MINNESOTA'S STATE PLAN FOR REFUGEE RESETTLEMENT

[45 CFR 400.5 (a) – (i) and State Letter #13-03]

DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
ECONOMIC ASSISTANCE AND EMPLOYMENT SUPPORTS DIVISION
RESETTLEMENT PROGRAM OFFICE

AUGUST 15, 2020

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I. Administration

A. Organization.45.CFR 400.5

1. State Agency Designee

The Minnesota Department of Human Services is designated as the State agency responsible for services designed to meet the resettlement needs of refugees funded through the US Health and Human Services Office of Refugee Resettlement.

The Commissioner of the Minnesota Department of Human Services has delegated the responsibility for developing the Refugee Resettlement State Plan, supervising the administration of the plan and designation of the State Coordinator to the Assistant Commissioner for Children and Family Services.

2. State Refugee Coordinator Designee

Ms. Rachele King is designated as the State Coordinator for Minnesota. The State Coordinator has the responsibility and authority to ensure coordination of public and private resources for refugee resettlement statewide. The State Coordinator manages the Resettlement Programs Office within the Economic Assistance and Employment Supports Division.

3. Organizational Structure

The Minnesota's Resettlement Programs Office is responsible for administering the US Refugee Program in the State. The Resettlement Programs Office mission, vision, and values are as follows:

Mission: The Resettlement Programs Office works with many others to support the effective resettlement of refugees in Minnesota by helping meet their basic needs so that they can live in dignity and achieve their highest potential.

Vision: Refugees[1] and their families are healthy, stable, and live in strong, welcoming communities.

Values:

- We focus on people and use a holistic person-centered approach to refugee resettlement, recognizing the complexity for refugees individually to rebuild their lives.
- We work to ensure ladders up and safety nets are both available and accessible to refugees in Minnesota because we recognize they have unique barriers to access and advancement.
- We work in partnership with local community partners, counties, and other state agencies to enhance a welcoming environment for refugees because we value the assets that everyone contributes and acknowledge refugee integration is a two-way street.
- We are accountable for results and strive to deliver services that are appropriate, effective and efficient because we hold ourselves accountable to meeting the needs of the refugees we serve.

[1]The term "refugees" is used to refer to refugees, asylees, Cuban and Haitian entrants, unaccompanied minor children, Special Immigrant Visa holders (SIVs), victims of severe form of trafficking and other populations defined in 45 CFR 400.43.

B. Assurances. 45 CFR 400.5

The Department of Human Services has the responsibility to:

1. Comply with Title IV, Chapter 2 of the Refugee Act (8 USC 1522) and official issuances of the Office of the Director.

2. Meet the requirements of 45 Code of Federal Regulations (CFR) Part 400.

3. Comply with all applicable Federal statutes and regulations in effect during the time that Minnesota is receiving grant funding.

4. Amend this plan as necessary to comply with the standards, goals, and priorities established by the Director, as needed.

5. Ensure assistance and services funded under this plan are provided to all ORR-eligible populations without regard to race, religion, nationality, sex, or political opinion.

6. Convene meetings of public/private sectors at least quarterly unless exempted by the Office of Refugee Resettlement.

7. Provide all ORR-eligible populations with the benefits and services described in the State Plan.

II. Assistance and Services

A. Cash and Medical Assistance Coordination

The Minnesota Department of Human Services administers an array of programs and services to help Minnesotans meet their basic needs so they can live in dignity and achieve their highest potential. People with refugee status are generally eligible for all programs and services under the same rules as US citizens.

With funding from the Office of Refugee Resettlement, the Minnesota Department of Human Services purchases supplemental services designed to complement mainstream services and support wellbeing for eligible populations. The state employs staff to administer Refugee Cash and Medical Assistance programs and to ensure meaningful access to mainstream cash and health-related programming within the state. Pursuant to the US Refugee Program's philosophy of early employment and economic self-sufficiency as quickly as possible, all procured services under this plan operationalize this philosophy.

Additional Cash and Medical Assistance (CMA) resources promote integration and community awareness of refugee resettlement in Minnesota. This includes public engagement activities, community presentations and consultation, development and distribution of print/web-based materials, publication of data and research related to impact of refugees in the state, and training on communication framework. In the next year, the Resettlement Programs Office will initiate contracts with local agencies to capitalize on increased community interest in refugee resettlement programing by supporting programming at local agencies through CMA funding to support outreach and engagement activities with Minnesota residents. Various trainings, seminars, and meetings are hosted by the Resettlement Programs Office each year to promote collaboration, inclusion, awareness, and enable consultation across the state and included in estimated costs for FY21.

