Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"Protecting Unaccompanied Children: The Ongoing Impacts of the Trump Administration's Cruel Policies"

September 19, 2019

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The Honorable Ann Kuster (D-NH)

1. What criteria is employed in determining which out-of-network facilities are used?

   RESPONSE: Where the Office of Refugee Resettlement's (ORR) in-network providers are unable to provide for the individual needs of an unaccompanied alien child (UAC), ORR may determine that an out-of-network (OON) provider is better able to serve the child. A child is usually placed in an OON is due to medical reasons (e.g., the child has significant health needs that require a prolonged stay in a hospital), acute mental health, or behavioral concerns that cannot be met within ORR's network of specialized care providers.

2. Are out-of-network facilities held to the same requirements outlined in ORR policies, as in-network placements?

   RESPONSE: OON providers follow the requirements of their licensing authority and applicable federal and state regulations. The ORR care provider "base facility" that made the referral for the OON placement remains responsible for the child's case management services (including family unification services), as these can be managed remotely.

   For children placed in OON for mental health or behavioral reasons, the child's in-network "base facility" is also responsible for the child's case management services, including reporting allegations of abuse, and for providing notice to the child for the reasons for their placement in an OON facility[1] via the *Notice of Placement in a Restrictive Setting* (see ORR Policy Guide, section 1.2.4 Secure and Staff Secure Care Provider Facilities, 1.4.2 30 Day Restrictive Placement Case Review, and 1.4.6. Residential Treatment Center Placements, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1).

   a. If so, how is that monitored?

[1] ORR procedures allow an OON Residential Treatment Center to provide the *Notice of Placement in a Restrictive Setting* as well if the facility so chooses. Otherwise, the responsibility remains with the ORR care provider "base facility."

RESPONSE: OON providers are monitored by the state licensing agency that has jurisdiction over the facility. Additionally, ORR's interim guidance provides that ORR Federal Field Specialists visit the child and maintain ongoing contact with the OON provider and child.

3. Have all youth currently placed in out-of-network facilities been determined to be a danger to themselves or others by a licensed psychologist or psychiatrist?

   RESPONSE: For those children placed in an OON facility that provides services as a Residential Treatment Center, yes. This is in line with requirements laid out in ORR policy (see ORR Policy Guide, section 1.4.6 Residential Treatment Center Placements, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4.6).

4. What is ORR's policy around informing Vera-funded legal service providers, including those who have not formally entered an appearance for a child, prior to a child being transferred to an out-of-network facility?

   RESPONSE: Attorneys of record, or the ORR-funded legal service provider when a child has no attorney of record, are notified whenever a child is transferred to another facility, including an OON provider, in accordance with the terms of the Flores Settlement Agreement (FSA) and ORR Policy (see ORR Policy Guide, section 1.4 Transfers within the ORR Care Provider Network, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4).

5. How is ORR accommodating a youth's need to access the court in which their case has been docketed?

   RESPONSE: ORR transports children in custody to all proceedings to which they are a party as required by law. When ORR transfers children to a different jurisdiction, the referring care provider requests a change of venue and address with the appropriate DHS chief counsel's office, who in turn notifies the immigration court.

6. How is ORR ensuring that youth at out-of-network facilities have access to counsel, and minimizing the need to transfer counsel?

   RESPONSE: ORR's primary mission is to provide for a child's individual needs, which is the underlying basis for their transfer to an OON provider. Children are provided access to counsel regardless of where they are placed, and in some instances ORR has collaborated with a child's counsel to identify an OON provider that can both meet the child's needs and allow the child's attorney to continue effectively representing the child.

7. How do you currently track the administration of psychotropic medications to children in custody?

RESPONSE: All medication, including psychotropic and over-the-counter, must be logged in accordance with state licensing requirements and ORR policy. For more information on medication management, see ORR Policy Guide, section 3.4.4 Medication Administration and Management, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.4.4. For record keeping requirements, see section 5.6.2 Maintaining Case Files, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.6.2.

