STUDY OF DOMESTIC CAPACITY TO PROVIDE MEDICAL CARE FOR VULNERABLE REFUGEES

A survey and policy study examining medical case management and healthcare accessibility for refugees

The project was conducted by the U.S. Committee for Refugees and Immigrants with funding support from the Bureau of Population, Refugees, and Migration, United States Department of State, but does not necessarily represent the policy of that agency.

TABLE OF CONTENTS

Acronyms

ACA	Affordable Care Act
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CSI	College of Southern Idaho, Twin Falls, Idaho
CWS	Church World Service
DPH	Department of Public Health
ECBO	Ethnic Community-Based Organization
ECDC	Ethiopian Community Development Council
ECHOS	Epiphany Community Health Outreach Services
EMM	Episcopal Migration Ministries
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent Employee
HIAS	Hebrew Immigrant Aid Society
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration, U.S. Department of Health and Human Services
IIMN	International Institute of Minnesota, St. Paul, Minnesota
IINE	International Institute of New England, Boston, Massachusetts

IOM	International Organization for Migration
LCSW	Licensed Clinical Social Worker
LEP	Limited English Proficiency
LIRS	Lutheran Immigration and Refugee Services
LTBI	Latent Tuberculosis Infection
MA	Medical Assistance
MAA	Mutual Assistance Association
MAGI	Modified Adjusted Gross Income
MBHP	Massachusetts Behavioral Health Partnership
MCM	Medical Case Manager
MDH	Minnesota Department of Health
MG	Matching Grant
MORI	Massachusetts Office of Refugees and Immigrants
MSW	Medical Social Worker
NSC	Nationalities Service Center, Philadelphia, Pennsylvania
ORR	Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Services
PC	Preferred Communities
PCP	Primary Care Providers
PPA	Participating Provider Agreement
PRM	Bureau of Population, Refugees, and Migration, U.S. Department of State
PRHC	Philadelphia Refugee Health Collaborative
R&P	Reception and Placement
RCA	Refugee Cash Assistance

RHA	Refugee Health Assessment
RHP	Refugee Health Program
RHS-15	Refugee Health Screener - 15
RMA	Refugee Medical Assistance
RMCAC	Refugee Medical Care Advisory Committee
RSC	Resettlement Support Center
SMC	Significant Medical Condition
SRC	State Refugee Coordinator
SRHC	State Refugee Health Coordinator
SSI	Supplemental Security Income
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
USCCB	U.S. Conference of Catholic Bishops
USCRI	U.S. Committee for Refugees and Immigrants
USRAP	U.S. Refugee Admissions Program
WR	World Relief

Glossary

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (PPACA) 2010 HR5390, or Affordable Care Act (ACA), is the healthcare reform law that expands Medicaid coverage to millions of low-income Americans and promotes expanded health insurance coverage, lower health care costs, and more health insurance programming options.

Affordable Care Act (ACA) Subsidies: The ACA establishes a system to provide assistance for low and middle-income families and individuals who are trying to purchase health insurance. The amount of assistance, or subsidies, varies based on location, family structure, and income level.

Assistance-Based Approach: The method used to determine a refugee's eligibility for this study. Considers refugees eligible if they receive medical case management services that fell outside the standard assistance involved with ensuring timely access to initial refugee health assessments. A more detailed explanation is available in the "Methodology" section.

Bio-Psychosocial Assessment: Refers to a series of questions asked at the beginning of treatment of an individual that obtain information about the major physical (biological), psychological, and social issues of the individual.

Biographical Data Form (Biodata): The Biographical Data form is generated for each arriving refugee by the overseas Resettlement Support Center. The form includes information on each member of the case including name, date of birth, education, employment history, and health history.

Community-Based Organization (CBO): Civil society non-profits operating within a local community.

Complex Medical Condition: A descriptive term for conditions that qualify a refugee for inclusion in this study based on the **assistance-based** approach to eligibility. For the purposes of this study, a complex medical condition is any medical condition that requires additional medical services beyond what is required for a healthy refugee in a refugee health assessment (RHA). This is the broadest category of eligibility in this study, and includes severe medical cases.