Local administrative services also includes the maintenance and ongoing development of data systems to support the reporting requirements of the program. This includes both personnel and hardware expenses associated with significant data system development and maintenance to support program and reporting requirements and changes. This year the office will continue to work on development of a localized analysis of the return on investment of refugee resettlement to Minnesota through internal and external analysis of available data.

In addition, system and reporting enhancements will be added to support program monitoring, evaluation, and provider collaboration. This year we will embed our family wellbeing inventory tool into our data system. This inventory is conducted with new enrollments upon service entry and at six month intervals thereafter. Collection of this information and entry into our statewide information system supports service coordination and informs program planning decisions. Costs for these activities such as completing the inventory, data entry, technical assistance and service coordination meetings are estimated in the CMA budget and may be adjusted based on actual costs as we move forward with implementation.

B. Language Training and Employment Service Certification

Language training and employment services are made available to refugees statewide through the Minnesota Adult Basic Education system administered by the Minnesota Department of Education. This system provides English Language Learner classes free of charge for adult learners to improve skills in speaking, reading, listening and writing English. Licensed adult education teachers deliver instruction and monitor performance using state-approved standardized English tests. Work readiness and economic self-sufficiency content are an important part of the English Language Learner curricula. Participation in employment related services are a requirement of any individual accessing any cash program in Minnesota. Providers offering employment services funded through ORR are required to report activities and employment status monthly to cash program administration, and within 10 days of any change in employment status. In this way, there is coordinated communication about the programs individuals are accessing to assist with employability.

C. Refugee Cash Assistance 45CFR Part 400.45

The Minnesota Family Investment Program (MFIP) is the state's Temporary Assistance to Needy Families program for low-income families with children. Refugee Cash Assistance is available to ORR-eligible populations who are not eligible for TANF or SSI and are not full time students. In Minnesota, Refugee Cash Assistance is utilized for single adults and childless couples to provide benefits for up to eight months[2] after arrival to the US.

1. RCA Administration

Refugee Cash Assistance is administered in a Public-Private Partnership with five local resettlement affiliates in eight counties (Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, Washington.) In the 79 remaining counties, Refugee Cash Assistance is publically-administered by county human services under state supervision. Refugee Cash Assistance policies are the same in all 87 Minnesota counties.

2. Language Access

In accordance with 45 CFR 400.55, all agencies who implement the RCA program have LEP plans to ensure language access for all program participants. All participants have an in-person interview to determine eligibility and provide program orientation in their own language[3]. All forms and notices, if not available in the language of the participant, include a language block of how to access information in other languages.

3. Mediation and Fair Hearing Standards

The state follows the mediation and fair hearing standards and procedures outlined at 45 CFR 400.83.

[2] Since June 2020, Minnesota has been granted a federal waiver to expanded eligibility beyond 8 months which is currently set to expire on September 30, 2020. If there is an opportunity to extend this waiver, eligibility may extend beyond 8 months for certain individuals.

[3]In accordance with local public health guidelines, the requirement for in-person interviews has been waived during the public health emergency.

4. Criteria for Exemption from Employment Services

Each Refugee Cash Assistance participant is required to enroll in available Employment Services within 30 days after Refugee Cash Assistance is approved. Once enrolled, participants are required to develop and comply with an employment plans unless he/she meets one of the following conditions:

- Employed at least 30 hours per week
- Age 60 or over
- Temporarily or permanently ill or disabled (with verification from medical authority for any condition expected to last more than 30 days)
- Responsible for the care of a family member who is ill or disabled (with medical authority verification)
- Experiencing a personal or family crisis, as determined by the agency (re–assessed monthly)

As a condition for the receipt of Refugee Cash Assistance, a refugee who is not exempt must also:

- Accept at any time, from any source, an offer of suitable employment
- Comply with monthly reporting requirements if receiving earned income

5. Eligibility and Payment Levels. 45 CFR 400.66

a. Determination of eligibility for Refugee Cash Assistance is based on income and asset verification prospectively for the first two months, and retrospectively for months three through eight. Refugee Cash Assistance income and asset eligibility follows Minnesota Family Investment Program policy, including an disregarding the first $65 of earned income per wage earner plus 50% of the remaining earned income of the assistance unit, with a dollar for dollar reduction from benefit level for household size thereafter. Counted assets must not exceed $10,000 to be eligible for Refugee Cash Assistance.

In the coming year, the State will explore using RCA to provide cash assistance to a larger pool of primary arrivals who are not eligible for MFIP benefits until their 31st day in the country due to a 30 day residency requirement in the MFIP program. This would provide resources through RCA to TANF-eligible primary arrivals during their first month after arrival until they fulfil the Minnesota residency requirement on their 31st day after arrival.

b. See chart below for TANF assistance levels by number of individuals in household.