8. On what legal authority does ORR or its contracted providers, authorize the use of psychotropic medications without parental or patient consent?

RESPONSE: ORR is the recognized legal custodian of UAC in HHS custody by authority delegated by Congress under 8 U.S.C. 1232(b). Psychotropic medication is prescribed by a physician, not by ORR staff.

9. Is there any independent review or oversight of non-consensual administration of psychotropic medication to children in ORR's custody?

RESPONSE: ORR policy allows the use of chemical restraints in emergency safety situations in accordance with state law and licensing requirements. Most states prohibit the use of chemical restraints for children. See ORR Policy Guide, section 3.3.15 Use of Restraints or Seclusion in Emergency Safety Situations in Residential Treatment Centers (RTCs), available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.3.15

10. What is ORR's process for informing Vera when a new contract facility for unaccompanied children is opened to ensure legal services are immediately made available?

RESPONSE: The ORR Contract Officer Representative for the legal service contract is in weekly contact with Vera and provides regular updates as to where and when ORR care providers are coming online.

The Honorable Joseph P. Kennedy III (D-MA)

1. Is HHS still using unreliable, invasive dental exams as an age verification method to move children out of ORR care and into adult detention facilities?

RESPONSE: ORR may use dental exams (specifically radiographs to determine age) in conjunction with other evidence to determine whether an unidentified alien child in ORR custody is a minor or an adult. Maintaining custody of an adult in a state licensed facility is a serious licensing violation that may lead to punitive action against the facility including loss of license. There are also prohibitions of maintaining children with adults as well under the terms of the FSA.

a. Are you comfortable with the fact that there are most likely children in adult facilities because the OIG's own report recognizes that the science used in those reports cannot pinpoint a child's age, and instead can only provide broad age ranges?

RESPONSE: As required by law and ORR policy, ORR does not rely exclusively on radiographs, including dental radiographs. See 8 U.S.C. 1232(b)(4); and ORR policy (see ORR Policy Guide, section 1.6 Determining the Age of an Individual without Lawful Immigration Status, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.6). The TVPRA requires the age determination procedures, at a minimum, to take into account multiple forms of evidence, and specifically says such evidence include radiographs. Accordingly, under these procedures, each case must be evaluated carefully based on the totality of all available evidence, including the statement of the individual in question. Specifically, in regards to medical age determinations, please refer to ORR Policy Guide, section 1.6.2 Instructions, available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.6.2).

2. Are children still being separated from their parents and if so, how many children currently in your custody have been separated from their parents?

RESPONSE: HHS has no role in immigration enforcement and does not separate parents and children. ORR publishes reports to Congress on separations, which can be viewed online. For information on parental separations, including numbers of children in ORR custody who were separated from their parents for cause, please visit: https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/report-to-congress-on-separated-children/index.html.

a. If a child is separated from their parent, what legal recourse does that parent and child have to immediately challenge that decision?

RESPONSE: ORR defers to the Departments of Homeland Security and Justice for questions pertaining to the separation of parents and children.

3. Earlier this month, it was reported that ORR was not funding legal services for detained immigrant children in at least 3 facilities. Are there currently any licensed detention facilities that do not maintain a contract with a legal aid organization to meet your legal obligations to detained children?

RESPONSE: Under the terms of the FSA, ORR must provide children in custody with a notice of their rights, the right to be represented by counsel at no expense to the government, the right to a removal hearing before an immigration judge, and the right to apply for political asylum or to request voluntary departure in lieu of deportation. ORR typically provides such notice to all children upon entry into an ORR care provider via a Know Your

Rights (KYR) presentation by a contracted legal service provider, but can provide the KYR via video if necessary.

Please note that the contract with the legal service provider is between ORR and the legal service provider contractor, not between the ORR care provider and a legal service provider. The legal service provider, in turn, subcontracts services to local legal service providers who provide KYRs, legal screenings for children (to determine potential eligibility for legal immigration relief), referrals to pro bono counsel, training of pro bono counsel, and in some instances direct representation for children in their immigration proceedings.

