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Healthcare Barriers for the Undocumented Immigrant in the United States

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Abstract

We are taught early in our education that the United States of America was founded by immigrants. The United States is a very diverse country that people of other countries see as a land of opportunity. However, not everyone that enters into our beautiful country enter legally. Many residents of other countries are so desperate to provide a better life of opportunities to their families that they will do anything to make that happen. Even if it means breaking, the immigration laws in place by the United States and enter illegally by crossing the border. Many reasons play a part in the decision to leave their home country. It can be conflict within the country, lack of employment of opportunities and even discrimination. Once an undocumented immigrant is successfully across the border into the United States, they begin to establish their lives by obtaining employment and finding housing. For many of these undocumented immigrants, the employer typically pays cash to the undocumented immigrant and cannot provide any form of healthcare coverage to undocumented immigrant, which then leaves the undocumented immigrant without healthcare when the need for healthcare comes about. When an undocumented immigrant needs to seek healthcare, they face many barriers in seeking that healthcare. This paper will explore the barriers that the undocumented immigrant faces. The paper will look at where they can seek healthcare, the cost of the healthcare to them and the fear the undocumented immigrant faces while seeking out healthcare. The paper will also look at the healthcare provider and the issues that facilities are facing when providing services. The expense and reimbursement to the healthcare provider will be discussed. This paper will review the current situation in healthcare for undocumented immigrants and then will discuss on what can be done by healthcare providers and the United States to ensure that all persons living in our beautiful country can obtain healthcare regardless of the citizenship status.

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Introduction

Immigrants founded the United States. We were taught in our early childhood education of the pilgrims/pioneers who landed on our great country's land. These pilgrims/pioneers were residents of another country in search of a new and better life for their families. Of course, the pilgrim's/pioneers were not faced with immigration laws and regulations like we have in place in today's time. Over time, as more and more settlers from other countries descended upon this great county, the need for immigration restrictions and guidelines became apparent.

Timeline of Immigration Policies

In an effort to better understand the United States and immigration we need to take a brief look at the history and timeline of the evolution of immigration laws as we currently know them. The history of immigration listed below was obtained from the website of fairus.org.

Beginning in 1790, The Naturalization Act of 1790 established the very first set of guidelines in order for a person to establish citizenship in the United States of America. According to FAIRUS.ORG (2019), this act "required immigrants to live in the United States for two years and their respective state of residence for one year prior to applying for citizenship."

The Bureau of Immigration was created in 1891 and was established with a primary role of administering on behalf of the United States all immigration laws with the exception of the Chinese Exclusion Act (FAIRUS.ORG, 2019). In 1906, English was declared a requirement for to become a naturalized citizen of the United States.

One of the most talked about subjects in today's current news, the Border Patrol was established in 1924 along with the quota system (FAIRUS.ORG, 2019). The quota system requirements established in 1924 were made permanent in 1929.

During the world wars, many soldiers, men and women, developed relationships with foreign-born immigrants. In 1946, processes and procedures were enacted to assist the United States armed forces personnel in bringing their new spouses, fiancé (e)s and even children home with them after their tour of duty oversees was completed (FAIRUS.ORG, 2019).

In 1948, the first policy regarding refugees was adopted. At that time, it allowed 205,000 refugees to enter into the United States of America over a course of two years (FAIRUS.ORG, 2019).

In 1953, Congress passed the Refugee Relief Act of the Special Migration Act of 1953. It increased the refugee admission number to greater than 200,000 to approximately 400,000 (FAIRUS.ORG, 2019).

The next major change to immigration law did not occur until 1986 with the establishment of the Immigration Reform and Control Act (IRCA). This act developed several processes and are listed below:

1. "legalized aliens who had resided in the United States in an unlawful status since January 1, 1982,
2. Established sanctions prohibiting employers from hiring, recruiting or referring for a fee aliens known to be unauthorized to work in the United States,
3. Created a new classification of temporary agricultural workers and provided for the legalization of certain such works; and
4. Established a visa waiver pilot program allowing the admission of certain non-immigrants without visas (FAIRUS.ORG, 2019).

Our country was rocked with the worst terrorist attack in its history on September 11, 2001. Immigration laws became a highlight in the news and with politicians. As a result, in 2002, the executive branch of the government of the United States in the wake of the horrendous terrorist attack on the World Trade Center on September 11, 2001 established The Homeland Security Act. The creation of the Department of Homeland Security resulted in the combination of 22 different federal agencies into one unified department to better serve and protect our great nation. The mission of the Department of Homeland Security is "with honor and integrity, we will safeguard the American people, our homeland, and our values (Department of Homeland Security, 2019)." "DHS investigates immigration violators who fraudulently obtain visas to the United States, fail to maintain their authorized status, or otherwise violate the terms of their lawful admission pursuant to federal laws (Department of Homeland Security, 2019)."

In 2012, the Deferred Action for Childhood Arrivals (DACA) was established by executive order under President Obama. DACA allowed for deferred action from deportation and eligibility for a work permit for illegal aliens brought into the United States as Children (FAIRUS.ORG, 2019). DACA is currently under litigation as opponents fight it claiming it is unconstitutional. As the Obama administration left office and the Trump administration transitioned, President Trump has issued numerous executive orders related to the Pro-American immigration reform agenda. These orders include "authorization of a border wall construction, withdrawing the United States from TPP, Buy American and Hire American (FAIRUS.ORG, 2019)" to name a few.

Defining Immigration vs Illegal Immigration

"Immigration to the United States is based upon the following principles: the reunification of families, admitting immigrants with skills that are valuable to the U.S. economy,

protecting refugees and promoting diversity (American Immigration Council, 2019)." Each year a limited number of visas to immigrants under the family preference system. The immigrants that receive these visas are required to "meet standard eligibility criteria, and petitioners must meet certain age and financial requirements (American Immigration Council, 2019)." The preference system includes adult children, spouses and unmarried minor children. Immigrants are also granted admission to the United States through employment-based immigration. This can provide as a temporary visa or permanent immigration. Under the temporary visa, employers are allowed to hire immigrants' jobs for a certain period. Some examples include, athletes, religious workers, farm hands and educational. The permanent visa allows for immigrants with advanced education such as professors and physicians and business owners. Those that are fleeing their country due to life-threatening or extreme conditions are considered refugees and are granted admittance to the United States. The refugees must apply for admission to the United States from an outside country. The President along with Congress reviews the number of refugees allowed to enter into the United States annually. In 2016, the limit was listed at 85,000 (American Immigration Council, 2019).

In order to apply for United States Citizenship through the naturalization process, the immigrant must have held their green card "for at least five years (or three years if he or she obtained the green card through a U.S.-citizen spouse or through the Violence Against Women Act, VAWA) (American Immigration Council, 2019)."

As a nation of immigrants, the United States currently has more foreign-born residents than any other country with approximately 28% of these being undocumented immigrants (Hilfinger, McEwen, & Clark, 2014). The specific legal position of who are considered undocumented can differ from country to country because of an individual country's

immigration laws. For the United States, according to the IRS website, an undocumented alien (immigrant) is someone who has entered the United States without the proper authorization and documents or a person who was in the United States legally but has violated the terms of their visa or stayed beyond the allowed time (irs.gov, 2019). "Undocumentedness is a social construction of the 20th century that refers to the lack of tangible proof of identity (e.g., birth), status (e.g., nationality, citizenship, or immigration status), or qualifications (e.g., education, licensure, or professional training); (Hilfinger, McEwen, & Clark, 2014)."

In an effort to accurately estimate the number of unauthorized immigrant population in order to develop processes for border control, immigration enforcement and admission policies the government had to develop a process to estimate the number of undocumented immigrants in the United States. The method in place to do this "involves subtracting the known legal immigrant population from the total foreign-born population (Capps, Gelatt, Van Hook, & Fix, 2018)."

According to the United Nations, "the United States currently host 46 million international immigrants, accounting for 13% of the national population (Hilfinger, McEwen, & Clark, 2014)." It is estimated "that among the estimated 40 million foreign-born individual living in the United States in 2010, approximately 11.2 million were undocumented immigrants (Hilfinger, McEwen, & Clark, 2014)." "Mexican immigrants are the largest immigrant group residing in the United States, only 22% of them are US citizens (Bustamante, et al., 2012)." This 22% comes from El Salvador, Honduras and Guatemala.

"The US Conference of Catholic Bishops has explained that yes, immigrants should come to this country lawfully, but that our current immigration laws are broken. They do not adequately reunify families and they are not responsive to our country's need for labor (Faith

ND, 2018)." There are ways for the undocumented immigrant to become a permanent resident. According to the University of Notre Dame (Faith ND, 2018), "there are three core means by which an immigrant might become a permanent resident.

1. A qualified family member in the U.S. can request residency for their spouse, parents, children, or siblings.
2. Immigrants can seek asylum in the U.S. if they are fleeing persecution, but there is a high standard of proof of these claims, and the U.S. only accepts a limited number of refugees (typically around 80,000).
3. There are several immigration categories that allow American employers to sponsor workers to come to the U.S. to work and live lawfully."

Healthcare Access Availability

For any person entering a new country, documented or undocumented, it can be very stressful. However, for a person entering illegally under deplorable conditions, the increase in physical and emotional stress rises. Often these individuals come from conditions of poverty and dangerous conditions. Many of these undocumented immigrants lack access to healthcare and social services. For some undocumented immigrants, the status of "undocumented status may result in a stigma for some individuals as a result of social attitudes (Trinidad Young & Madrigal, 2017)." This influences how the undocumented immigrant integrates socially and economically into society.

For an undocumented immigrant the need for healthcare is the same as the need for those that are here legally. However, the undocumented immigrants face many challenges in regards to healthcare. It can be access, cost, and ability to pay and fear of deportation. There are many avenues of healthcare access available to any individual in the United States. Many

undocumented immigrants are sick when they cross the border and really need to seek healthcare at that time. “Legal immigrants and refugees are required to have a medical examination for migration to the United States (SMA, 2015).” The Centers for Disease Control and Prevention is responsible for the guidelines for the medical exam. The medical exam can include a physical examination, skin testing and blood testing. Depending on the results of the testing, vaccinations can be recommended or a denial of the request to enter the United States. The undocumented immigrant who enters the United States illegally can expose infectious diseases to those living in the United States. Many of the diseases that are being seen in undocumented immigrants are diseases that had been vanished from the United States. TB is one that is becoming more commonly seen by those undocumented. According to the American Journal of Public Health (2018), “in 2016, foreign-born individuals accounted for 67.9% of people diagnosed with active tuberculosis in the United States; the incidence of active tuberculosis among foreign-born persons was approximately 14 times that among US-born persons.” However, other diseases such as chicken pox and methicillin-resistant staphylococcus aureus (MRS) are also being seen. These are highly contagious diseases and MRSA can be deadly if not treated appropriately. “These health burdens are sustained and magnified by language barrier, lack of knowledge about the US healthcare system, and fear of detection by immigration authorities (Kullgren, 2003).”