Payment standards by household size		
Household size	**Minnesota Family Investment Program payment standard as of 2/1/2020**	**Refugee Cash Assistance payment standard**
1	$460	$460
2	$647	$647
3	$742	N/A
4	$831	N/A
5	$907	N/A

c. Resources and income are considered as outlined at 45 CFR 400.66(b)-(d).

d. The date of application is used as the start date for Refugee Cash Assistance benefits.

6. Notification to Local Resettlement Affiliate. 45 CFR.68

a. In county-administered locations, local resettlement affiliates connect directly with counties to assist primary refugee arrivals with RCA applications while other eligible people access benefits directly through the county.

b. All refugee employment service providers are required to report any change in employment status within 10 days of the change and to report at least monthly a participant's compliance with the employment plan, including any offers of employment.

7. Eligibility and Payment Levels. 45 CFR 400.50 and 400.60

a. Determination of eligibility for Refugee Cash Assistance is based on income and asset verification prospectively for the first two months, and retrospectively for months three through eight. Refugee Cash Assistance income and asset eligibility follows Minnesota Family Investment Program policy, including an disregarding the first $65 of earned income per wage earner plus 50% of the remaining earned income of the assistance unit, with a dollar for dollar reduction from benefit level for household size thereafter. Counted assets must not exceed $10,000 to be eligible for Refugee Cash Assistance. Employment status and income are assessed monthly. In PPP locations, participants meet with RCA eligibility coordinators in person on a monthly basis to receive RCA benefits via check[4]. This allows for regular updates on any changes that may impact eligibility. In non-PPP sites, participants are required to report any change in income, household composition, or basis of eligibility within 10 days of the change.

b. Assistance levels are based on the size of the assistance unit. Payment standards are listed below for both the Minnesota Family Investment Program and Refugee Cash Assistance participants. Refugee Cash Assistance applies a $65 standard disregard per wage earner plus a 50% disregard on remaining earned income in the assistance unit, with a dollar for dollar reduction in cash benefits thereafter.

Household size	**Minnesota Family Investment Program payment standard as of 2/1/2020**	**Refugee Cash Assistance payment standard**
1	$460	$460
2	$647	$647
3	$742	N/A

[4] Due to declaration of health emergency, and in accordance with local public health guidance, monthly check-ins may be done remotely. In addition, benefits have been shifted to electronic benefit transfer (EBT) cards until the health emergency has ended and fully in-person services resume.

4	$831	N/A
5	$907	N/A

c. The state follows requirements related to financial eligibility and consideration of resources and income as outlined in 45 CFR 400.59.

d. The Public-Private Partnership model provides transportation assistance to participants who are actively seeking employment and are engaged with their employment provider. Job search activities are verified on a monthly basis to ensure compliance prior to issuance of transportation assistance. Vouchers are purchased to support monthly travel costs for job search activities, based on the local transit system in PPP sites.

e. The State annually develops budgets for direct assistance and administration costs of the Public-Private Partnership model for Refugee Cash Assistance, which are monitored to ensure spending is within approved limits. RCA expenses submitted as a part of the Cash and Medical Assistance estimate are based on projected number of primary, secondary, SIV and asylee arrivals and the average number of months on assistance for each enrollee. Because there is little variance in assistance levels, if arrival projections are within the projected amount, the estimate will be in line with projected expenses. The administrative costs for RCA stay consistent across arrival patterns as long as they are within the funded service capacity.

8. Refugee Cash Assistance Program Administration. 45 CFR 400.13

a. In the eight counties receiving the highest number of refugee arrivals, Refugee Cash Assistance eligibility is completed through a Public-Private Partnership with local resettlement affiliates. The remaining 79 counties have county (public) administered Refugee Cash Assistance.

b. Refugee Cash Assistance benefit checks are issued by the state in all counties. Participants who meet certain criteria and are employment exempt may opt to receive benefits via Electronic Benefits Transfer (EBT). In the eight counties listed above which are Public-Private Partnerships, assistance payments are sent to contracted local resettlement affiliates who meet monthly with Refugee Cash Assistance participants and distribute benefit checks in person[5]. In all other counties, payments are issued directly to Refugee Cash Assistance participants.

c. At the state level, there is one staff person responsible for oversight and implementation of Refugee Cash Assistance programming. This individual is responsible for the coordination of the

[5] Due to declaration of health emergency, and in accordance with local public health guidance, monthly check-ins may be done remotely. In addition, benefits have been shifted to electronic benefit transfer (EBT) cards until the health emergency has ended and fully in-person services resume.

