

# FATAL FLIGHTS

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MEDICAL DEPORTATION  
IN THE U.S.

**2021**

PREPARED BY



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Finally, we would like to thank A.V.'s entire team, and especially Claudia—A.V.'s fiercest advocate, for their input as we formulated our report and for continuing to organize to bring an end to medical deportation.

Erica Rodarte Costa and Jacqueline Monnat

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David Bennion and Adrianna Torres-García

## EXECUTIVE SUMMARY

Medical deportation is the physical removal by a non-government entity of an immigrant patient who is critically injured or ill from one country to another without the informed consent of the patient or the patient’s authorized caretaker. This practice is usually not in the patient’s best medical interests and typically results in poorer health outcomes or even death for the removed patient. Hospitals disguise the practice as medical repatriation—when a patient who is traveling or working abroad wants to return to their home country to receive medical care. But this is *not* medical repatriation.

Medical deportations happen all across the U.S. but are rarely reported. In 2020, Jefferson Torresdale Hospital attempted to deport A.V., a member of the Philadelphia community, after he suffered catastrophic brain injuries from a motorcycle accident. To carry out medical deportations, hospitals hire medical transport companies to fly patients to their countries of citizenship. Just one flight can cost as much as \$50,000. In the U.S., there are more than 350 airplane ambulances in operation that have the capacity to medically deport people. One of these airplane ambulance companies, MedEscort, has transported over 6,000 patients to more than 100 countries. These deportations typically happen without any involvement by immigration courts or the Department of Homeland Security. Once undocumented immigrants leave the U.S., it may be difficult or impossible to return.

By exploring the limited existing data on medical deportation and interrogating the systems and actors implicated in the practice, this report details that:

- **Medical deportations often go unreported.** Without a systematic reporting scheme in place, data on known incidents of medical deportation is extremely limited. The last comprehensive study to document individual cases of medical deportation was published in 2012 and found more than 800 cases of attempted or successful medical deportations in just six years. Because undocumented immigrants live in fear of deportation and interacting with hospital and government authorities, however, we expect the actual number of cases of medical deportation to be much higher.
- **Lack of healthcare coverage gives rise to medical deportations.** While the ACA made health insurance more accessible for many U.S. citizens, it failed to extend coverage options to all non-U.S.-citizens. Moreover, the “marketplace” of health insurance plans created by the ACA does not offer long-term care insurance. Medicaid is the primary source of long-term care coverage in the U.S. and many non-U.S.-citizens only have access to emergency Medicaid. Rarely is emergency Medicaid approved to cover long-term care needs.
- **Hospitals violate their obligations to patients by engaging in medical deportation.** Federal statutes and regulations, as well as accreditation standards, impose certain obligations on hospitals, including the need to obtain patients’ informed consent and, where necessary, to provide effective discharge planning that prioritizes patient goals.
- **Doctors violate their ethical obligations by resorting to medical deportation.** The AMA publishes non-legally binding ethical standards of conduct. These

standards call on doctors to oppose discharging patients when doing so would compromise patient safety. The AMA, moreover, specifically denounces the practice of medical deportation.

- **Hundreds of medical transport companies stand to profit from medically deporting people.** Some of these companies actively market their medical deportation services. Relying on spurious justifications, the companies falsely claim, among other things, that medical deportation actually benefits the patient.

Despite the obligations hospitals and doctors have to their patients, medical deportations are certain to continue to occur as long as most noncitizens remain ineligible for comprehensive healthcare coverage, and as long as medical transport companies are able to profit off medical deportations, operating unchecked. We urge advocates and policymakers to take a stand against medical deportation and to consider the following solutions to bring the practice to an end:

- **Pass universal healthcare coverage.** Universal healthcare coverage is the most direct solution to address the issue of medical deportation. If all immigrants had access to healthcare coverage, there would be no motivation on the part of hospitals to medically deport their patients. The Medicare for All Act of 2021 (H.R. 1976), introduced by U.S. Representatives Pramila Jayapal (WA-07) and Debbie Dingell (MI-12), contemplates a health insurance system that provides long-term care and covers *all* United States residents, including immigrants.
- **Rely upon rulemaking to impose regulations aimed at curbing medical deportation.** Through some combination of federal and state rulemaking, agencies could impose heightened discharge planning requirements (specifically regarding informed consent), a reporting mechanism to document patient transfers abroad, and sanctions for hospitals or medical transport companies that fail to comply.
- **Expand breadth of coverage under emergency Medicaid.** Without universal healthcare coverage, emergency Medicaid provides some relief to uninsured immigrants with emergency medical conditions. When an emergency medical condition requires ongoing or long-term care, emergency Medicaid ought to cover such care.
- **Push localities to become jurisdictions unequivocally opposed to the practice of medical deportation.** Localities can play a vital role in denouncing, reporting, and sanctioning the practice of medical deportation through local resolutions and ordinances.
- **Engage in further research and advocacy efforts.** Further research around charity care spending, filing ethics complaints against individual doctors, and the intersection between medical deportation and international human rights laws could unlock additional paths forward in the campaign to end medical deportation.

Finally, the Appendix to this report provides a “Toolkit for Action,” which contains an example of a resolution that could be adopted in local jurisdictions to denounce medical deportation, as well as tools for advocates to use while assisting a patient facing imminent medical deportation. These tools include information on initiating a rapid response, a sample press release designed to draw attention to an impending medical deportation and rally support behind stopping it, and a directory of organizations committed to assisting in the campaign to end medical deportation.

## INTRODUCTION

Medical deportation is an issue that sits at the intersection of healthcare and immigration policy. It strips immigrant patients of the dignity and autonomy to make their own healthcare-related decisions, due in large part to their lack of healthcare coverage, and plays off a power differential that causes immigrants to fear the intervention of government authorities. Putting an end to medical deportation, then, will require action in the healthcare system that acknowledges the complexity of immigration policy in the United States. This report seeks to unpack medical deportation, identify potential levers for change in the systems that have produced the issue, and propose legislative advocacy, among other remedies. Section I provides an overview of the various aspects of medical deportation, Section II contains multiple advocacy proposals and suggestions for further research, and the Appendix includes tools for advocates and other community members to use in the fight against medical deportation.

## I. OVERVIEW OF MEDICAL DEPORTATION

Medical deportation is the physical removal by a non-government entity of an immigrant patient who is critically injured or ill, from one country to another without the informed consent of the patient or the patient’s authorized caretaker. This practice is usually not in the patient’s best medical interests and typically results in poorer health outcomes or even death for the transported patient.

The practice of medical deportation has been viewed through different lenses. As such, advocates and researchers have referred to the practice in many ways, including: medical repatriation, extralegal deportation, private deportation, or even international patient dumping.<sup>1</sup> Our report recognizes the extralegal nature of this practice, which functions entirely outside of the U.S. immigration system. Moreover, we acknowledge it as a form of patient dumping—a domestic practice that generally affects people who are unhoused—which in this instance crosses international borders and targets people based on their presumed citizenship status.

However, this report moves away from terminology that describes the practice as medical repatriation because medical repatriation may involve legitimate government transportations of a person who is working or traveling abroad, is critically ill or injured, and, as a result, *wants* to return to their country of origin. Instead, we recognize the practice as medical deportation and define it as the physical removal by a non-government entity of an immigrant patient who is critically injured or ill, from one country to another without the informed consent of the patient or the patient’s authorized caretaker. This practice is usually not in the patient’s best medical interests and typically results in poorer health outcomes or even death for the transported patient.

In the following sections, we hope to provide updates on the practice of medical deportation, explain immigrants’ access to healthcare coverage under our current system, and provide an overview of key actors that play a role in contributing to the practice of medical deportation, including hospitals, doctors, and medical transport companies.

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<sup>1</sup> See generally Sana Loue, *The “Passport Biopsy” and De Facto Deportation: Hospitals’ Involuntary International Transfer of Patients*, 18 IMMIGR. BRIEFINGS, Mar. 2018 (citing to different sources using various terminology).

## A. Cases of Medical Deportation

Cases of medical deportation very often go unreported. There are a few reasons why this happens, including the lack of a governmental or nonprofit reporting mechanism. Beyond the absence of a reporting mechanism, affected immigrant communities already live in a climate of deeply embedded fear, and they tend to avoid both seeking healthcare services and interacting with law enforcement. Immigrants, especially undocumented immigrants, face a daily fear of deportation, which leads them to make fewer visits to hospitals and to have a deep mistrust of police forces who often collaborate with federal immigration authorities for deportation purposes.<sup>2</sup>



### A.V.'s Attempted Medical Deportation in Philadelphia, PA

In 2020, Jefferson Torresdale Hospital, a hospital in Philadelphia, attempted to deport A.V., a member of the Philadelphia community, after he suffered catastrophic brain injuries from a motorcycle accident. According to A.V.'s family, Jefferson Torresdale tried to pressure A.V.'s family into consenting to his transfer by failing to provide appropriate language access, working with a medical transportation company that intimidated the patient's family, and misrepresenting the treatment he would receive in Guatemala, his country of origin. A.V. had lived in the United States for about 20 years, and he could have died if he had been forcibly transported.

Moreover, hospitals, the primary non-governmental actors practicing medical deportations, have a stake in actively covering up the practice of medical deportation. Hospitals are able to rely on the government's role in terrorizing immigrant communities with the threat of deportation to swiftly conduct involuntary transportations or coerce patients into consenting to their transportation.

Thus, it is difficult to rely on reported figures as the actual amount of medical deportations that happen across the country. In December 2012, the Center for Social Justice at Seton Hall Law School and the Health Justice Program at New York Lawyers for the Public Interest released a report documenting hundreds of cases of

<sup>2</sup> See Luis H. Zayas & Laurie Cook Heffron, *Disrupting Young Lives: How Detention and Deportation Affect US-Born Children of Immigrants*, AM. PSYCH. ASS'N (Nov. 2016), <https://www.apa.org/pi/families/resources/newsletter/2016/11/detention-deportation> ("Citizen-children of undocumented parents access and utilize health care services much less than children with citizen parents. In spite of the fact that citizen-children have the right to health care, their parents may avoid encounters with providers for fear of discovery."); Ileana Najarro & Monica Rhor, *Deeper Underground: Fear Drives Mistrust Between Police, Immigrant Communities*, HOUS. CHRON. (Sept. 22, 2017), <https://www.houstonchronicle.com/deeperunderground/1/> (explaining how fear of local police forces can also lead to less crime reporting within immigrant communities).

medical deportation.<sup>3</sup> Through extensive research efforts, the report revealed more than 800 cases of attempted or successful medical deportations in just six years.<sup>4</sup> The identified cases included deportations from hospitals in fifteen states—Arizona, California, Florida, Georgia, Illinois, Maryland, Michigan, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Tennessee, and Texas—to El Salvador, Guatemala, Honduras, Lithuania, Mexico, the Philippines, and South Korea.<sup>5</sup>

Since 2012, the media has continued to report on cases of medical deportation. In 2016, NPR reported on an undocumented and uninsured man who had suffered a stroke and required months of intensive therapy.<sup>6</sup> After three months of therapy, the hospital described facing “a real financial burden” in continuing to care for the patient, and rehabilitation facilities refused to admit him.<sup>7</sup> Although choosing to deport the patient was a large expense—roughly \$50,000 depending on the distance and equipment involved—a doctor involved in this case described the hospital’s choice as follows:



From the hospital's point of view, it was easy to see that this large one-time expense would be worthwhile. The transfer to Mexico would put a stop to the indefinite, uncompensated costs of continued hospitalization. Further, the transfer would open up the patient's bed to a new (and presumably insured) patient.<sup>8</sup>

Given the lack of formal reporting mechanisms through either government or nonprofit entities, the number of cases reported on continues to represent only a fraction of the actual number of cases of medical deportation. Based on available information, both from advocates working in the field and from the growing medical deportation transportation market described below, it is likely that thousands of people have been subject to medical deportation over the last several years. From the small number of reported cases, we know that instances of successful medical deportations have had serious or deadly consequences for patients. With the help of foreign

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<sup>3</sup> See CENTER FOR SOC. JUST., SETON HALL L. SCH. & HEALTH JUST. PROGRAM, N.Y. LAWS. FOR THE PUB. INT., DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS: A STUDY ON THE PRACTICE OF MEDICAL REPATRIATION 5 (2012), <https://www.nylpi.org/images/FE/chain234siteType8/site203/client/FINAL%20MED%20REPAT%20REPORT%20FOR%20WEBSITE.pdf> [hereinafter DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS].

