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MEDICAID AND SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES

2007 UPDATE

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March 2007

This report was made possible with the generous support of The California Endowment.

MEDICAID/SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES 2007 UPDATE

In 2000, the Centers for Medicare & Medicaid Services (CMS) reminded states that they could include language services as an administrative or optional covered service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet only a handful of states are directly reimbursing providers for language services. Currently, the District of Columbia and 12 states (Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming) are providing reimbursement. Three states have initiated discussions about reimbursement. Texas enacted legislation requiring a pilot program but it has not yet been implemented. North Carolina expects to provide reimbursement after establishing interpreter credentialing. And California has a Task Force established by the Department of Health Services that is identifying methods of initiating reimbursement.

The remainder of this issue brief outlines existing state mechanisms for directly reimbursing providers for language services for Medicaid and SCHIP enrollees.[1] (For more information on funding for Medicaid and SCHIP services, see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?*[2]). While only some states currently provide reimbursement, the examples below can help you identify promising ways to evaluate and establish reimbursement mechanisms to meet your state's needs and goals.

STATES CURRENTLY PROVIDING REIMBURSEMENT

State	For which Medicaid and SCHIP enrollees?	Which Medicaid and SCHIP providers can submit for reimbursement?	Who does the State reimburse?	How much does the state pay for language services provided to Medicaid/SCHIP enrollees?	How does the state claim its federal share – as a service or administrative expense[3]?	What percentage of the state's costs does the federal government pay (FY 2006)[4]?
DC	Fee-for-service[5] (FFS)	FFS < 15 employees	language agencies[6]	$135-$190/hour (in-person) $1.60/min (telephonic)	Admin	50%
HI	Fee-for-service (FFS)	FFS	language agencies	$36/hour (in 15 min. increments)	Service	Medicaid (MA) – 57.55% SCHIP – 70.29%
ID	FFS	FFS	providers	$12.16/hour	Service	MA – 70.36% SCHIP – 79.25%
KS	Managed care	not applicable (state pays for language line)	EDS (fiscal agent)	Spanish – $1.10/minute; other languages – $2.04/minute	Admin	50%
ME	FFS	FFS	providers	reasonable costs reimbursed	Service	MA – 63.27% SCHIP – 74.29%
MN	FFS	FFS	providers	lesser of $12.50/15 min or usual and customary fee	Admin	50%
MT	all Medicaid	all[7]	interpreters	lesser of $6.25/15 minutes or usual and customary fee	Admin	50%
NH	FFS	FFS	interpreters (who are Medicaid providers)	$15/hour $2.25/15 min after first hour	Admin	50%
UT	FFS	FFS	language agencies	$28-35/hour (in-person) $1.10/minute (telephonic)	Service	MA – 70.14% SCHIP – 79.10%
VA	FFS	FFS	Area Health Education Center & 3 public health departments	reasonable costs reimbursed	Admin	50%
VT	All	All	language agency	$15/15 min. increments	Admin	50%
WA	All	public entities	public entities	50% allowable expenses	Admin	50%
WA	All	non-public entities	brokers; language agencies	brokers receive administrative fee language agencies receive $33/hour ($34 as of 7/1/07)	Admin	50%
WY	FFS	FFS	interpreters	$11.25/15 min	Admin	50%

District of Columbia

Beginning in March 2006, the District of Columbia's Medical Assistance Administration (MAA) began providing access to a telephone language line that fee-for-service Medicaid/SCHIP providers could use – at MAA expense – to obtain an interpreter. Only fee-for-service primary care providers who employ less than fifteen (15) persons are eligible to use this language line. All FFS providers with fifteen (15) or more employees must provide and pay for interpreter services themselves.

According to the MAA transmittal sent to all Medicaid providers, eligible providers must request interpreter services at least seven (7) business days prior to the date of service or appointment. The provider sends the request to MAA's designated language agency. MAA approves or disapproves each request and the language agency then confirms the availability of an interpreter and notifies the requesting provider and Medicaid beneficiary. If emergency interpreter services are required, the provider can contact the language agency directly.

Managed care organizations have a separate obligation to provide language services under both federal law and the terms of DC's Medicaid managed care contract. Health care providers serving Medicaid managed care enrollees must request an interpreter directly from the MCO. The MCO notifies the requesting provider and Medicaid beneficiary of the availability of an interpreter within three (3) business days of the request.

