ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/programs/orr

Clarification on the Domestic Medical Screening Program

Dear Colleague Letter 23-08 November 4, 2022

Dear Colleague:

This Dear Colleague Letter (DCL) reiterates ORR's expectations for the domestic Medical Screening program. The DCL also provides examples of programmatic initiatives states[1] may implement to address challenges presented by rapid increases in arrivals, the resettlement of arrivals into localities where there are limited established Medical Screening programs, and other forms of heightened demand on the domestic Medical Screening program and existing health systems.

I. Medical Screening Program Administration and Management

The domestic Medical Screening program, administered in accordance with State Letter (SL) 12-09, *Revised Medical Screening Guidelines for Newly Arriving Refugees*[2] is the core responsibility of the Refugee Health Coordinators (RHC)[3]. ORR expects State Refugee Coordinators (SRC) and RHCs to collaborate to regularly assess developing situations that impact their state's domestic Medical Screening program. Based on results of these assessments, states may need to adjust their programming to meet the domestic medical screening needs in their state. SL12-09 recommends that ORR-eligible populations complete their domestic medical screenings within 30 days and up to 90 days from their date of eligibility for ORR benefits. Given the current challenges ORR reiterates that the Refugee Medical Assistance (RMA) program can cover medical screening costs if conducted within the first year of eligibility for ORR benefits as long as costs are not covered by Medicaid or CHIP.

Provided below are some examples of programmatic initiatives that states might consider.

A. Increase Domestic Medical Screening Efficiency and Capacity

1. Prioritize components of medical screening to ensure the most urgent physical and mental health issues are addressed in a timely manner.
2. Prioritize individuals and families with urgent medical needs to ensure these are addressed in a timely manner.
3. Establish new sub-recipient agreements in areas currently unable to meet screening demands or in locations where there are no screening providers.
4. When and where appropriate, consider alternative mechanisms to alleviate the strain on traditional screening sites and/or provide screening options in areas where there are limited screening providers (e.g., integration of virtual screening services for some conditions; use of mobile clinics and/or alternative screening locations to

[1] The term 'states' refers to states and replacement designees
[2] 'Refugees' refers to all ORR-eligible populations
[3] Policy Letter 16-05, *The Role of Refugee Health Coordinators*

support components of the medical screening such as vaccinations).

5. As allowed under SL 12-13, *Guidance on Reporting and Estimating Administrative Costs For the Refugee Cash and Medical Assistance (CMA) Program*, increase Medical Screening program staff at state and clinic level and medical screening coordination costs, including scheduling appointments, interpretation, and transportation if not already covered by another federal program, as well as data collection and reporting for the provision of medical screenings, as necessary.
6. Collaborate with local Tuberculosis (TB) programs to leverage TB resources and avoid duplication of TB testing. TB testing is a component of the domestic medical screening and may be covered by RMA if completed through the domestic Medical Screening program and not covered under another federal program. Interferon Gamma Release Assay (IGRA) blood test screens completed to meet the Uniting for Ukraine (U4U) medical parole requirements may be used to inform the domestic medical screening.

B. Offer Technical Assistance and Resources to Healthcare Partners

1. If expansion of the Medical Screening program's sub-recipients or screening network is not possible, provide technical assistance to primary care providers, local health departments, and/or other healthcare partners caring for ORR-eligible populations on the Centers for Disease Control and Prevention (CDC) medical screening guidance. This includes guidance on prioritizing key components of the medical screening.
2. Connect healthcare partners to medical screening resources, including the CDC medical screening guidance, tools (e.g., CareRef), health profiles, and other resources.

C. Propose Innovative Projects

1. ORR welcomes states to propose innovative projects to achieve the goals of the Medical Screening program as outlined in SL 12-09. States should reach out to their health liaison within the Division of Refugee Health to discuss any innovative proposals outside of what is normally expected of the traditional Medical Screening program and to seek ORR approval.

States must submit a revised ORR-1 for any anticipated significant increases in estimated cost.

II. **Other Considerations: Connection to Primary Care**

ORR encourages all ORR-eligible populations to get a domestic medical screening to the extent that is possible. However, for states experiencing medical screening backlogs, a delay in medical screenings should not delay the connection to primary care.

States should consider alternative mechanisms beyond the domestic Medical Screening program to connect individuals to primary care if the person cannot complete a domestic medical screening within the recommended 90-day timeframe. For example, linkage to primary care could occur prior to scheduling the medical screening to help ensure access to a regular source of healthcare. Primary care providers unfamiliar with the domestic medical screening and caring for ORR-eligible populations can be connected with resources such as CDC's medical screening guidance, tools (e.g., CareRef), health profiles, and other resources.

If individuals have not received a domestic medical screening within 12 months from the date of eligibility for ORR benefits and services, they should be referred to a primary care provider,

even if the provider is not a traditional domestic medical screening provider. States should prioritize early connection to primary care for individuals with urgent medical needs. ORR has increased funding for the Refugee Health Promotion (RHP) program which may assist with medical and mental health care navigation and support. In addition, states should consider intensive case management and other services available through the Preferred Communities program.

III. Resources and Points of Contact

If you have any questions about medical screenings or allowable implementation of programming, please contact your health liaison within the Division of Refugee Health. ORR also encourages you to use ORR's technical assistance providers for additional resources for serving refugees.

In addition, ORR recommends that you regularly visit the ORR web page on Policy Letters to remain abreast of additional policy, information on flexibilities and waivers, and other ORR resources and publications.

Further questions can be directed to:

- **Medical Screening program**: Your DRH Health Liaison and Margaret Brewinski Isaacs, Director of the Division of Refugee Health, at Margaret.BrewinskiIsaacs@acf.hhs.gov
- **Eligibility for Benefits or Services**: ORR's Refugee Policy Unit at RefugeeEligibility@acf.hhs.gov.

Sincerely,

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