<sup>4</sup> *Id.*

<sup>5</sup> *Id.* at 15.

<sup>6</sup> John Henning Schumann, *When the Cost of Care Triggers a Medical Deportation*, NPR (Apr. 9, 2016, 7:00 AM), <https://www.npr.org/sections/health-shots/2016/04/09/473358504/when-the-cost-of-care-triggers-a-medical-deportation>.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

hospitals and consulates, at least two news articles have documented the deaths of immigrant patients after hospitals transferred them to foreign hospitals.

In 2009, Grady Memorial Hospital in Atlanta, Georgia closed its dialysis clinic, which primarily had been serving undocumented immigrants ineligible for insurance.<sup>9</sup> Grady offered to pay to relocate patients to their home countries and to cover dialysis for three transitional months. The flight transportation company, MexCare, offered to cover one year of Seguro Popular health insurance for the patients.<sup>10</sup> Of the ten to thirteen patients who relocated, many faced difficulty obtaining dialysis after the transition period and two died. In 2011, Advocate Christ Medical Center in Chicago deported Quelino Ojeda Jiménez, a young Mexican laborer in his twenties who fell from a roof and became quadriplegic, without his consent.<sup>11</sup> The hospital in Mexico where he was sent “couldn’t afford new filters for his ventilator and would simply clean them daily.” The man died just over a year after he was medically deported from the United States.

In addition to deterioration in their health, people who experience medical deportation can suffer serious negative consequences relating to their physical departure from the U.S. For instance, upon leaving the U.S., noncitizens who have accrued over one year of unlawful presence in the U.S. trigger a ten-year bar to return. Departure from the U.S. can disrupt the period of validity of certain visas, such as the U Visa for victims of serious crimes. Regardless of whether legal penalties are triggered upon departure, many noncitizens have no legal route to return given the restrictive nature of the U.S. immigration system. For many noncitizens, physical departure from the U.S. for any reason can result in lifelong exile from family and community, even for people who had lived in the U.S. for decades.

U.S. citizens who have been wrongfully deported by ICE have at times had great difficulty returning to the U.S. in cases where they cannot obtain documentation of their status or suffer from mental disabilities. It stands to reason, then, that in cases where U.S. citizens are subject to medical deportation, they could also be trapped outside the U.S. indefinitely.

Hospitals and medical transport companies may not be aware of the serious legal consequences that medical deportation can have relating to a person’s immigration status and ability to return to the U.S. This factor should be acknowledged in any discussion of law and policy relating to medical deportation.

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<sup>9</sup> Kevin Sack, *For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES (Dec. 31, 2009), <https://www.nytimes.com/2010/01/01/health/policy/01grady.html>.

<sup>10</sup> MexCare did not correctly inform the patients that Seguro Popular did not cover dialysis or kidney transplants.

<sup>11</sup> Becky Schlikerman, *Quadriplegic Immigrant Dies After Chicago-Area Hospital Returned Him to Mexico*, CHI. TRIB. (Jan. 4, 2012), <https://www.chicagotribune.com/lifestyles/ct-xpm-2012-01-04-ct-met-quelino-death-20120104-story.html>.

## A. *The State of Our Healthcare System*

With the ever-increasing costs of medical care in the United States, health insurance is critical to community health. But healthcare coverage can be hard to come by for immigrants without status. The Affordable Care Act (ACA) expanded Medicaid eligibility, constructed a marketplace exchange for buying affordable insurance, and created a premium tax credit to lower healthcare costs for individuals and families with low income.<sup>12</sup> While the ACA made health insurance more accessible for many citizens and some noncitizens, it failed to extend coverage options to all noncitizens.<sup>13</sup> Moreover, the health insurance “marketplace exchanges” created by the ACA do not provide long-term care coverage options. Medicaid has long been, and remains, the primary source of long-term care coverage in the U.S.<sup>14</sup> Under a pre-existing law restricting immigrant access to public benefits, even some lawful permanent residents (green card holders) must wait five years before they are eligible for Medicaid coverage.<sup>15</sup> For immigrants whose status makes them ineligible for Medicaid, emergency Medicaid is their only option.



Emergency Medicaid benefits provide coverage of treatment of emergency medical conditions. (See “Hospitals’ Obligations” section, below, for a summary of hospitals’ duty to treat and stabilize all patients presenting with an emergency, regardless of their insurance coverage or other ability to pay.) An emergency medical condition is a condition “manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient’s health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.”<sup>16</sup> Some

<sup>12</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at scattered sections of 25, 26, 29 & 42 U.S.C.).

<sup>13</sup> STEVEN P. WALLACE, JACQUELINE M. TORRES, TABASHIR Z. NOBARI & NADEREH POURAT, UCLA CTR. FOR HEALTH POL’Y RSCH., UNDOCUMENTED AND UNINSURED: BARRIERS TO AFFORDABLE CARE FOR IMMIGRANT POPULATIONS 7 (2013).

<sup>14</sup> *Long Term Services and Supports*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/long-term-services-supports/index.html> (last visited May 5, 2021).

<sup>15</sup> Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 403, 110 Stat. 2105, 2265 (codified as amended at 8 U.S.C. § 1613); *Coverage for Lawfully Present Immigrants*, HEALTHCARE.GOV, <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/> (last visited Apr. 1, 2021).

<sup>16</sup> 42 U.S.C. § 1396b(v)(3).

emergency medical conditions persist over extended periods of time and ongoing medical attention is needed to prevent serious health consequences. However, at present, emergency Medicaid is seldomly approved to cover the long-term care, often received at places like nursing or rehabilitation facilities, that is needed to treat some emergency medical conditions.

Despite the ACA’s expansion of healthcare coverage, many patients are still walking into hospitals with no insurance or insufficient coverage. Most of these hospitals are private, nonprofit hospitals and are considered charities by the IRS.<sup>17</sup> The IRS gives nonprofit hospitals tax exemptions with the understanding that the hospitals will provide charity care to patients, as well as other services to the broader community.<sup>18</sup> The ACA mandates certain requirements for nonprofit hospitals in an effort to increase transparency around their expenditures. For example, the IRS requires nonprofit hospitals to keep a written Financial Assistance Policy (FAP), which “must apply to all emergency and other medically necessary care provided by the hospital facility” and “must specify the eligibility criteria that an individual must satisfy to receive each discount, free care, or other level of assistance available under the FAP.”<sup>19</sup> Hospitals also must complete a Community Health Needs Assessment every three years and submit the hospital’s charity care policy to the government.<sup>20</sup>

Regrettably, the ACA established no minimum amount of charity care or community services that hospitals must perform to retain tax-exempt status. There has been a fair amount of criticism in recent years that some nonprofit hospitals are not providing enough care to make their tax-exempt status worth it to the community. Noting that hospitals have the discretion to devise the bounds of their FAPs, Ge Bai, an associate professor at Johns Hopkins Carey Business School, maintains that “top-earning hospitals, which have substantial financial strength, should design more generous eligibility criteria to help uninsured and underinsured patients. The hospitals’ nonprofit status and tax exemptions require such action.”<sup>21</sup> Jefferson-Torresdale Hospital, where A.V. was nearly deported, is part of a larger health system. In 2017, only 6.47% of that health system’s total expenditures amounted to community benefit spending.<sup>22</sup>

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<sup>17</sup> *Fast Facts on U.S. Hospitals Infographics*, AM. HOSP. ASS’N, <https://www.aha.org/infographics/2020-07-24-fast-facts-infographics> (last visited on Apr. 1, 2021).

<sup>18</sup> Jenny Chiang & Hannah Kandt, *Centering Community Needs Through Transparent Community Benefit*, CMTY. CATALYST (Mar. 5, 2021), <https://www.communitycatalyst.org/blog/centering-community-needs-through-transparent-community-benefit#.YGZFTGRKHo5>.

<sup>19</sup> *Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4)*, IRS (Sept. 19, 2020), <https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4>.

<sup>20</sup> *Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3)*, IRS (Aug. 21, 2020), <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>.

<sup>21</sup> Jacqueline LaPointe, *Top-Earning Non-Profit Hospitals Offer Less Charity Care*, REVCYCLEINTELLIGENCE (Feb. 18, 2020), <https://revcycleintelligence.com/news/top-earning-non-profit-hospitals-offer-less-charity-care>; see also Ge Bai, Farah Yehia & Gerald F. Anderson, *Charity Care Provision by US Nonprofit Hospitals*, JAMA NETWORK (Feb. 17, 2020), [https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2760774?guestAccessKey=2df21eb7-fab6-4071-98c8-9e05e04676c7&utm\\_source=For\\_The\\_Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tfl&utm\\_term=021720](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2760774?guestAccessKey=2df21eb7-fab6-4071-98c8-9e05e04676c7&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=021720); Mami Jameson Carey, *How Nonprofit Hospitals Get Away with the Biggest Rip Off in America*, MED. ECON. (Jan. 17, 2020), <https://www.medicaleconomics.com/view/how-nonprofit-hospitals-get-away-biggest-rip-america>.

<sup>22</sup> *Aria Health*, CMTY. BENEFIT INSIGHT, <http://www.communitybenefitinsight.org/?page=search.view.hospital&id=2559> (last visited Apr. 1, 2021).

## B. Hospitals' Obligations to Patients

Although immigrants at risk of medical deportation lack health insurance, hospitals still have certain obligations to meet with respect to their care. First, under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals are required to treat and stabilize any patient who comes to the hospital with a medical emergency.<sup>23</sup> If a patient is uninsured, the hospital will be reimbursed through emergency Medicaid. Once a patient is stable, however, the hospital's obligation to provide care ends.<sup>24</sup> It is at that point



that hospitals begin to arrange for the patient's discharge and/or transfer to another facility. This policy poses a problem for uninsured patients who need longer-term care. Without insurance, long-term care facilities are often unwilling to accept these patients and take on the expense of their unreimbursed care.

But hospitals must also operate according to guidelines from the Department of Health & Human Services. If a hospital receives Medicare funding, it must follow various Conditions of Participation, as provided for in the Code of Federal Regulations (CFR).<sup>25</sup> That is, to qualify for Medicare funding, hospitals need to meet certain conditions that demonstrate high-quality patient care. One of those conditions involves discharge planning. When patients are admitted, hospitals must identify early on those "patients who are likely to suffer adverse health consequences upon discharge" if they don't have a discharge plan in place.<sup>26</sup> Those patients are then evaluated for their "likely need for appropriate post-hospital services."<sup>27</sup> Importantly, the plans must prioritize "the patient's goals and treatment preferences" and "ensure an effective transition of the patient from hospital to post-discharge care."<sup>28</sup> The Conditions of Participation also include a section on patients' rights, which incorporates patients' right to make informed decisions about their care,<sup>29</sup> as well as a right to privacy.<sup>30</sup>

<sup>23</sup> 42 U.S.C. § 1395dd(b)-(c).

<sup>24</sup> *Id.* § 1395dd(c).

<sup>25</sup> 42 C.F.R. pt. 482 (2020).

<sup>26</sup> *Id.* § 482.43(a).

<sup>27</sup> *Id.* § 482.43(a)(2).

<sup>28</sup> *Id.* § 482.43.

<sup>29</sup> *Id.* § 482.13(b)(2). Informed decision making necessarily includes informed consent. An entire informed consent doctrine has developed over time in which lack of informed consent can create the basis for a medical malpractice claim. 4 MEDICAL MALPRACTICE § 22.04 (2021). Many state laws also require physicians to obtain a patient's informed consent before treatment. *See e.g.*, N.Y. PUB. HEALTH LAW § 2805-d (Consol. 2021); WASH. REV. CODE ANN. § 7.70.050 (LexisNexis 2021); 12 VT. STAT. ANN. tit. 12, § 1909 (2021).

<sup>30</sup> 42 C.F.R. § 482.13(c)(1) (2020). HIPAA regulations govern the privacy of patients' protected health information (PHI) and typically require covered entities to get explicit patient authorization before disclosing PHI. 45 C.F.R. § 164.502(a) (2020). Exceptions to that general principle include that covered entities may share PHI with other providers involved in the patient's care or with entities that furnish services the provider relies upon for patient

### English Language Proficiency & Informed Consent

In the medical deportation context, language presents a significant barrier to informed decision making and informed consent. Hospitals must have systems in place that guarantee access to language assistance and adequate translation so that patients who do not proficiently speak or understand English fully comprehend their treatment options and, in particular, the risks of transport to another country. 45 C.F.R. § 92.101 requires hospitals to provide patients with limited English proficiency “meaningful access” to hospital services through language assistance. HHS guidance around this regulation explains that, “[c]onsistent with longstanding principles under civil rights laws, the final rule makes clear that the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities’ health programs and activities.” DEP’T OF HEALTH & HUMAN SERVS., SECTION 1557: ENSURING MEANINGFUL ACCESS FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY 1 (2020), <https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf>.

