Ready to Leave the Hospital but No Way Out

For some immigrants, hospital admission in medical emergencies may save their lives, but the stay may be permanent

By Julie Stoil Fernandez

William Moran,[1] a 70-year-old man of Trinidadian origin, limped painfully while transferring from his bed to his chair in a private hospital in Manhattan. It was March, 2020, and I was visiting him as a Court Evaluator in a Mental Hygiene Law Article 81 guardianship proceeding. The limp was caused by four gangrenous toes that have refused to heal, coupled with diabetes and related circulatory problems. While hospitalized, Mr. Moran suffered a stroke, from which he will require significant rehabilitation before being able to ambulate or otherwise care for himself.

Mr. Moran's mental condition has also been compromised by the stroke. Whereas he was reported to be alert on admission, he is now short-term memory impaired and cannot recall exactly where he was residing before he walked into the hospital's emergency department. He has no money, nor documents to verify his identity. He recalls that he arrived in the U.S. in the 1980s with a visa to pick fruit, which long ago expired. He said he worked off the books in restaurants until his hospital admission, and believes that he can return to cooking and living in a rooming house, if he can learn to walk again. He is fully cooperative, but he is unaware of his own memory deficits or the extent of rehabilitation he would need to regain independence.

It was Mr. Moran's 121st day in the hospital, and in spite of the fact that he was medically cleared to be transferred to an admitting skilled care and rehabilitation center 100 days earlier, his immigration status remains unknown, and therefore his eligibility for public benefits is also undetermined. It is unlikely that a nursing home will accept a patient in Mr. Moran's position, who requires long-term care amd has no means to pay for his care, especially when it is apparent that he is unlikely to qualify for Medicaid to reimburse the facility.

The hospital has brought a guardianship proceeding to seek the appointment of a Guardian for Mr. Moran with authority to inquire after his immigration status and determine his eligibility for New York State Medicaid and other benefits. Even after a Guardian is appointed, if he does not qualify for benefits, Mr. Moran may spend the rest of his life in his hospital room. He is not alone.

New York hospitals house unknown numbers of undocumented patients, many of whom have lived in the United States for most of their adult lives and have worked, raised entire families, and survived under the radar. An undocumented patient who is unable to continue working and earning as a result of illness or injury, and who requires supervision and assistance with activities of daily living, is only eligible to receive Medicaid from New York State to finance necessary skilled care in limited circumstances related to one's immigration status.

Absent a designated eligibility status, no benefits to cover long-term care costs are available. Unless charitable placement in a nursing home is offered, or family members present themselves as willing to shoulder the burden of care, the patient cannot be safely discharged from the hospital and becomes, for all intents and purposes, a permanent resident of an acute care hospital bed, to the frustration of both the host hospital and the patient.

Problems related to the care and management of such patients are enormous. Some suffer from psychiatric conditions and cannot be contained in their rooms, wandering the unit restlessly all day needing one-to-one supervision by hospital staff. Others are simply stuck in bed and spend months or years without fresh air, exercise, or rehabilitation.

While advocates have argued for years that the prolonged hospital stays are dangerous to these patients, with the advent of COVID-19, these fears have been actualized by patients like Mr. Moran, who contracted the virus while hospitalized. Even if Mr. Moran becomes ill from COVID-19, requires intubation, and later needs rehabilitation to be weaned off of a ventilator, he will nonetheless remain in the hospital without rehabilitation.

For both patients and hospitals, the inconsistency between the law that compels a hospital to treat patients

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A special thanks to Randye Retkin, Esq., Director of Legal Health, NYLAG; Norma Tinubu, Senior Supervising Attorney, Legal Health, NYLAG; Elizabeth Stasiak (rising 3L at NYLS and NYSBA student member) and Jeffrey Ezros (rising 3L at NYLS and NYSBA student member).

in medical emergencies (and from which the hospital can expect reimbursement), and the laws prohibiting public benefits to be accessed by these same patients after emergency care abates, cause some undocumented patients to remain stuck in hospitals, sometimes for years, while these hospitals receive no compensation for their care.