Available healthcare services and facilities include hospitals, clinics, outpatient care centers, specialized care centers and local health departments. In 2019, The American Hospital Association reported 6217 active hospitals in the United States (aha.org, 2019). In a hospital, when the patient presents to the emergency room for care, it is required by a federal law to provide treatment regardless of ability to pay. This federal law is Emergency Medical Treatment and Active Labor Act (EMTALA) enacted in 1986 by Congress (cms.gov, 2019). As part of

EMTALA a hospital emergency room is required to provide a medical screening by a physician. A patient is to be stabilized or transferred to another facility for a higher level of care. For physician access, the United States Department of Health and Human Services reports that there is "approximately 209,000 practicing primary care physicians in the United States (ahrq.gov, 2018)." A sample policy for EMTALA, Appendix B, is provided as an example of a policy that a healthcare provider would need to have in place to ensure that the proper process is followed to prevent an EMTALA event. If an EMTALA event occurs, the healthcare provider can face financial penalties for the violation. Certain healthcare services can be access through a local health department. Local health departments can typically be located in a county seat but can be considered a regional center. There are approximately 3000 local health departments in the United States.

Although there are numerous avenues for an undocumented immigrant to seek healthcare, many still do not seek out care when needed. Many undocumented immigrants tend to put off seeking any needed healthcare services for a number of reasons. In a study reported in the American Journal of Public Health (Rhodes, PhD, MPH, et al., 2015), "participants report that they often rely on nonmedical sources of care, such as self-diagnosing and self-treating and using medications purchased from Latino stores, brought from their home country, or left over from others' prescriptions." Unfortunately, this self-treatment that is done out of fear of being discovered as undocumented can cause more complications from not receiving healthcare than if they had received when they were first ill. When care is delayed, the undocumented immigrant ends up in the emergency room facing severe complications and in some cases death due to the delay. The cost for the healthcare is much more than it would have been if care had been sought earlier. Many are barriers by the healthcare system in the United States but often times it is

personal barriers from the undocumented immigrant themselves. It is also noted that the children of these undocumented immigrants are very well aware of their parents not being in the United States legally and thus they have fear of sharing information with those that they come in contact with as well. The Affordable Care Act does not allow healthcare coverage to be extended to undocumented immigrants. There is only coverage available for those certain immigrants that have certain status through the federal marketplace created through the Affordable Care Act. According to healthcare.gov (2019), the following are the statuses of immigrants who qualify to use the federal Marketplace:

- Lawful Permanent Residence (LPR/Green Card Holder)
- Asylee (applicants for asylum are eligible for Marketplace coverage only if they've been granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days)
- Refugee
- Cuban/Haitian Entrant
- Paroled into the United States
- Conditional Entrant Granted before 1980
- Battered Spouse, Child and Parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withhold of Removal, under the immigration laws or under the Convention against Torture (CAT)

- Individuals with Non-Immigrant Status, includes worker visa, student visas, U-visa, T-visa and other visas and citizens of Micronesia the Marshall Islands, and Palu
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)
- Lawful Temporary Resident
- Administrative order staying removal issued by the Department of Homeland Security
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa

As you can see, there are many ways that an immigrant can access healthcare coverage like any United States citizen in the United States; they just have to have some form of documentation. Many of the immigrants that meet the criteria above still do not use the Marketplace to obtain healthcare coverage out of fear of the government using the tool as a means for immigration enforcement but in fact the law enacted for this coverage indicated that the Marketplace can only be used to determine eligibility for healthcare coverage not for enforcement of immigration. This brings us back to the fact that undocumented immigrants do not seek healthcare coverage due to lack of documentation. Many of the undocumented immigrants do work for employers many of which are factories that offer insurance to their employees. However, if an employer who offers healthcare employs the undocumented

immigrant, they are not allowed to participate in the coverage and any healthcare services that are sought out have to be paid 100% out of pocket by the undocumented immigrant. The fear of deportation is the strongest barrier for an undocumented immigrant to receive healthcare. In the United States, the state of Arizona, legislators sought to pass a law that would force healthcare providers to check immigration status on patients that seek treatment (Monga, Keller, & Venters , 2014). The federal government but state, regional and local governments that target undocumented immigrants do not only give the fear of deportation when accessing healthcare. Many undocumented immigrants see seeking healthcare as a form of punishment and choose to delay care in fear of being deported back to their home nation.

Another large barrier to healthcare access for the undocumented immigrant is basic lack of knowledge. Being in a country that they are unfamiliar with has many disadvantages. If the undocumented immigrant is part of a large ethnic community that has established roots in a community, they can take advantage of those that have been in the United States and use the resources that have been used by others in the community. Knowing where to go and how to get there is a number one priority.

Cost Impact of Illegal Immigration

"At the federal, state, and local levels, taxpayers shell out approximately $134.9 billion to cover the cost incurred by the presence of more than 12.5 million illegal aliens (O'Brien & Raley, 2017)." This comes to approximately $8,075 per illegal alien. There are a couple of other ways to look at this expense to the United States. The $8,075 is the equivalent to a six-month salary for someone who is earning an hourly rate of $8.41 per hour. This is just a small amount above minimum wage. Another way to look at this is that "the average American college student receives only $4,800 in federal loans each year (O'Brien & Raley, 2017)." It is

clear that we are spending much more dollars on those here with an undocumented status than we are on United States citizens. According to an article on FAIRUS.org ((O'Brien & Raley, 2017), "the federal government spends a net amount of $45.8 billion on illegal aliens and their U.S.-born children." This is not on healthcare alone; this also includes education provided in the public setting, law enforcement costs and other miscellaneous costs.

Many of the undocumented immigrants come to the United States for the vast opportunities of employment. They work as field workers and in factories where the background checks are limited on verification of citizenship status. Many of those that are working are contributing to the government. According to the website newamericancompany.com (2016), undocumented immigrants had a total estimated income of $215.2 billion, paying in $15.9 billion in federal tax and $9.4 billion in state and local taxes. Contributions were even made to Medicare in the amount of $3.3 billion and social security of $13.3 billion. According to the same site California, Texas and New York all had contributions of over $1 billion in 2016.

Even though the United States is spending a large amount of funds per undocumented immigrant, there is definitely recovery to a portion of that expense in the contributions made in the tax payments of those working in the United States. These undocumented immigrants are paying in Medicare and social security and will never be able to draw benefits from the amounts they have paid in.

Under EMTALA, (Emergency Medical Treatment and Active Labor Act), which remember is the federal law that requires hospitals to treat patients when they present to the emergency room regardless of financial status. However, 'federal policy is to prohibit federal tax funding of health care to unauthorized immigrants through Medicaid or the Affordable Care Act (Conover, 2018)." This means they are not eligible for healthcare services. However, this

rule typically only applies to non-emergency care as in many cases the undocumented immigrant can find eligibility and coverage for emergency Medicaid. As a taxpayer you may wonder how is the federal government paying for this care when the rule to not provide coverage for them. It happens indirectly through a variety of federal programs that provide funding to various institutions. Hospitals and local health departments are typically the healthcare providers that receive the funding from the federal government. Although, there is some funding to physicians who provide the care to an undocumented immigrant in case of an emergency treatment or the treatment of a female in active labor.

It is estimated that undocumented immigrants accounts for $11.9 billion in uncompensated healthcare costs (Conover, 2018). The breakdown of how this is covered is "$4.6 billion by federal taxpayers, $2.8 billion by state and local taxpayers, $3.0 billion by hospital charity care and bad debts and $1.5 billion by physician charity care (Conover, 2018)." Many medical facilities recover uncompensated care losses by "cost-shifting". Cost shifting is when "higher payments by insured patients (Conover, 2018)" to cover the losses the hospital for those that receive care that no compensation is received.

Funding for Healthcare

As mentioned above, there is funding available to healthcare providers for the treatment and services that are provided to undocumented immigrants. The first source of funding that we will look at is Section 1011 of the Medicare Modernization Act. Section 1011 was enacted by congress to set aside $1 billion dollars to be used between 2005 and 2008 to allow hospitals and emergency providers such as physicians to be reimbursed for some of the expense of providing the emergency care to the undocumented immigrant (CMS, 2005). Section 1011 allotted two-thirds of funding to all 50 states and the District of Columbia. The amount allotted was based on

the "relative percentages of the total number of undocumented aliens (CMS, 2005)." The other one-third was allotted to the six states that had the highest number of undocumented immigrants. Those six states included California, Texas, Arizona, New York, Illinois and Florida (CMS, 2005). The coverage that Section 1011 would provide reimbursement for would begin with the EMTALA obligation. This obligation continues until the individual was stabilized. The Section 1011 allows for up to 2 days for the undocumented individual to be stabilized. Even though the initial funding was limited to a three-year period, states that still have fund allotment available are allowed to submit claims for payment.

Medicaid and CHIP (Children's Health Insurance Program) provide payment for emergency services for the undocumented immigrant who otherwise is eligible for Medicaid but the immigration status prevents them being eligible (Conover, 2018). Under the Medicaid program, there an undocumented immigrant can be granted emergency Medicaid coverage if they have a medical emergency or deliver a newborn. The undocumented immigrant is required to provide proof of the medical emergency exist. In the state of Kentucky, the medical records documenting the visit to the emergency room can be submitted electronically to have the application for assistance reviewed for coverage eligibility. This program typically covers women and newborns due to the fact that a pregnant woman in active labor is considered an emergency under EMTALA. It should be noted that in California, they passed a law in 2015 that uses state funding and provides healthcare coverage to all children in the state regardless of the immigration status of the child. California is the sixth state to enact this coverage (Conover, 2018).

The Affordable Care Act that was enacted by congress under the term of President Obama does not allow immigrants must here legally in order to purchase a health care plan for

healthcare service. The restrictions of coverage in the Medicaid and Affordable Care Act are impacted by work-arounds that allow for healthcare to undocumented immigrants to be indirectly federally funded. There are five different ways for undocumented immigrants to receive healthcare using federal dollars. These five are discussed below.

Medicaid DSH is a primary source for indirect federal funding. DSH of disproportionate share is funded to hospitals "that serve a large number of Medicaid and low-income uninsured patients (Conover, 2018)." The DSH program is a general subsidy that goes against the "hospital's aggregate uncompensated care losses from uninsured patients. Nothing requires hospitals to back out their spending on uncompensated care for unauthorized immigrants from their aggregate losses (Conover, 2018)." To dig a little deeper into the DSH program, we will look at the DSH program in the state of Kentucky. Any hospital in Kentucky that participates in the Kentucky Medicaid program is considered a DSH hospital. To be eligible for DSH the undocumented immigrant must be a resident of the state of Kentucky, meet income requirements and not have any type of medical coverage. This includes health insurance, Medicare, or be Medicaid eligible. If an undocumented immigrant is eligible for emergency Medicaid, they are not eligible for DSH coverage. They cannot maintain dual coverage. The state defines a Kentucky resident as "an individual residing in a foreign country who may file federal income tax returns as a nonresident citizen and who immediately prior to residing in a foreign country was domiciled in Kentucky, is presumed to be a Kentucky resident (Commonwealth of Kentucky, 2019)." The definition of domicile means the place where an individual has established permanent residency. The process of determining eligibility for DSH coverage in the state of Kentucky requires the completion of an application for Disproportionate Share Hospital Program and Medicaid/KCHIP Screening Form. This screening form is a four- page document

that requires that the undocumented immigrant provide information such as their date of birth, address, telephone number, all members of their household with age and relationship. It requires income information, employer information, countable resources such as banking information. If approved the application is valid for a six-month period. The DSH program only covers the hospital and does not include any funding for any physician related services. Once a person is deemed eligible, the hospital is required to report the eligibility to the state on a quarterly basis. Funding is distributed to the hospital on yearly basis and is pro-rated amount dependent on the number of claims submitted and the location of the facility.