At this time all ORR care providers have coverage from a local legal service provider. Because of the difficulty in predicting when new beds (or additional beds at an existing ORR care provider) may come online, the time between modifying the legal service contract and the opening of a facility may not always align. Historically, this gap has been temporary. Where there have been temporary gaps in coverage, in some instances ORR has requested the nearest contracted legal service providers to travel to new facilities to provide the required notices or else provided the notifications via video presentations. When legal service providers for new care provider facilities are contracted, they immediately visit the facilities and provide all required services. As a result, all children in ORR custody receive all legally mandated notices regarding availability of legal services, access to counsel, and notices regarding their rights.

The Honorable Brett Guthrie (R-KY)

1. Under the TVPRA, except in exceptional circumstances, unaccompanied children must be transferred to ORR within 72 hours of determining a child is an unaccompanied child. CBP and ORR appear to have a difference of opinion regarding when the clock starts on the 72-hour limit. What is ORR's view is on when that 72-hour clock starts?

   RESPONSE: DHS may make the UAC determination at or after the point of apprehending the child. The start time for the 72-hour clock may thus vary based on the facts and circumstances of each individual case.

   a. Does Congress need to more clearly define how much time each agency has for their respective role in the process? If so, what is ORR's suggestion on what those allotted times should be for each agency?

      RESPONSE: Congressional action on comprehensive immigration reform could prevent future surges at the border.

2. Is there a need to examine, and possibly amend, the TVPRA with respect to the definition of a UAC so that in addition to parents and legal guardians, children are not separated by DHS from other family members, such as a grandparent or adult sibling?

   RESPONSE: HHS does not have a formal position on amending the TVPRA to treat other family members as parents and legal guardians.

a. As child welfare experts, does ORR have any concerns or possible unintended consequences of amending that definition?

RESPONSE: Confirming a parent-child relationship is less difficult than confirming other familial relationships. If other family members were treated the same as parents and legal guardians, there would need to be adequate safeguards to prevent fraudulent claims of familial relationships. ORR is concerned such a change could encourage fraudulent claims of familial relationships and place children at risk. Additionally, even where there is a confirmed familial relationship, relatives may have little, if any, connection to the child, other than having been apprehended together. It may not be in the child's best interest to be placed with an adult who may essentially be a stranger to the child.

b. Is there a need to further specify when a child can or cannot be separated for cause? For example, specifying what past criminal convictions pose a danger to the child and/or what communicable diseases would warrant a temporary separation?

RESPONSE: ORR is not responsible or involved in the decision to separate families. With this in mind in order to ensure the safety of children, ORR recommends tying the criteria described in Section 2.7.4 of the ORR Policy Guide as the basis for denying sponsorship, as the basis for separating families. (See https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-2#2.7.4.).

3. Understanding that migration patterns are unpredictable, what steps is ORR taking to evaluate its capacity modeling to ensure ORR has sufficient capacity and there isn't a backlog at CBP facilities when referrals inevitably go up again?

RESPONSE: ORR continually evaluates its capacity modeling to ensure there is not a backlog of UAC at CBP facilities, utilizing data from DHS and HHS. ORR uses a series of data points and trends to determine its capacity needs, including its statistics describing placements, referrals, and discharges over previous months and years. However, ORR's short-term capacity needs are always subject to change, as there is no definitive method to predict the amount of future UAC that will come into ORR care.

a. What would an ideal capacity model be given ORR's experience with the ebb and flow of referrals they receive?

RESPONSE: It is in the best interest of every child to be with their family or a caregiver. And when family or a caregiver is not available – even temporarily – it is in the best interest of the child to be in the least restrictive environment and most child friendly setting available. To this end, ORR is working to build permanent capacity composed of family-foster care and small-or medium-sized permanent shelters. While efforts to build such capacity are underway, HHS-run facilities, whether licensed or unlicensed, large or small, are always better equipped to serve

children than any border patrol facility. Therefore, we have made it an equal priority to obtain as much capacity as necessary, both using traditional state-licensed beds as well as influx shelter beds (in facilities that may or may not be state-licensed), in order to ensure children are expeditiously placed with an ORR-care provider facility. Our long-term goal is to create a system where ORR is able to carry sufficient permanent hard-sided state-licensed capacity that can adapt to changing needs efficiently, such that influx care facilities are needed only in extreme circumstances. Our short-term goal is to ensure that children spend as little time in border patrol facilities as possible and are safely released or reunified with family or other sponsors as quickly as possible.

