comment maintains that asylum may be an effective means of providing relief to both hospitals and (some) patients. Eventually, of course, the federal government may address these problems more comprehensively, obviating either the need for or the availability of an asylum claim. Until that time, however, it makes sense to pursue whatever avenues may be available to individual patients, including asylum, within the existing legal framework.

## CONCLUSION

The Medicare and Medicaid laws put hospitals in a difficult situation with regard to the treatment of undocumented immigrants in need of long-term care. In addition to the significant costs associated with providing care to unfunded patients, hospitals have limited capacity and are designed to provide acute, rather than long-term, care.[181] Regardless of these difficulties, however, immigration is the province not of hospitals, but of the federal government, and repatriations can be fought on jurisdictional grounds alone.[182]

As matters currently stand, blocking a forced repatriation generally means that the immigrant will remain in an acute-care facility that is not suited to his needs and that will incur enormous costs in caring for him. But there may be another option. Some disabled immigrants have a legitimate fear of extreme suffering or even death if returned to their home country's health care system, and this fear of persecution can be linked to their disabled status.[183] Therefore, these immigrants could assert asylum claims that, if successful, would allow them to stay in the United States and qualify for programs that would fund their long-term care. Such asylum claims

while LPRs are ineligible for Medicaid until they have worked for forty qualifying quarters, they are eligible for naturalization after five years of residency (some LPRs are eligible even earlier due to marriage to a U.S. citizen). 8 U.S.C. §§ 1427(a)(1), 1430 (2006) (stating, respectively, the five-year naturalization requirement and the three-year requirement for an LPR married to a U.S. citizen throughout the three-year period). Therefore, LPRs who choose to naturalize could become eligible for Medicaid sooner than if they retained LPR status.

[180] Other categories would include documented nonimmigrants, such as individuals on student or visitor visas. These individuals might also qualify for changed circumstances asylum claims if they suffered catastrophic injuries during their stay in the United States.

[181] Sontag, *Deported, by U.S. Hospitals*, *supra* note 1. One hospital administrator in Arizona expressed this problem rather bluntly, saying "it puts a strain on our system, where we're unable to provide adequate care for our own citizens. . . . A full bed is a full bed." *Id.*

[182] *See supra* Part II.

[183] *See supra* text accompanying note 163.

may be controversial, particularly since the immigrants asserting them did not meet the statutory criteria upon entering the United States. However, so long as circumstances have changed such that they now qualify for asylum, they should be granted the relief intended by the Refugee Act. Perhaps an examination of medical repatriation situations by the immigration courts will give notice to legislators that government action is needed in order to establish national policy with regard to repatriations, potentially bringing relief to both patients and hospitals.