Coverage Gap: Refers to a situation where a refugee is not eligible for state, subsidized federal health insurance plans or employer plans and cannot afford to purchase private insurance. This individual would fall into a coverage gap.

Ethnic Community-Based Organization (ECBO): A community-based organization that provides services for a specific ethnic group(s).

Federally Qualified Health Center: Health Centers that are federally operated through the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) to provide services to low-income adults.

Hard Cross Reference: Cases that are almost always interviewed overseas together, allocated together, scheduled to travel together, and resettled together.

Health Exchange (or Exchange): See definition for Health Insurance Marketplace.

Health Insurance Marketplace (or Marketplace, Health Exchange or Exchange): A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources to pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Plan (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. Also known as "Health Exchanges".

Matching Grant: A grant administered by ORR that is an alternative to public cash assistance. It enables eligible populations (including refugees) to become economically self-sufficient within 120 to 180 days of program eligibility. Participating agencies agree to match the ORR grant at a 50% rate with cash and in-kind contributions.

Medically Vulnerable: Used in the report when discussing refugees with medical issues in general terms. It includes a larger universe of refugees with medical conditions.

Mutual Assistance Association (MAA): Ethnic Community-Based non-profit organization that provides linguistically and culturally sensitive services to members of a locally-based ethnic community.

Navigator or Healthcare Navigator: An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms.

Preferred Communities: A grant administered by ORR that supports programming focused on early employment and sustained economic independence. In addition, the program supports special needs populations including medically vulnerable refugees.

Reception and Placement (R&P): The Department of State's Reception and Placement program provides assistance for refugees to settle in the United States. It supplies resettlement affiliates a per capita amount to provide refugees with basic necessities and core services during their first three months (90 days) in the United States.

Reception and Placement Period: The Department of State's Reception and Placement program is limited to the first three months (90 days) after arrival.

Refugee Health Assessment: The initial post-arrival health assessment, generally performed by local health departments or clinics. Assessments vary in scope and are informed by CDC guidelines.

Refugee Health Screener-15 (RHS-15): The RHS-15 is a tool to screen refugees for emotional distress and mental health status. This tool was developed by Pathways to Wellness and has not been tested for validity of use with individual ethnic groups.

Refugee Medical Assistance (RMA): RMA is a 100% federally funded program that provides up to eight months of health care coverage for refugees and other eligible persons.

Refugee Resettlement Agency: An agency that has a cooperative agreement with the Department of State to provide R&P services through a network of affiliates and field offices. In FY2014, there were nine such organizations.

Resettlement Affiliate: A local resettlement agency field office or an independent non-profit that has an agreement with a refugee resettlement agency to provide R&P services.

Severe Medical Condition: A descriptive term used to identify a subgroup of refugees in this study who have the highest level of need due to their medical condition(s). This is the narrowest category of eligibility in this study, and is a subset of complex medical conditions. Eligibility criteria for this subgroup can be found in the "Methodology" section.

Significant Medical Condition Form: The Significant Medical Condition (SMC) form is designed to collect and transmit advance information on refugees' post-arrival follow-up, placement or additional assistance needs to receiving affiliates in the country of destination. The form is used by IOM panel physicians for approximately 15% of U.S. bound refugees diagnosed with significant medical conditions requiring additional assistance from the resettlement affiliates and/or local health care providers. IOM panel physicians conduct assessments for about 70-80% of U.S. bound refugees.

State Refugee Coordinator (SRC): The State Refugee Coordinator implements the State Plan for Refugee Resettlement, oversees federal grants for refugee services, and may administer

medical and social assistance programs. The SRC collaborates with federal, state, and local partners in the private and public sector to design and implement policy related to refugee resettlement in their state.

State Refugee Health Coordinator (SRHC): The State Refugee Health Coordinators are responsible for administering refugee health programs in their state or territory. Refugee health programs focus on linkage with health care services and care coordination, refugee health assessments and immunizations, health education, and reducing health disparities.

U.S. Tie: A U.S.-based relative or friend of a refugee.