Public-Private Partnership and RCA policy implementation statewide, and serves as a resource and policy advisor for refugee access to all county administered cash and food programs.

d. Staff at the five local resettlement affiliates in the Public-Private Partnership total 3.6 FTEs. Current staffing levels are designed to maintain a minimum infrastructure to serve eligible populations during times of low arrival levels. Counties who administer Refugee Cash Assistance do time studies on a regular basis to report time spent on Refugee Cash Assistance activities. Based on these studies, the Resettlement Programs Office is billed quarterly for Refugee Cash Assistance related activities for county eligibility workers.

e. The state charges a 10% indirect rate on all direct expenses for which HHH is the cognizant agency.

D. Refugee Medical Assistance (RMA) 45CFR 400 Subpart G

1. Applications, Determinations of Eligibility, and Furnishing Medical Assistance. 45 CFR 400.93 and 400.94

a. Process for determining eligibility for Medicaid and CHIP: Medical Assistance is a federal program established under Title XIX of the Social Security Act to provide health care to needy people. Funding is a combination of Federal and State monies. Individuals under 133 percent of the federal poverty level are eligible for MA with higher income thresholds for children and pregnant women.

All Minnesotans, including refugees, who apply for health care coverage through MNsure (the state health care exchange) are screened for eligibility for MA, state subsidized health insurance, and Refugee Medical Assistance. Minnesota's exchange includes Medicaid expansion as of 1/1/2014, expanding eligibility for all Minnesotans.

b. A "Designated Application Process for New Arrivals to the United States" streamlines health care application processing for primary refugee arrivals in Minnesota. This process began in July of 2014 as a result of the Affordable Care Act and the state exchange which combined applications for all health programs onto one platform. Applications are screened first for eligibility for Medicaid. If ineligible for Medicaid based on income, refugee applicants are screened for eligibility for other local health insurance programs.

2. Eligibility for RMA. 45 CFR 400.100 Through 400.104

a. The financial eligibility standards for Refugee Medical Assistance is currently 100% of the federal poverty level. Since all refugees are screened first for Medical Assistance eligibility, all refugees who would qualify for Refugee Medical Assistance should also qualify for Medical Assistance. The methodology used to determine income eligibility is MAGI.

b. The state considers income and resources as outlined at 45 CFR 400.102.

c. The state provides continued coverage of recipients as required by 45 CFR 400.104.

3. Scope of Medical Services. 45 CFR 400.105 and 400.106

a. Refugee Medical Assistance will cover at least the same services in the same manner and to the same extent as Medicaid on a fee for service basis.

b. For eligible populations without health coverage or whose health insurance does not cover the refugee health screening, a flat-fee reimbursement for the cost of the refugee health screening – if completed within the first three months after date of arrival in the US or of eligible status grant - is charged to RMA. The Minnesota Department of Health oversees this process as a part of health screening administration.

4. RMA Program Administration. 45 CFR 400.13

a. RMA is delivered on a fee-for-service basis. Services follow Medicaid services, including coverage for transportation and interpretation.

b. Refugee Medical Assistance administration costs include staffing with the Minnesota Department of Human Services to ensure policies and systems are aligned with federal and state regulations, conduct outreach and training to counties, and trouble-shoot application issues. In the coming year, Minnesota will continue efforts to strengthen RMA program administration, prioritizing updates to the health care programs manual, policy updates to increase RMA income eligibility from 100% to 200% FPG, and outreach and training to county providers to ensure accurate RMA program implementation. A staff within the Department of Human Services works with the health care administration to move these priorities forward. In coordination with MDH, this position will continue work to improve access to other mainstream health programs administered within the Department of Human Services, including managed health care programs. This happens in coordination with MDH. Because the Refugee Health Coordinator is based within the Minnesota Department of Health, they do not directly participate in the administration of the Refugee Medical Assistance program.

E. Refugee Medical Screening (RMS). 400 CFR 400.107

1. Coordination of Refugee Medical Screening Program. 45 CFR 400.5(f)

a. The Minnesota Department of Human Services implements the Refugee Medical Screening program through an interagency agreement with the Minnesota Department of Health. The Minnesota Department of Health coordinates the Refugee Medical Screening program and works with local refugee resettlement agencies, local public health offices, community based agencies and DHS to identify newly arrived primary and secondary refugees in need of care.

Local resettlement agencies directly refer each new primary arrival to a designated local public health contact in the county of residence along with biodata forms and any medical information received from overseas, with a copy sent to the Minnesota Department of Health. A nurse at the Department of Health reviews medical records and assists local refugee resettlement agencies

to interpret medical information. Information is entered into a Minnesota Department of Health database and the local public health contact in the county of residence is notified.