In addition to statutory and administrative guidelines, hospitals also observe standards published by the Joint Commission, the primary accreditation organization for U.S. hospitals. In the Comprehensive Accreditation Manual for Hospitals (CAMH), the Joint Commission publishes a list of standards it uses to evaluate “patient safety” and “quality of care” at healthcare facilities.<sup>31</sup> Because attaining accreditation can deem a hospital to have satisfied the Centers for Medicare and Medicaid Services’ Conditions of Participation in some states and because many states model their own licensing requirements after the Joint Commission’s standards, hospitals are motivated to comply with the guidelines laid out in the CAMH.<sup>32</sup> The Joint Commission’s standards for discharge planning largely echo the Conditions of Participation in the CFR,<sup>33</sup> but more fully address the issue of informed consent. The CAMH standard requires that hospitals “honor[] the patient’s right to give or withhold informed consent” after a discussion about the “[p]otential benefits, risks, and side effects” of a proposed treatment plan as well as the reasonable alternative treatment options.<sup>34</sup>

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treatment, like laboratories. *Id.* § 164.506(c)(1)–(2). These exceptions have utility when a patient agrees to be treated at a new facility or by a new provider who needs to understand the patient’s history and condition. But healthcare providers stand to violate a patient’s general right to privacy under Medicare’s Conditions of Participation if they rely upon these exceptions too broadly, such as when a patient’s PHI is shared with a medical transport company or a medical facility abroad despite the patient’s lack of informed consent to the transfer and when discharge is ineffective by virtue of not being in the patient’s best medical interests.

<sup>31</sup> *About Our Standards*, JOINT COMM’N, <https://www.jointcommission.org/standards/about-our-standards/> (last visited Apr. 27, 2021).

<sup>32</sup> 1 HEALTH CARE LAW: A PRACTICAL GUIDE § 8.03 (2d. ed. 2020).

<sup>33</sup> COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS, §§ PC.04.01.01; PC.04.01.03; PC. 04.01.05 (JOINT COMM’N 2021).

<sup>34</sup> *Id.* § RI.01.03.01.

So, once a hospital has stabilized a patient admitted pursuant to EMTALA, it is subject to Medicare’s Conditions of Participation, which require it to evaluate uninsured patients for any ongoing care and services the patient may need and provide a plan that effectively transitions the patient out of the hospital, all while centering the patient’s own treatment preferences and providing the patient with the information necessary to make an informed decision. A hospital’s plan to medically deport a patient through an unconsented removal can hardly be considered effective or focused on the patient’s preferences, especially when the patient is essentially “dumped” and left without adequate care in another country.

### C. Doctors’ Ethical Obligations

#### Hippocratic Oath

*“Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.”*

Like hospitals, doctors also have obligations to fulfill in the provision of patient care. The American Medical Association maintains ethical guidance that it expects doctors to follow. The AMA’s Code of Medical Ethics consists of (1) AMA Principles of Medical Ethics and (2) Opinions, which provide more detailed guidance. The Principles and accompanying opinions are not legally binding, but are “standards of conduct that define the essentials of honorable behavior for the physician.”<sup>35</sup> Accordingly, a violation of the Code of Medical Ethics does not amount to breaking the law, but it does disturb the ethical duty a doctor owes to their patients. (Because the AMA itself does not have legal authority, it recommends all ethical complaints be filed through a complainant’s state medical licensing board.)<sup>36</sup>

Some of the AMA Principles of Medical Ethics most relevant to the context of medical deportation include:

- (1) A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights. . . . (3) A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient. . . . (8) A physician shall, while caring for a patient, regard responsibility to the patient as paramount. . . . (9) A physician shall support access to medical care for all people.<sup>37</sup>

<sup>35</sup> *AMA Principles of Medical Ethics*, AMA, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> (last visited Mar. 3, 2021).

<sup>36</sup> *Frequently Asked Questions on Ethics*, AMA, <https://www.ama-assn.org/about/publications-newsletters/frequently-asked-questions-ethics> (last visited Mar. 3, 2021).

<sup>37</sup> *AMA Principles of Medical Ethics*, *supra* note 35.

While these overarching standards are helpful in understanding how physicians ethically approach medical decision making, it is Opinion 1.1.8, regarding Physician Responsibilities for Safe Patient Discharge from Health Care Facilities, that is most instructive: “As advocates for their patients, physicians should resist any discharge requests that are likely to compromise a patient’s safety. The discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations.”<sup>38</sup> With many documented cases of medical deportation flights resulting in the patient’s death after arriving in another country, a discharge plan that contemplates medical deportation would likely compromise patient safety. We have not come across any cases of forcible medical deportation that resulted in patients getting the appropriate treatment abroad and having better or similar outcomes than they would have had if they stayed in the United States. Moreover, Opinion 1.1.8 specifically calls out the practice of making clinical decisions with immigration status or the patient’s ability to pay in mind. Arguably, these considerations are two of the driving forces behind cases of medical deportation.

A 2012 report from the AMA’s Council of Ethical and Judicial Affairs goes one step further and applies Opinion 1.1.8 to medical deportation specifically.

For patients with extensive care needs, the physician should keep in mind that many countries throughout the world are struggling to provide even basic medical care for their citizens, and are unlikely to be able to provide resource intensive care with public funds. Regardless of whether or not the discharging hospital itself is the best environment for the patient’s needs, the physician should not discharge the patient to care conditions that are inadequate to his or her needs.<sup>39</sup>

And, driving at the notion of patient autonomy, the report goes on to say that doctors “should decline to authorize a discharge that would result in the patient’s involuntary repatriation” because “[f]orcing an immigrant to leave the U.S. is a prerogative of the federal government, and should only occur following due process.”<sup>40</sup>

Dr. Sana Loue has written extensively on the ethical implications of medical deportation. In 2020, Dr. Loue argued that individual physicians are well-positioned to navigate the ethical issues raised by medical deportation.<sup>41</sup> She acknowledges the competing interests of the hospital and the patient, as well as the physician’s precarious position between the two. But, in advocating for an individual patient, she argues, the physician can assemble a team (including family members, an attorney, a social worker, religious leaders, etc.) to “consider the various dimensions of the patient’s family, social, and legal circumstances” in connection with the patient’s treatment plan.<sup>42</sup> With a physician advocating on behalf of an immigrant patient, the chances of finding a more workable solution than the patient’s removal from this country are much, much greater. Furthermore, as a matter of professional ethics, physicians should advocate for changes in hospital

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<sup>38</sup> AMA Code of Med. Ethics, Op. 1.1.8 (2012).

<sup>39</sup> SHARON P. DOUGLAS, COUNCIL ON ETHICAL & JUD. AFFS., PHYSICIAN RESPONSIBILITIES FOR SAFE PATIENT DISCHARGE FROM HEALTH CARE FACILITIES 4 (2012).

<sup>40</sup> *Id.*

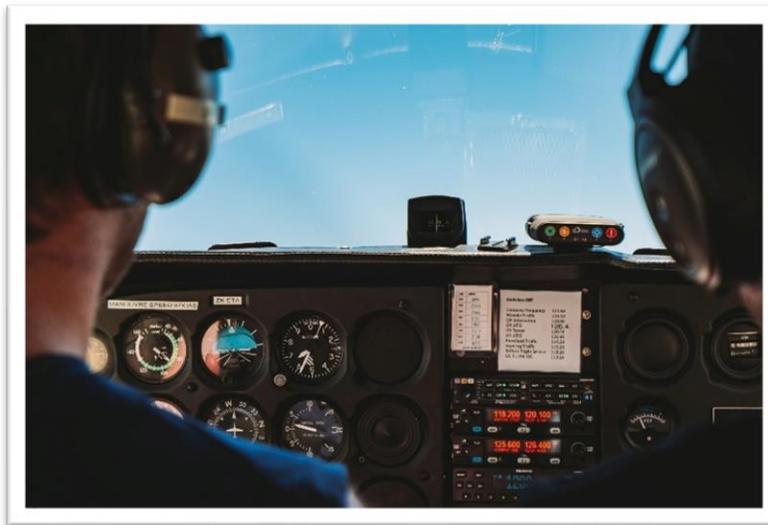
<sup>41</sup> Sana Loue, *The New Wallet Biopsy and Involuntary Patient Transfers Abroad: How Physicians Can Help Protect Patients*, HASTINGS CTR. REP., Mar.–Apr. 2020, at 19.

<sup>42</sup> *Id.* at 22.

policy that would limit the possibility of compulsory medical deportation and expand access to medical care.<sup>43</sup>

#### D. *The Role of Medical Transport Companies*

Medical transport companies that operate airplane ambulances play a vital role in bringing about medical deportations. In fact, the healthcare transportation market globally is projected to keep growing by a factor of billions of dollars.<sup>44</sup> Just one medical deportation flight can cost at least \$50,000, a very rough estimate that does not take into account the different equipment or travel distances for each patient’s flight.<sup>45</sup> Medical transportation companies have capitalized on hospitals’ practices of medical deportation and, at times, market themselves as providing the very specific service of medical deportation.



#### *A Growing Market to Medically Deport*

Understanding medical transport companies requires a review of air ambulance terminology. An air ambulance and/or EMS airplane is “[a]n airplane designated for transportation of ambulatory patients or other patients requiring special care including, but not limited to, basic

<sup>43</sup> *Id.* at 23; *AMA Principles of Medical Ethics*, *supra* note 35.

<sup>44</sup> While our team was unable to access the full report, a sample report by Big Market Research showcased figures in the billions for global air ambulance services’ market growth. *See Air Ambulance Services Market Status Analysis, Scope, Trend, Capacity and Forecast 2021–2026*, KSU SENTINEL NEWSPAPER (Mar. 31, 2021), <https://ksusentinel.com/2021/03/31/air-ambulance-services-market-status-analysis-scope-trend-capacity-and-forecast-2021-2026/> (referring to the market report) (sample market report on file with author); *see also COVID-19 Outbreak Global Healthcare Transportation Services Market Report Development Trends And Competitive Landscape Till 2025*, ORBIS MKT. REPS. (Jan. 29, 2021), <https://www.orbismarketreports.com/covid-19-outbreak-global-healthcare-transportation-services-market-report-development-trends-and-competitive-landscape-till-2025> (“A significant development has been recorded by the market of Healthcare Transportation Services, in [the] past few years. It is also for it to grow further. Various important factors such as market trends, revenue growth patterns[,] market shares and demand and supply are included in almost all the market research report[s] for every industry.”).

<sup>45</sup> *See* Schumann, *supra* note 6.

life support (BLS) or advanced life support (ALS).”<sup>46</sup> There are two types of air ambulances: (1) rotor wing aircraft, or helicopters, and (2) fixed-wing aircraft, or airplane ambulances.<sup>47</sup> Helicopters usually provide “on-scene responses and shorter distance hospital-to-hospital transports” and make up seventy-four percent of all air ambulances.<sup>48</sup> Fixed-wing aircraft provide “longer transports between airports.”<sup>49</sup> Because medical deportation may require international hospital-to-hospital transportation, for the purposes of our research, we provide data for airplane ambulances (fixed-winged aircraft), which are equipped for the longer distance travel required for medical deportation.

The Center for Transportation Injury Research (CenTIR), the National Highway Traffic Safety Administration, and the Association of Air Medical Services (AAMS) annually collaborate on a report in which medical air transportation companies voluntarily report on their aircraft and services. In 2019, this collaboration detailed the existence of 303 air medical service companies with a total of 359 airplane ambulances across 212 bases.<sup>50</sup> *Figure 1*’s white and blue markers below show the presence of airplane ambulance bases scattered all across the U.S. *Figure 2* below showcases a seventy-eight percent increase—at least in reporting—in airplane ambulance aircrafts and bases from 2007 to 2019.