MAA contracts with one language agency and pays between $130-$190 per hour. The rate varies based on the language needed and how much advance notice is provided. For example, Spanish interpreters cost MAA $135./hour if 3-5 business days notice is provided and $160/hour if less notice is provided; the rates are $160 and $190 respectively for Amharic, Chinese, Korean, and Vietnamese interpreters. After the first hour, charges range from $3-$5 per minute. All encounters are subject to a $25. administrative charge. MAA pays $1.60/minute for telephonic interpretation.

In the first six months the program was operational, MAA spent $895. on interpreters and $2723.09 for translation of written materials.

Hawaii[i]

The state contracts with two language service organizations to provide interpreters. The eligible enrollees are Medicaid fee-for-service patients or SCHIP-enrolled children with disabilities. The state pays the language service agency a rate of $9 per 15 minutes. If an interpreter is needed for more than 1½ hours, a report must be submitted stating the reason for the extended time. Interpreters who are staff or bilingual providers are not reimbursed.

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i The information from Hawaii is from 2002. The author made repeated attempts to contact Hawaii agency staff to update this information but received no response.

Interpreters are allowed to charge for travel, waiting time, and parking. The state has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire. The state spends approximately $144,000 per year on interpreter services for approximately 2570 visits (approximately $56 per visit). Hawaii receives reimbursement for the interpreter services as a "covered service" (similar to an office visit or other service covered by the state's Medicaid plan). The state receives federal reimbursement of approximately 57% for Medicaid patients and 70% for SCHIP patients.

The costs of providing interpreters for in-patient hospital stays are included in hospitals' existing payment rates; separate reimbursement is not allowed. QUEST, the state's Medicaid managed care program, includes specific funding in its capitated rates for enabling/translation services (based on volume and claims submission data).

Idaho

Idaho began reimbursing providers for the costs of interpreters prior to 1990. The state reimburses for interpreters provided to fee-for-service enrollees and those participating in the Primary Care Case Management program. Providers must hire interpreters and then submit claims for reimbursement. Providers must use independent interpreters; providers can only submit claims for reimbursement for services provided by members of their staff if they can document that the staff are not receiving any other form of wages or salary during the period of time when they are interpreting. No training or certification requirements for interpreters currently exist.

Hospitals may not submit claims for reimbursement for language services provided during in-patient hospital stays. The costs of language services are considered part of the facilities' overhead and administrative costs.

Idaho reimburses the costs of language interpretation at a rate of $12.16 per hour (this is the same rate for sign language interpreters). In 2006, the state spent $87,913. on 7,438 units of interpretive services. These services were for 768 unduplicated clients. In FY 2004[8], the state spent $37,621 on language services for 4137 encounters.

Kansas

In 2003, Kansas began offering Medicaid managed care healthcare providers access to a telephone interpreter/language line. The service is provided to primary care providers (for example, individual doctors and group practices, rural health centers, federally qualified health centers, Indian health centers, advanced registered nurse practitioners, and Nurse Mid-wives) and specialists.

The state began providing this service in part because of federal Medicaid managed care regulations and in response to results from a provider survey. The survey results – collected from 87 providers – identified that Spanish is the most frequently spoken language requiring interpretation services. Other languages are less frequently encountered. Nineteen providers reported that they never needed access to an interpreter. Twenty-five providers reported needing an interpreter 1-10 times per month and seven providers responded they needed an interpreter over 100 times per month.

The state's Medicaid fiscal agent, EDS, administers the language line. The provider calls into the Managed Care Enrollment Center (MCEC) and provides a password to the customer service rep (CSR). The CSR then connects to the language line and the provider uses their services. The bill is returned to the MCEC who then passes it on to the state Medicaid agency for reimbursement. The state utilizes two language lines – Propio Language Services for Spanish interpretation (charging $1.10/minute) and Certified Languages International for other languages ($2.04/minute).

From January through December 2006, Kansas spent $46,479.74. Total minutes for calendar year 2006 was 41,193 – 39,951 was Spanish and 1,242 was all other languages.

Maine

According to the National Conference of State Legislatures, interest in adding sign language as a reimbursable service under Medicaid paved the way for adding foreign language interpreters. In January 2001, after public hearings and public comment, Maine revised its Medicaid program manual to add interpreters for sign language and foreign language as covered services.[9]

The state reimburses providers for the costs of interpreters provided to Medicaid and SCHIP enrollees. The selection of the interpreter is left up to the provider. Providers are encouraged to use local and more cost-effective resources first, and telephone interpretation services only as a last resort. Providers then bill the state for the service, in the same way they would bill for a medical visit, but using a state-established interpreter billing code. When using telephone interpretation services, providers use a separate billing code and must submit the invoice with the claim for reimbursement.