Referrals for secondary migrants come to the Minnesota Department of Health from various sources including local resettlement affiliates, local public health departments, private clinics, local service providers, and other states. The Minnesota Department of Health requests overseas medical records and confirms screening status from the previous state of residence. When appropriate, the Minnesota Department of Health then follows up with the notifying agency to complete screening and generates notification for local public health in the county of residence.

Once a county receives electronic notification from the Minnesota Department of Health, they move forward with the localized process for scheduling health screenings. The Minnesota Department of Health monitors screening results and timelines. Follow up is initiated with local public health contacts to offer support or appropriate interventions, as needed.

b. The Minnesota Department of Health is designated as the single point notification entity for CDC's Electronic Database Notification system (EDN). The Minnesota Department of Health completed the enhancements to eSHARE, the state refugee health database to enable attachment of medical records and overseas digital chest x-rays. Starting February 2019, all 87 local public health agencies have been given access rights to eSHARE to view and download overseas medical records for residents of their respective counties; eSHARE is also designed to allow clinic level access however clinics have opted to receive records from local public health. Hard copies of the medical records or digital chest x-rays may be mailed to local public health or clinics if sites are unable to access records. The eSHARE system continues to be updated with revised or newly-issued CDC refugee screening guidelines.

The information provided aids practitioners to use appropriate screening protocols based on demographic and medical history, including age and risk factors. Follow up referrals are made based on conditions identified on the overseas health information or during the screening.

c. The Minnesota Department of Health receives funding through federal Cash and Medical Assistance funding to coordinate activities related to refugee health screenings. A public health nurse contact in each of the 87 county health departments in Minnesota works with the Department of Health to implement screenings state-wide. Local Public Health contacts establish relationships with select private clinics or public health clinics and provide training to clinicians providing the screening. Counties with high-volumes of screenings receive funding through CMA to support coordination and scheduling of screenings.

d. Refugees in Hennepin and Olmsted Counties receive health screenings within public health clinics. All other counties utilize private clinics to deliver refugee health screenings. All refugees who need active TB or latent TB follow-up receive services at local public health TB clinics.

2. Operation of Medical Screening Program

Minnesota requests approval to bill RMA for health screenings when an individual is not eligible for MA, and does not have other health coverage to pay for the screening expense. In these cases, RMA is billed a flat rate equal to the MA rate for the same services. In recent years, fewer than ten screenings have been billed to RMA each year.

3. Scope of Refugee Medical Screening Services. 45 CFR 400.107

a. Refugee Medical Screening Services are administered in accordance with the Office of Refugee Resettlement's 2012 refugee screening guidelines.

b. See "Attachment A" for description of service elements of the Refugee Health Screening covered by Medicaid, including services provided based on age and risk factors.

c. All aspects of the refugee medical screening checklist are billed to Medicaid, when available. If an individual is not eligible for MA, the screening is billed, as a flat rate, to RMA.

d. There are two additional services beyond those outlined in ORR's medical screening checklist which are included as part of health screening. These are Medical Systems Coordination and secondary arrival administration.

The Minnesota Department of Health has integrated health systems coordination to assist with care plans for refugees with acute or complex health care needs into its core activities. To accomplish this task, a medical social worker (Health Systems Coordinator) works with local refugee resettlement agencies to develop and set-up care protocols and assure initial health care services for cases with significant health conditions prior to arrival. The Minnesota Department of Health medical social worker identifies resources and communicates with Local Public Health, primary care providers and referral specialists to inform of the refugee's health status, and forwards overseas relevant medical records to the appropriate health care facilities.

Coordination of refugee health screening for secondary arrivals and other ORR-eligible populations: The Minnesota Department of Health, with RPO, has established referral and linkage to health care protocols to assist secondary migrants, SIV holders and U.S.-granted asylees to health care. Through the established referral mechanisms, local public health agencies, community-based organizations or resettlement agencies refer these newcomers to the Minnesota Department of Health. If available , program staff request overseas medical records from the primary arrival state or CDC for secondary migrants or SIV holders; the documents are transferred from primary arrival state and forwarded to local care providers, avoiding unnecessary repetition of screening or vaccinations. This coordinated approach has been embraced locally, but requires resources to support care access for these eligible populations. The health screening budget supports screening coordination in the counties most impacted by secondary arrivals, asylees and SIV holders.

e. Refugee Medical Screening cost reimbursement by Medicaid is $640 per person. For eligible populations without health coverage or whose health insurance does not cover the refugee health screening, a flat-fee reimbursement is made in the same amount for the cost of the refugee health screening – if completed within the first three months after date of arrival in the US or of eligible status grant - is charged to RMA. The Minnesota Department of Health oversees this process as a part of health screening administration.

f. The Minnesota Department of Health regularly monitors the screening status of all new arrivals to ensure that screening is initiated within 90 days of arrival (or status grant for US granted asylees and victims of human trafficking). The Minnesota Department of Health also monitors the completeness of the screening. Local Public Health contacts are called and reminded if health screenings are delayed and are offered support or appropriate interventions.