Wilson-Fish: The Wilson-Fish program is an alternative to traditional state-administered refugee resettlement programs for providing assistance (cash and medical) and social services to refugees.

Charts and Tables

Executive Summary

Introduction

The United States resettles more refugees than all the other countries of the world combined. This achievement is possible through strong partnerships between the U.S. Government, the United Nations High Commissioner for Refugees (UNHCR) and domestic and international non-governmental organizations. Identifying and addressing challenges to successful resettlement is critical to the success of the U.S Refugee Admissions Program (USRAP).

Refugees who are resettled in the United States face many challenges that are part of building their new lives in a new country such as learning a new culture, language and overall adjustment. Some of these refugees arrive with medical conditions that add to the challenge of resettlement and become an obstacle to early self-sufficiency.

One of the challenges to successfully assisting medically vulnerable refugees is the lack of evidence regarding the cost of managing the medical conditions of resettled refugees. The intent of this multi-disciplinary study is to provide a concrete assessment and recommendations to address the U.S. domestic capacity to resettle refugees with medical conditions during the resettlement process and specifically for the initial 90-day Reception and Placement (R&P) period.

This study assesses the capability, impact, and service models implemented in resettlement communities to resettle medically vulnerable refugees during the 30 to 90 days after arrival in the U.S. The research was implemented at five resettlement sites: Boston, Massachusetts; Houston, Texas; Philadelphia, Pennsylvania; St. Paul, Minnesota; and Twin Falls, Idaho. Data generated by this project in the five study sites shows a need for additional post-arrival support for the medically vulnerable, particularly for those with mental health conditions and mobility issues, as well as for those requiring hospitalization shortly after arrival. Through this study, the U.S. Committee for Refugees and Immigrants (USCRI) provides research findings based on qualitative and quantitative data that are used to support policy recommendations. The recommendations generated by this report offer options for providing this additional support, as well as some critical health-related issues to consider in the resettlement of these refugees. Further, this study considers national variations in the accessibility of health services and provides options for service provision.

The findings and conclusions of this study are organized considering the following four study areas:

1. To analyze the challenge of providing care when resettling medically vulnerable refugees;
2. To assess the impact of the Affordable Care Act and efforts to expand Medicaid coverage on medically vulnerable refugees;
3. To evaluate the various resettlement models utilized at the five research project sites and highlight models that reduce the challenge of providing care in resettling medically vulnerable refugees; and
4. To provide relevant policy recommendations.

CHALLENGES OF PROVIDING CARE

Cost

Findings

- Data shows that refugees with complex medical conditions (as defined by this study) require, on average, an additional 5.13 hours of case management and 27.27 miles driven by case management staff per refugee during the 90-day post-arrival period. These hours and miles indicate an investment beyond what is required for the medical case management of a healthy refugee who only needs the general services provided by resettlement staff to coordinate a Refugee Health Assessment (RHA).
- Data shows that refugees with severe medical conditions (as defined by this study) require on average an additional 7.69 case management hours and 63.76 miles during the 90-day post-arrival period.
- This translates to an average of approximately $164.19 in additional investment by resettlement affiliates for refugees with complex conditions and $258.95 additional investment for refugees with severe conditions per refugee.

Conclusions:

- The R&P program Cooperative Agreement requires resettlement affiliates to provide assistance in accessing health screenings and appropriate health services. Resettlement affiliates are covering additional costs for the case management of medically vulnerable refugees, with a particularly high investment required for refugees with severe medical conditions.
- These additional expenditures for refugees with severe medical conditions are typically not covered by the R&P funding provided to resettlement affiliates for resettlement, but come from either privately-raised funds or affiliate reserves. Although services for the medically vulnerable are required under the Cooperative Agreement, the disparity in the

amount of investment required by resettlement staff warrants further funding for these specific types of medical conditions and situations.

- The per capita discretionary amount of $200 is specifically for direct assistance to the refugees, and does not cover the additional administrative and medical case management costs of resettling medically vulnerable refugees.