The provider must include a statement of verification in the patient's record documenting the date and time of interpretation, its duration, and the cost of providing the service. The state reimburses the provider for 15-minute increments. The reimbursement does not include an interpreter's wait time; travel time is not specifically addressed although its policy states that it will not reimburse an interpreter who is transporting an enrollee. The state no longer has an established reimbursement rate but reimburses "reasonable costs". The provider must ensure that interpreters protect patient confidentiality and have read and signed a code of ethics. The state provides a sample code of ethics as an appendix to its Medical Assistance Manual.

The state is explicit that family members and friends should not be used as paid interpreters. A family member or friend may only be used as an interpreter if: 1) the patient requests it; 2) the use of that person will not jeopardize provider-patient communication or patient confidentiality; and 3) the patient is informed that an interpreter is available at no charge.

Hospitals (for language services provided during an in-patient stay), private non-medical institutions, nursing facilities, and intermediate care facilities for the mentally retarded may not bill separately for interpreter costs. Rather, costs for interpreters for these providers are included in providers' payment rates. *(MaineCare Benefits Manual,* formerly *Medical Assistance Manual,* Chapter 101, 1.06-3.)

Minnesota

In 2001, Minnesota began drawing down federal matching funds for language interpreter services for Medicaid and SCHIP fee-for-service and managed care enrollees. All fee-for-service providers can submit for reimbursement for out-patient services. The state's managed care capitation rate includes the costs of language services.

Under Minnesota's provisions, providers must both arrange and pay for interpretation services and then submit for reimbursement. The state established a new billing code and pays either $12.50 or the "usual and customary charge" per 15-minute interval, whichever is less.

Providers may only bill for interpreter services offered in conjunction with an otherwise covered service. For example, a physician may bill for interpreter services for the entire time a patient spends with the physician or nurse, and when undergoing tests, but not for appointment scheduling or interpreting printed materials. Providers serving managed care enrollees must bill the managed care plan. The managed care plan has the responsibility, pursuant to its contract with the state, to ensure language access; these costs are included in its payment rate.

Hospitals may obtain reimbursement for interpreter costs provided for out-patient care. The costs of language services in in-patient settings are bundled in the hospital payment rate. This payment rate, called the DRG (Diagnosis Related Group), does include a differential to address the costs of language services. When the DRG rates are set by the state, it considers historical data and makes rate adjustments. Although there are not specific adjustments for language services; these costs are generally assumed to be included in the hospital's overhead costs. But because the state bases the DRG on each hospital's own expenses (rather than peer groups or one DRG for the entire state), if a particular hospital has high language services costs, these should be included in the hospital's overall expenses, resulting in a higher DRG rate to compensate.

In FY 2005[10], the state spent $1,644,400 on language services for fee-for-service enrollees. Approximately 15,000 distinct recipients received interpreter services for a total of approximately 42,400 encounters. In FY 2004, the numbers were $1,637,900 for 15,000 distinct recipients and 43,000 encounters.

Website: http://www.dhs.state.mn.us

Montana

Montana began reimbursing interpreters in 1999 following an investigation by the federal HHS Office for Civil Rights. Montana pays for interpreter services provided to eligible Medicaid recipients (both fee-for-service and those participating in the Primary Care Case Management program) if the medical service is medically necessary and a covered service. The interpretation must be face-to-face; no reimbursement is available for telephone interpretation services. The interpreter must submit an Invoice/Verification form signed by the interpreter and provider for each service provided; Montana then reimburses the interpreter directly. Reimbursement is not available if the interpreter is a paid employee of the provider who provides interpretation services in the employer's place of business, or is a member of the patient's family. In addition, the interpreter and provider must attest that the interpreter is qualified to provide medical interpretation.[11]

The reimbursement rate is the lesser of $6.25 per 15-minute increment or the interpreter's usual and customary charge. Interpreters may not bill for travel or waiting time, expenses, or for "no-show" appointments. The interpreter can bill for up to one 15-minute increment of interpreter time outside the Medicaid provider's office (i.e., at the Medicaid client's home or pharmacy) for each separate interpreter service performed per day. This time is specifically used for the interpreter to exchange information and give instructions to the Medicaid client regarding medication use.