There is a similar plan to Medicaid DSH that falls under Medicare DSH payments. The formula is more complicated and hospitals are paid by Medicare as a subsidy to offset uncompensated care. This form of funding does not require the hospital to make the distinction of legal or not. (Conover, 2018)

Community Health Centers or local health departments can provide primary care in aspects from healthcare, dental, mental health and pharmacy. All those that seek treatment at a community health center are treated regardless of their immigration status or source of income. (Conover, 2018)

In nonprofit hospitals, many billions of dollars are distributed annually through a federal tax exemption. There is also an employer tax exclusion that "provides an indirect federal tax subsidy to everyone with employer-sponsored health insurance (Conover, 2018)."

The community of Mayfield, Kentucky is located in far western Kentucky in the middle of the Jackson Purchase. According to the US Census Bureau (Fact Finder, 2019), Mayfield, Kentucky has a population of approximately 9936. During a US Census interview, a resident is asked to identify their household as Not-Hispanic or Latino or Hispanic. During the 2017

survey, 1396 residents in Mayfield identified as Latino or Hispanic (Fact Finder, 2019). Mayfield, Kentucky has a 107-bed medical facility, Jackson Purchase Medical Center, that operates for the surrounding Jackson Purchase area. Jackson Purchase has a very simple yet very clear mission and vision statement along with five guiding principles. They are as follows:

Making Communities Healthier

We want to create places where:

- People choose to come for healthcare
- Physicians want to practice
- Employees want to work

High Five Guiding Principles of:

- Delivering high quality patient care
- Supporting physicians
- Creating excellent workplaces for our employees
- Taking a leadership role in our communities
- Ensuring fiscal responsibility

Jackson Purchase Medical Center (Jackson, 2018) provided documentation of data that is provided to the state of Kentucky annually. The information provided was documentation was provided as a hardcopy directly from their facility. We will be looking at this data and breaking it down in Non-Hispanic and Latino or Hispanic. The data that is provided and we will discuss is published by the state as the official record of the medical facility's hospital utilization and services for the time period. The data provided by Jackson Purchase Medical is for the calendar year 2018 and is submitted to the State of Kentucky annually for statistical purposes. For this time period, the facility recorded 18,906 visits to the emergency room, 42,179 ancillary

outpatient visits, 2,354 ambulatory surgery cases, 2,462 endoscopy procedures. On the inpatient side, Jackson Purchase Medical Center, recorded 3,519 inpatient admissions that included 310 obstetrics admissions. Jackson Purchase Medical Center also has a Senior Behavioral Health Unit that recorded 274 admissions. A swing bed unit is also a service provided by Jackson Purchase Medical Center and there were 447 admissions to that unit.

Next, we will be breaking down how much of the previous data is related to Non-Hispanic or Latino. Jackson Purchase Medical Center provided documentation for this data as well. For 2018, Jackson Purchase recorded an overall number of 962 individuals treated for healthcare services listed who identified himself or herself as Hispanic or Latino with a total charge of $4,639,397.51. Of this number, 228 individuals with total charges of $1,167,910.87 were not converted to some form of funding for services and were listed and treated as self-pay. Additionally, four individuals for charges of $16,943.32 were listed as inmates in the county jail, 14 individuals with total charges of $20,433.20 were listed as county indigent or from the local health department and 10 individuals with total charges of $23,168.08 were listed as being funded by the DSH federally funded program discussed previously. The largest number is 356 individuals recorded with a total charge of $1,276,281.56 receiving services funded by Medicaid. It should be noted that, the state of Kentucky has a traditional plan coverage along with five active managed Medicaid plans to cover individuals. The remaining 350 individuals who identified themselves as Hispanic with total charges of $2,134,660.48 were listed to having coverage through a commercial payer to pay for their healthcare services. Jackson Purchase Medical Center records that of the 962 accounts identified as Hispanic, 417 individuals were treated in the emergency room for a total charge of $1,631,303.71, 37 individuals were obstetrics patients with total charge of $277,527.03 and 15 newborns for total charge of $44,871.85.

I would like to look at the emergency room visits that Jackson Purchase Medical Center has recorded with the state of Kentucky (Jackson, 2018). As stated, there were 417 individuals treated in the emergency room that identified as Hispanic. This represents less than 0.5% of the overall emergency room visits recorded for the entire year, which was 18,906 visits. It also represents less than 1% of the population of Mayfield that identified himself or herself as Not-Hispanic or Latino in the US Census survey. There were 117 individuals identified as Hispanic that were converted from self-pay to Medicaid for a total of $333,110.21. There were 156 individuals that were covered by a commercial payer for a total of $626,601.40. The remaining 144 individuals identified as Hispanic were listed as self-pay and accounted for a total charge of $671,592.81. Although the overall number of visits by those that identify as Hispanic is small, the total charge amount of $1,631,303.71 indicates that those that identify has Hispanic are extremely ill when they do seek service at the emergency room. The average emergency room visit from this number at Jackson Purchase Medical Center is $3,911. There are six different levels of emergency room level of use charges. The charge is determined on the care and services provided to the patient in the emergency room. The most commonly charged level at Jackson Purchase Medical Center is a level three charge that is $1,814.82 (Jackson, 2018). This level charge is just for the use of the emergency room and does not include any ancillary charges, medications, supplies or physician services. The level three charge is assigned a national CPT code of 99284, which is defined below per the website of Revenue Cycle Pro (2019):

> "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care

> professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do pose an immediate significant threat to life or physiologic function."

"The average cost of an emergency room visits paid in the United States is $5036 (Cost Evaluation, 2019)." With the data that Jackson Purchase Medical Center provided to me, I broke down the data for those identifying as Hispanic and self-pay in the emergency room by sex, male and female. There were 90 male individuals presented as self-pay and treated for a total charge of $464,484.48 and there were 54 female individuals presented as self-pay and treated for a total charge of $207,108.33. When the data provided by Jackson Purchase Medical Center (Jackson, 2018) is reviewed, the overall total for all payer sources who identified as Hispanic were 248 male individuals for total charges of $1,017,194.80 and 169 female individuals for total charges of $$613,449.50. The use of the emergency room for healthcare for the male Hispanic is almost doubled that of the female Hispanic individual in visits and charges. It is hard to say that the males are more ill than the females that presented for treatment. However, with the dollar amount of total charges one can assume that the male individual is more ill than the female individual when presented to the emergency room. It is most likely that the females seek healthcare at a local clinic or health department more so than men do. Jackson Purchase Medical Center has advised that they do not obtain the immigration status of any patient that presents for any health care services. The system that they use to record patient demographics is not designed to hold that information. If they were to need to begin obtaining the immigration status

of the patients they serve, their current system would need to have an upgrade to accommodate the request of immigration status of the patients.

The fear that an undocumented immigrant faces when they are in the United States illegally is apparent due to the persons waiting until they are extremely ill to seek treatment. From a personal view, in professional job duties that I encounter individuals who are undocumented immigrants. When an interview is done to obtain the necessary information for the facility to seek reimbursement and to be able to reach the patient for any follow-up care, we do encounter a hesitation from the undocumented immigrant when answering questions. In many cases, they claim they do not speak English but then cannot tell you the language they speak. There are so many variations of the Hispanic language that the facility uses a language line interpreter to assist with carrying out the conversation. Often, we are able to reassure the undocumented immigrant that the medical staff and those asking questions are only trying to help make them better and assure them that they are safe.

As we know, not all undocumented immigrants in the United States are Hispanic or Latino. The undocumented immigrants can and do come from a number of countries outside of the United States. With the data that Jackson Purchase Medical Center provided to me, I broke out those that were not identified as Hispanic, white or black. There 30 individuals who listed a race of India, Asian and Other and unknown. Jackson Purchase Medical Center explained that the unknown race is selected when the race is unable to be determined or the patient refuses to provide their race.

As mentioned, another source for healthcare for the undocumented immigrants is the local health department who receive funding from the government. The local health department provides care to anyone that presents for services regardless of their immigration status. In the

following paragraphs, we will examine data obtained from the Purchase District Health Department and the Graves County Health Department. These two health departments provide the same services to the residents of the counties they serve. These services include clinical services, immunizations, oral health, school health requirements, WIC, nutrition services, family planning, prenatal care, tuberculosis care, colon and breast cancer screening, STD/HIV testing, general health education, substance abuse education, environmental safety, public building plan review, public facility inspections and general sanitation.

We will examine the data from the Purchase District Health Department first. According to The Purchase District Health Department website (2019) their mission and vision statement are as follows:

> "The mission of the Purchase District Health Department is to provide environmental, preventive, curative, and health maintenance services to area citizens. Our primary goal is to have individuals in the Purchase adopt habits and behaviors that support a long and productive life span. This goal can be reached by direct health care, health education and counseling, and enforcement of laws that protect health and the environment."
>
> "To enable our clients to achieve their optimal functional level, we provide quality, cost effective care to all clients served regardless of their race, color, religion, age, sex, economic status, handicap status, political beliefs, or national origin. We treat all clients with dignity and respect as we strive to help them."

The Purchase District Health Department serves five surrounding counties of Mayfield and Graves County. The Purchase District Health Department reports on their website a community needs assessment. According to the assessment, the five counties they serve have a

population of 1.44% identifying as Hispanic or Latino (Purchase District Health Department, 2016). Each of the five counties listed a percentage of Hispanic or Latino in their county. There was not any data listed publicly regarding the dollar amount spent on healthcare provided or the breakdown of the types of care provided nor a breakdown of care provided by the five health departments regarding Hispanic or Latino versus non-Hispanic. According to The Purchase District Health Department statement of public funding, The Purchase District Health Department (2016) received $1,086,176 from federal funding, $1,183,985 from the State of Kentucky, $1,313,004 in local funding from tax distribution, $1,341,125 in services fees paid for healthcare services to patients and a carryover of $524,800 for a total revenue of $5,449,090. The statement of public funding shows total expenses paid for 2016 of $5,233,007, which included salaries, administrative expenses, medical supplies and capital expenses.

Another source for healthcare for the undocumented immigrant in this community is the Graves County Health Department. The Graves County Health Department serves as partner with the surrounding medical community in providing care for the members of Mayfield and Graves County Kentucky regardless of their immigration status. The mission and vision statement of the Graves County Health Department (Graves County Health Department, 2019) is:

> "Promote the lifelong physical and emotional well-being of our community through the provisions of preventative health services, health education and environmental services."
>
> "To be a healthy community where our residents can achieve optimal health in a clean environment, enjoy protection from public health threats and can access

> quality healthcare. We are committed to working together to enhance promote, and protect the health of Graves County."