Impact of Medical Conditions

Findings:

- The level of resettlement affiliate outlay varies based on the type of condition a refugee has, even within the subset of severe medical conditions as defined by this study. Certain medical conditions require a much higher level of resettlement affiliate support than others.
- Although many conditions fall under the category of severe, two conditions were found to require the most management and support from resettlement affiliates. These conditions are mental illness and mobility issues. Data shows that mental health issues require an average investment of 9.19 hours and 11.25 miles per refugee by resettlement affiliates during the 90-day post-arrival period. This translates into an additional cost of $273.09 per refugee to support refugees with this specific condition. Similarly, mobility issues require an additional average investment of 9.23 hours and 85.53 miles per refugee during the 90-day post-arrival period, resulting in an additional $315.85 per refugee for refugees resettled with these kinds of conditions.
- Emergency hospitalizations require a significant amount of investment from resettlement affiliates. Emergency hospitalizations, or hospitalizations that occur within the first two weeks of arrival, require an average investment of 19.81 hours and 139.25 miles per refugee by resettlement affiliates during the 90-day post-arrival period. This translates into an added investment of $652.92 per refugee.

Conclusions:

- On average, resettlement affiliates in this study invested more resources providing services for refugees with mental illness and mobility issues than any other conditions.
- Emergency hospitalizations, or hospitalizations that occur within the first two weeks of arrival, require significant support from resettlement affiliates.
- Resettlement affiliates do not have consistent or dependable funding mechanisms to support refugees with these specific conditions.

Flow of Refugee Health Information

Findings:

- Pre-arrival information on specific medical conditions is critical in determining whether a medically vulnerable refugee will continue to need assistance from the resettlement affiliate in order to manage their medical needs after the 90-day R&P period ends.
- Resettlement affiliate staff expressed a desire to understand how specific errors in pre-arrival information were addressed by the Bureau of Population, Refugees, and Migration (PRM), U.S. Department of State and to improve the system that supplies pre-arrival information about a refugee to the resettlement affiliate.

Conclusions:

- Incomplete or inaccurate pre-arrival medical information creates an additional challenge for resettlement affiliates engaged in pre-arrival planning. This is because it limits affiliates' ability to make appropriate arrangements for the management of these conditions in advance of arrival.
- Resettlement also suffers when medical information is not shared appropriately within resettlement affiliate offices, as well as between resettlement staff, state refugee officials (when appropriate) and medical service providers. Notification of local medical service providers and health officials on the medical status of a refugee, and ensuring this information is accurate, are critical components of a resettlement community's capacity to build relationships that will help provide appropriate health services to refugees.
- Information should be shared in a timely manner, appropriate to a refugee's medical needs (may be pre-assurance, pre-arrival, or post-arrival), and in accordance with recommended timeframes found in biodata and other medical forms, in order to ensure quick access to medical services.

Refugee Access to Medication

Findings:

- Medical Case Managers (MCMs) reported that refugees sometimes arrive without critical medications, having given them away prior to travel, and assuming that either replacement pharmaceuticals would be available upon arrival or that traveling with pharmaceuticals was not allowed.
- Resettlement affiliates reported that assisting refugees in accessing essential medication post-arrival often requires additional resettlement staff time. Resettlement affiliates may also need to pay for medication in situations where a lag in accessing health coverage prevents refugees from acquiring medication.

- Texas, one of the five research sites, limits recipients to three prescriptions per month. Many refugees with severe medical conditions require more than three prescriptions to manage their medical needs.
- A study conducted in 2012 identified 16 states that put some sort of limit on the number of prescription medications that an individual could receive through Medicaid.

Conclusions:

- For medically vulnerable refugees in certain states, there are obstacles to accessing essential medications. These obstacles can result in medical conditions being untreated, and lack of compliance with medical care providers' treatment protocols. Resettlement affiliates draw upon staff and financial resources to overcome these obstacles.
- Obstacles include insufficient orientation to managing prescriptions, both overseas and domestically, and state-specific Medicaid policies regarding medication coverage and payment.
- Refugees in 16 states may face prescription medication limits imposed through Medicaid policy, impacting their ability to address medical needs.