As ORR's mission is to provide temporary care of all minors referred to our care, ORR must maintain sufficient bed space to accommodate regular seasonal fluctuations in migrations as well as any future influxes that may occur. Since passage of the TVPRA in 2008, the Federal Government has seen a continued increase in border crossings by UAC. Unfortunately, while migration patterns have shown a historic upward trend for this population, the relative rate of increase in referrals from year-to-year has been difficult to predict.

4. On average, how long does it take for a new ORR grantee facility to come online from the time HHS posts a funding opportunity announcement, to the time a facility is approved to accept and provide direct care for unaccompanied children?

   RESPONSE: The average time from announcing a grant via a Funding Opportunity Announcement (FOA), to providing a notice of award, to the time a facility is able to accept children varies considerably based on several factors including, but not limited to: internal administrative requirements inherent to the competitive grant review process; state/local licensing agencies awarding of a license in certain circumstances; and the extent of any community opposition.

   Typically ORR uses a 60-day FOA announcement (in some instances, the office has used a 45-day announcement). It takes roughly four to five months after an FOA closes to send notice of awards to selected grantees. During this four to five month period, grant panels review applications and make selections following the competitive process. If an awardee already has a license in good standing, the program typically is able to hire staff and be ready for placements within anywhere of 60-120 days of the notice of award. If the grantee awardee needs to obtain a license, the process can take upwards of one year from the date of the notice of award before the facility may accept UAC placements. ORR notes that the recent trend has been it takes longer to bring licensed capacity, especially for new grantees, based on increased scrutiny from state and local officials over the licensing process.

   a. How does that compare to the temporary influx facilities that ORR has used in the past?

RESPONSE: ORR utilizes an influx care facility to provide temporary emergency shelter and services for UAC during an influx, natural disaster, or other emergency event (e.g., fire, terrorism). Depending on state law, influx care facilities may not require licensure or may be exempted from licensing requirements because they are operated on federally-owned or leased properties. Because influx facilities may not need state licensing, historically ORR has been able to bring influx facility beds online more quickly than permanent facility beds.

Comparing specific influx care facilities is difficult because each site ORR has used in the past has presented unique circumstances that either helped or hindered bringing the beds online. Generally, it can take anywhere from a few weeks to a few months to prepare an influx care facility, depending on many factors, including: site preparation; paperwork (e.g., Memoranda of Agreement, leases/licenses, fire life safety reporting requirements, and contracts/grant supplements, as needed); and site operator requirements (e.g., hiring, materials).

5. When did ORR first start trying to bring Carrizo Springs online, how long did that process take, and what is the status of Carrizo Springs?

RESPONSE: ORR began exploring options to acquire the Carrizo Springs site for possible influx beds in May 2019. The first UAC arrived at Carrizo Springs on June 30, 2019, and the last UAC left by July 25, 2019. Carrizo Springs is currently on "warm" status, meaning that ORR does not currently place any children at the facility, but that it nevertheless continues to fund a minimum number of support staff sufficient to secure and maintain the facility in case ORR needs influx beds on short notice.

a. Unlike traditional influx facilities, HHS holds a three-year lease on the Carrizo Springs facility. What will holding this lease mean going forward? For instance, will HHS be able to activate Carrizo Springs when you reach influx levels quicker than ORR was able to stand-up previous influx facilities?

RESPONSE: Because of the three-year lease and the improvements to the infrastructure, ORR believes it has the ability to quickly activate Carrizo Springs if influx beds are needed.

b. How does ORR see Carrizo Springs helping with the inevitable ebb and flow of the referrals that it receives?