With this vision statement, it is evident that the Graves County Health Department is most concerned over public health and it does not matter the immigration status of the individual who is in need of healthcare. The health department mainly serves women and children but male patients are treated if care is sought. However, males are most likely to not seek healthcare until absolutely necessary and then are most likely to seek it at the emergency room. As with the case of Jackson Purchase Medical Center, neither Purchase District Health Department nor Graves County Health Department ask for the immigration status of any patient that seeks healthcare at their centers. However, the health department is able to distinguish by race. Their primary purpose as mentioned previously is to provide care to the members of the communities that they serve. According to Graves County Health Department (2014), their statement of public funds received and disbursed, indicates that there was $$559,738.70 received in federal funding, $260,602.40 in funding from the state of Kentucky, $420,000.00 in public health tax distributions, $892.50 in donations and $733,135.13 in service fees collected from those seeking healthcare services. The statement of public funds showed total receipts of $2,770,258.77 for this time period that included $795,890.04 in cash on hand from prior year. The statement of public funds also shows a total disbursement of $1,767,689.57 for salaries, medical supplies, capital expenses, and administrative expenses. Data provided by Graves County Health Department (2019) shows from the time period July 1, 2018 to June 30, 2018, there were 7495 patients that sought healthcare services at the Graves County Health Department. The Graves County Health Department tracks patients via race and healthcare services sought. The breakdown for the above date range is as follows (2019):

White Female	3505
Black Female	254
Non-Hispanic Female	129
Hispanic Female	498
White Male	2537
Black Male	188
Non-Hispanic Male	97
Hispanic Male	287

The Non-Hispanic number consists of races of Asian, Native American Indian/Alaskan, and Hawaiian/Pacific Island races. The percentage of Hispanics that reached out to the Graves County Health Department for healthcare services is small. Of the overall total of patients seen the percentage seen as Hispanic was less than 1%. This is an indication that undocumented immigrants are still hesitant to seek healthcare even from a provider that will provide that care for little or no costs or that they are unaware of the services that are available for them to receive care.

Impact on Health Care

There are number impacts on a healthcare and the providers who provide the healthcare when providing care for undocumented immigrants. In the previous section, we looked at three providers and the cost that is associated in charges for the care that is provided to the undocumented immigrants. Although, it is not possible with the systems that the healthcare providers use and the fact that they do not currently request the immigration status we cannot determine specific cost impacts that the undocumented immigrant has on healthcare providers. In the previous section, we did a deep look into the charges that Jackson Purchase Medical Center provided to Hispanic or Latino's. The data in the previous section did not include the amount of bad debt expense that the facility encounters for providing care that is uncompensated. We are going to look at specifically data provided by Jackson Purchase Medical Center in

regards to their bad debt expense. First, what exactly is meant by bad debt expense? According to Centers for Medicare and Medicaid Services (CMS) (2019), "bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future." Some bad debts that a healthcare provider incurs can be deemed an allowable bad debt. According to CMS (2019), "allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts." According to CMS Provider Manual (2019) section 308, the criteria for allowable bad debt is as follows:

> A debt must meet these criteria to be an allowable bad debt:
>
> 1. The debt must be related to covered services and derived from deductible and coinsurances amounts.
> 2. The provider must be able to establish that reasonable collection efforts were made.
> 3. The debt was actually uncollectible when claimed worthless
> 4. Sound business judgement established that there was no likelihood of recovery at any time in the future.

According CMS (2019), a reasonable collection effort must involve the issuance of a statement of patient responsibility, follow up letters and collections letters, collection calls. Not all providers have the staffing to handle detailed collection follow-up, therefore, the use of an outside collection agency for collections is a valid source for verification of reasonable collection efforts.

As stated above allowable bad debts are those allowed on balances after a patient's healthcare insurance has paid and they have a balance they leave unpaid. The healthcare facilities are allowed to submit an annual cost report to receive some funding in return for the deeming of a balance as uncollectible. The healthcare provider will not receive direct payment for any particular patient to reduce the balance. The payment the receive is a cost report settlement and a lump sum payment is received. There is a process that the healthcare provider must follow to report any payment that does happen to be received on an account deemed uncollectible. That amount is taken away from the total bad debt that is reported as allowable. With this in mind, the healthcare facilities face a financial burden in providing uncompensated care to undocumented immigrants, as well as, those patients who are citizens of the United States but do not have personal healthcare insurance coverage. Some citizens choose to not enroll in healthcare coverage that is provided to them or simply are over income for any assistance.

Becker's Hospital Review prepared a list of the Top 10 trends that they saw in bad debt with health care providers. A summary of the Top 10 trends that they identified are listed as follows (Gooch, 2017):

1. The Affordable Care Act increased the number of Americans that were insured. Hospitals still face bad debt due to those who are uninsured not paying for services received.
2. Study shows that 55% of people surveyed stated they have received a bill they could not afford.
3. Study shows 37% could not pay for that bill if it was greater than $100 without going into debt.
4. Avoidable claim denials can account for 2% to 5% of lost revenue.

5. Most healthcare facilities write off lost revenue due to lack of payment
6. Write-offs are often reversed if a patient request financial assistance. This stops the account from being deemed uncollectible for allowable bad debt.
7. Profit facilities must now follow nonprofit guidelines in establishing written guidelines regarding financial assistance. Meaning, financial assistance is required to be established prior to any collection efforts taking place.
8. Attempts to lower bad debt expenses by implementing prepayment for services provided.
9. Attempts to uncover hidden health coverage on self-pay patients.
10. Expanded Medicaid eligibility under Affordable Care Act lowered charity care and bad debt.

We have established what a bad debt expense is and what healthcare providers do with the bad debt from uncompensated care. We will now proceed to look at the impact that healthcare provided to undocumented immigrants has on healthcare and healthcare providers. "The current cost of treating uninsured undocumented immigrants primarily at emergency rooms and free clinics, is estimated to be at $4.3 billion annually (Moore, 2013)." Along with providing the unreimbursed cost for those undocumented there was a "record high $41.1 billion in 2011 (Moore, 2013)" in care provided for all uninsured patients. As mentioned previously, it is difficult for healthcare providers to track the care that is provided to undocumented immigrants because they do not ask for the immigration status. "In California alone, where approximately 2.5 million residents are undocumented immigrants, the annual cost of unpaid hospital care is between $1 billion and $1.5 billion (Moore, 2013)." This does take into consideration all uninsured but the magnitude of the expense that is incurred by the healthcare

providers is a key indicator that there is a need for a resolution to providing uncompensated care to the undocumented immigrant as well as the uncompensated care providing to legal citizens and documented immigrants. A healthcare facility can be reimbursed as we mentioned earlier for providing uncompensated care. There is a process that the facility must follow through accounting processes and generate cost-reporting documents that can be submitted to the federal and state government indicating the number of patients that they have treated and have deemed a bad debt expense.

We are now going to take an in depth look at the data provided by Jackson Purchase Medical Center in regards to the self-pay bad debt that the facility had in 2018 and how much was related to those that presented for healthcare and identified themselves as Hispanic or Latino versus those that were not listed as Hispanic or Latino. Jackson Purchase Medical Center shared with me that a patient out of pocket expense is deemed a bad debt from day one. This means the accounting department books an estimated accrual on the likelihood of the patient out of pocket expense to be paid. According to the data provided by Jackson Purchase Medical Center (2019), the overall outstanding bad debt for 2018 that is related to emergency room patients who were identified as self-pay at the time services were rendered is 1842 patients for an outstanding total charge of $7,053,822.98 in uncompensated care provided to these patients. Of this total, 64 patients for total charges of $223,759.37 was specifically related to the healthcare services provided to patients who identified themselves as Hispanic or Latino. To breakdown this number for male versus female the numbers are as follows: The total male self-pay identified as Hispanic or Latino in the emergency room is 31 patients for total charges of $141,289.97. The total number for female self-pay identified as Hispanic or Latino in the emergency room is 33 patients for total charges of $82,469.40. These numbers are a very small percentage of care

provided to those identifying as Hispanic or Latino for emergency services where their care is not compensated in some fashion. Jackson Purchase Medical Center (2019) also provided documentation that shows that there have been 35 patients admitted to the facility for inpatient healthcare services and were not eligible for any assistance and therefore were not converted to another payer source. The total charges for these 35 patients was $824,498.07. The time period was for 2019 to date and have already been classified as a bad debt for cost reporting purposes. Of these 35 accounts, only three of these were listed as identifying themselves as Hispanic or Latino and the total charge was $88,860.05.

It was shared that many patients do take advantage of prompt pay discounts available to those who are listed as self-pay. Jackson Purchase Medical Center shared with me that they have a lucrative self-pay discount policy. The self-pay discount policy at Jackson Purchase Medical Center extends to those who are not eligible for any form or assistance an opportunity for a significant savings on their patient out of pockets. According to the self-pay policy, Appendix A, from Jackson Purchase Medical Center (2019):

> "All self-pay patients are referred to the MedAssist representative located on-site for eligibility determination for Affordable Healthcare Act. If the patient does not eligibility requirements, they are referred to a Patient Services Benefits Advisor for payment arrangements of their account balance. A deposit is required on all scheduled procedures".

According to the policy from Jackson Purchase Medical Center (2019), self-pay patients can get a discount on total charges ranging from 50% off total charges to a settlement of Medicaid rate for the facility. The current Medicaid rate that is received by Jackson Purchase Medical Center (2019) is an average of 22% of total charges. Jackson Purchase Medical Center (2019) shared

that there are five Medicaid Managed Care plans in Kentucky, Humana Caresource, Wellcare, Passport, Anthem and Aetna Better Health. Each of these managed care plans reimburses different percentages based on negotiated contracts. The 22% Medicaid rate is an average of the combined reimbursement of all five of these payers. Jackson Purchase Medical Center stated that the facility is not allowed to discount a patient's out of pocket expense to an amount greater that the negotiated Medicaid rate. The facility is required to report to the payers the amount of balances written off for prompt pay discount or general discount. There is a stipulation for the patient to receive the stated discounts listed in the self-pay policy. The payment must be paid within seven days of the patient out of pocket amount being provided to the patient. Jackson Purchase Medical Center does not charge self-pay patients a different charge for any healthcare services provided than they charge a patient with commercial insurance or a government payer. The self-pay policy was put in place to allow for a discounted amount to those patients who do not have any healthcare coverage a similar benefit to those that do pay for their insurance coverage for healthcare. The full policy is provided as an attachment at the end of the paper for further review.

Political Impact

Almost any time anyone turns on a television to any news channel, opens social media, reads the newspaper, local, regional or national levels, there is at least one story where immigration is the topic. The United States is struggling to address the issue of immigration and how to handle to number of immigrants that are entering the United States legally and illegally. As far as any political impact of the healthcare of the undocumented immigrant on politics, it is a fairly large arena. The healthcare of the undocumented immigrant is a large fraction of the

issues the United States is facing with the immigration debate and crisis that is currently being faced in our nation.

It seems that just overnight, the topic of healthcare to undocumented immigrants has "morphed from a fringe, left-wing fancy to a plant of many 2020 Democratic' presidential campaigns (Shaw, 2019)." For anyone who was witness to the Democratic primary debate that occurred on June 27, 2019, you witnessed all the candidates respond that were in support of health care plans that would include undocumented immigrants. Therefore, the Democratic party and their candidates are in support of providing health care to undocumented immigrants, how are they going to pay for it. That is the question that many are asking and the candidates will have to come up with a plan. According to Fox News (Shaw, 2019), "the Center for Immigration Studies (CIS), a policy group that advocates for lower levels of immigration overall, published a study finding that the cost could be up to $23 billion a year." According to Fox News (Shaw, 2019), the same study estimated that "4.9 million illegal immigrants have incomes below 400% of the poverty line and also do not have insurance—meaning they have incomes low enough to receive coverage via either Medicaid or the Affordable Care Act." One Democrat, Congresswoman Alexandria Ocasio-Cortez, D-N.Y. a bill titled "The Embrace Act" that allows illegal immigrants to claim the same benefits as United States citizens and those immigrants that are in the country legally. The Embrace Act is a small bill but carries a large impact. It is listed as follows (Ocasio-Cortez, 2019):

> "To provide access to Federal public benefits for aliens, without regard to the immigration status of that alien, and for other purposes.
>
> Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Section 1. Short Title.

This Act may be cited as the "A Just Society: The Embrace Act".