4. Refugee Medical Screening Program Administration. 45 CFR 400.13

a. Medical screening payment model: All costs related to Refugee Medical Screenings are charged to Medicaid, including translation and transportation. In the rare case where an individual is not eligible for other coverage, RMA is billed one flat fee for all services related to the screening.

b. All administrative costs are incurred by the Minnesota Department of Health to coordinate refugee health screening activities statewide. The Refugee Health Coordinator and her staff work to ensure strong screening rates, positive health outcomes, meaningful health education, and reliable data analysis related to health screening activities for new refugee arrivals. Under the leadership of the Refugee Health Coordinator, staff engage in a broad array of activities including the following:

- Provide clinical consultation, administrative guidance and training to local public health agencies and private health care providers which provide medical screening;
- Ensure standard implantation of the Office of Refugee Resettlement and Centers for Disease Control and Prevention refugee screening guidelines across the state;
- Identify health care entry points, systems and specialists to ensure refugees with acute and chronic health conditions are linked to care in a timely manner;
- Maintain a local public health nurse contact in each county health department who is responsible for coordination of health screenings for newly arrived refugees under their jurisdiction;
- Provide assistance to local resettlement agencies in identifying refugees needing medical treatment or observations at the time of resettlement as needed and requested;
- Provide medical care coordination for primary arrivals with acute or complex health care needs upon arrival;
- Facilitate positive working relationships between health screening providers, health care systems and plans, local public health and Local resettlement affiliates;
- Serve as subject matter expert on issues related to health needs of newly arrived refugees;
- Coordinate disease outbreak and prevention efforts for newly-arrived refugees, and consult on the state's emergency preparedness (all-hazards response and recovery) plans;

- Analyze and summarize health screening data to identify trends and outcomes;
- Complete federal reporting requirements related to health screening activities;
- Monitor and assess health screening implementation statewide;
- Develop and implement health education for new arrivals in coordination with program partners; and,
- Administer the flat fee reimbursement program to cover refugee medical screenings and related services.

F. Refugee Supportive Services (RSS). 45 CFR 400 Subpart I

1. Supportive services provided to refugees within criteria outlined at 45 CFR 400.154 and 400.155.

Funding supports social services within Office of Refugee Resettlement prioritization criteria[6]. Beginning October 2019, four Regional Resettlement Networks and service hub locations were established in Minnesota. These networks provide coordinated, quality, family-centered service delivery structure for all ORR state formulary funds. Within Resettlement Networks, DHS funds specialized service components of Immigration, Community Orientation Workshops, Employment, Family Coaching, and Family assisters. Currently, these include the following activities:

- Employment Placement and Job Upgrade services
- Social Adjustment Services
- Outreach
- Information and referral services
- Case management and service navigation
- Transportation
- Translation/Interpretation services
- Citizenship and naturalization preparation services (services offered do not include any resources for fees paid to the United States Citizenship and Immigration Services (USCIS).

Assistance applying for EAD

2. Social services provided are consistent with 45 CFR 400.154 and 400.155.

3. Set-Aside Services

a. STUDENT SERVICES: RSS funding is used to support refugee students and is awarded to support student mentoring and coaching utilizing the Check and Connect model through support of family coaches matched with students to support academic success and social wellbeing.

b. ELDERLY SERVICES: RSS funding is used to support elderly refugees, application supports for adjustment of status and citizenship applications and connections to other support services.

[66] Minnesota was approved a federal waiver to in May of 2020 to extend services to people with eligible statuses who have not become US Citizens. This waiver is currently set to expire on September 30, 2020. If offered the opportunity to extend this waiver, expanded eligibility may continue into federal fiscal year 2021.

c. YOUTH MENTORING: RSS funding is used to support refugee youth through a contract to provide coaching services utilizing the check and connect model through family coaches matched with youth to support academic and career goals for eligible youth.

d. REFUGEE HEALTH PROMOTION SERVICES: RHP funding is used to promote the health and well-being of ORR eligible populations by providing opportunities to increase health literacy, coordinating health care and improving health care access.

G. Unaccompanied Refugee Minors (URM) Program. 45CFR 400 Subpart H

1. Administrative Structure and State Oversight.

Minnesota does not currently operate an Unaccompanied Refugee Children program. Children in need of protection are referred to child protective services for assessment and referral to available interventions.