The state does not have any interpreter certification requirements. Thus it is the responsibility of the provider to determine the interpreter's competency. While a state referral service operates for sign language interpreters, no equivalent exists for foreign language interpreters. The state spent less than $2000. on interpreters in FY 2006.[12]

New Hampshire

New Hampshire has had policies to reimburse sign language and foreign language interpreters since the 1980's. While the state initially reimbursed for interpreters as a covered service, it currently reimburses interpreters as an administrative expense.[13]

Currently, interpreters are required to enroll as Medicaid providers, although through an abbreviated process since they do not provide medical services. Each interpreter has a provider identification number and can bill the state directly for services provided. The state contracts with EDS – a company that oversees all provider enrollment and billing – which also oversees interpreter enrollment. The state reimburses interpreters $15. for the first hour, and $2.25 for each subsequent quarter hour ($25/hour for sign language interpreters).

Interpreters can bill directly or can work for an organization that coordinates interpreter services. Each interpreter, however, must individually enroll as a Medicaid provider regardless of who bills for reimbursement. Currently, interpreters (or language services organizations) can submit claims for reimbursement for language services only for clients of fee-for-service providers; interpreters cannot submit claims for hospital (in- or out-patient services) and community health center clients. At the present time, the state has 76 interpreters enrolled as Medicaid providers; training programs funded in part by the state have helped increase this number. The state is also examining ways to lessen the administrative burdens on interpreters and increase the availability of Medicaid interpreters.

In FY 2006[14], the state spent $17,809.75 on interpreters (both foreign language and sign language) for 1,763 encounters serving 331 distinct Medicaid recipients. In FY 2005, the numbers were $15,334.50, 1,116 encounters, and 233 Medicaid recipients. In FY 2004, the state spent $9,017 on 157 Medicaid recipients for 605 encounters. In FY 2003, the state spent $5,870 on interpreters. Eighty-two Medicaid recipients received interpreter services for a total of 310 encounters.

Utah

Utah covers medical interpreter services as a covered service; in FY 2007, the state will receive a 72% federal matching rate for Medicaid interpretations and 80% for SCHIP expenditures. The state pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP); 2) the client receives services from a fee-for-service provider; and 3) the health care service needed is covered by the medical program for which the client is eligible.

The state contracts with four language service organizations – two provide both in-person and telephonic and two only provide telephonic interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients. The health care provider must call the language service organization to arrange for the service. The language service organizations are reimbursed by the state between $28-$35 (with a one-hour minimum). The rates vary by company, time of day (higher rates are paid for after hours services) and less frequently encountered languages. If an in-person interpreter is not available, the provider may use a telephone interpretation service for which the state pays $1.10/minute.

Providers cannot bill Medicaid directly, and they do not receive any rate enhancements for being bilingual or having interpreters on staff. Rather, interpreters bill the Medicaid agency. Hospitals can utilize Medicaid-funded interpreters for fee-for-service Medicaid enrollees for all services covered by Medicaid, both in- and out-patient. Hospitals may not use the Medicaid language services for Medicaid managed care enrollees. For enrollees in managed care, Utah requires health plans to provide interpretation services for their patients as part of the contract agreements. For services covered by Medicaid but not the health plan,[15] the state will pay for interpreters.

In FY 2003, Utah spent $46,700 for interpretation although the amount nearly doubled in FY 2004 to $87,500. (Utah's costs for sign language interpretation were approximately $8,000 in FY 2003 and $13,000 for FY 2004 although these figures include non-Medicaid expenses as well). In calendar year 2006, the state spent approximately $263,000 on interpreting of which $180,000 was for foreign language interpreters and $83,000 for sign language interpreters.

Website: http://health.utah.gov/medicaid/html/interpreter.html, http://health.utah.gov/medicaid/pdfs/InterpretGuide10-06.pdf

Vermont

Vermont began reimbursing for interpreters provided to Medicaid clients a few years ago. Medicaid providers hire interpreters and can submit the costs of interpreters along with the medical claim. Reimbursement is limited to $15. for each 15-minute increment. The state does not reimburse for travel or waiting time. Further, reimbursement is not allowed for bilingual staff that serves as interpreters.

While providers may hire any interpreter, services are primarily provided by one language agency. The state Agency for Health Services has a contract with the language agency to meet its interpretation needs and informs providers of this agency. However, providers must make their own arrangements with the agency. The agency also has a statewide telephonic interpretation contract to provide interpreters in rural areas but providers who use telephonic interpretation cannot currently submit for Medicaid reimbursement.

