July 8, 2010

Honorable Senator Thomas K. Duane
Chair, Senate Health Committee
Room 430
State Capitol Building
Albany, NY 12247

Re: Senate Bill S7429: Establishes the Transition Authorization Panel Demonstration Program

Dear Senator Duane:

The New York Immigration Coalition (NYIC) and the New York Lawyers for the Public Interest (NYLPI) request that you take into consideration our concerns, discussed below, with regard to Senate Bill S7429 (Assembly Bill A8647-B Canestrari). The proposed legislation creates a transfer authorization panel demonstration program to initiate and facilitate the transfer of “medically ready” patients, who lack the requisite capacity to consent to such a transfer, from participating hospitals to post-acute care facilities.

Our interest in the proposed legislation arises from our work as co-conveners of a statewide workgroup on “medical deportation,” a practice in which hospitals send indigent non-citizen patients, usually those in need of long-term care, back to their countries of origin for health services outside of the federal immigration process. We have learned that many hospitals in New York engage in this form of international patient dumping, and we are concerned about the impact S7249 may have on medical deportation practices. Although the proposed legislation purports to serve the best interests of eligible patients and the public at large, there are a number of items within the legislation that could inadvertently facilitate the process by which medical
deportation occurs and thereby place at risk the lives and well-being of the low-income immigrant patients sent to international facilities ill-equipped to meet their health care needs. Below, we have summarized our primary concerns. Although we recognize that S7429 raises a number concerns relating to the rights of people with disabilities more generally, we have chosen to limit our remarks to this particular issue:

**Eligible Post-Acute Care Facilities**

First and foremost, under § 2803-s(2)(c) of the proposed legislation, post-acute care includes care provided by “inpatient treatment facilit[ies] or residential facilit[ies] licensed by a health, mental hygiene or social services agency of another state.” The proposed legislation fails to clarify whether eligible post-acute care facilities may be licensed by agencies outside of the United States and leaves open the possibility that eligible patients may be transferred to foreign post-acute care facilities, which may lack the means to care for transferred patients appropriately.

**Capacity & Consent**

Section 2803-s(2)(a)(i)-(ii) of the proposed legislation defines an “eligible patient” as “an inpatient at a participating hospital who, according to the patient’s attending physician: (i) is ready to be discharged as an inpatient, but needs to be transitioned to post-acute care; [and] (ii) lacks capacity to consent to the discharge and to admission to post-acute care ….” The proposed legislation fails to define “capacity to consent,” effectively leaving the final determination of whether a patient lacks the capacity to authorize a transfer to the sole discretion of the attending physician. We are concerned that without general guidelines to help the attending physician determine whether a patient lacks capacity to consent to a transfer, the attending physician may declare a patient incapacitated in deference to administrative pressure, particularly given the high costs associating with providing prolonged inpatient care.

Section 2803-s(2)(a)(v) of the proposed legislation further defines an “eligible patient” as one who “has not expressed an objection to … being transitioned to the proposed post-acute facility or service ….” There is very little clarity with respect to both the form that a patient’s transfer objection must take in order to render the patient ineligible for participation in the authorization program and the procedural channels the patient or a representative must navigate to make any such objections valid. There is also very little guidance provided as to the notification and education hospitals must provide in order to make the lack of an objection meaningful. For example, in research that our medical deportation workgroup conducted, we found that hospitals frequently claimed to obtain “consent” from patients or their representatives for transfers to foreign post-acute care facilities. However, it was not clear that the patients were made aware of the potential immigration and medical consequences associated with such transfers, rendering the consent obtained in these cases highly suspect. We are concerned that S7429 as currently drafted would further encourage hospitals to take shortcuts in the process of obtaining meaningful consent from vulnerable patients, particularly immigrant patients at risk of medical deportation.