Minnesota's State Plan for Resettlement submitted by Rachele King, Minnesota State Refugee Coordinator.

Signature: 

Date: *8/15/2020*

ATTACHMENT A

Service Elements of the Refugee Health Assessment

Minnesota follows the Office of Refugee Resettlement's 2012 refugee screening guidelines, along with Centers for Disease Control and Prevention refugee screening guidelines. A Refugee Health Assessment consists of a series of two to three visits. Essential elements of the exam include a medical and physical assessment focused on the identification and treatment of infectious diseases and indicators of chronic conditions, according to standardized Office of Refugee Resettlement, Centers for Disease Control and Prevention and Minnesota Department of Health refugee screening protocols. The exam also includes treatment for any conditions identified or referral to appropriate follow-up care and basic health education.

The providers of initial health assessments are expected to provide the following medical services to each refugee:

1. History- Overseas medical records are reviewed for all newly arrived refugees and necessary follow-up are initiated.

2. Physical Exam and Review of Systems: Refugees receive a complete physical exam (with special attention to suspected signs of Hansen's Disease), including assessment of acute mental health concerns, dental, hearing, vision, height/weight, nutritional assessment (Vitamin B12, D) with necessary referrals.

3. Complete blood count with differential to identify hematologic disorders.

4. Tuberculosis screening and follow-up: Refugees are screened for tuberculosis (TB) prior to leaving their country of origin and the TB component of overseas evaluations are determined by the individual's age, the prevalence of TB in the local population, and the resources in that country to implement CDC's enhanced screening protocol developed in 2007. Those found to have TB-related conditions are given a "TB Class" which is then reflected in the Electronic Disease Notification system notification of that arrival and documented on their DS forms. These TB Classes are:
   - Class A TB – active pulmonary TB disease, sputum smear or culture positive; requires a waiver (i.e., on treatment and smear-negative prior to travel).
   - Class B0 TB – active TB disease treated overseas by panel physicians
   - Class B1 TB – evidence of pulmonary or extra pulmonary TB disease, sputum smear-negative; includes "old healed TB", and previously treated TB
   - Class B2 TB – Latent TB infection (LTBI) if TST ≥ 10 mm or positive interferon-gamma (IGRA)
   - Class B3 TB – Contact of a known TB disease case
   - No Class – none of the above.

The *domestic TB screening* of newly arriving refugees includes the following:

a. Draw an interferon-gamma (IGRA) blood assay for all refugees ≥2 years and older regardless of the refugees' BCG history unless the person has a reliable history of previous treatment for TB or reliable documentation

of a previous positive test. IGRA testing is approved and recommended for use in anyone ≥2 years of age. Administer a tuberculin skin test (TST) for all refugees six months to < 2 years old. For most refugees, the TST is positive if ≥10 mm induration. A 5 mm cutoff is used if: (1) HIV+, (2) recent close contact to infectious TB case, (3) arrivals with TB Class A or B1 conditions, (4) chest X-ray (CXR) with fibrotic changes, (5) organ transplant, or (6) otherwise significantly immune-compromised.

b. Perform a chest x-ray for refugees with:
   - Positive IGRA results or TST (≥10mm induration)**or**
   - TB Class A or B1 designation from overseas exam, regardless of TST **or** IGRA results
   - Symptoms of tuberculosis, regardless of the TST or IGRA results.

c. Diagnose infection or rule out active/LTBI:
   - **Diagnosing TB disease, suspected or confirmed**: If the refugee arrives as a Class A TB, or the chest x-ray is abnormal and consistent with TB disease, or the individual has signs or symptoms of TB, regardless of the TST/IGRA results, sputum specimens should be collected for bacteriologic examination and a "TB suspect" reported to the Minnesota Department of Health TB Prevention and Control Program. Providers need to remember to consider extra pulmonary TB disease, which is also reportable to the Minnesota Department of Health. Further diagnostic testing may be necessary to confirm or rule out TB disease. Treatment for TB disease should be initiated as soon as possible and directly observed therapy (DOT) is the standard of practice for treating active TB.
   - **Diagnosing Latent TB infection (LTBI):** If the IGRA or TST is positive and the chest x-ray is normal or abnormal but tuberculosis disease is ruled out, then treatment for LTBI should be initiated. For specific treatment regimens, providers consult the CDC guidelines available on the Minnesota Department of Health TB Program website at: www.health.state.mn.us/tb.