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<sup>46</sup> U.S. DEP’T OF TRANSP., FED. AVIATION ADMIN., EMERGENCY MEDICAL SERVICES/AIRPLANE (EMS/A), A.C. 135-15, iii (1990), [https://www.faa.gov/documentLibrary/media/Advisory\\_Circular/AC%20135-15.pdf](https://www.faa.gov/documentLibrary/media/Advisory_Circular/AC%20135-15.pdf).

<sup>47</sup> U.S. GOV’T ACCOUNTABILITY OFF., AIR AMBULANCE: DATA COLLECTION AND TRANSPARENCY NEEDED TO ENHANCE DOT OVERSIGHT 4 (2017), <https://www.gao.gov/assets/690/686167.pdf>; *see also* *When to Call a Fixed-Wing or a Helicopter Air Ambulance*, CSI AVIATION, <https://www.csiaviation.com/when-to-call-a-fixed-wing-or-a-helicopter-air-ambulance/> (last accessed May 5, 2021) (describing the differences between helicopters and fixed-wing airplanes).

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> ASS’N OF AIR MED. SERVS. & CUBRC, ADAMS 2019: ATLAS & DATABASE OF AIR MEDICAL SERVICES 9 (17th ed. 2019) (originally accessed through <http://www.adamsairmed.org/>, but the website pulled all ADAMS data in February 2021) [<https://drive.google.com/file/d/1W-CxxIpyM8ujDtLtlCKf1C6iJDL5U3Rv/view?usp=sharing>].

Figure 1. ADAMS 2019, Map<sup>51</sup>

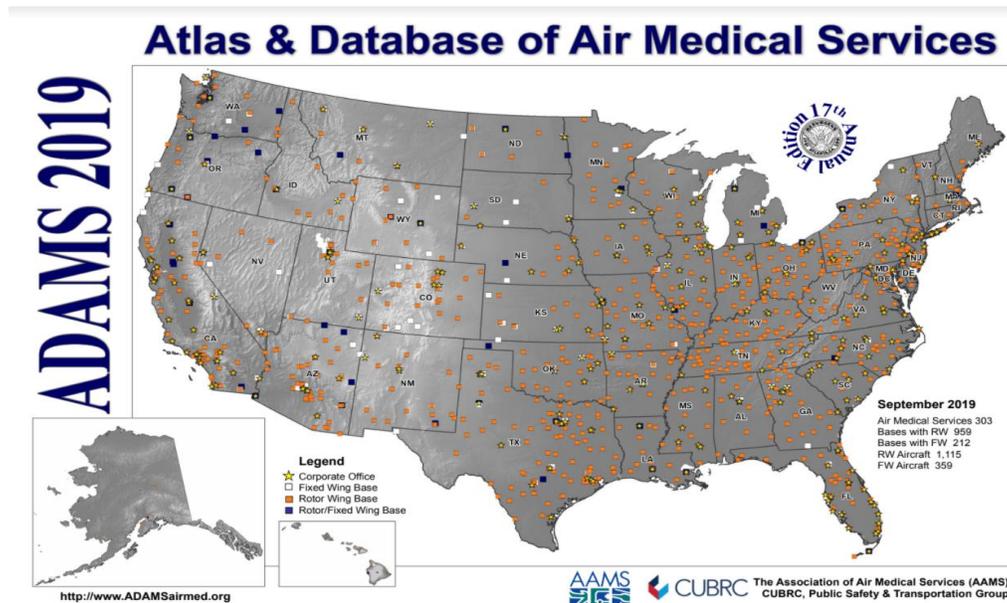


Figure 2. Number of Fixed-Wing Bases and Fixed-Wing Aircraft by Year (ADAMS 2007 to 2019)<sup>52</sup>

Table 5. Service, Base, and Aircraft Totals by Year (ADAMS 2004-2019)

	RW Services	Bases with RW	RW Aircraft	Bases with FW	FW Aircraft
2004	256	546	658	--	--
2005	272	614	753	--	--
2006	270	647	792	--	--
2007	312	664	810	148	282
2008	310	699	840	154	292
2009	307	714	867	155	309
2010	309	731	900	165	311
2011	306	764	929	173	311
2012	302	776	942	171	314
2013	299	812	970	181	331
2014	300	846	1,020	188	346
2015	301	864	1,045	200	362
2016	302	879	1,045	200	360
2017	300	908	1,049	209	362
2018	300	960	1,111	206	350
2019	303	959	1,115	212	359

<sup>51</sup> ADAMS 2019: Atlas & Database of Air Medical Services (illustration), in ASS’N OF AIR MED. SERVS. & CUBRC, ADAMSAIRMED.ORG (Sept. 2019) (originally accessed at <http://www.adamsairmed.org/>, but the website pulled all ADAMS data in Feb. 2021) [<https://drive.google.com/file/d/1yvTop3yUVmduB0Bri5TrzAD4kd6RoUZQ/view?usp=sharing>].

<sup>52</sup> ASS’N OF AIR MED. SERVS. & CUBRC, *supra* note 50, at 14.

## Marketing Medical Deportation

Below are just a few examples of medical deportation companies that market their services online.

### Allista: San Diego, CA<sup>53</sup>

**Medical emergencies happen all the time, with Allista finding the appropriate care is simple.** When you or a patient suffers from an accident abroad, getting the right care can become difficult. This is mainly due to the life-threatening nature of a medical emergency that requires medical attention and immediate internment to a medical facility. Without the right insurance, hospitals are not always equipped to deal with migrant patients. **Repatriation of migrants for medical reasons (also sometimes called medical deportation) makes it possible for patients to return to their native country to receive proper medical treatment.** Allista seamlessly carries out the medical repatriation process for migrants by connecting patients to Mexico's leading hospitals.

### MedEscort: Allentown, PA<sup>54</sup>

## Global Medical Transportation

MedEscort International has **successfully repatriated over 6000 patients to more than 100 countries**



MedEscort offers unmatched expertise and 35 years of experience serving domestic hospitals, international insurance, and medical assistance companies with cost-effective repatriation services. Aviation and home-country medical solutions are geared to match patient condition.

<sup>53</sup> ALLISTA CHRONIC CARE SOLS., <https://alista.care/> [<https://perma.cc/PA9T-6XES>] (last visited May 5, 2021).

<sup>54</sup> *Global Reach*, MEDESCORT, <https://www.medescort.com/global-reach> [<https://perma.cc/4ERY-44C4>] (last visited May 5, 2021).

**RepatPro (division of Comp-X Medical Management Services): Matawan, NJ<sup>55</sup>**

In 2015, Med-X launched our **Foreign Worker Repatriation program** combining our knowledge of international air ambulance, our relationships with foreign hospitals and our extensive care management skills. This unique program is designed to assist catastrophically injured foreign workers in returning home while still receiving continued care. With little or no family to act as a support system in the United States, most of these injured workers are being placed in LTC with **significant cost to the insurer**. These patients tend to degrade quickly while in LTC due to culture, dietary and language differences between the United States and their native culture. By providing a way to return a patient home, Med-X serves the distinctive needs of both the insurer and the patient.

*Misleading Services*

Many times, medical transport companies justify their involvement in medical deportation by claiming that (1) patients do not have a supportive familial network in the United States and (2) patients' country of origin would provide better healthcare, and thus, these transportations benefit the patient. However, these presumed justifications are often simply false.

First, we know that many times patients or their caretakers do not consent to the patient's physical removal, resulting in an involuntary transportation of the patient. Quelino Ojeda Jiménez, the young Mexican laborer who died a year after arriving at a Mexican hospital, never consented to being transported.<sup>56</sup> In Philadelphia, Jefferson Torresdale also attempted to forcibly transport A.V., despite and against his family's wishes that he remain in the United States.<sup>57</sup> Moreover, even when a patient provides consent, it may be the result of hospital coercion or misinformation. As Professor Sana Loue explains, "[a] patient may experience subtle pressure to accede to a proposed transfer perceived by care providers as being in the patient's best interest as coercion or duress, raising issues with respect to the authenticity of any consent that may be forthcoming."<sup>58</sup> Beyond being misled about the medical consequences of their deportation, a patient may also be

<sup>55</sup> *About Us*, RE-PAT REPATRIATION SERVS., <https://www.repatpro.com/about-us/> [<https://perma.cc/8MN2-A4AD>] (last visited May 5, 2021).

<sup>56</sup> Schlikerman, *supra* note 11.

<sup>57</sup> Judith Graham, Becky Schlikerman, & Abel Uribe, *Undocumented Worker Who Became Quadriplegic Is Moved to Mexico Against His Will*, ORLANDO SENTINEL (Feb. 6, 2011, 7:05 PM), <https://www.orlandosentinel.com/health/ct-met-quadruplegic-immigrant-deporte20110206-story.html>; Schlikerman, *supra* note 11.

<sup>58</sup> Sana Loue, *Care of the Stranger: Medical Deportation of Noncitizens*, in CASE STUDIES IN SOCIETY, RELIGION, AND BIOETHICS 171, 182 (2020) (citations omitted) (presenting the issue of medical deportation from a bioethical perspective).

misinformed about the immigration consequences of their transport—which may entail up to permanent exile from the country.

Second, patients that are medically deported are typically *not* receiving higher quality medical care in their country of origin. Below are some stories of immigrants who have been forcibly and physically removed from the U.S., or coerced to consent to their transport with false promises of medical coverage. The commonality among these stories stands in that the medical care the patients received in their country of origin was exceedingly inferior to the medical care they should have received in the United States.

Luis Alberto Jiménez was medically deported to Guatemala after suffering devastating injuries in a car crash with a drunk driver in Florida.<sup>59</sup> Despite sustaining severe traumatic brain injuries, Martin Memorial Hospital leased an air ambulance for \$30,000 to forcibly and physically remove him from the country. Years after his deportation, the extent of medical care he receives from his sole caretaker, his elderly mother, includes “Alka-Seltzer and prayer.”<sup>60</sup> These home remedies have not stopped his condition from deteriorating. After his medical deportation, he experienced “routine violent seizures, each characterized by a fall, protracted convulsions, a loud gurgling, the vomiting of blood and, finally, a collapse into unconsciousness.”<sup>61</sup>

Similarly, the patients that Grady Hospital transported to Mexico were left uninsured and unable to access dialysis, despite MexCare’s—the medical transportation company—assurances that they would have at least one year of medical coverage.<sup>62</sup> This forced patients to host communal raffles and fundraisers to afford their treatments, and at least one patient, Adriana Ríos Fernández, died as a result of spacing out her appointments.<sup>63</sup>

In 2011, Advocate Christ Medical Center in Chicago deported Quelino Ojeda Jiménez, a man who suffered workplace injuries and became quadriplegic.<sup>64</sup> In Mexico, the hospital where Quelino was cared for couldn’t even afford filters for his ventilator. Quelino died in just over a year.

While these stories represent only a fraction of medically deported patients’ experiences, they highlight the reality that many of the foreign countries where hospitals and medical transport companies are deporting patients have inadequate and inaccessible medical care. Below is a list of just a few of the countries that we know patients have been medically deported to, including countries that MedEscort, a Pennsylvania airplane ambulance company, touts as their top

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<sup>59</sup> Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES (Aug. 3, 2008), <https://www.nytimes.com/2008/08/03/us/03deport.html>.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Kevin Sack, *For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES (Dec. 31, 2009), <https://www.nytimes.com/2010/01/01/health/policy/01grady.html>.

<sup>63</sup> *Id.*

<sup>64</sup> Schlikerman, *supra* note 11.

destinations for “uninsured foreign patients,” and countries that Seton Hall Law reported on in 2012.<sup>65</sup>

**Figure 3. Overall Health Performance Ranking Based on WHO’s Reporting in 2000<sup>66</sup>**

<b>Country</b>	<b>Ranking</b>
Dominican Republic	51
El Salvador	115
Guatemala	78
Haiti	138
Honduras	131
India	112
Iran	93
Iraq	103
Israel	28
Jamaica	53
Jordan	83
Lebanon	91
Lithuania	73
Mexico	61
Nigeria	187
Philippines	60
Poland	50
South Korea	58
Turkey	70

<sup>65</sup> See *Global Reach*, *supra* note 54 (listing top ten countries to which it transports patients, including Mexico, Dominican Republic, India, Haiti, Philippines, Honduras, Poland, Nigeria, Jamaica, El Salvador, and six countries in the Middle East: Iraq, Iran, Lebanon, Israel, Turkey, and Jordan); DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 3, at 5 (listing cases of medical deportation to El Salvador, Guatemala, Honduras, Lithuania, Mexico, the Philippines, and South Korea).