Section 2. Federal Public Benefit Accessibility for Aliens

(a) In General. –Notwithstanding any other provision of law (including title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (eight U.S.C. 1601 et seq.)), an individual who is an alien (without regard to the immigration status of that alien) may not be denied any Federal public benefit solely on the basis of the individual's immigration status.

(b) Definition –For the purposes of this section, the term "Federal public benefit means

(1) Any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and

(2) Any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States."

It is interesting that in previous years the Democratic Party has not supported providing full healthcare coverage to undocumented immigrants. In fact, "nine years ago, the Democratic-led Congress banned such immigrants from the Obamacare marketplaces-even if they used their own money to buy a plan (Cunningham, 2019)."

As mentioned earlier, all the current 2020 Democratic Party presidential candidates are in support of providing healthcare to the undocumented immigrant. Former Vice-President Joe Biden stated the following in the debate "you cannot let people who are sick, no matter where they come from, no matter their status, go uncovered. It's just going to be taken care of, period…it's the humane thing to do (Cunningham, 2019)." Many of the Democratic candidates for 2020 believe that since many of the undocumented immigrants already pay in social security and taxes if they hold a job, that that they should be entitled to the benefits the same as others who have paid social security and taxes. They believe that the United States is already paying for the undocumented immigrants' health care through the use of the emergency room.

"While the Republican platform is grounded in heightened concerns about border and national security…the Democratic platform focuses on increased rights and protections for the unauthorized population (Chishti & Pierce, 2016)." Every election year, each party puts together a platform at their convention. Since the 2020 election campaign is just beginning and the national conventions have not taken place, we can only look at the previous election platform. In 2016, the Republican platform had two central themes that were embraced by the nominee Donald Trump." (Chishti & Pierce, 2016). These themes of the platform was in support of building a wall along the border of the United States and Mexico and the screening of immigrants from certain countries or immigrants that had certain religious associations (Chishti & Pierce, 2016). Interestingly, the platform was "silent on enforcement measures against the estimated 11 million unauthorized immigrants (Chishti & Pierce, 2016)." The Democratic platform in 2016 "centers on expansion of rights for unauthorized immigrants living in the United States and recently arrived children and families from Central America (Chishti & Pierce, 2016)." The platform also "endorses a path to citizenship for law-abiding unauthorized

immigrants (Chishti & Pierce, 2016)." It would be expected that the platforms for both parties would not change much for the upcoming 2020 Presidential campaign. Especially with all current Democratic candidates expressing their support of providing healthcare to undocumented immigrants.

According to *The Federalist* (2019), in a poll published by Marist/NPR in July 2019, it shows that "60 percent of Democrats polled believe that free healthcare for illegal immigrants is a good idea." The people that were polled were broken down into eight groups based on their self-proclaimed political identities. According to *The Federalist*, (2019), the results are below "when asked if taxpayer-paid health care for illegally present foreign citizens is a good or bad idea:

- Registered Voters: 32 percent good/62 percent bad
- Democrats: 60 percent good/32 percent bad
- Republicans: 6 percent good/93 percent bad
- Independents: 27 percent good/67 percent bad
- Moderate Democrats: 43 percent good/47 percent bad
- Whites: 28 percent good/68 percent bad
- Non-Whites: 43 percent good/51 percent bad
- Millennials & Gen-Z: 45 percent good/51 percent bad"

The results of the poll above show how divided our parties are on providing fully paid healthcare to undocumented immigrants. However, none of the Democratic Party Presidential candidates has not shared any specific details of a particular plan other than the need for paid healthcare for undocumented immigrants. In order to provide this paid healthcare for

undocumented immigrants funds will have to come from the government and this is where the Democratic candidates are not discussing how they propose to fund this paid healthcare.

Political beliefs of individuals are "deeply rooted in one's cultural environment and are reflective of their cultural ideologies. People develop a cultural worldview as a result of both internal processes and the belief structures of the culture they are in (Haltinner & Sarathchandra, 2017)." This is saying is that your beliefs are from the environment you come from. Many people develop their beliefs from their parents. As a child you watch your parents and they teach you the way they believe in. As you grow up and develop your own thoughts and beliefs some tend to lean away from the beliefs of their family but many continue to believe as their parents did. This is the culture of how we live. As a parent, I taught my children what I knew but I always had them have an open mind on any topic and form their own opinion. In my household, we currently have three Republicans and one Democrat. Interesting to watch the culture in which we live in daily impacts our political beliefs.

The latest topic in the political arena in regards to healthcare in relation to immigration is the proclamation made by President Donald Trump on the suspension of entry of immigrants who will financially burden the United States healthcare system. This proclamation is directed at those immigrants seeking to enter the United States legally and does not impact those here illegally. However, it is directed to ensure that those seeking to enter the United States legally demonstrate their ability to pay for their healthcare costs and reduce the amount of uncompensated care that is faced by the providers in the United States. Although this new proclamation does not impact the undocumented immigrant, it does impact immigration as a whole. Many of the immigrants seeking to come to the United States legally do not have the funds available to purchase healthcare coverage. The proclamation is unclear if eligibility for

Medicaid coverage would be sufficient proof of the ability to have healthcare coverage when entering the United States.

As the Presidential election for 2020 begins to heat up, the people of the United States will be a key driving force in which way the United States handles the undocumented immigrant issues in healthcare. In 2018, Pew Research Center conducted a poll to determine the differences between those identifying as Republican and those identifying as Democrat. The poll was indicated a wide gap in how the younger and older voters viewed the midterm elections of 2018. Based on the results of the poll, one would assume that the opinions of those surveyed remain the same for the upcoming 2020 Presidential election. We will now look at the outcome of some of the results of the poll completed by Pew Research Center in 2018, which was conducted four weeks before the midterm elections in 2018. The poll indicated, "Republican and Democratic voters differ widely in views of the seriousness of numerous problems facing the United States, including the fairness of the criminal justice system, climate change, economic inequality and illegal immigration (Doherty, Kiley, & Johnson, 2018)." "Illegal immigration is the highest-ranked national problem among GOP voters, but it ranks lowest amount the 18 issues for Democratic votes (75% and 19% respectively, say it is a very big problem) (Doherty, Kiley, & Johnson, 2018)." "The new national survey by Pew Research Center, conducted Sept. 24-Oct.7 among 10,683 adults, including 8,904 registered voters, finds that majorities of GOP voters view several issues as either very big or moderately big problems facing the country (Doherty, Kiley, & Johnson, 2018)." The outcome of an election is big for both parties with both parties aiming at gaining control. In this Pew Research poll, the age gap in whether or not who controls Congress or the Office of President is quite different.

> "Only about half of the registered voters younger than 30 (48%) say partisan control of Congress really matters, the lowest percentage for any age group and nearly 40 points lower than the share of voters 65 and older (83%) saying this. Young voters also are less likely than older voters to say they know a great deal or fair amount about the candidates running in their districts and to express satisfaction with the quality of candidates (Doherty, Kiley, & Johnson, 2018)."

These results indicate to me that the younger voters possibly do not fully understand the impact of partisan controlled Congress, Senate or Office of President. It is my opinion that this is a reflection of the family dynamics and the culture that we are raised in. Many families are divided or single parent and those parents may not be as engaged in politics as their parents were. However, there was another poll by CNN (Gage, 2019), that showed that a large majority of Americans do not agree with the Democratic Presidential candidates and their views on healthcare. The poll released shows "58% of Americans oppose giving government-backed healthcare to illegal immigrants while 38% say they support giving healthcare to illegal immigrants (Gage, 2019)." The United States is in a turmoil on how things should be handled. The upcoming year and the events that will be unfolding will make for a very interesting 2020.

Ethical and Moral Responsibilities

When it comes down to it, the main question in the issue of healthcare for undocumented immigrants, is this…Do we as a nation have a moral obligation to provide such healthcare to illegal immigrants? The American Medical Association has a Code of Medical Ethics that describes the expected behavior and professional duties for healthcare providers to follow as a guide when treating patients seeking healthcare services. "In 1803, Thomas Percival, an English physician and philosopher published a Code of Medical Ethics describing professional duties and

ideal behavior relative to hospitals and other charities (Riddick, Jr. MD, 2003)." Through the years, the Code of Medical Ethics has been modified. Changes took place in 1847, 1903, 1912, 1947, 1957, 1980 and 2001. "The Code of Medical Ethics of the American Medical Association (AMA) consists of three components: 1) The Principles of Medical Ethics, 2) Ethical Opinions of the Council on Ethical and Judicial Affairs, and 3) Reports of the Council on Ethical and Judicial Affairs (Riddick, Jr. MD, 2003)." According to *The Ochsner Journal* (2003), the latest Code of Medical Ethics followed by American Medical Association (2003) is as follows:

> "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.
>
> A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
>
> 1. A physician shall uphold standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
> 2. 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.

3. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
4. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
5. A physician shall, in the provisions of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
6. A physician shall, recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
7. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
8. A physician shall support access to medical care for all people."

This Code of Medical Ethics is referred to as the Hippocrates Oath. Our healthcare providers specifically physicians are ethically bound to treat any patient regardless of the circumstances and most certainly should not have to worry whether or not the patient they are treating is in the United States legally or illegally. Their first and foremost concern is the health and well-being of the patient. To be honest, any patient seeking healthcare should want to be treated by someone who is not concerned of the status of being in the United States. According to the *American Medical Association [AMA] Journal of Ethics* (2019), "The AMA Code of Medical

Ethics outlines the role of health in the lives of all people and calls upon physicians to care for those who need it, regardless of medically irrelevant details. Opinion 11.11, "Defining Basic Health Care," defines health care as a "fundamental human good" and health as a necessary component of a full life." *The American Medical Association Journal of Ethics* (2019) reports that the American Medical Association [AMA] has developed policies on how providers of health care can best take care of any undocumented immigrant that seeks care and is not part of the Deferred Action for Childhood Arrivals (DACA) program. "The AMA policy H-440.876, "Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients, opposes "any policies, regulation or legislation that would criminalize or punish physicians and other health care providers" for providing care to undocumented immigrants and opposes proof of citizenship status as a factor in receiving health care. *The American Medical Association Journal of Ethics* (2019) continues to report that, the "AMA Policy H-160.917, "Federation Payment for Emergency Services for Undocumented Immigrants," supports the expansion of legislation providing federal funding to states for emergency services for undocumented immigrants."

In order for the healthcare providers to continue to honor the mission that they swore to uphold when they became a healthcare provider, the sanctuary doctoring approach was developed. What is sanctuary doctoring you might wonder? Below is a descriptive of sanctuary doctoring as describe by the AMA.

> "The sanctuary doctoring approach combines the emotional support of an empathetic physician-patient relationship with patient empowerment by supporting patient networking and identifying helpful actions the patient can take. Sanctuary doctoring works so the precept that health care should be a safe environment that provides support

> and resources to help patients deal with chronic stress and its sources. The materials in this toolkit—i.e., a brief lecture outlining the objectives of the intervention, a demonstration video, and templates of a patient-centered resource brochure and clinician lapel buttons—were designed by drawing on suggestions for addressing needs of undocumented immigrant patients as articulated by experts in public health, law, and advocacy and modestly adapt the principles common to public health awareness campaigns. The patient needs to feel safe enough to present for care and able to trust that the physician to harm him or her will not use what he or she says to a physician. As stress can take a significant toll on a patient's health and well-being, physician can and often do become skilled at addressing common sources of stress among their patients (*American Medical Association [AMA], Journal of Ethics*, 2019)."