Virginia

Virginia began a pilot project for reimbursement in 2006. Senate Joint Resolution 122 (2004) directed the Department of Medical Assistance Services (DMAS) to seek reimbursement for translation and interpreter services from the Centers for Medicare & Medicaid Services. The state will submit claims to CMS as part of its administrative expenses. The project began in Northern Virginia.[16] Other areas may join as the project proceeds and DMAS intends to eventually expand the program statewide.

The state has a contract with Virginia Commonwealth University (VCU) to facilitate DMAS payment for these services. VCU is the contracting entity for the Virginia statewide area health education centers program, one of which (Northern Virginia AHEC, hereinafter AHEC) is participating in the pilot project. In addition to AHEC, three health departments (Alexandria City, Arlington County, and Fairfax County) will provide language services. The three health departments currently offer language services through the use of salaried staff, contracted staff, telephonic resources, and administration of services. AHEC will both provide language services and act as a broker to receive calls from recipients requesting language services; confirm that a covered medical service is involved; and schedule the language services. AHEC will aggregate the claims from itself and the health departments and submit them to DMAS through VCU.

AHEC and the three health departments will contribute the state's share of costs and obtain 50% federal reimbursement. This agreement is similar to Washington state's Intergovernmental Transfer (see below).

DMAS requires the participating interpreters and translators to meet proficiency standards, including a minimum 40-hour training for interpreters. The state will reimburse for the reasonable costs incurred by the providers. It anticipates that each health department will have contracts to provide telephonic and/or in-person interpreters; since the health department contracts and language agencies will differ, the state chose not to set a reimbursement rate but rather to monitor spending and evaluate whether a state-wide reimbursement rate should be implemented at a later date. There is no formal budget for the pilot project.

In FY 2006, Virginia spent $8546 for 507 hours of service.

Website: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD222004/$file/SD22.pdf

Washington

Providers that are not public entities.[17] In 1998, the Department of Social and Health Services' (DSHS) Language Interpreter Services and Translation (LIST) program began contracting with language agencies through a competitive procurement process. Beginning in 2003, the state changed its system to contract with nine regional brokers for administrative scheduling of appointments. The brokers contract with language agencies. In FY 2004,[18] the Department provided interpreters for over 180,000 encounters. Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 10 miles.

Rather than require clients to schedule interpreters, providers – including fee-for-service providers, managed care organizations, and private hospitals – call a regional broker to arrange for an interpreter. The state requires providers to schedule interpreters to avoid interpreters independently soliciting work and/or acting as advocates rather than interpreters. Once services are provided, the language agency then bills the broker for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician, as well as the diagnosis or nature of illness or injury.

The state pays the brokers an administrative fee; the brokers then pay the language agencies. For Medicaid and SCHIP enrollees, the state obtains federal reimbursement for these costs. Currently, payments to language agencies are $33.00 per hour, increasing to $34.00 per hour effective July 1, 2007. The state spends approximately $1 million a month on all DSHS language services; from November 2005 to October 2006, Washington provided 217,865 encounters. The Medicaid spending during this time period was $38,225.47.

Washington has a comprehensive assessment program for interpreters. Now called the "Language Testing and Certification program", the state requires medical interpreter certification for interpreters in the seven most prevalent foreign languages in Washington: Spanish,

Vietnamese, Cambodian, Lao, Chinese (both Mandarin and Cantonese), Russian, and Korean. Interpreters for all other languages must be qualified rather than certified (because of limited resources available for full certification in all languages). The state has given tests for 88 languages plus major dialects and offers statewide testing at five sites, with four days of testing per month per site. Additional tests are available upon request. The state also offers emergency/ provisional certification for those who have passed the written test but await oral testing, and in other limited situations.

Website: http://www1.dshs.wa.gov/msa/LTC/index.html

Public hospitals and health departments. Washington has a separate reimbursement program for interpreter services provided at government and public facilities, such as public hospitals or local health jurisdictions. These entities can receive federal reimbursement for expenses related to language services if they enter into a contract (e.g. interlocal or intergovernmental agreement) with the state and agree to:

- provide local match funds (locally generated private funds);
- ensure that the local match funds are not also used as matching funds for other federal programs;
- ensure that the local match funds meet federal funding requirements;
- ensure that the local match funds are within the facilities' control;
- use only certified interpreters (as certified by Washington's LIST program);
- coordinate and deliver the interpreter services as specified by the state;
- collect, submit and retain client data as required; and
- accept all disallowances that may occur.