AFFORDABLE CARE ACT (ACA) AND MEDICAID EXPANSION

Effect of the ACA

Findings:

- State policies related to the ACA are still in a transitional phase and state officials remain actively involved in managing this transition.
- Healthcare Navigator programs are useful for informing refugee populations on options for health insurance coverage and providing education and orientation regarding the enrollment process.
- The ACA promotes Healthcare Navigator programs through grant funding. A Health Navigator program in Boise, ID, showed a dramatic decrease in missed medical appointments after the engagement of Health Advisors via this program.

Conclusions:

- Given the current status of the implementation of the ACA, it is not possible to measure the full impact of the new law on the resettlement of medically vulnerable refugees.
- In resettlement areas (counties) with large ethnic communities (10% of total population) advocacy and outreach should be conducted by resettlement affiliates to ensure that medical interpretation services are provided by federally funded healthcare providers.
- Healthcare Navigator services should be pursued by resettlement affiliates and community stakeholders to ensure that refugee populations have the information needed to access and utilize health insurance programs. These services include linking refugees

to appropriate health insurance options and providing education on appropriately utilizing this programming.

Impact of Medicaid Expansion

Findings:

- Refugees who are ineligible for Medicaid and do not live in a Medicaid expansion state are still able to access health coverage through Refugee Medical Assistance (RMA) during their first eight months post-arrival.
- If a refugee is no longer eligible for RMA (eight months post-arrival) and s/he is not able to access health insurance through the health insurance marketplace, through an employer, or by purchasing private insurance, the state of residency plays a large role in whether health coverage is accessible.
- If a refugee is resettled in one of the 24 states not expanding Medicaid, s/he has a much smaller chance of gaining health coverage via Medicaid in the post-RMA period due to restrictive eligibility criteria in those states. Note that at the time of this study, there were 24 states without expanded Medicaid. This number remains fluid, and in January 2015 (outside the confines of this report), Pennsylvania will join the ranks of the states that have expanded Medicaid, lowering the number of non-participating states to 23.
- Benefits of Medicaid expansion include continuity of coverage for refugees beyond the eight-month period, greater flexibility in programming, and a simplification in billing medical costs.
- State Refugee Coordinators (SRCs) interviewed for this study, who operate in the two Medicaid expansion states, report that they expect their RMA costs to drop significantly, if they are not eliminated entirely.
- Technical glitches in some new state health exchanges (including Minnesota) have prevented refugees from enrolling in expanded Medicaid in a timely manner.
- In cases where a refugee is unable to meet eligibility criteria to access affordable insurance options after the initial eight-month period through subsidies or traditional Medicaid in non-expansion states, resettlement affiliates try to link refugees with alternative federally or locally funded healthcare services such as free or low-cost clinics or federally Qualified Health Centers (FQHCs) to ensure that critical health services are accessible. This can occur either during the R&P period or after.

Conclusions:

- Adoption of Medicaid expansion has allowed participating states to enroll most refugees in state Medicaid programs in lieu of RMA.
- New Medicaid expansion states that do not account for refugees in the planning and implementation of healthcare exchanges may face issues when enrolling refugees into Medicaid.

- Because of the limitations posed by the length of the study it was not possible to track refugees' insurance status after the initial eight-month RMA period.
- Refugees over 18 and under 65 years of age, with no children, and in a state without expanded Medicaid, may have difficulty meeting strict eligibility standards.

SERVICE MODELS: A COST-BENEFIT ANALYSIS

Findings:

- The models examined can be placed in one of three categories:
    1. **Community-Based Collaborative Model**: This model serves the entire local resettlement community in which it operates, and functions with a centralized structure dedicated to the medical case management of medically vulnerable refugees across resettlement affiliates. The cost of this model is shared across affiliates, as are the benefits of sharing a coordination function across affiliates. Considering that the costs of programs that serve the communities utilizing this approach are moderate and that the client base is larger, these models (currently operational in St. Paul, Minnesota and Philadelphia, Pennsylvania) are more cost effective than the other models studied. The other models, however, are effective for the provision of medical services and referrals for their refugee populations.
    2. **Independent Center Model**: This model is managed by an individual agency in a multi-affiliate resettlement community. Affiliates operating under this model function independently of each other. All medical case management services occur within the confines of the independent affiliates. Costs are not shared between sites in these locations. The two affiliates considered operating within the confines of this model are those located in Boston, Massachusetts and Houston, Texas.
    3. **Single Agency Model**: This model is found in settings that contain a relatively small resettlement community consisting of a single affiliate and healthcare provider. In these type of cases, which can be found in Twin Falls, Idaho, the size of the refugee community does not lend itself to centralized coordination. This also precludes the possibility of collaboration between resettlement affiliates.
- Each of the five research sites works within different models to manage the additional challenge of providing medical services to medically vulnerable refugees. These models are supported by a variety of funding mechanisms, which vary significantly between sites. Funding for the positions that support these models are from private organizations, R&P, local grants (such as City of Boston's Community Block Grants), and various Office of Refugee Resettlement (ORR) grant programs. Funding sources are time-limited and sustainability of programming and their funding sources requires regular and continued attention by resettlement affiliate personnel.

- Models used at sites are adapted to existing local infrastructure, including the region's population density, number of resettlement affiliates present, engagement of state officials, and level of participation of Community Based Organizations (CBOs) and Mutual Assistance Associations (MAAs).
    - In **Boston**, services are provided by numerous stakeholders with little inter-organizational coordination, but with a concentration on robust provision of mental health services at the International Institute of New England (IINE). The model employed by this site uses dedicated medical case management, with associated personnel costs of $105,651 (1.75 FTEs).
    - In **Houston**, YMCA International Services centralizes the management of care within the affiliate, with little engagement by other local stakeholders. The model employed by this site uses dedicated medical case management personnel, with associated personnel costs of $120,744 (2.0 FTEs).
    - In **Philadelphia,** The Nationalities Services Center (NSC) and the Philadelphia Refugee Health Collaborative (PRHC) work collaboratively with other local resettlement affiliates, but with little engagement from the SRC and the State Refugee Health Coordinator (SRHC). The model employed by this site uses dedicated medical case management, with associated personnel costs of $102,558 (2.5 FTEs).
    - In **St. Paul**, the International Institute of Minnesota (IIMN) and other local resettlement affiliates work closely with the Minnesota Department of Health (MDH) to develop a medical services management plan with a strong focus on pre-arrival planning. The model employed by this site uses dedicated medical case management, with associated personnel costs of $90,558 (1.5 FTEs).
    - In **Twin Falls**, the College of Southern Idaho (CSI) is the only resettlement affiliate within that community, and all medical case management is managed by that affiliate. The model employed by this site uses dedicated medical case management, with associated personnel costs of $60,372 (1.0 FTEs).
- Two of the sites (Boston, Massachusetts and Twin Falls, Idaho) considered in this study are located in Wilson-Fish states. The affiliate receiving Wilson-Fish funds may prioritize their allocation to address the special needs of medically vulnerable refugees. Funds utilized in Wilson-Fish states serve a roughly equivalent purpose to Preferred Communities (PC) funds available in non-Wilson-Fish states.
- The Wilson-Fish program does not provide dedicated support for medical case management for medically vulnerable refugees, although it does provide additional case management support that can be utilized to support medical case management at the discretion of the administering affiliate. ORR is currently implementing regulations to

ensure that no state can accept both PC and Wilson-Fish funding for extended case management.

Conclusions:

- Communities should consider many variables when determining which model would be most appropriate for the provision of medical case management. These variables include the size of the resettlement population, the engagement of other local community organizations, including CBOs, MAAs, and other resettlement affiliates, the relative level of engagement of the SRC and SRHC, and available funding from various sources.
- In locations where there are multiple resettlement affiliates and robust state engagement, the model practiced in Minnesota's Twin Cities region is efficient for the provision of services to medically vulnerable refugees. In locations where there is limited state-level engagement, the PRHC is a robust model to ensure that refugees receive needed care in an efficient manner.
- In all localities, resettlement affiliate staff can assist refugees in acquiring emergency medical services before the RHA or initiation of primary care.
- Findings show that the varying administrative procedures related to Wilson-Fish do not affect medical case management of arriving refugees. A refugee resettled in a Wilson-Fish state will receive the same medical insurance coverage as one resettled in non-Wilson-Fish state.