We just looked at the role that the healthcare provider plays in their responsibility to provide ethically and morally correct healthcare services to undocumented immigrants.

At this point, we are going to look at how Christians think about undocumented immigrants and their entrance into the United States. Specifically, we will be looking at the United States Conference of Catholic Bishops opinion and recommendations. "The Catholic Catechism instructs the faithful that good government has two duties, both of which must be carried out and neither of which can be ignored (Catholic Church's Position on Immigration Reform, 2013)." The two duties the Catholic Catechism instructs are:

> "To welcome the foreigner out of charity and respect for the human person. Persons have the right to immigrate and thus government must accommodate this right to the greatest extent possible, especially financially blessed nations: "The more prosperous nations are obliged, to the extent they are able, to welcome the foreigner in search of the

> security and he means of livelihood which he cannot find in his country of origin. Public authorities should see to it that the natural right is respected that places a guest under the protection of those who receive him." Catholic Catechism, 2241 (Catholic Church's Position on Immigration Reform, 2013)."
>
> "The second duty is to secure one's border and enforce the law for the sake of the common good. Sovereign nations have the right to enforce their laws and all persons must respect the legitimate exercise of this right: "Political authorities, for the sake of the common good for which they are responsible may make the exercise of the right to immigrate subject to various juridical conditions, especially with regard to the immigrants' duties toward their country of adoption. Immigrants are obliged to respect with gratitude the material and spiritual heritage of the country that receives them, to obey its laws and to assist in carrying civic burdens. Catholic Catechism, 2241 (Catholic Church's Position on Immigration Reform, 2013)."

Academic health center (AHCs) are the leaders in providing healthcare to minority, underserved individuals of the United States. They typically are the leaders in providing care of the undocumented immigrant as well. The University of New Mexico Hospital worked with researchers on how to respond to the challenges and barriers they face in providing the care to this population of individuals. There are three recommendations that have come out of the research they performed. They believe that these recommendations will bring together the social missions and professional ethics. The three recommendations are

> "(1) that AHCs determine eligibility for financial assistance based on residency rather than citizenship, (2) that models of medical education and health professions training provided students with service-learning opportunities and applied community experience,

and (3) that frontline staff and health care professionals receive standardized training on eligibility policies to minimize discrimination towards immigrant patients (Cacari Stone, PhD., Steimel, MPH, Vasquez-Guzman, MA, & Kaufman, MD, 2014)."

As we have established, it is ethically and morally correct to take care of any person in the United States regardless of the status of their citizenship. The Catholic Church has established that we need to put the human factor into consideration and not immediately look at whether someone is documented or undocumented. As humans, we have the responsibility to take care of each other. Healthcare should be provided to anyone of any status, color, race or financial status if they seek it. We should all follow the Hippocrates Oath that healthcare providers are required to honor. Does this mean it should be provided free and no cost, that is and will be the continue subject of this immigration reform we are under. However, someone should not live in fear of being arrested if they seek healthcare just because they are undocumented.

Lessons Learned/Recommendations

Throughout the research that I have done on the topic of undocumented immigrants and healthcare, there is one thing for certain and that is the United States is clearly divided on how the crisis surrounding immigration should be handled. Many of the undocumented immigrants need healthcare but we as a country have instilled so much fear that they refuse to seek any healthcare unless it is in an extreme emergency. The fear of the unknown is scary to the undocumented immigrant. I have learned that some healthcare providers do in fact notify ICE if they suspect a person seeking healthcare is undocumented.

The United States Conference of Catholic Bishops does oppose an enforcement only policy but does support a comprehensive immigration reform. The United States Catholic

Bishops have developed proposals that they believe will help build comprehensive immigration reform. The proposals made by the United States Conference of Catholic Bishops (2013) are listed below:

> "Earned legalization: An earned legalization program would allow foreign nationals of good moral charger who are living in the United States to apply to adjust their status to obtain lawful permanent residence. Such a program would create an eventual path to citizenship, requiring applicants to complete and pass background checks, pay a fine, and establish eligibility for resident status to participate in the program. Such a program would help stabilize the workforce, promote family unity, and bring a large population "out of the shadows," as members of their communities.
>
> Future Worker Program: A worker program to permit foreign-born workers to enter the country safely and legally would help reduce illegal immigration and the loss of life in the American desert. Any program should include workplace protections, living wage levels, safeguards against the displacement of U.S. workers, and family unity.
>
> Family-based Immigration Reform: It currently takes years for family members to be reunited through the family-based legal immigration system. This leads to family breakdown and, in some cases, illegal immigration. Changes in family-based immigration should be made to increase the number of family visas available and reduce family reunification waiting times.
>
> Restoration of Due Process Rights: Due process rights taken away by the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) should be restored (Catholic Church's Position on Immigration Reform, 2013)."

As a healthcare worker in healthcare for the past thirty years, I have been a witness to a large number of immigrant workers that needed healthcare. Some have been seriously ill and some seeking care for minor needs. I have witnessed patients hesitate to answer questions when we are trying to obtain emergency Medicaid funding for their care. We have had to do lots of explaining to them that we are trying to help them. It works the majority of the time; however, I have seen patients sign out against medical advice and even though they do not indicate the reason, I am quite certain it was fear of being reported to the government.

As a member of the healthcare workforce, I have experience working with the undocumented immigrants is that we need to ensure that they have a safe place to seek healthcare without fear. I think there should be more community clinics provided to them. A mobile healthcare clinic would be an excellent tool to provide to the community, go to their neighborhoods, and offer free screenings to attempt to prevent diseases that are more serious. The language barrier has been established as one reason for not seeking healthcare. Seek volunteers from local school districts who are bilingual that can assist the mobile healthcare clinic. This will help to make the undocumented immigrant feel more comfortable. Provide notices of clinic setup and times at the local school system and even the local health department. The country needs to come together and look beyond a status in providing healthcare. Most of the undocumented immigrants do not want it free; they are willing to pay so setting up a sliding fee schedule for simple screenings would be fair. Yes, the money to provide a mobile clinic and the screenings would need to come from somewhere. Communities can do fundraisers and even join in with a local healthcare provider such as a doctor or hospital that is willing to provide equipment to assist. Many doctors and hospital employees are willing to donate their time to help make someone feel better.

Conclusion

Immigration status is going to be in front and center in the upcoming 2020 Presidential election. It is important that during all of this that the fact that these are human beings not be forgotten. Yes, we have a broken system that needs to be fixed. No building of a wall is going to resolve this issue. This is not going to be an overnight resolution to the problem. Healthcare providers are spending millions of dollars to care for the undocumented immigrant without much reimbursement. Yes, there are ways they get some reimbursement back for the care they provided but it does not even begin to cover the expenses it incurs to provide that care. Salaries of clinical staff and paying for the most up to date equipment takes its toll on facilities. The facilities that offer the services cannot sustain providing care with little or no reimbursement for long term. However, even with this expense to the providers, how can us as Americans, who came to this country hundreds of years ago as immigrants ourselves, deny those that come here in the 21st century basic healthcare needs. The United States government needs to forget party lines and think of the humanitarian side of the issue. Working together as a team will always produce a winning outcome. I have to wonder how the undocumented immigrants feel. This is supposed to be the country of plenty but we refuse to help them. I cannot imagine being sick and not being able to get the care I needed. These people live this way every day of their life. The resources are available if we so choose to really solve this problem. There is not a quick fix to this issue. Doing something quickly can cost more in the end. However, temporary assistance can and should be developed to roll out within the next 12 months. There should be a limit on what temporary assistance will cover. The undocumented immigrant should not be allowed to have any procedures or testing done that are not life threatening unless they pay for them in full following any healthcare facilities self-pay policy guidelines. Basic healthcare is

things such as blood pressure checks, glucose testing, flu shots and other immunizations, complete blood count (CBC), vision exam and dental exam. I think the government could come to some conclusion to find a way to fund these basic life services. I cannot say it enough, the undocumented immigrants are humans and we must remember this. God created all of us in his likeness. We are all brothers and sisters, regardless of our skin color or citizenship. Do you not want your family taken care of?

Appendix A

Current Status: *Active* Policy Stat ID: *6314655*

Jackson Purchase Medical Center

Origination:	*09/2000*
Effective:	*04/2019*
Approved:	*04/2019*
Last Revised:	*04/2019*
Next Review:	*04/2022*
Owner:	*Anita Gipson: Business Office Director*
Policy Area:	*Registration*
References:	
Applicability:	*Jackson Purchase Medical Center*

Self-pay Accounts

PURPOSE:

The hospital identifies self-pay patients and advises them of options available to them for payment of services.

PROCEDURE:

All self-pay patients are referred to the Medassist representative located on-site for eligibility determination for the Affordable Healthcare Act. If the patient does not meet eligibility requirements, they are referred to a Patient Services Benefits Advisor for payment arrangements of their account balance. A deposit is required on all scheduled procedures (when patients do not qualify for Affordable Healthcare Act). All patients are provided an estimated charges worksheet at the time of service.

Bariatric and cosmetic procedures are to paid at 100% prior to date of service.

Self-pay Outpatient Patients are eligible for discounted balances as follows:

- 50% of total charges if balance is paid at the time of service or within 7 days of date of service.
- 30% of total charges if balances paid >7 days of date of service.

Self-pay Inpatient Patients are eligible for discounted balances as follows:

- Medicaid DRG rate if paid within 7 days of discharge date.
- If >7 days from discharge date 50% of total charges.

Self-pay Same Day Surgery Patients are eligible for discounted balances as follows:

- Current Medicaid rate if paid at the time of service or within 7 days of date of service.
- 50% of total charges if paid >7 days of date of service

Arrangements for the remaining balance due can be made with the following payment options:

1. **Payment arrangements interest free through two flexible options:**
    - Account balances payable in twelve months or less with a valid credit/debit card.
    - Account balances payable greater than twelve months based upon propensity to pay score from Change Healthcare. Accounts will be placed with CarePayment for account maintenance.

If a self-pay patient is unable to make the required deposit on a scheduled procedure, the procedure is to be rescheduled until the deposit can be made. Exceptions can be made on a case-by-base basis by the Patient Financial Services Director, Chief Financial Officer or Chief Executive Officer.

If a procedure is an 'Emergency'or is due to a 'life-threatening' or 'terminal' diagnosis, no deposit is required.

Self pay obstetric patients are eligible for discounts as follows:

- **2 day normal vaginal delivery will be settled as follows:**
    - $2000 if paid within 7 days of the day from discharge.
    - $2500 if paid >7 days but prior to 30 days from discharge.
    - 30% discount off total charges if paid > 30 days from day of discharge.
- **C-Section will be settled as follows:**
    - $5000 if paid within 7 days of the day from discharge.
    - $6000 if paid >7 days but prior to 30 days from day of discharge.
    - 30% discount off total charges if paid >30 days from day of discharge.
- Both settlements above include for a well baby. However, if the mother stays longer than two days the patient will be responsible for any charges beyond two days and will be entitled to the normal self pay discounts mentioned above. If the baby has complications or stays longer than the mother, the responsible party is responsible for any charges above a well baby or days beyond the mothers discharge. Normal self pay discounts will apply on the additional charges.