<sup>66</sup> See THE WORLD HEALTH ORG., THE WORLD HEALTH REPORT, HEALTH SYSTEMS: IMPROVING PERFORMANCE 152 (2000), [https://www.who.int/whr/2000/en/whr00\\_en.pdf?ua=1](https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1).

## II. MEDICAL DEPORTATION ADVOCACY

In this section, our team identifies different methods of advocacy to end the practice of medical deportation at the federal, state, and local levels. First, we expand on federal advocacy related to universal healthcare coverage and rulemaking. Second, we address the need to expand emergency Medicaid at both the state and federal level. Third, we detail the need for localities to create jurisdictions that protect immigrant communities from the practice of medical deportation, using the City of Philadelphia as an example to ground these efforts. Lastly, we identify areas for further research and advocacy, including expanding hospitals’ accountability in their use of charity care for immigrant patients, increasing doctors’ accountability through ethics complaints, and further exploring medical deportation as a violation of international human rights law.

### A. Universal Healthcare

Universal healthcare coverage, regardless of a person’s immigration status, is the most direct solution to address the issue of medical deportation. Under our current healthcare system, more than ten million undocumented immigrants cannot enroll in Medicaid, Medicare, and CHIP, or purchase coverage through the ACA marketplaces.<sup>67</sup> These restrictions directly reflect in uninsured populations as noncitizens are overrepresented when it comes to uninsured rates.<sup>68</sup> “[A]mong the nonelderly population, 23% of lawfully present immigrants and more than four in ten (45%) undocumented immigrants were uninsured compared to less than one in ten (9%) citizens.”<sup>69</sup> “[A]mong citizen children, those with at least one non-citizen parent are more likely to be uninsured compared to those with citizen parents (8% vs. 4%).”<sup>70</sup>

While calls for universal healthcare have gained traction, legislators are far from reaching a consensus when it comes to immigrants’ access to universal healthcare.<sup>71</sup> During the first Democratic debate in 2019, President Biden raised his hand when asked whether his government healthcare plan would cover undocumented immigrants.<sup>72</sup> In fact, all ten candidates at that presidential debate raised their hands.<sup>73</sup> In practice, however, these presidential candidates and our legislators disagree as to the extent and nature of immigrants’ access and coverage. As part of President Biden’s promise to Build Back Better, it is vital that we advocate for universal healthcare coverage for both citizens and noncitizens alike. This type of coverage would at least remove hospitals’ financial considerations in pursuing medical deportation and would allow for stronger

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<sup>67</sup> *Health Coverage of Immigrants*, KAISER FAM. FOUND. (Mar. 18, 2020), [https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#:~:text=In%202018%2C%20more%20than%20three,in%20ten%20\(9%25\)%20citizens;Lawrence%20Gostin,Is%20Affording%20Undocumented%20Immigrants%20Health%20Coverage%20a%20Radical%20Proposal?](https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#:~:text=In%202018%2C%20more%20than%20three,in%20ten%20(9%25)%20citizens;Lawrence%20Gostin,Is%20Affording%20Undocumented%20Immigrants%20Health%20Coverage%20a%20Radical%20Proposal?), JAMA HEALTH F. (Sept. 5, 2019), <https://jamanetwork.com/channels/health-forum/fullarticle/2759639>.

<sup>68</sup> *Health Coverage of Immigrants*, *supra* note 67.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *See Do You Believe All Undocumented Immigrants Should Be Covered Under a Government-Run Health Plan?*, WASH. POST, <https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/undocumented-immigrant-health-care/> (last visited Apr. 20, 2021) (detailing responses from Democratic candidates in the 2020 presidential election).

<sup>72</sup> *Id.*

<sup>73</sup> *See Gostin*, *supra* note 67.

and healthier communities to develop through preventive medicine, rather than more costly emergency care.<sup>74</sup>

“You cannot let people who are sick, no matter where they come from, no matter what their status, go uncovered.”

-Then Presidential Candidate Joe Biden

The Medicare for All Act of 2021 (H.R. 1976), introduced by U.S. Representatives Pramila Jayapal (WA-07) and Debbie Dingell (MI-12), already incorporates a national health insurance program with undocumented immigrants in mind.<sup>75</sup> According to H.R. 1976, “[n]o person shall, on the basis of . . . citizenship status . . . be excluded from participation in or be denied the [healthcare] benefits of the program established under this Act . . . .”<sup>76</sup> H.R. 1976 also proposes an Office of Health Equity charged with monitoring, tracking, and making publicly available data on the “disproportionate burden of disease and death among people of color,” including data based on immigration status.<sup>77</sup> While we foresee cases of medical deportation to decrease drastically with this type of universal healthcare coverage, the Office of Health Equity could spearhead federal reporting efforts on cases of medical deportation resulting from medical providers’ racial, ethnic, or national origin animus.

<sup>74</sup> See generally Helena Legido-Quigley, et al., *Healthcare Is Not Universal If Undocumented Migrants Are Excluded*, BMJ, Sept. 16, 2019 (arguing for undocumented immigrants’ healthcare coverage based on economic advantages). While Thailand is the only country to provide universal health care to all migrants, European countries like France, England, Germany, Italy, Netherlands, Spain, and Switzerland provide some health care access to undocumented migrants with restrictions. Wudan Yan, *Only One Country Offers Universal Health Care To All Migrants*, NPR (Mar. 31, 2016, 10:19 ET), <https://www.npr.org/sections/goatsandsoda/2016/03/31/469608931/only-one-country-offers-universal-health-care-to-undocumented-migrants>; BRADFORD H. GRAY & EWOUT VAN GINNEKEN, COMMONWEALTH FUND, HEALTH CARE FOR UNDOCUMENTED MIGRANTS: EUROPEAN APPROACHES, (Dec. 2012), [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_issue\\_brief\\_2012\\_dec\\_1650\\_gray\\_hlt\\_care\\_undocumented\\_migrants\\_intl\\_brief.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_dec_1650_gray_hlt_care_undocumented_migrants_intl_brief.pdf).

<sup>75</sup> *Jayapal Introduces Medicare for All Act of 2021 Alongside More Than Half of House Democratic Caucus After Millions Lose Health Care During a Pandemic*, PRAMILA JAYAPAL: CONGRESSWOMAN FOR WA-07 (Mar. 17, 2021), <https://jayapal.house.gov/2021/03/17/medicare-for-all/>.

<sup>76</sup> Medicare for All Act of 2021, H.R. 1976, 117th Cong. § 104 (2021). The text of the bill is available at <https://jayapal.house.gov/wp-content/uploads/2021/03/Medicare-for-All-text.pdf>.

<sup>77</sup> *Id.* at § 1712.

## B. *Federal and State Advocacy: Establishing Reporting Mechanisms and Ensuring Informed Consent*

Below our team identifies the relationship between federal agencies and Pennsylvania agencies<sup>78</sup> to illuminate where the focus for rulemaking advocacy should be to create mechanisms for reporting cases of medical deportation, as well as sanctions for hospitals or medical transport companies engaging in the practice.

### *Department of Health and Human Services*

The Department of Health and Human Services (HHS) already regulates discharge planning. With heightened discharge planning standards, HHS is in the position to obligate hospitals to provide more informed discharge planning for patients facing medical deportation.<sup>79</sup> Throughout our section of advocacy we propose various avenues for hospitals to inform patients in danger of medical deportation of their rights and the consequences of their transport to a foreign country. Mainly, we propose informed discharge planning through the provision of the following information: (1) information on informed consent and medical deportation; (2) reporting resources for patients who suspect they are victims of medical deportation; (3) a directory of non-profit organizations who can counsel the patient; and (4) information about the health and immigration consequences of medical deportation. As with any medical information, this information should be provided in the language most accessible to the patient and the patient’s caregivers.

### *Department of Transportation (DOT)*

The federal government has less oversight over airplane ambulances, and largely defers to states.<sup>80</sup> As a result, it is less likely that the DOT could provide a reporting mechanism or avenue for sanctions through its current regulatory framework, unless (1) it comes through joint rulemaking with the Department of Homeland Security (DHS), an option which our team identifies as potentially having negative immigration consequences for undocumented patients or (2) Congress passes legislation authorizing the Federal Aviation Administration to regulate the practice of medical deportation.

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<sup>78</sup> Because the Free Migration Project and the University of Pennsylvania are located in Philadelphia, our report includes a focus on Pennsylvania and Philadelphia in terms of state and local advocacy. However, we hope that the information and advocacy strategies provided may be useful in considering research and advocacy opportunities in other states. For more on local advocacy, see “Local Advocacy: Denouncing Medical Deportation, Grassroots Accountability, and Sanctions” section, below.

<sup>79</sup> Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 84 Fed. Reg. 51836 (Sept. 30, 2019).

<sup>80</sup> *Aviation Consumer Protection: Air Ambulance Service*, U.S. DEP’T OF TRANSP., <https://www.transportation.gov/individuals/aviation-consumer-protection/air-ambulance-service> (last visited May 5, 2021) (noting that the Department of Transportation has “limited authority under the Airline Deregulation Act to regulate the prices, routes, or services of an air carrier”). *But see* Helicopter Air Ambulance, Commercial Helicopter, and Part 91 Helicopter Operations, 79 Fed. Reg. 9932 (Feb. 21, 2014) (describing regulation authorized by the FAA Modernization and Reform Act of 2012 to “address an increase in fatal helicopter air ambulance accidents, the FAA is implementing new operational procedures and additional equipment requirements for helicopter air ambulance operations”).

According to the DOT, states are “responsible for regulating medical services provided by air ambulance operators and the insurance issues related to those services.”<sup>81</sup> However, commercial airline carriers do have to comply with federal regulations related to: (1) the certification which the FAA—a subdivision of the DOT<sup>82</sup>—oversees, and (2) the security program which the Transportation Security Administration (TSA)—a subdivision of the DHS—oversees.<sup>83</sup> The security program spearheaded by TSA and DHS could provide the necessary reporting mechanism for cases of medical deportation. However, given DHS’s treatment of immigrants and the department’s continued goals of detention and deportation, we do not endorse advocating for the regulation of medical deportation through DHS. This could result in worse immigration and health consequences for people who are already vulnerable due to their citizenship status.<sup>84</sup>

### *Pennsylvania Bureau of Aviation and Department of Health*

The Pennsylvania Bureau of Aviation is authorized to “[p]rovide for the licensing of commercial operators.”<sup>85</sup> Moreover, “[a]ll crimes, torts, and other wrongs committed by . . . a pilot . . . while in flight over or above the lands and waters of [Pennsylvania], [are] governed by the law of [Pennsylvania].”<sup>86</sup> Any potential criminal or tort issues and liability arising while over Pennsylvania must be determined by the law of Pennsylvania.<sup>87</sup>

Moreover, the Pennsylvania Department of Health requires each emergency medical service (EMS) complete “an EMS patient care report for each response made in which it encounters a patient or a person who has been identified as a patient to the EMS agency.”<sup>88</sup> The Department of Health uses an electronic EMS patient care reporting process that solicits “standardized data and patient information.”<sup>89</sup> While the patient information collected is confidential, the Department of Health may release reports “for specific research or EMS planning purposes approved by the department, subject to department approval and supervision to ensure that use of the report is strictly limited to the purposes of the research.”<sup>90</sup>

Through joint regulation, the Pennsylvania Bureau of Aviation and Department of Health could provide the necessary avenues to create a statewide reporting mechanism for cases of medical deportation. First, the agencies could collaborate on collecting patient data related to the patient’s discharge process and document explicit consent to their transport after requiring medical

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<sup>81</sup> See *Aviation Consumer Protection: Air Ambulance Service*, *supra* note 80.

<sup>82</sup> *Organization Chart*, U.S. DEP’T OF TRANSP., (Aug. 2, 2017) <https://www.transportation.gov/org-chart>.

<sup>83</sup> See *14 CFR Part 135 Air Carrier and Operator Certification: General Requirements for Certification*, FED. AVIATION ADMIN., [https://www.faa.gov/licenses\\_certificates/airline\\_certification/135\\_certification/general\\_req/](https://www.faa.gov/licenses_certificates/airline_certification/135_certification/general_req/) (citing 14 C.F.R. §135); 49 C.F.R. §1544.101–03 (describing security program applicability and requirements for Part 135 certificate holders).

<sup>84</sup> For a brief overview of the immigration consequences people facing medical deportation might confront, see *supra* Section I.A.