RESPONSE: Carrizo Springs is critical for ORR's planning purposes, which project a need for up to 3,000 beds at temporary influx facilities.

As stated above, ORR is expanding state-licensed permanent capacity with the goal of decreasing reliance on temporary unlicensed influx care facilities, using a series of

data points and trends to determine its capacity needs, including the need for temporary influx care facility beds for events not related to an influx, such as a natural disaster or other emergency event that would disable a permanent facility's ability to care for children or operate. But ORR's short-term capacity needs are always subject to change, so it is important to maintain the ability to quickly activate new beds in the event they are needed.

6. One of the OIG reports released in September states that ORR facilities reported challenges in accessing external mental health specialists. One of the reasons cited is specialists hesitated to continue treatment of children, or initiate new treatment, because prior reimbursements had been delayed. How are providers reimbursed through the ORR program?

   RESPONSE: ORR uses a third party administrator and the Veteran's Administration's Financial Services Center (VAFSC) to manage the medical services for UAC. Point Comfort Underwriters, Inc. (PCU) is a licensed insurance underwriter and third party administrator responsible for administrative functions related to medical (including mental health and prescription drugs), and dental services for UAC. PCU's functions include approval of Treatment Authorization Requests (TAR) required for services, processing, and payment of claims.

   A Treatment Authorization Request (TAR) is a document used by ORR care providers to request approval of medical services for UAC placed at that facility. The ORR care provider must describe the circumstances giving rise to the need for services on the TAR. The TAR is then submitted by the ORR care provider to PCU. TARs are reviewed and adjudicated by PCU, and returned to the care provider with confirmation of approval, disapproval or request for additional information (see ORR Policy Guide, section 3.4.9 Provider Reimbursement at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.4.9).

   TARs for non-emergency office visits (primary care, specialty consultations, mental health, and dental care), laboratory tests, surgeries and procedures, physical therapy, and other specialized health treatments must be pre-approved before services are rendered. Some services are not covered (e.g., cosmetic treatment, experimental treatment). Each UAC undergoes an Initial Medical Examination (IME) upon admission to an ORR Care Provider program. All IME components are pre-authorized (see ORR Policy Guide, section 3.4.2 Initial Medical Examination at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.4.2).

   PCU maintains a network of doctors, hospitals, urgent care facilities and other medical and mental health providers who will provide services to children in custody at a discounted rate. Their goal is to ensure that quality medical service providers, encompassing a full range of specialties and sub-specialties, are available and accessible at all times. Reimbursement for medical services are paid through VAFSC.

a. Is ORR looking at ways to improve this process?

RESPONSE: Although ORR is aware of anecdotal reports on delays for payment, to the office's knowledge the issues reported by OIG are unusual. If medical providers report concerns to ORR, ORR works with PCU to ensure that payment is made expeditiously.

7. One of the recent HHS OIG reports focused on required background checks, and challenges in hiring, screening, and retaining employees. Specifically, HHS OIG found that ORR granted six facilities waivers from conducting child protective services checks, for employees with direct access to children. Why were these waivers were granted?

Response: OIG identified six care providers for which ORR waived child abuse and neglect checks (CA/N checks), also known as child protective services checks, at the time of their review. Four of the six care providers were licensed as behavioral health residential facilities by the state of Arizona, and the state did not require CA/N checks and, therefore, refused do to the background checks.

Two of the six facilities were influx care facilities (ICF): Homestead ICF in Florida and Tornillo ICF in Texas. The state residential licensing agency in Florida does not have jurisdiction to license an influx facility because it is operated on federal land. The applicable Florida statutes and regulations only allow access to the child abuse and neglect registry for licensed providers. Therefore, ORR and the contractor operating Homestead ICF were unable to run CA/N checks on Homestead employees. ORR's ICF provider in Texas was similarly denied access to child abuse and neglect registries based on similar restrictions in state law and regulations.

a. Do the waivers still exist? If not, when were they terminated?