The Emergency Medical Treatment and Labor Act (EMTALA), enacted by Congress in 1986, made it Federal law that Medicare-participating hospitals offering emergency services must provide a Medical Screening Examination (MSE) when requested to examine or treat an Emergency Medical Condition (EMC), *regardless of an individual's ability to pay*, and to provide stabilizing treatment for the patient with an EMC or, if the hospital is not capable of treating the individual's EMC, to provide an appropriate transfer to another hospital with the capability to treat the condition, which must accept the transfer.

Once the crisis has abated and the stabilizing of the medical condition is "satisfactory," EMTALA protections terminate. If the patient is unable to care for himself or herself and lacks capacity to make independent safe discharge decisions and cannot finance his or her own care, he or she may be ineligible to receive the benefits needed to finance step-down care like rehabilitation or long-term chronic care. It is at this point that the bottom drops out for such a patient.

Despite the risk of deportation for undocumented patients, inquiries to determine immigration status are necessary for patients who need further treatment and services and whose immigration status cannot otherwise be determined. In some cases, the very act of communicating with federal immigration authorities can lead to deportation, and is a risk that must be considered by representatives seeking to help immigrant patients meet the complex criteria for public benefits funding for rehabilitation and other medical care.

Advocacy organizations like New York Legal Assistance Group (NYLAG) partner with New York hospitals (including New York City's Health & Hospitals Corporation), to provide free legal services to patients and patients' Guardians (appointed or otherwise), to screen for eligibility for immigration status and medical insurance. If appointed as Guardian, an attorney such as myself, who has never practiced immigration law, would be unable to safely navigate this assessment without significant exposure of what would otherwise be privileged information, which could be damaging to the client.

Outside of the hospital, persons who are New York State Medicaid-ineligible due to their immigration status, and who suffer from mental disturbances, are also blocked from receiving behavioral health services, including treatment for chronic and persistent mental illness. As a result, persons in this category are likely to resurface in an emergency department in the same or another hospital, when the condition again becomes exigent.

Hospitals have had to cope with the inaccessibility of funding for step-down care for these patients for years and have borne and continue to bear the heavy burden of occupied, uncompensated beds. In some instances, the hospitals themselves have financed the return of patients to their countries of origin or arranged for the patients to be reunited with family members or others willing to assume custody. This is minimally effective because of an inability to reach family members in the countries of origin or to secure travel visas for physically and mentally unstable patients without documentation. Hospitals have also privately financed transfers to nursing homes and paid long-term care costs for non-benefits-eligible patients, after concluding in a cost/benefit analysis that it was financially more prudent than maintaining the patients indefinitely in the hospital at the hospital's daily bed rate.

Immigration advocates nationally have cited instances in which hospitals have attempted to self-help by removing these patients unethically. Hospitals have been reported to have discharged patients into homelessness or without a discharge plan to seek care on their own, in cases where capacity was questionable. One advocate cited a case in which a hospital's outside counsel served USCIS as an "interested party" in a guardianship proceeding—an act that imperiled the patient's legal status while being treated medically. Acts like that could deter persons in need of medical treatment from seeking help, out of fear of deportation.

Practitioners in guardianship, health law and public benefits advocacy are likely to encounter hospital patients whose legal status may be at issue and whose ability to receive funding for step-down care is unknown. Having a basic understanding of benefits eligibility as it relates to these patients' immigration status may facilitate eligibility under one of the categories and will accelerate discharge to a less restrictive setting. In cases of those who are public benefits ineligible, elder law, immigration law, and health law attorneys need to understand the significant ramifications in representing the patient or serving as Guardian, without risking the patient's ability to remain in the United States.

More comprehensive information on immigration categories and New York State Medicaid eligibility can be found at the Empire Justice Center's New York Exchange Portal: https://empirejustice.org/wp-content/uploads/2019/10/Crosswalk-Report-October-2019.pdf.

Endnotes

1. William Moran is the fictitious name used here to protect the privacy of the patient at issue. Some facts were also changed to protect privacy.