<sup>85</sup> 74 PA. CONS. STAT. § 5301(a)(b) (2021).

<sup>86</sup> *Id.* § 5503.

<sup>87</sup> *Id.*

<sup>88</sup> 35 PA. CONS. STAT. § 8106(a) (2021).

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* § 8106(e)(2).

transportation companies to provide information on the health and immigration consequences of medical deportation. Second, the agencies could sanction companies who have coerced consent or forcibly transported patients to their countries of origin. These sanctions could come in the form of withdrawing the licensing of commercial operators or even fines imposed on carriers who engage in the practice of medical deportation. Reporting mechanisms are an important step to shed light on how frequent the practice of medical deportation takes place. Moreover, although earlier reports showcase medical deportations happening all across the country, the data could help advocates develop coalitions between regions and legislators where the practice is more prevalent, a necessary step on the path to bring medical deportation to an end.

The Commonwealth of Pennsylvania could also work to curb the practice of medical deportation in hospitals through its regulation of discharge planning.<sup>91</sup> Currently, discharge planning for patients who have a designated lay caregiver must include:

- (i) The name and contact information of the lay caregiver designated under this act;
- (ii) [a] description of all after-care assistance tasks necessary to maintain the patient's ability to reside at home; (iii) [c]ontact information for any health care, community resources, long-term care services and support services necessary to successfully carry out the patient's discharge plan and contact information for a hospital employee who can respond to questions about the discharge plan . . . .<sup>92</sup>

To these requirements, Pennsylvania could add information for patients who will be transferred to another facility in a foreign country. The information could provide: (1) information on informed consent and medical deportation; (2) reporting resources for patients who suspect they are victims of medical deportation; (3) a directory of non-profit organizations across the state who can counsel the patient; and (4) information about the health and immigration consequences of medical deportation. As with any medical information, this information should be provided in the language most accessible to the patient and the patient's caregivers.

### *C. Federal and State Advocacy: Emergency Medicaid for Long-Term Care*

#### *At the State Level*

We believe the development of clear policy stating the availability of emergency Medicaid for ongoing and long-term care is one of the most impactful steps states can take to end the practice of medical deportation. Some hospitals may resort to medical deportation when a patient needs long-term care, but no long-term care facilities will accept the patient because the facilities believe emergency Medicaid will not cover long-term care costs.

When Medicaid and other forms of insurance are unavailable to immigrants who either lack status or are subject to the five-year bar on public benefits after gaining status, federally-funded emergency Medicaid, also referred to as emergency medical assistance, is available to treat emergency medical conditions. In general, states enjoy fairly wide latitude in setting the

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<sup>91</sup> 35 PA. STAT. ANN. § 447.5.

<sup>92</sup> *Id.*

parameters of their Medicaid programs. As long as they administer Medicaid within certain federal guidelines, states are free to customize the program as they see fit.<sup>93</sup> As a result, factors such as eligibility, covered services, and administration vary from state to state.<sup>94</sup> The same is true for emergency Medicaid.

Federal policy provides that emergency Medicaid must be made available to immigrant patients who ordinarily cannot access Medicaid if they experience “a medical condition . . . manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) Placing the patient’s health in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part.”<sup>95</sup> But states differ in their approach to fulfilling this mandate. Some states limit emergency Medicaid coverage to emergency room visits. A few states, however, recognize that some emergency medical conditions may never require an emergency room visit or may persist after emergency room treatment ends, and that the absence of ongoing medical care may result in very serious impairment of bodily functions or dysfunction of bodily parts. In these states, emergency medical assistance is available for ongoing care, and even long-term care.<sup>96</sup>

While some states have explicit policies about the availability of long-term care coverage through emergency medical assistance, others are silent on the issue—at least officially. It is possible in those states that the state agency makes case-by-case determinations. In Pennsylvania, for example, emergency medical assistance may be approved for ongoing care, and even long-term care, in certain situations.<sup>97</sup> In *A.V.’s* case, for example, Pennsylvania approved emergency Medicaid to cover the long-term care he needed to treat his traumatic brain injury.

Providing long-term emergency Medicaid in these cases makes good sense. It not only potentially saves lives, it also very likely saves money. If patients are discharged from the hospital without access to the treatment and services they need, there is a substantial likelihood they will end up back in the emergency room repeatedly, where the cost of treatment is much higher than the cost of ongoing care.

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<sup>93</sup> *Policy Basics: Introduction to Medicaid*, CTR. BUDGET & POL’Y PRIORITIES (Apr. 14, 2020), <https://www.cbpp.org/research/health/introduction-to-medicaid#:~:text=Each%20state%20operates%20its%20own,widely%20from%20state%20to%20state>. Each state must submit to the Centers for Medicare & Medicaid Services (CMS) a state plan “describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity” with title XIX and federal regulations. 42 C.F.R. § 430.10 (2020). The plan is subject to the review and approval of CMS. *Id.* § 430.14.

<sup>94</sup> *Policy Basics: Introduction to Medicaid*, *supra* note 93.

<sup>95</sup> 42 U.S.C. § 1396b(v)(3).

<sup>96</sup> See e.g., *Emergency Medical Assistance*, MINN. DEP’T HUMAN SERVS. (Apr. 17, 2019), [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=La testReleased&dDocName=dhs16\\_157743](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=La testReleased&dDocName=dhs16_157743) (describing the criteria for qualifying for long-term EMA coverage, including that the long-term care is “medically necessary and directly responsible for preventing the member’s medical condition(s) from quickly becoming an emergency medical condition, typically within 48 hours.”)

<sup>97</sup> The Pennsylvania Department of Human Services’ Medical Assistance Eligibility Handbook section 322.34 recognizes the availability of ongoing Emergency Medical Assistance: [Medical Assistance Eligibility Handbook \(state.pa.us\)](#). However, as of May 2021, the availability of long-term care is an unofficial policy. There is no indication of it on the Pennsylvania Department of Human Services website.

The issue of funding emergency Medicaid for long-term care is a salient one. Because CMS affords states discretion in operating their Medicaid programs, CMS has not provided states with more detailed guidance surrounding what constitutes an “emergency medical condition” eligible to receive emergency Medicaid coverage. Without such guidance, many states define “emergency medical condition” very narrowly, fearing adverse action. A 2004 report released by the United States Government Accountability Office, however, cited a CMS eligibility expert who affirmed that “the agency’s position is that each case needs to be evaluated on its own merits, and the determination of what constitutes an emergency medical service is left to the state Medicaid agency and its medical advisors.”<sup>98</sup> CMS thus acknowledges that states have discretion when defining and identifying emergency medical conditions. Accordingly, states can and should argue that they are able to draw down federal funds when the state determines that an emergency medical condition exists and long-term care is required to treat it.

We urge more states to adopt policies permitting emergency Medicaid for long-term care. Alternatively, states could construct a program like Washington’s,<sup>99</sup> which is state-funded and covers long-term care in many settings, including adult family homes, assisted living facilities, in-home care with private duty nursing, etc. While the number of slots in Washington’s program may be limited due to constrained funding, the program, which operates on a rolling basis and accepts immigrants off the waitlist as soon as a slot becomes available, makes a drastic difference in the lives of those it covers. In a recent conversation our team had with state officials, not one could recall hearing about a case of medical deportation in the state.

If the goal of emergency Medicaid is to protect the patient from “serious jeopardy,” “serious impairment,” and “serious dysfunction,” it is illogical to remove coverage for care that prevents the same.<sup>100</sup> Advocacy on a state-by-state basis could replicate policies like those in Minnesota, Washington, or Pennsylvania by approving emergency Medicaid to cover necessary long-term care for emergency medical conditions. And if other states do in fact already provide such coverage, public education will be critical. Doctors, nurses, and hospital social workers must be aware of the resources available to their immigrant patients to avoid the disastrous consequences of forced medical deportation.

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<sup>98</sup> U.S. GOV’T ACCOUNTABILITY OFF., UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS (GAO-04-472) 10 (2004), <https://www.gao.gov/assets/gao-04-472.pdf>. See also JANE PERKINS, NATIONAL HEALTH LAW PROGRAM, MEDICAID COVERAGE OF EMERGENCY MEDICAL CONDITIONS: AN UPDATE 7, (2007) (discussing the “complex issues” involved with determining when an emergency medical condition terminates); 55 Fed. Reg. 36813, 36816 (1990) (preamble) (“[T]he significant variety of potential emergencies and the unique combination of physical conditions and the patients’ response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions.”).

<sup>99</sup> To learn more about Washington’s state-funded program that covers long-term care for immigrant patients, see *Apple Health Alien Emergency Medical*, WASH. STATE HEALTH CARE AUTH. (Dec. 16, 2014), <https://www.hca.wa.gov/health-care-services-supports/program-administration/apple-health-alien-emergency-medical>.

<sup>100</sup> 42 U.S.C. § 1396b(v)(3).

### *At the Federal Level*

Rather than seek favorable emergency Medicaid policy on a state-by-state basis only, advocates should also focus their efforts on driving change at the federal level. Centralized, federal policy that affirms the availability of emergency Medicaid for long-term care would apply to all states drawing down federal dollars to fund their emergency Medicaid programs. Options for change at the federal level could entail the creation of amendatory legislation clarifying the definition of “emergency medical condition” currently codified in the United States Code,<sup>101</sup> new CMS regulations that provide states with additional guidance on what constitutes an emergency medical condition subject to emergency Medicaid coverage, or interpretative guidance containing similar direction. In each of these cases, the goal should be to produce official federal policy that affirmatively makes emergency Medicaid coverage available for the cost of necessary long-term treatment of the emergency medical condition.

Legislation, regulations, or interpretive guidance that signal to states that the federal government will provide funding for long-term care that is necessary to prevent serious health consequences could mean the difference between a patient receiving medically indicated care or facing the devastating health and immigration consequences of medical deportation.

#### *D. Local Advocacy: Denouncing Medical Deportation, Grassroots Accountability, and Sanctions*

Local and state advocacy may be easier to navigate in the shorter term, at least for jurisdictions that have a track record of protecting their immigrant and undocumented immigrant communities through efforts like the sanctuary jurisdiction movement. In this section, we first describe what a sanctuary jurisdiction entails and how sanctuary protections have played out in the City of Philadelphia. Then, we identify three key areas for advocacy against medical deportation in Philadelphia, efforts that could be replicated in localities across the country, and at the state level.

##### *What Are Sanctuary Jurisdictions and How Can We Replicate the Movement for Medical Deportation Protections?*

Federal immigration authorities heavily rely on and collaborate with cities, counties, and state agencies to tear immigrant communities apart through detention and deportation. Sanctuary jurisdictions exist all across the United States and offer varying levels of “sanctuary” or protection for immigrant communities by diluting local collaboration with federal immigration authorities. While there is no universal definition of sanctuary policies, these can take on many forms, including:

- policies restricting the ability of state and local police to make arrests for federal immigration violations, or to detain individuals on civil immigration warrants;
- policies prohibiting “287(g)” agreements through which ICE deputizes local law enforcement officers to enforce federal immigration law;

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<sup>101</sup> *Id.*

- policies that prevent local governments from entering into a contract with the federal government to hold immigrants in detention;
- policies preventing immigration detention centers;
- policies restricting the police or other city workers from asking about immigration status;
- policies restricting the sharing of certain information on immigrants with the federal government;
- policies restricting local police responses to federal immigration detainees; and
- policies refusing to allow ICE into local jails without a judicial warrant.<sup>102</sup>

For example, the City of Philadelphia has passed a series of resolutions conforming to the City’s sanctuary protections and other areas of support for its immigrant communities. Below are a few examples of the types of resolutions the City of Philadelphia has passed throughout the years:

- January 29, 2004: “Authorizing City Council’s Legislative Oversight Committee to hold public hearings on strategies to increase foreign immigration to Philadelphia and to improve the immigrant experience within Philadelphia.”<sup>103</sup>
- June 23, 2011: “Condemning the City of Philadelphia’s agreement with the United States Immigration and Customs Enforcement (ICE) to allow immediate access to arrest information, and urging the City to discontinue that agreement with ICE when it expires August 31, 2011 as well as any other involvement in the Secure Communities program or additional data-sharing agreements with ICE.”<sup>104</sup>
- October 13, 2016: “Calling on Congress to immediately rectify the injustice of the ‘1996 Immigration Laws’ by restoring due process to immigration procedures, ending automatic deportation, and discontinuing mass detention, in order to uphold human rights and dignity in the United States immigration system.”<sup>105</sup>
- April 27, 2017: “Recognizing every person’s fundamental right to earn a living, regardless of immigration status, and affirming the City of Philadelphia’s commitment to protect and secure a safe and dignified workplace for all.”<sup>106</sup>
- May 18, 2017: “Supporting House Bill 1302 which would prohibit Pennsylvania law enforcement agencies from using state resources to investigate, interrogate, detain, or arrest people for immigration enforcement purposes.”<sup>107</sup>

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<sup>102</sup> *Fact Sheet, Sanctuary Policies: An Overview*, AM. IMMIGR. COUNCIL (Oct. 21, 2020), <https://www.americanimmigrationcouncil.org/research/sanctuary-policies-overview>.