Furthermore, the proposed legislation does not contain sufficient safeguards to ensure that participating hospitals understand and respect the objections of persons of limited English proficiency and persons with disabilities. In one particularly troubling case that our medical deportation workgroup handled, a Spanish-speaking patient and his wife were repeatedly denied interpreter services at a hospital in Brooklyn, making it virtually impossible for them to register their objections to a proposed transfer to a hospital in Mexico. Only after advocates from our
workgroup became involved did hospital administrators consider the patient’s objections and acknowledge that his condition was still too severe to warrant a transfer to any post-acute facility, domestic or international. The dearth of safeguards is particularly problematic given the demographic groups served by some of the participating hospitals. Wyckoff Heights Medical Center, located in Brooklyn, New York, for example, serves a very diverse population, which includes persons with limited English proficiency.\(^1\)

**Impartiality of Transfer Authorization Panel**

Pursuant to § 2803-s(5)(a), each transfer authorization panel must consist of one individual from each of three classes of members designated by the participating hospital, the local social services commissioner, and the New York State Office of Long Term Ombudsman, respectively. We are concerned about the impartiality of the members of the panel pool as well as the impartiality of the appointed transfer authorization chair.

Furthermore, although the health care professional actively involved in the treatment of the patient whose care is under consideration may not serve on the panel under § 2803s(5)(b), otherwise qualified hospital personnel may. We are concerned that permitting such personnel to serve on the panel may constitute a conflict of interests, which may unduly bias the transfer authorization panel’s deliberations.

**Notice of Transfer Authorization Panel Meeting**

Under § 2803-s(6)(b) of the proposed legislation, once a patient’s attending physician requests that the transfer authorization panel convene, the administration may notify the patient, “a family member or friend of the patient who may be reasonably available and willing to make a transition decision on his or her behalf, if there is any such person”, and “mental hygiene legal services which shall inform the patient that he or she will be afforded an opportunity to address the panel”. We are concerned that this language is overly permissive, allowing the transfer authorization panel to convene and decide a patient’s future without requiring the panel to give notice to either the patient or a representative, including a family member or legal services advocate.

Additionally, § 2803-s(6)(b)(i) of the legislation provides that should a transfer authorization panel decide to give notice to the patient or a representative, the panel may convene as early as three days after the attending physician’s request and notice is sent to determine whether to transfer the patient. We are concerned that the length of time between when the physician submits a request and notice is sent is unnecessarily brief. It is highly unlikely that three days will provide the patient or a representative with sufficient time to prepare to address the panel, should the panel provide such an opportunity.

**Agreement between Participating Hospital, Local Social Services Department, and Any Other Person, and Post-Acute Care Provider to Petition for Eligible Patient Guardians Following Transfer Authorization**

Under § 2803-s(9) of the proposed legislation, “a participating hospital, the local social services department, and any other person may, but shall not be required to, enter into an agreement with a post-acute care provider for such hospital, department, or other person to

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\(^1\) Wyckoff Heights Medical Center Community Service Plan 2005 Interim Report, p. 9.
petition for the appointment of a guardian under article eighty-one of the mental hygiene law for a patient transitioned pursuant to the order of a transfer authorization panel, either before or after the transition, as a way to provide for broader and longer term decisionmaking authority with respect to the transitioned patient” (emphasis added). We are concerned that unless the participating hospital and post-acute care facility enter into an agreement requiring the post-care facility to petition for the appointment of a guardian before the transition as a condition of participation in the program, the transferred patient will be left vulnerable, without the protection of a guardian.

**Appeals Process**

The proposed legislation fails to provide any mechanisms through which a patient or advocate may appeal the transfer authorization panel’s final decision. Given the enormity of the decision to transfer a patient from the care of a participating hospital to a post-acute care facility, the availability of such a mechanism is absolutely necessary.

**Annual Report Data Collection**

Lastly, § 2803-s(11) of the proposed legislation requires the administrator of each panel to submit an annual report to the Commissioner of Health, setting forth, among other items, the length of time between the attending physician’s request for a patient’s transfer to the final determination, the types of persons who addressed the panel, whether financial arrangements were made with the post-acute care facility, and the participating hospital and social services department’s evaluation of the program. The proposed legislation does not, however, require that the report contain information about the demographic characteristics of patients recommended for transfer, including race, ethnicity, income, and insurance status, or detailed information about the post-acute facilities to which patients are transferred, including the location and name.

We recognize the complexities involved in providing long term in-patient care to persons of diminished capacity as well as the proposed legislation’s efforts to facilitate the transfer of such persons to facilities that may be better suited to manage their needs. We are concerned, however, that portions of the proposed legislation may jeopardize the health and well-being of these already vulnerable patients in the interest of expediting the transfer process. We hope that you will take these concerns into consideration. We are eager to discuss our concerns about the proposed legislation with you.

Sincerely,

Jenny Rejeske  
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New York Immigration Coalition

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