Summary of Policy Recommendations

Challenges of Providing Care

COST

1. PRM should increase the administrative component of the per capita funding for a subset of medically vulnerable cases identified pre-arrival, on a per-capita basis. The conditions to be considered for additional per capita assistance should include mental health, cases with mobility issues and those requiring hospitalization within two weeks of arrival, as these require a level of investment far exceeding that of an average medically vulnerable case. This study found those conditions and situations to cost on average an additional $273.09, $315.85, and $652.92 respectively over the 90-day post-arrival period. In addition, ORR should continue to support extended case management for medical cases (including those with conditions identified above) through the PC and Wilson-Fish programs.

IMPACT OF MEDICAL CONDITIONS

2. The Centers for Disease Control and Prevention (CDC) should convene a working group and review multiple mental health assessment tools (such as the RHS-15), selecting the most appropriate tool for post-arrival mental health screening. The CDC mental health guidelines currently used should be assessed by this working group. The goal of this assessment would be to determine whether greater guidance could be provided to states and clinicians regarding the provision of mental health services to refugees.

FLOW OF REFUGEE HEALTH INFORMATION

3. Resettlement affiliates should continue to develop and improve information sharing and coordination related to Significant Medical Condition (SMC) and other medical forms, especially during the pre-arrival planning phase of resettlement of refugees with severe medical conditions. The recommendations in the biodata concerning when treatment should be received, as well as other medical forms, should be utilized to determine when medical information should be shared with medical service providers and local health officials. Information should be shared, where applicable, through secure, electronic channels.

REFUGEE ACCESS TO MEDICATION

4. Where possible, PRM, International Organization for Migration (IOM), CDC, UNHCR, and other pertinent agencies, should coordinate to provide two months' worth of critical medications in a sealed package to refugees immediately prior to departure.

5. PRM should reinforce orientation on medication and prescription management with Resettlement Support Centers (RSCs) overseas by incorporating the topic into Cultural Orientation where offered. National resettlement agencies should promote adoption of best practices for prescriptions management post-arrival and reinforce it through Community Orientation delivery across affiliate sites.

Affordable Care Act (ACA) and Medicaid Expansion

EFFECT OF THE ACA

6. Resettlement affiliates should participate in Health Navigator and Health Advisor programs by engaging in partnerships with organizations that provide these services, accessing existing programs, or seeking grant opportunities.
7. The ACA requires robust and professional medical interpretation services when a county has a particular language group represented at levels higher than 10% of the total population of the county. SRCs and resettlement affiliates should identify local communities who meet eligibility requirements and advocate to ensure established ethnic communities receive mandated language support. These advocacy efforts should include educating federally-assisted local medical service providers in regards to their obligation to provide accordant access to programs and activities for limited English proficiency individuals, as required by title VI of the Civil Rights Act.

IMPACT OF MEDICAID EXPANSION

8. Resettlement affiliates, SRCs and SRHCs should strengthen partnerships to address any possible gap in coverage by focusing on federal and local health options in locations without Medicaid expansion.
9. In states pursuing Medicaid expansion, SRCs and SRHCs should incorporate refugees' unique circumstances into the planning and implementation of new policy.

Service Models: A Cost-Benefit Analysis

MODEL COST-BENEFIT ANALYSIS

10. Use external organizations to support resettlement services. SRCs and resettlement affiliates should identify local MAAs and CBOs and build partnerships with them to promote successful resettlement of the medically vulnerable.
11. Build a collaborative model. Three categories of service model were identified during this study. Resettlement affiliates should consider the models presented and determine which have characteristics or functions that would be appropriate for their site. In cases where characteristics of a collaborative community-based model are appropriate, local

resettlement stakeholders should build partnerships to manage the implementation of a centralized coordination structure.