<sup>103</sup> Philadelphia, Pennsylvania, City Council Res. No. 040068 (2004).

<sup>104</sup> Philadelphia, Pennsylvania, City Council Res. No. 110536 (2011).

<sup>105</sup> Philadelphia, Pennsylvania, City Council Res. No. 160886 (2016).

<sup>106</sup> Philadelphia, Pennsylvania, City Council Res. No. 170379 (2017).

<sup>107</sup> Philadelphia, Pennsylvania, City Council Res. No. 170490 (2017).

- June 21, 2018: “Condemning the Trump Administration's ‘zero tolerance’ immigration policy, which has resulted in thousands of children being separated from their parents after being detained at the United States border, and opposing the use of indefinite family detention as inhumane.”<sup>108</sup>

Just like Philadelphia and other localities have been swift to denounce immigration policies that terrorize and tear apart immigrant families, communities should strive to denounce the practice of medical deportation through decisive local action.

Jurisdictions against medical deportation may face challenges in replicating the sanctuary city movement. First, the primary actors involved in medical deportation are not police officers, who fall under local governmental jurisdiction, but rather hospitals who may function as private or public entities. Second, states and the federal government usually regulate hospital licensing, which provides points of leverage in prescribing hospital conduct and practices. Despite these differences, localities can still play a vital role in **denouncing, reporting, and sanctioning** the practice of medical deportation through local resolutions and ordinances.

### *Denouncing the Practice of Medical Deportation*

Cities and local governments should mirror their sanctuary movement efforts in the field of medical deportation.<sup>109</sup> For example, the City of Philadelphia could pass a resolution denouncing the practice of medical deportation and giving authority to the Public Health and Human Services Committee to hold public hearings on strategies to counter the practice. While a resolution is not as binding as an ordinance, it presents the opportunity to publicly discredit hospitals and medical transportation companies for engaging in this practice. As we have seen in the case of A.V.’s attempted medical deportation by Jefferson Torresdale, hospitals respond to public outcry of their practices and may even refrain from medically deporting members of our community in the future. Appendix E contains a sample resolution for the City of Philadelphia to denounce the practice of medical deportation.

### *Government and Grassroots Accountability and Reporting*

However, a campaign that solely publicly shames hospitals leaves immigrants vulnerable. Without a reporting and enforcement mechanism, hospitals could continue to hire medical transportation companies to privately deport patients. Immigrant patients and their families are also not likely to seek help from localities if the practice is perceived as legal and no accountability method is in place. For this reason, we propose cities, in addition to denouncing the practice of medical deportation, develop reporting mechanisms through a joint effort with grassroots organizations. These mechanisms would serve multiple purposes, including helping cities track bad actor hospitals and medical transportation companies, working with hospitals and patients to find funding for the type of long-term or chronic medical care patients need, and delegitimizing this practice that continues to happen across the United States, mostly unreported. Grassroots

<sup>108</sup> Philadelphia, Pennsylvania, City Council Res. No. 180714 (2018).

<sup>109</sup> See Stephanie Waters, *City of Philadelphia Action Guide: Immigration Policies*, CITY OF PHILA. (Jan. 8, 2018), <https://www.phila.gov/2018-01-08-immigration-policies/> (explaining Philadelphia’s immigration policy in the context of broader immigration policy).

organizations can play a crucial and intermediary role in ensuring that any information collected, whether it’s personal information or information related to immigration status, is not used against the patient or used to collaborate with immigration authorities.

In the City of Philadelphia, the Office of Immigrant Affairs, an office that already supports immigrants through know your rights resources in the spaces of employment and discrimination,<sup>110</sup> could work with grassroots organizations like the Free Migration Project and Community Legal Services to develop this network of reporting and support for patients and their caretakers.

### *Sanctions for Medical Providers*

It is not likely that localities could impose and leverage tax sanctions on hospitals in the particular field of medical deportation, beyond reporting requirements, as set out above, and discharge requirements discussed in this section.

The City of Philadelphia, through the Pennsylvania Constitution, the Home Rule Act, and its Home Rule Charter, has “complete powers of legislation and administration with regard to its municipal functions, except as to when the legislature has expressly or impliedly indicated its intent to assume exclusive jurisdiction over a field in which the local government has sought to regulate.”<sup>111</sup> As long as the state legislature does not intend “exclusive jurisdiction” over a particular field, the City of Philadelphia could pass an ordinance related to hospital reporting and discharge requirements.<sup>112</sup> While the Commonwealth of Pennsylvania regulates hospitals’ licensing, Medicare designations and payments, caregiver designations, and discharge planning, the state legislature has not proclaimed an intent to be the sole regulator of hospitals.<sup>113</sup> In fact, the City of Philadelphia already closely regulates hospitals that may face closure.<sup>114</sup> Instituting reporting requirements for hospitals who want to transport patients to a foreign country presents a much smaller area of regulation than hospital closures.

In practice, a city ordinance would allow the city to identify cases of medical deportation and ensure that hospitals provide certain information during discharge planning, including the four pieces of information identified in our state advocacy section above: (1) information on informed consent and medical deportation; (2) reporting resources for patients who suspect they are victims of medical deportation; (3) a directory of non-profit organizations across the state who can counsel the patient; and (4) information about the health and immigration consequences of medical deportation. While statewide reporting and discharge requirements would have a much larger

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<sup>110</sup> *Office of Immigrant Affairs: Resources*, CITY OF PHILA., <https://www.phila.gov/departments/office-of-immigrant-affairs/resources/> (last visited April 15, 2021).

<sup>111</sup> *Nutter v. Dougherty*, 921 A.2d 44, 63 (Pa. Commw. Ct. 2006).

<sup>112</sup> *Id.*

<sup>113</sup> See e.g., 35 PA. STAT. ANN. § 448.808 (providing for licensing of healthcare facilities); *id.* § 449.82 (covering Medicare designations and payments); *id.* § 447.3 (involving caregiver designation and consent); *id.* § 447.5 (regulating hospital discharge planning).

<sup>114</sup> Philadelphia, Pennsylvania, The Philadelphia Code § 6-408 (“A hospital shall not close any such units or departments as part of a general hospital closing or engage in a significant impact unit closing except pursuant to a written Closure Plan that has been approved by the Commissioner in relevant part with respect to such unit or department.”).

impact and could provide more extensive enforcement measures, localities, like the City of Philadelphia, could play an important role in beginning to identify and educate patients in danger of medical deportation.

### E. *Areas for Further Research and Advocacy*

#### *Charity Care*

In the absence of federal, state, or local policy addressing medical deportation or its root causes, namely lack of health care coverage for undocumented immigrants, heightened discharge standards, and reporting requirements, we believe hospitals have a moral imperative to use charity care dollars to bring an end to the practice. As described above, in Section I.B., nonprofit hospitals receive tax breaks for providing charity care along with other community benefits. A comprehensive analysis of hospital charity care spending is beyond the scope of this report,<sup>115</sup> but if the IRS’s goal in providing tax exemptions to nonprofit hospitals is to incentivize these hospitals to provide for community health needs, the hospitals should at least provide enough community benefit—and especially enough charity care—to exceed the tax savings afforded to them by their tax-exempt status.<sup>116</sup>

The Affordable Care Act aimed to make community benefit spending more transparent by requiring tax-exempt hospitals to maintain written Financial Assistance Policies (FAPs) and to conduct Community Health Needs Assessments (CHNAs) every few years.<sup>117</sup> While this was an important first step, evaluating hospitals’ use of FAPs and CHNAs will be necessary for measuring their effectiveness and maximizing actual community benefit, including charity care. One organization, Community Catalyst, has launched the Community Benefit and Economic Stability Project, which aims to “work with hospitals to ensure they have transparent and accessible financial assistance policies, and that their billing and collection policies do not exacerbate existing inequities.”<sup>118</sup> As Community Catalyst notes, there have been many documented instances of hospitals failing to screen eligible patients for financial assistance.<sup>119</sup> Making FAPs more accessible and screening for eligibility more routine could prove critical in cases involving the possibility of medical deportation and for ensuring that hospitals are allocating charity care dollars that they have committed to spend.

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<sup>115</sup> Community Catalyst has created a tool to detail hospitals’ community benefit expenses. CMTY. BENEFIT INSIGHT, <http://www.communitybenefitinsight.org/> (last visited May 5, 2021).

<sup>116</sup> A 2018 study found that “on average, the amount of incremental community benefits is comparable to the value of the tax exemption,” but that “there are many hospitals whose community benefits are less than their tax exemption” and “the extent to which a hospital’s community benefits exceed the tax exemption is explained by relatively few hospital and market characteristics.” Bradley Herring, Darrell Gaskin, Hossein Zare & Gerard Anderson, *Comparing the Value of Nonprofit Hospitals’ Tax Exemption to Their Community Benefits*, 55 INQUIRY: J. HEALTH CARE ORG., PROVISION & FIN. 1, 2 (2018). The researchers conclude that the government “could consider being more explicit in specifying certain levels of community benefits from nonprofits as a requirement and be willing to rescind nonprofit status to those hospitals deemed to be providing insufficient community benefits.” *Id.* at 9.

<sup>117</sup> For an excellent overview of what is required of hospitals in implementing FAPs, see JESSICA CURTIS, CMTY. CATALYST, *WHAT DOES THE AFFORDABLE CARE ACT SAY ABOUT HOSPITAL BILLS?* (2015).

<sup>118</sup> Chiang & Kandt, *supra* note 18.

<sup>119</sup> *Id.*

Further research on medical deportation should explore the extent to which private, nonprofit hospitals use charity care to cover the cost of uninsured immigrant patients' treatment. More specifically, further research can address the accessibility of FAPS to immigrant patients, how consistently hospitals inform immigrant patients of those FAPS, and any cases in which reliance on charity care has successfully prevented medical deportation. Future advocacy might include lobbying Congress to enact more concrete requirements for hospitals to follow (i.e., requiring a minimum amount of charity care to be spent per fiscal year) to retain tax-exempt status. Moreover, advocates might consider following Community Catalyst's lead in working directly with hospitals to create more robust financial assistance procedures and campaign for hospitals to turn to charity care in place of resorting to medically deporting their patients.

### *Filing Ethics Complaints*

For individuals who have experienced medical deportation or have been threatened with it, an ethics complaint against the treating physician might be in order. Medical deportation involves lack of informed consent and making discharge plans based on a patient's perceived immigration status, which are clear violations of the AMA's standards for ethical conduct. Additional research and medical deportation advocacy might consider the utility of using ethics complaints against individual physicians as a form of accountability. Although the AMA's standards are not legally binding, patients have the option of filing ethics complaints with the medical licensing board in the state where a physician practices. The effectiveness of ethical complaints made to state licensing boards is not immediately apparent.

One source claims that a single complaint against a doctor might not be enough to result in discipline, but that "if the medical board or other agency receives multiple complaints against the same physician, they will have good reason to launch a formal investigation."<sup>120</sup> According to DocInfo, a database created by the Federation of State Medical Boards, once a complaint has been lodged with a state licensing board, it is prioritized based on the potential for harm.<sup>121</sup> In "cases in which an investigator determines imminent patient harm is possible," like allegations of substandard care, the complaints are "typically 'fast-tracked' to ensure swift action by the state medical board."<sup>122</sup> Disciplinary actions taken against physicians are a matter of public record.<sup>123</sup>

Further research might aim to identify whether ethics complaints lodged against physicians in medical deportation cases have ever resulted in disciplinary action. Even if such complaints have not been successful in the past, it is possible that repeated and consistent use of the complaint

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<sup>120</sup> Heather R. Johnson, *How to File a Complaint Against a Doctor*, LEGAL ZOOM (Aug. 24, 2020), <https://www.legalzoom.com/articles/how-to-file-a-complaint-against-a-doctor>.