These facilities receive reimbursement for both direct (e.g. interpreter services provided as part of the delivery of medical/covered services) and indirect (e.g. time spent coordinating or developing interpreter programs, billing, equipment purchasing) interpreter expenses. The facilities receive reimbursement for 50% of their costs – the federal administrative share. Because these entities act as the state for the purposes of reimbursement, the 50% state "match" is paid by the facility.

There are currently 20 public hospitals with interlocal agreements. Thus far, 12 have been reimbursed $393,414.09 for the last calendar year (the remaining 8 are not current on their billing).

Website: http://fortress.wa.gov/dshs/maa/InterpreterServices/FFP.htm

Wyoming

Beginning in July 2006, Wyoming began paying for language services for its Medicaid enrollees. The interpretation may be provided in-person or via telephone language line.

To access interpreter services, a provider must: 1. determine a need for interpreter services; 2. utilize an agency-approved interpretation provider; 3. provide a medical service for which the interpretation is used. Interpreter services are not provided for in- and out-patient hospital services; intermediate care facilities for persons with mental retardation (ICF-MR); nursing facilities; ambulance services by public providers; residential treatment facilities; comprehensive in- or out-patient rehabilitation facilities; and other agencies/organizations receiving direct federal funding. Further, the state will not pay for interpretation provided by family members, friends or by volunteers.

Interpreters must abide by the national standards developed by the National Council on Interpreting in Health Care (www.ncihc.org). They can bill only for time spent with the client and are not reimbursed for travel.

Interpreters are paid in 15 minute increments (but interpreters can bill for the unit only after 10 minutes into the unit). Interpreters are reimbursed at $11.25/15 min. and are limited to billing no more than six units per date of service for any individual Medicaid recipient.

STATES DEVELOPING REIMBURSEMENT

California

The Department of Health Services (DHS) has convened the Medi-Cal Language Access Taskforce. The Taskforce is charged with forming recommendations to DHS on "a model for the economical and effective delivery and reimbursement of language services in Medi-Cal." The Taskforce includes 22 representatives from the following categories: Office of Multicultural Health Council, Government Agencies, Providers and Practitioners, and Consumers and Advocates.

Website:
http://www.dhs.ca.gov/director/omh/html/MC_Language_Access_Services_Taskforce.htm

North Carolina

In 2002, the federal Department of Health and Human Services' Office for Civil Rights entered into a Voluntary Compliance Agreement (VCA) with the North Carolina Department of Health and Human Services (DHHS) to identify and meet language needs at the state and county levels. In part because of the VCA and in part from suggestions from the DHHS Compliance Attorney and the Department's Title VI Advisory Committee[19], North Carolina has embarked on plans to initiate reimbursement. The impetus for these discussions is to ensure competent interpreters are available to provide much-needed resources to healthcare providers.

The process is twofold – development of interpreter credentialing and establishment of reimbursement.

Credentialing

Two organizations have been training interpreters in North Carolina since the '90's. Originally, the NC Area Health Educational Center (AHEC) launched a Spanish language interpreter training project. Recognizing the additional needs for interpreter brought on by newly arrived refugees, the Center for New North Carolinians (CNNC) contracted with NCDHHS/DSS

to train interpreters in languages other than Spanish. This contract lasted from the spring of 1999 through July of 2003. Following this contract, CNNC continued interpreter training on a fee for service basis. In 2004, AHEC partnered with CNNC statewide to provide interpreter training through the AHEC network. Last year, given CNNC's long history of providing interpreter training, DHHS requested CNNC develop an interpreter credentialing program for interpreters providing language services to DHHS and the healthcare providers it funds.[20]

The current CNNC training program, using a model developed by AHEC, has three levels: Level I is a two day introductory level; Level II is a one day practicum to reinforce the Level I; and Level III is an advanced two day training, currently focused on Spanish medical vocabulary. The new curriculum will continue to include levels I and II but will incorporate recently released National Standards of Practice and Code of Ethics from the National Council on Interpreting in Health Care. It will start with an assessment of an individual's language competency and require a demonstration of interpreter competency. A basic credentialing process will be developed first, followed by specialized credentialing (level III) in advanced areas such as social service, public health, and mental health, using the AHEC Level III construct. DHHS would only reimburse interpreters who are credentialed in the areas for which they interpret.