Response: ORR rescinded all waivers to non-influx care providers for CA/N checks on May 23, 2019. ORR also notes that the Tornillo ICF closed in January of 2019, and Homestead ICF is on warm status with no direct care staff onsite. No children have been placed at Homestead since July 3, 2019.

b. Under what circumstances would ORR grant additional waivers in the future?

Response: Care providers must notify ORR's Prevention of Sexual Abuse Coordinator if they cannot complete required background investigation components. ORR provides technical assistance to ensure that all background investigation components are completed, rather than providing waivers to non-influx care providers. For example, when a non-influx care provider requested a waiver for an applicant pending a lengthy interstate CA/N check, ORR declined to provide the waiver.

If ORR operates an ICF in the future, and the facility is unable to conduct CA/N checks, ORR may use its regulatory authority to waive CA/N checks. ORR

regulations allow the ORR Director to waive or modify background check requirements for influx care facilities for good cause. (See 45 C.F.R. § 411.10(c)).

c. Has ORR or its grantees had any challenges with the states and/or the FBI with regards to completing the required background checks?
   i. If so, what are the challenges and which states are there issues with?

Response: ORR and our grantees have faced a number of challenges related to required background checks. As noted in the OIG report, records are state-specific and the check is performed by state officials. There is no central database of CA/N records and states can take anywhere from three weeks to three months to process CA/N checks. Additionally, interstate CA/N checks can be particularly challenging. Interstate CA/N checks are required for employees who moved from another state or territory within five years prior to employment with the care provider. Some states do not share information in their CA/N registry with other states. Some state officials experience delayed responses, or a lack of response, when they request information from other states. ACF is working to identify ways to facilitate the implementation of federally required CA/N checks by conducting outreach to state CA/N registry officials. Generally, ORR has not had challenges with the FBI in performing background checks for state licensed facilities.

8. One of the HHS OIG reports released in September focused on employee ratio issues, both for case managers and mental health clinicians. A chart in the report shows many facilities being out of ratio for these personnel. Given this was based on a sample of ORR facilities, how common is it across all of ORR's network for the staff to child ratios to exceed 1:12 for mental health clinicians and 1:8 for case managers respectively?

RESPONSE: ORR maintains one of the most robust clinician to child ratios of any child welfare program in the nation. Historically, ORR's clinical ratio was 1:25 for clinicians and 1:20 for case managers. The ratios set in more recent years were adjusted to better serve children and to help concentrate resources on release from custody. While ORR care providers occasionally may not meet clinical ratios as maintained in their cooperative agreements, ORR has been able to ensure that all children are receiving legally mandated services in a timely fashion in accordance with the FSA. The same is true for case management ratios. While maintaining such a high ratio may be difficult on a facility-by-facility basis, generally the provision of case management services to UAC follows all legally mandated requirements under the FSA.

   a. What happens when a facility is out of ratio? Is there risk of losing their license? Can they still care for children?

RESPONSE: ORR care provider requirements for case manager and clinician ratios far exceed those of state licensing requirements, and some states do not specify a specific number of clinicians for a residential facility. If a specific care provider does not maintain adequate clinical or case management ratios to such an extent that the care provider is at risk of not being able to meet FSA mandated service requirements, ORR may stop placement at the facility or reduce the bed capacity.

State licensing does address direct care staffing ratios (i.e., the direct supervision of children). ORR requires that care providers supervise children and youth in their facilities in accordance with these state licensing requirements. Additionally, ORR policy requires minimum supervision ratios. Direct care staff-to-children ratios must be maintained at a minimum of:

- One on-duty youth care worker for every eight children or youth during waking hours; and
- One on-duty youth care worker for every 16 children or youth during sleeping hours

(See ORR Policy Guide, section 4.4.1 Staffing Levels at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-4#4.4.1).

An inability to maintain the supervision ratio required by licensing would lead to disciplinary action by state licensing officials. Specific sanctions would vary by state, and the specific reason for being out of ratio. ORR's response would also vary depending on the nature of the concern but may lead to a stop in placements or a reduction in bed capacity.