<sup>121</sup> *Reporting a Doctor for Unprofessional Conduct*, DOCINFO, <https://www.docinfo.org/report-a-doctor/> (last visited Mar. 12, 2021).

<sup>122</sup> *Id.*

<sup>123</sup> See, e.g., *File a Complaint*, PA. DEP'T OF STATE, <https://www.dos.pa.gov/ProfessionalLicensing/FileaComplaint/Pages/default.aspx> (last visited Apr. 30, 2021) ("All disciplinary actions become a permanent part of the licensee's record on file with the respective board or commission. Disciplinary actions are a matter of public record and are subject to release by the Department of State's Office of Communications and Press to various news agencies in the Commonwealth."). DocInfo maintains state licensing board data on medical doctors, including any disciplinary actions taken against the doctors by their state boards. DOCINFO, <https://www.docinfo.org/> (last visited Apr. 30, 2021).

system could eventually result in consequences sufficient to deter individual physicians from engaging in the practice of medical deportation. At minimum, filing an ethics complaint allows victims of medical deportation or their family members to make their voices heard, which could impact hospital and physician reputation. The threat of reputational harm might dissuade physicians from participating in medical deportation. To the extent that hospitals are pressuring doctors to transfer patients at risk of medical deportation as quickly as possible, hospitals should not be encouraging doctors to commit ethical violations, and doctors should not agree to work at hospitals that compel them to harm patients.

### *International Human Rights*

Finally, we acknowledge that this report has not addressed a salient area of law in the context of medical deportation: international human rights law. International human rights law demands due process, due diligence, the right to life, and the preservation of health and well-being, all of which are violated when hospitals medically deport ill immigrant patients.<sup>124</sup> For a comprehensive overview of these points of law and how they interact with the practice of medical deportation, see Seton Hall Law’s *Discharge, Deportation, and Dangerous Journeys: A Study on the Practice of Medical Repatriation*.<sup>125</sup> We view international human rights law as yet another avenue for future advocacy to stop the practice of medical deportation.

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<sup>124</sup> DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 3, at 35–50.

<sup>125</sup> *Id.*

**APPENDIX: TOOLKIT FOR ACTION**  
*Appendix A: Legal Toolkit Checklist*

<p><b>Immigration Court:</b></p> <ul style="list-style-type: none"> <li>• Motion to Suppress Evidence</li> <li>• Persuade ICE to withdraw the NTA</li> <li>• Administrative Closure</li> </ul>
<p><b>BIA Appeal</b> – 30-day deadline, automatic stay</p>
<p><b>Motion to Reopen</b> – Immigration Court or BIA – 90 day deadline, with exceptions</p>
<p><b>Motion to Reconsider</b> – 30 day deadline</p>
<p><b>Petition for Review in Circuit Court</b> – 30 day deadline</p>
<p><b>Agency Discretionary Action:</b></p> <ul style="list-style-type: none"> <li>• ICE Enforcement &amp; Removal Operations (ERO) <ul style="list-style-type: none"> <li>○ Stay of removal (Form I-246)</li> <li>○ Order of Supervision</li> </ul> </li> <li>• ICE Office of Chief Counsel (OCC) <ul style="list-style-type: none"> <li>○ Administrative closure</li> <li>○ Decline to oppose or appeal a grant</li> <li>○ Join a Motion to Reopen</li> </ul> </li> <li>• U.S. Citizenship &amp; Immigration Services (USCIS) <ul style="list-style-type: none"> <li>○ Medical deferred action</li> </ul> </li> </ul>
<p><b>Obtain Legal Status:</b></p> <ul style="list-style-type: none"> <li>• Asylum, withholding, or Convention Against Torture relief</li> <li>• U or T visa</li> <li>• Family-based petition for permanent residence</li> <li>• Cancellation of removal</li> <li>• Other (SIJS, DACA, TPS, NACARA, employment-based)</li> </ul>
<p><b>Domestic Agencies (State or Federal):</b></p> <ul style="list-style-type: none"> <li>• DHS Office for Civil Rights and Civil Liberties (CRCL)</li> <li>• EPA, Human Services (child welfare), or other regulatory agencies</li> </ul>
<p><b>International Bodies:</b></p> <ul style="list-style-type: none"> <li>• Inter-American Commission on Human Rights (IAHCR) – petition &amp; precautionary measures</li> <li>• UN Human Rights Committee</li> </ul>
<p><b>Private Bill – House and/or Senate</b></p>
<p><b>Civil Suit:</b></p> <ul style="list-style-type: none"> <li>• Racial profiling by state or local law enforcement</li> <li>• Trafficking Victims Protection Reauthorization Act (TVPRA) violations</li> <li>• Forced labor</li> </ul>

## ***Appendix B: Public Medical Deportation Defense Campaigns–Fact Sheet***

A medical deportation defense campaign integrates community support and public pressure with legal and medical advocacy to stop a deportation. This strategy has typically been used to stop deportations by the government, but can also be used to stop medical deportations.

### **Components of a Public Campaign:**

- **Organizing:** Community organizers provide support to the patient and family, engage with the media, stage public events, engage elected officials, and fundraise to cover expenses.
- **Legal & Medical Advocacy:** The impacted patient’s attorney represents a client before the courts and government agencies and engages with the public and decisionmakers about legal aspects of the case. Medical advocates such as social workers, health care advocates, or medical students engage with the hospital to obtain information and advocate on behalf of the patient.
- **Media & Communications:** The campaign team reaches out to media through press releases, press conferences, and TV or radio appearances. Digital engagement may include social media outreach, videos, or online petitions.
- **Policy:** The campaign team engages elected officials on the local, state or federal level with specific requests such as engaging with hospital administrators, visiting the patient, attending media events, or providing other public signs of support such as a public letter.

### **Public Campaign Strategy:**

1. Legal and medical advocacy halts or delays the medical deportation while searching for a long-term remedy such as permanent legal status or reliable health insurance.
2. Organizers mobilize community supporters to drive media attention and engage elected officials.
3. Elected officials, motivated by public support and media attention, pressure the hospital or medical transport company to stop the medical deportation.

### **Objectives of a Public Campaign:**

1. Aside from protecting the patient from being medically deported, potential objectives of a public campaign may include building power in the community, and changing policy. Each of these objectives can be strengthened by the others in a well-managed campaign.
2. Successful campaigns may educate the public about the practice of medical deportation and encourage others to mobilize to stop medical deportations. Public campaigns can build capacity and expertise among community groups and advocates, leading to a virtuous cycle that builds momentum towards a shift in norms and policy change.

**For Additional Information & Resources, visit [freemigrationproject.org](http://freemigrationproject.org)**

## Appendix C: Sample Press Release

[Optional: organization or group’s logo(s)]

### FOR IMMEDIATE RELEASE

#### Press Contacts:

(1-3) Name Last Name, hyperlinked email, phone number

### [Descriptive Title That is Not Too Long]

*[Subtitle That Provides Additional Context, Perhaps Mentions Demands]*

If this press release is meant to announce a specific action (e.g., protest, sit-in, rally etc.) include the section below. If there is no action, omit this section.

**When:** *Saturday, May 1, 2021 at 12 p.m. (ET)*

**Who:** *[Who is involved in putting together the action]*

**What:** *[What can members of the press expect?] example: Virtual press conference to Ask for X*

**Where:** *[Physical or virtual location. If virtual, include [hyperlink](#)]*

*City, May 1, 2021*– Don’t bury the lead, describe clearly here what is happening, who is involved and what the demands are. No more than one paragraph, 5 sentences.

Give context or background information regarding why action is being taken now and talk about who the person is (if appropriate). Include the hospital, length of stay, medical condition, and any relevant information that gives the press enough details to write their piece/report. Use your best judgment on what information to include. Your best bet is to ask the family or the person being deported what you can share. This can be 1-1.5 paragraphs.

This next paragraph explains in detail the demands of the person/group and points to the person, people, or entity who have the power to make the demands happen. Explain how the person, people, or entity in power can meet the demands and *why* they should do so.

This is your closing paragraph, make sure to reiterate what is happening (when, if appropriate), who is involved, and your demands. **For additional emphasis, you can bold your thesis sentence, where you mention the person, people, or entity who has the power and how they can meet the demands.** If there is an action attached to this press release, have one short sentence here reminding the reader, and add any instructions to join (e.g., “to register for the press conference, visit this link: ...”).

#####

**[Organization Name]** *[short description or tagline about the org].*

**[Organization Name]** *[short description or tagline about the org].*

### *Appendix D: Directory of Organizations*

Free Migration Project is working on a National Directory of advocates who are available for patients and fellow advocates facing the issue of medical deportation. Organizations who opt into the National Directory on a rolling basis may be found [here](#).

If your organization would like to opt-in to the National Directory, please email David Bennion ([david.bennion@freemigrate.org](mailto:david.bennion@freemigrate.org)) and Adrianna Torres-García ([adrianna.tg@freemigrate.org](mailto:adrianna.tg@freemigrate.org)).

*Appendix E: Sample City Council Resolution*

**Please note, this is a sample resolution and has not been introduced or enacted.**

**SAMPLE RESOLUTION**

Condemning hospitals and medical transportation companies' practice of medical deportation, which has resulted in thousands of patients across the country who are in need of chronic medical care being forcibly transported to another country, and recognizing every person's fundamental right to access and obtain quality healthcare, regardless of immigration status.

WHEREAS, In June 2020, Jefferson Torresdale Hospital attempted to forcibly transport A.V., an immigrant member of the Philadelphia community, after he suffered catastrophic brain injuries from a motorcycle accident and required long-term medical care; and

WHEREAS, Members of this Council rallied with A.V.'s family and local advocates to physically stop A.V.'s deportation and were successful; and

WHEREAS, Extrajudicial medical deportations of this nature happen all across the country when hospitals hire medical transportation companies to fly patients to their countries of citizenship or presumed countries of citizenship; and

WHEREAS, Immigrant communities already live in a climate of deeply embedded fear as a result of our nation's immigration policies, which causes them to avoid seeking healthcare services or reporting crimes. As a result, cases of medical deportation very often go unreported, jeopardizing our community's well-being; and

WHEREAS, Medical deportations will continue to have disastrous effects on immigrant communities, including family separation, the inability to access much needed chronic medical care, the inability to return to the United States, and even death; and

WHEREAS, The City of Philadelphia recognizes the significant positive contributions of immigrants, regardless of immigration status, to our City's economy and our well-being; and

WHEREAS, Article 12 of the International Covenant on Economic, Social and Cultural Rights, to which the United States is a signatory, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and

WHEREAS, Healthcare should be given equally to all Philadelphians, regardless of immigration status; and

WHEREAS, A relationship of trust between the City's immigrant community and our healthcare providers is central to the public safety of our community. When hospitals take on the role of transporting, or forcing community members to consent to their transport, to another country because of patients' insurance status or immigration status, this trust can be compromised, a detriment to the public safety and well-being of our entire community; and

WHEREAS, Philadelphia has taken significant steps through its Sanctuary City Policy to extend protections to undocumented immigrants; now, therefore, be it

RESOLVED, THAT THE COUNCIL OF THE CITY OF PHILADELPHIA, Hereby condemns hospitals' and medical transportation companies' practice of medical deportation, which has resulted nationally in thousands of patients in need of chronic medical care being forcibly transported to another country, and recognizes every person's fundamental right to access and obtain quality healthcare, regardless of immigration status.

FURTHER RESOLVED, That authority be given to the Public Health and Human Services Committee to collect data on medical deportation by implementing reporting obligations in Philadelphia hospitals and to hold public hearings on strategies to counter the practice of medical deportation and improve immigrants' access to healthcare, including long-term and chronic medical care.

## LEARN MORE

### Contact

150 Cecil B. Moore Ave.  
Suite 203  
Philadelphia, PA 19122

### Web Presence

**Website:**

[www.freemigrationproject.org](http://www.freemigrationproject.org)

**Email list:** <https://freemigrationproject.org/email-list/>

**Facebook:** @FreeMigration or <https://www.facebook.com/FreeMigration>

**Instagram:** @freemigrationproject or <https://www.instagram.com/freemigrationproject/>

**Twitter:** @Free\_Migration or [https://twitter.com/Free\\_Migration](https://twitter.com/Free_Migration)

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