Reimbursement

After the certification curriculum is approved by the agency, DHHS expects to submit a State Plan Amendment to include language services as a "covered service" in Medicaid. It is expected that reimbursement will include an array of Medicaid services and support the adequate provision of medically necessary care. DHHS will establish procedure codes and anticipates providing reimbursement for both in-person and telephonic interpreters. If an agency providing telephonic interpretation is used, it will be the responsibility of the agency to assure that training is at least equivalent to the requirements of the DHHS approved curriculum.

It is expected that reimbursement will include all types of Medicaid services -- in- and out-patient as well as fee-for-service and managed care. Depending on the development, testing and implementation of certification, reimbursement may begin in early 2008.

Texas

In 2005, Texas enacted legislation establishing a Medicaid pilot project for reimbursement for language services in five hospital districts.[21] The Health and Human Services Commission (HSSC) is tasked with developing the project. HSSC is working to identify the most appropriate model for the pilot. There has been some delay because the majority of Medicaid enrollees in the designated hospital districts are in managed care. Since the managed care organizations' costs of language services are already included in their capitated rate, the pilot project does not cover them.

Thus, HSSC is working with the hospitals to identify the best methods to track language services provided to fee-for-service and emergency Medicaid recipients. Originally, HSSC offered two cost allocation methodologies – 1) a direct charge allocation method, meaning that the contractor must document that the entire cost is completely related to the performance of an allowable activity, or 2) a Medicaid Eligibility Ratio (MER) allocation method. Since the hospitals assert that both these approaches are administratively cumbersome, they requested

consideration of a third approach – a documentation method called a random moment time study (RMTS) approach. HHSC is in the process of seeking approval for this approach with the federal Centers for Medicare and Medicaid Services (CMS).

HHSC is consulting CMS on the possibility of utilizing an RMTS for the pilot. Once CMS guidance is received, HHSC will proceed with the contract development process. The estimated date of program implementation is dependent on CMS direction and contract negotiation.

The state is using the administrative cost mechanism and thus will receive 50% reimbursement from CMS (since TX's covered service FMAP rate is also 50% for Medicaid, it would not gain financially from having language services added to its state plan). The pilot project will likely be financed through "fund certifications" from the participating hospital districts. A fund certification requires the hospital to certify that it has spent a certain amount on language services but, unlike intergovernmental transfers, does not involve the actual transfer of dollars. Because the hospital districts act as the state for the purposes of reimbursement, the 50% state "match" is paid by the facility that will receive reimbursement for 50% of its costs. The program expires on September 1, 2009, if no further action is taken.

Under Texas' two managed care models, the state pays for interpreter services. The state's contracted Medicaid and Children's Health Insurance Program (CHIP) HMOs, as well as the PCCM administrator, are contractually required to provide interpreter services. The state includes the costs of these services into rates paid by the state to these contractors.

A status report on the pilot project was submitted to the State Legislature in January 2007: *Medicaid Interpreter Services Pilot: Report on Program Effectiveness and Feasibility of Statewide Expansion* is available at http://www.hhsc.state.tx.us/reports/RPCMemo121906LangInterpretPilotRept.pdf.

STATES PREVIOUSLY PROVIDING REIMBURSEMENT

Massachusetts

From FY 2002-2005, Massachusetts provided direct reimbursement for language services in Medicaid for hospital emergency rooms and in-patient psychiatric institutions The legislature did not include an appropriation in FY 2006, possibly because the state raised general hospital payment rates. Massachusetts now bundles payment for interpreter services into its payment rates. Massachusetts does not make discrete provider payments for interpreter services because such costs are incorporated in the fee-for-service payment and the agency considers interpreter services to be part of the cost of doing business for hospitals as well as other providers. The following describes the program as it had operated.

In April 2000, the legislature passed Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services." This law, effective July 2001, mandates that "every acute care hospital . . . shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment." The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights.

In 2003, Massachusetts received approval of three State Plan Amendments (one each for psychiatric hospitals, and in-patient and out-patient acute-care hospital care) to obtain federal reimbursement. In FY2005, the last year the program operated, the state budget included an appropriation of $1.1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The state's Medicaid agency made "supplemental payments" to "qualifying" hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute hospitals, and private psychiatric hospitals. The distribution was based on an "equity formula" comparing expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals.

In addition, the state's Medicaid agency previously considered interpreter costs in its DSH (Disproportionate Share Hospital) distribution formula. Medical interpreter costs were identified by the hospitals on their cost reports, which were used to determine unreimbursed costs for DSH purposes. Distribution of DSH funds was then based on these unreimbursed costs.