5. Immunizations and follow-up: Clinics are advised to assess the immunization history of each refugee referring to the overseas records, any records brought by the refugee or in the state immunization information system (MIIC). The Minnesota Department of Health electronically transmits overseas immunization records into MIIC for newly arrived primary refugees in the state. All previous vaccinations should be recorded if not already captured in MIIC. Lab evidence of immunity may be obtained and recorded as is history of disease. All previous vaccinations are considered valid if they were given according to the Minnesota child or adult schedule.
   - If there is no documentation, assume the refugee is unvaccinated
   - All age appropriate vaccinations are given as recommended by the Advisory Committee on Immunization Practices (ACIP)
   - Documentation of all vaccination administrated is given to the refugee and entered into the state immunization information system (MIIC).

6. Hepatitis A, B, C and follow-up: All refugees receiving initial health assessments should be assessed for hepatitis B status with serologic screening for hepatitis B HBsAg, anti-HBs, anti-HBc. Household contacts of those identified as carriers of the virus (HBsAg) who are themselves HBsAg negative should have determination of their antibody status. All susceptible contacts should receive a three-dose series of hepatitis B vaccine; those who initiated vaccines overseas should continue to receive the necessary doses to be up-to-date. Pregnant women identified as carriers should have test results forwarded to their prenatal care provider for appropriate follow-up for their infant. The Minnesota Department of

Health collaborates with hepatitis surveillance and perinatal hepatitis B prevention program to share all screening and demographic information to ensure follow-up.

Adult refugees should routinely be screened for hepatitis C (anti-HCV and confirmatory), if born between 1945 and 1965, if they have risk factors (ex: living with HIV, had unregulated tattoos, undergone female genital cutting/mutilation, had blood transfusions), or if originating from moderate to high prevalence countries or indicated by risk of exposure. Those < 18 years old may be screening if the present with risk factors.

Routine screening for hepatitis A is not recommended for refugees.

7. Intestinal Parasites and follow-up: Evaluation for significant parasitic disease or infestation followed by appropriate treatment:
   - Confirm pre-departure presumptive treatment
   - Routine eosinophil count

PLUS

If **no documented** pre-departure parasite treatment:

- Collect 2 stool specimens more than 24 hours apart for Ova and Parasites
- Strongyloides serology (all refugees)
- Schisotosoma serology for sub-Saharan Africans
- or presumptive domestic treatment

If **documented** pre-departure parasite treatment:

- *Single-dose* pre-departure with no praziquantel treatment requires strongyloides serology (all refugees) and schistosoma serology for Sub-Saharan Africans or presumptive domestic treatment
- *Single-dose* pre-departure with praziquantel treatment requires strongyloides serology (all refugees) or presumptive domestic treatment
- Eosinophilia with *high dose* pre-departure treatment requires either ova and parasite testing or a repeat eosinophil count in 3-6 months after arrival.

Treatment should be provided according to approved treatment schedules for any and all pathogenic parasites identified.

8. Malaria screening and follow-up:
   - Screen if symptomatic or suspicious history
   - Screen or presumptively treat if asymptomatic, from highly endemic areas (Sub-Saharan Africa) and **no documented** pre-departure therapy.
   - Obtain 3 thick and thin smears to screen or use PCR.

9. Sexually transmitted diseases screening and follow-up:

Universal testing of HIV and syphilis for arrivals from mid-high HIV prevalence regions

- Rescreen those 15 and older for syphilis according to clinic protocol, confirm
- Screen those 15 and under if risk factors are present according to clinic protocol

- Screen for HIV if 13-64 years and from non-endemic region; screen all family members if person is positive, confirm
- Screen sexually active patients for other STIs, if appropriate, using urine testing for GC/Chlamydia, if possible.

10. Lead Screening:
    - Screen all children < 17 years old
    - Screen all pregnant or lactating women and girls
    - Refer to Public Health and medical follow up if BLL ≥5 µg/dl.

11. Pregnancy test should also be performed when indicated.

12. Additional components include:
    - Basic metabolic panel, if indicated (especially if screening if occurring in a primary clinic setting)

13. Refugee Health Orientation: It is also essential to help orient the new refugee arrival to the need for the domestic health assessment and how to access health care services here in the U.S. Examples of topics addressed by Local Public Health with new refugee arrivals include:
    - knowing when to call the doctor
    - how to recognize an urgent medical problem
    - how to recognize a medical emergency
    - how to utilize the 911 system
    - how to ask for an interpreter
    - how to utilize Emergency Rooms
    - how to use prescription medications, etc.

Local Public Health provides most of this education, but providers in private clinics provide this education as well. Minnesota Department of Health provides technical assistance, resources or guidance as requested. The program is currently working with various partners across the U.S. to vet and update relevant health orientation materials. Resources and tools will be shared widely via the department's website.