Attachments:

Approval Signatures

Step Description	Approver	Date
	Anita Gipson: Business Office Director	04/2019

⊞ Older Version Approval Signatures

Applicability

Jackson Purchase Medical Center

Appendix B

Current Status: *Active* Policy Stat ID: 6022557

LIFEPOINT HEALTH

Origination:	11/10/2003
Effective:	5/31/2015
Approved:	5/30/2015
Review:	5/29/2020
Editor:	Scott Richardson: Associate General Counsel
Policy Area:	Legal
Applicability:	LifePoint Health

LL.026 EMTALA – Medical Screening and Treatment of Emergency Medical Conditions

SCOPE:

All Company-affiliated facilities including Hospitals and any entities operating under the Hospital's Medicare Provider Number including, but not limited to, the following:

All Clinical Departments
Administration
Ancillary Services
Quality Management
Admitting/Registration
Risk Management
Employed Physicians
Emergency Department
Hospital owned Medical Office Buildings
Urgent Care Centers/Clinics
Hospital owned emergency vehicles
Ambulatory Care Facilities
Nursing Finance
Hospital Department (on and off campus)
Hospital Based Entity (on campus)

PURPOSE:

To ensure that individuals coming to an affiliated Hospital's Dedicated Emergency Department seeking assessment or treatment for a medical condition, or coming to Hospital Property requesting (or obviously requiring) treatment for an Emergency Medical Condition receive an appropriate Medical Screening Examination as required by the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C., Section 1395 and all Federal regulations and interpretive guidelines promulgated thereunder; and, if an Emergency Medical Condition is determined to exist, such individuals are offered stabilizing treatment within the Hospital's capabilities and/or are transferred if appropriate, all without regard to the patient's insurance coverage or ability to pay.

DEFINITIONS:

A. **Appropriate transfer** occurs (once a physician has certified the need for transfer or the patient has requested transfer after an explanation of the risks and the Hospital's obligation to provide stabilizing services) when:

1. the transferring Hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and in the case of a woman in labor, the health of the unborn child;
2. the receiving facility has the available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment;
3. the transferring Hospital sends to the receiving Hospital all medical records (or copies thereof) related to the Emergency Medical Condition for which the individual has presented, available at the time of transfer, including records related to the individual's Emergency Medical Condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of diagnostic studies or telephone reports of the studies, and the informed written consent or certification required, name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment, and that any other records that are not readily available at the time of transfer are sent as soon as practicable after the transfer; and
4. the transfer is effected through qualified personnel, transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

B. **Campus** means the physical area immediately adjacent to the main Hospital, other areas and structures that are not strictly contiguous to the main Hospital buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the main Hospital's campus. (Campus does not include physician locations separately certified to participate in Medicare, or operated by entities other than the hospital, (e.g. café or restaurant). (Test)

C. **Capabilities** of a Hospital provider means the physical space, equipment, supplies and services (e.g., trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit or psychiatry), including ancillary services, available to Hospital patients. The capabilities of the Hospital's staff mean the level of care that the Hospital's personnel can provide within the training and scope of their professional licenses. For off-campus departments, the capability of the Hospital as a whole is included.

D. **Capacity** means the ability of the Hospital to accommodate the individual requesting examination or treatment of the transferred individual when the individual needs to receive the emergency treatment. Capacity encompasses number and availability of qualified staff, beds, equipment and consideration of the Hospital's past practices of accommodating additional patients in excess of its occupancy limits. For example, a hospital may have capacity to provide orthopedic services, but may lack capacity to provide such services on an emergency basis, if there is no orthopedist on call on a specific day.

E. **Central Log** is a log that a Hospital is required to maintain on each individual who comes to its emergency department or any location on the Hospital Property or Premises seeking assistance and that contains the disposition of each individual, whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged. he purpose of the central log is to provide a listing of each individual who comes to the Dedicated Emergency Department seeking examination or treatment for a medical condition, or who comes to the Hospital Property or Premises seeking care for an Emergency Medical Condition. The central log includes, directly or by reference, patient logs from other areas of the Hospital, such as labor and delivery, which may also be Dedicated Emergency Departments where a patient might present for behavioral health or emergency services or receive a Medical Screening Examination instead of in the traditional emergency department. The requirements for the Central Log are described in more detail in LL.029 EMTALA – Central Log.

F. **Dedicated Emergency Department:** A department of the Hospital, that can be either on or off the campus, which meets one or more of the following conditions:

1. Licensed by that state as an emergency department;
2. Held out to the public as providing care for emergency medical condition(s) on an urgent basis without an appointment; or
3. An outpatient treatment location which, in the last calendar year, provided at least one-third of all outpatient visits (based on random sample) for the treatment of Emergency Medical Conditions without requiring a previously scheduled appointment.
Note that a Hospital may have more than one location that satisfies the definition of "Dedicated Emergency Department."

G. **Department of Hospital** means a division of the Hospital through which the Hospital furnishes health care services of the same type as those furnished by the Hospital under the name, ownership, provider certification, and financial and administrative control of the Hospital, whether on or off campus. A department of a Hospital may not be licensed to provide health care services in its own right and may not by itself be qualified to participate in Medicare as a provider. The Medicare Conditions of Participation do not apply to a department as an independent entity but apply to the department as a part of the Hospital.

H. **Emergency Medical Treatment and Labor Act ("EMTALA")** refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, which obligates Hospitals to provide medical screening, treatment and transfer of individuals with Emergency Medical Conditions or women in labor. It is also referred to as the "anti-dumping" statute and COBRA.

I. **Emergency Medical Condition** means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
   b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

J. **Hospital** means a main hospital provider that has entered into a Medicare Provider Agreement, including a critical access or rural primary care hospital. For the purpose of these policies, hospital refers to the main building in which the emergency department is located.

K. **Hospital Property or Premises** means the entire Hospital campus, including the parking lot, sidewalk, driveway, and hospital departments in MOBs on campus, as well as any facility or organization that is located off the Hospital campus but satisfies the definition of Dedicated Emergency Department. Hospital Property or Premises excludes those locations on the campus that are either operated under a Medicare provider number that is different than the Hospital's, or that are not under the control of the Hospital, whether such location is used for medical or non-medical purposes (such as private medical offices, gift shops not operated by the Hospital, cafes, restaurants).

L. **Medical Screening Examination** is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an Emergency Medical Condition exists or a woman is in labor. Such screening must be done within the facility's capability and available personnel, including on-call physicians. The Medical Screening Examination must be performed by a Physician or other Qualified Medical Personnel. The Medical Screening Examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and must continue until the patient is either stabilized or appropriately transferred. Triage does not constitute a Medical Screening Examination.

M. **Movement from Off-Campus Department** means the movement of a patient from an off-campus department to the main Hospital campus. Movement of the individual from the off-campus department to the main Hospital campus is not considered a transfer.

N. **On-Call List** refers to the list that the Hospital is required to maintain which identifies those physicians who are "on-call", directly or by arrangement, to assist the emergency department physician or Qualified Medical Professional in the care of the patient after the initial Medical Screening Examination, to provide further evaluation and/or treatment necessary to stabilize an individual with an Emergency Medical Condition. The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists, directly or by arrangement, are available to provide treatment necessary to stabilize individuals with Emergency Medical Conditions. Additional requirements regarding the On-Call List are contained in Policy LL.031 (EMTALA – Provision of On-Call Coverage).

O. **Physician** means: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his/her license; (iii) a doctor of podiatric medicine to the extent that he/she is legally authorized to perform by the State within the scope of his/her license; or (iv) a doctor of optometry to the extent that he/she is legally authorized to perform by the State within the scope of his/her license.

P. **Physician Certification** refers to the pre-transfer written certification by the physician ordering the transfer, that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual with an unstabilized emergency medical condition and, in the case of a woman in labor, to the unborn child, from effecting the transfer. The certification shall include a summary of the specific risks and benefits upon which the certification is based and the reason(s) for the transfer. If a physician is not physically present at the time of transfer, a Qualified Medical Professional can sign the certification as long as the Qualified Medical Professional is in consultation with the transferring physician and the physician is in agreement with the certification and subsequently countersigns the certification.

Q. **Prudent Layperson** describes any non-medically trained but reasonably attentive observer.

R. **Qualified Medical Person or Personnel,** means an individual other than a licensed physician who has demonstrated current competence in the performance of Medical Screening Examinations and been approved by the main Hospital provider's governing board as qualified to administer one or more types of Medical Screening Examination and complete/sign a certification for transfer in consultation with a physician. The categories of non-physician practitioners who may be designated as Qualified Medical Professionals is set forth in Medical Staff Bylaws or Rules and Regulations in accordance with State law (i.e., scope of practice) and approved by the governing body of the Hospital. Ad hoc Qualified Medical Professional designations of other categories of non-physician practitioners are not permissible.

S. **Signage** refers to the Hospital requirement to post signs conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department, (e.g., outpatient departments, on campus Hospital based entities, labor and delivery, waiting room, admitting area, entrance and treatment areas), informing the patients of their rights under Federal law with respect to examination and treatment for Emergency Medical Conditions and women in labor. The sign must also state whether or not the Hospital participates in the State's Medicaid program. Specific Signage requirements are described in Policy LL.028 (EMTALA-Signage).

T. **Stabilized** with respect to an Emergency Medical Condition means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from the facility or in the case of a woman in labor, that the woman delivered the child and the placenta. A patient will be deemed stabilized if the treating physician of the individual with an Emergency Medical Condition has determined, within reasonable clinical confidence, that the Emergency Medical Condition has been resolved.

U. **To Stabilize** means, with respect to an Emergency Medical Condition to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or, in the case of a woman in labor, that the woman has delivered the child and the placenta.

V. **Stable for Discharge:** A patient is considered stable for discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. For the purpose of discharging a patients with psychiatric condition(s), the patient is considered to be stable for discharge when they are no longer considered to be an imminent threat to themselves or others. Also, a psychiatric patient is considered stable when they are protected and prevented from injuring or harming themselves or others. The use of restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate Emergency Medical Condition but the underlying medical condition may persist and if not treated for the patient may experience exacerbation of the Emergency Medical Condition. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after initiating restraints.

W. **Transfer** means the movement of an individual outside a Hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an individual who has been declared dead or who leaves the facility against medical advice or without being seen.

X. **Triage** is a sorting process to determine the order in which patients will be provided a Medical Screening Examination by a physician or qualified medical person. Triage is not the equivalent of a Medical Screening Examination and does not determine the presence or absence of an Emergency Medical Condition.

Policy:

Any individual who comes to the Hospital Property or Premises requesting examination or treatment is entitled to and shall be provided an appropriate Medical Screening Examination performed by a physician or other Qualified Medical Personnel to determine whether or not an Emergency Medical Condition exists.

If an Emergency Medical Condition is found to exist, the Hospital will (without regard for the patient's insurance coverage or ability to pay) provide: (a) stabilizing treatment within the capabilities of the Hospital and its staff (including on-call physicians and diagnostic services), and/or (b) an appropriate transfer to another medical facility (if required for the patient's treatment or requested by the patient).

Some states have separate emergency services laws or transfer requirements that may apply additional legal requirements to the Medical Screening Examination, diagnostic testing, stabilizing medical treatment, or transfers. Affiliated Hospitals should consult with Operations Counsel to identify and comply with any such requirements in addition to EMTALA.

Facility Policies

Each Hospital that provides emergency medical services must develop policies and procedures to insure compliance with EMTALA requirements. Such policies should contain the following provisions:

A. **General Requirements: Registration, Triage, and Medical Screening Examination.**

1. **Registration and Log**
   Each such presenting individual must be listed in the Central Log described in more detail in Policy LL.029 (EMTALA – Central Log). The Medical Screening Examination may not be delayed in order to secure the individual's insurance information or payment arrangements. Hospitals should request this information only after the Medical Screening Examination has begun.
   a. Insurance and payment information obtained from the patient shall not be used to communicate with insurance companies or to initiate discussions with the patient regarding copays, deductibles, or costs of the visit. Should a patient refuse to provide insurance and payment information, no further requests should be made until the Medical Screening Examination is completed.
   b. Patients who inquire about financial responsibility for emergency care will be encouraged to delay such discussion until after the Medical Screening Examination has begun. These patients should also be told that the Hospital will provide an Medical Screening Examination and stabilizing treatment, regardless of the patient's ability to pay.
   c. Hospitals are prohibited from seeking prior authorization for the screening or stabilizing services from the individual's insurer or managed care organization prior to the completion of the Medical Screening Examination and if applicable, initiation of stabilizing treatment. Each Hospital should ensure that it uses a reasonable registration process that does not delay screening or treatment and does not unduly discourage individuals from remaining for further evaluation.
2. **Triage**
   The Hospital should utilize the Triage Process described in CO. 008 (Triage Policy) to determine the order in which patients receive an Medical Screening Examination and further treatment as necessary. Triage does not determine the presence or absence of an Emergency Medical Condition.
3. **Medical Screening Examination**
   In general, when an individual (who is not a Hospital inpatient or a registered outpatient in the course of an appointment)
   - comes to a Dedicated Emergency Department and requests assessment or treatment for a medical condition (whether or not the individual believes it to be an emergency), or the request is made on the individual's behalf; or
   - presents to a location on the Hospital Property other than the Dedicated Emergency Department and a requests examination or treatment of an Emergency Medical Condition (or such request is made on the individual's behalf), or a Prudent Layperson would recognize that the individual needs emergency assistance

   The Hospital must provide for an appropriate Medical Screening Examination conducted by a physician or other Qualified Medical Professional, including to the extent necessary ancillary services within the Hospital's capabilities and on-call physician services, to determine whether or not an Emergency Medical Condition exists (or with respect to a pregnant woman having contractions, whether the woman is in labor).

   Provision of the Medical Screening Examination is required regardless of the Hospital's size or payor mix. Hospitals shall not discriminate against any individual seeking such services because of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, color, national origin, or handicap. A Medical Screening Examination is required each time a patient presents to the DED (or elsewhere on Hospital Property as described above).

   Depending on the patient's presenting symptoms, the Medical Screening Examination may range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.

   A Medical Screening Examination is not an isolated event. It is an on-going process. The record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation documented in the medical record prior to discharge or transfer. Emergency department physicians and Qualified Medical Professionals may consult with the patient's primary care physician or other physician who is treating the patient for information and guidance so long as the Medical Screening Examination is not delayed while awaiting physician response.

   A. **Location of Medical Screening Examination**
      The Hospital may move the patient to other Hospital-owned facilities that are on-campus or contiguous to the Hospital in order to access appropriate services as part of the Medical Screening Examination or subsequent stabilizing treatment. For example, pregnant women may be directed to the labor and delivery area of the Hospital (whether or not that area constitutes a Dedicated Emergency Department). The Hospital may deliver emergency services in areas of the Hospital that are also used for other inpatient or outpatient services. However, movement of the patient to other Hospital-owned facilities on the campus or contiguous to the campus during the Medical Screening Examination process may only occur when these three conditions are satisfied:
      - All persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
      - There is a bona fide medical reason to move the patient, and
      - Hospital personnel accompany the patient.

      Such movement does not constitute a transfer. Patients should not be moved to off-campus departments of the Hospital in the course of the Medical Screening Examination. Note that it is not appropriate to move a patient to a physician office, even if on campus, for completion of the Medical Screening Examination or stabilizing treatment.

   B. **Who May Perform Medical Screening Exam** A Medical Screening Examination may be performed by an emergency department physician, another physician, or a non-physician practitioner who is qualified to conduct such examination ("Qualified Medical Personnel" or "QMP") and approved by the Hospital's governing board.
      - Medical Screening Examinations must be performed by an emergency department physician, another physician or a non-physician practitioner who is qualified to conduct such examination.
      - A qualified medical person may conduct the Medical Screening Examination provided the individual is:
        i. determined qualified by Hospital medical staff bylaws, rules and regulations which are approved by the Hospital's governing body, and
        ii. functioning within the scope of his or her license and in compliance with State law and applicable State nurse and medical practice acts.
      - A Medical Screening Examination may be performed by an emergency department physician, another physician, or a non-physician practitioner who is qualified to conduct such examination ("Qualified Medical Personnel") and approved by the Hospital's governing board:
      - When non-physician personnel perform Medical Screening Examinations, the appropriate committees should approve specific screening protocols that outline the examination and/or diagnostic work-up required to determine if an Emergency Medical Condition exists. These protocols will normally be complaint specific and will be limited to those presenting complaints that lend themselves to screening by such non-physician personnel.
      - The competencies for any non-physician personnel performing Medical Screening Examinations should be documented. There should also be an education plan for measuring and developing core competencies in medical screening.
      - Hospitals must establish a process to ensure that an emergency department physician examines all patients whose conditions or symptoms require physician examination.
      - Hospitals must establish processes to ensure that 1) an emergency department physician on duty is responsible for the general care of all patients presenting themselves to the emergency department; and 2) the responsibility remains with the emergency department physician until the patient's private physician or an on-call specialist assumes that responsibility, or the patient is discharged.

B. **Results of Medical Screening Examination; Additional Obligations; Stabilizing Treatment.**

1. **Results of Medical Screening Examination and Next Steps**
   In general, if the physician or other Qualified Medical Professional performing the Medical Screening Examination determines that the individual does **not** have an Emergency Medical Condition, then the Hospital's EMTALA obligations to that individual cease. The Hospital may proceed to collect financial information and make financial arrangements for treatment.

   If the Medical Screening Examination reveals an Emergency Medical Condition, then the Hospital must provide stabilizing treatment within its capacity and capabilities (including on-call physician services and ancillary services) necessary to stabilize the patient or must appropriately transfer the patient to another facility. Admission as an inpatient may be required as part of the stabilizing treatment. Once a patient is admitted as an inpatient in good faith, EMTALA is satisfied; however, the Hospital continues to have responsibility to meet patient emergency needs in accordance with the Medicare Conditions of Participation.

   The Hospital may not condition or appear to condition the provision of stabilizing treatment on the patient's ability to pay. A patient should not be asked for payment until the patient has received the Medical Screening Examination and stabilizing treatment has been initiated. For patients with no Emergency Medical Condition or patients who are stabilized in the ED, payment is requested as part of the check out process when they are discharged. Fo patients who are admitted, payment is handled based on the Hospital's usual procedures regarding inpatients, if the patient is being admitted.
2. **Transfer Requirements**
   If the Medical Screening Examination reveals an Emergency Medical Condition, the patient may only be transferred while the condition has not been stabilized if: (a) the physician has certified that the medical benefits to be received at another Hospital outweigh the increased risks to the individual (and, as the case may be, to her unborn child) or (b) the patient, or a legally responsible person acting on the patient's behalf, requests the transfer, after being informed of the Hospital's obligations under EMTALA and of the risks and benefits of the transfer, among other requirements. Patients should not generally be transferred to a lower level of care (for example, patients should never be transferred to a physician office unless the office has specialized equipment which is generally limited to ophthalmologists).

   For a complete description of transfer requirements, please see Policy CO.003 (EMTALA – Transfers).

C. **Special Circumstances: Ambulances.**

1. A Hospital-owned ambulance is considered "Hospital Property" regardless of its location for purposes of determining whether an individual present on Hospital Property requests emergency medical treatment (or such a request is implied).
2. An individual being transported by ambulance (other than an ambulance owned or operated by the Hospital) is not considered to have arrived requesting treatment until they reach the Hospital Property, even if the ambulance personnel are in electronic or telephonic with emergency department personnel.
3. A Hospital may communicate with ambulance staff or EMS that it is unable to accept patients in the ED because it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time or lacks the capability or capacity to provide specific care needed as a patient (e.g. Cath lab is unavailable). However, if an ambulance disregards the Hospital's instructions regarding diversion and brings the individual to the Hospital, the individual has come to the Hospital, and the Hospital's EMTALA duties are triggered.
4. When helicopters and ambulances not owned by the Hospital enter Hospital grounds for the sole purpose of conveying a patient to another vehicle for transport to another Hospital, EMTALA obligations are not triggered unless the ambulance or helicopter crew requests assistance with the management of a patient. If such assistance is requested, the Hospital must meet all EMTALA obligations to the patient for whom assistance was requested.

D. **Special Circumstances: Withdrawal of Request for Examination.**

1. If a patient withdraws his or her request for examination or treatment, an appropriately trained individual from the emergency department staff should discuss the medical issues related to a voluntary withdrawal. In the discussion, the emergency department staff member should:
   a. Offer the patient further medical examination and treatment as may be required to identify and stabilize and/or Emergency Medical Condition;
   b. Inform the patient of the benefits or the examination and/or treatment, and of the risks of withdrawal prior to receiving the examination and/or treatment; and
   c. Use reasonable efforts to get the patient to sign a form indicating that the patient has refused the recommended examination and/or treatment. The form should contain a description of risks discussed and of the examination and/or treatment that was refused.
2. If a patient leaves the Hospital without notifying Hospital personnel, this should be documented. The documentation must reflect that the patient had been at the Hospital and the time the patient was discovered to have left the premises. Triage notes and additional records must be retained. The patient should still be included in the Central Log, with documentation that the patient left without notification.

E. **Special Circumstances: When MSE Is Not Required**

1. No Medical Screening Examination is required if a patient presents to the DED and requests **solely** one of the following preventative services: immunizations, allergy shots, or flu shots. However, Hospitals should be cautious of this exception as it must be clear to all involved the precise nature of what is being requested.
2. No Medical Screening Examination is required if law enforcement brings an individual requesting only a blood alcohol test and no other requests are made or implied. Hospitals should be cautious as a request for clearance for incarceration would require a Medical Screening Examination, as would a patient for whom law enforcement was requesting only a blood alcohol test but it would be apparent to a prudent layperson that the individual has sustained injuries or been involved in an accident such that they should be examined for the presence of an Emergency Medical Condition (must provide such patient with a Medical Screening Examination).
3. Off-campus facilities that do not meet the definition of Dedicated Emergency Departments must have written policies and procedures for appraisal of emergencies and provision of initial treatment and referral in accordance with the Medicare Conditions of Participation. EMTALA does not apply in such situations.

REFERENCES:

Social Security Act, Section 1867 (42 USC §1395dd) Examination and Treatment for Emergency Medical Conditions and Women in Labor

CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

42 CFR Part 482 Conditions of Participation for Hospitals

42 CFR 489.20 Basic Commitments

42 CFR 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases

The following Legal Department EMTALA policies and procedures:

EMTALA - Transfer Policy

EMTALA - Signage Policy

EMTALA - Central Log Policy

EMTALA - Duty to Accept Policy

EMTALA - Provision of On-Call Coverage Policy

CO.008 Triage Policy

Attachments:

Approval Signatures

Step Description	Approver	Date
Compliance Committee	Paula Swanson: Director, Compliance Education_Clinical Informatic	09/2018
Policy Committee	Paula Swanson: Director, Compliance Education_Clinical Informatic	09/2018

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