As part of its comprehensive Health Care Reform plan, passed in April 2006 and approved by the federal government in July 2006, Massachusetts technically no longer has a DSH program. MA has transitioned its federal DSH dollars, as well as other federal 1115 waiver-related dollars, into a new pool of money called the Safety Net Care Pool. Safety Net Care Pool funds are used to provide subsidies to low-income individuals to purchase private coverage through the Commonwealth Care program (which was implemented on October 1, 2006) and to fund a residual uncompensated care pool. For purposes of its Uncompensated Care Pool (UCP), Massachusetts allows hospitals to include the costs of language services in the base costs used to develop Medicaid rates and the UCP cost-to-charge ratio.

CONCLUSION

Given the requirements of Title VI of the Civil Rights Act of 1964 that health care providers who receive federal funds ensure access to services for people with limited English proficiency, more states should access available federal funds to ensure that their agencies – and the providers with whom they contract – have the means to hire competent medical interpreters. The use of competent interpreters can improve the quality of care, decrease health care costs by eliminating unnecessary diagnostic testing and medical errors, and enhance patients' understanding of and compliance with treatments.

ENDNOTES

[1] This document outlines information gathered as of March 15, 2007.
[2] This document is available in the *Language Services Action Kit* from NHeLP and The Access Project at http://www.healthlaw.org/library.cfm?fa=detail&id=71337&appView=folder.
[3] States can draw down Medicaid/SCHIP funding in two ways – as a "covered service" (paying for the cost of a service, such as a doctor's office visit or a hospital stay) or as an "administrative expense" (paying for the costs of administering the program). For information *see How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?* in NHeLP's *Language Services Action Kit, available at* http://www.healthlaw.org/langaccess/resources.html#nhelp.
[4] For "covered services", the federal reimbursement rate varies from 50-83%, based on the state's per capita income. For "administrative" expenses, every state receives 50% of its costs from the federal government.
[5] "Fee-for-service" generally refers to services *no*t provided through a managed care organization, community health center or in-patient hospital settings. Providers agree to accept a state-set "fee" for the specific "service" provided.
[6] Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training.
[7] Providers who have staff interpreters cannot submit for reimbursement.
[8] FY 2004 ran from July 1, 2003 through June 30, 2004.
[9] Language Access: Giving Immigrants a Hand in Navigating the Health Care System, NCSL's *State Health Notes*, volume 23, number 381, October 7, 2002).
[10] FY 2005 ran from July 1, 2004 through June 30, 2005.
[11] Interpreter Services, Medicaid Services Bureau, 11/27/02, *available from* National Health Law Program.
[12] FY 2006 ran from July 1, 2005 through June 30, 2006.
[13] NH switched from a covered service to an administrative reimbursement due to a change in CMS policy; subsequently CMS clarified that states can get reimbursed at the covered service rate. Since New Hampshire's FMAP for medical services, 50%, is the same as for administrative expenses, no practical difference exists in New Hampshire. For SCHIP, considering language services as a covered service would increase the federal share of costs.
[14] The state's fiscal year runs from July 1 through June 30.
[15] For example, pharmacy, dental and chiropractic services.
[16] The project will initially include Arlington County, Fairfax County, Falls Church and Alexandria City.
[17] Washington has two reimbursement mechanisms. The first is for non-public entities – this includes most fee-for-service providers, managed care providers, and non-public hospitals.
[18] The fiscal year runs from July 1, 2003 through June 30, 2004.
[19] The Title VI Advisory Committee composed of representatives from all divisions within the Department, including public health, social services, mental health, vocational rehabilitation, and Medicaid, and volunteers from the North Carolina Institute of Medicine, the Justice Center (legal aid) and several statewide advocacy groups. Its 25 members have a wide range of skills and hold various positions in and out of state government.
[20] In 1999, NCDHHSDSS contracted with CNNC to train health and human service interpreters in languages other than Spanish (the state contracted with NC Area Health Education Centers (AHEC) to train Spanish interpreters) and provide refugee interpreter services in the state. Beginning three years ago, AHEC began contracting with CNNC for the bulk of its interpreter training services. CNNC also maintains an interpreter bank from which health care providers can contract trained interpreters.
[21] S.B. No. 376 passed the Senate on March 17 and the House on May 9, 2005. A separate bill, H.B. No. 3235, was also enacted requiring provision of interpreter services to deaf and hard of hearing Medicaid patients subject to the availability of funds. The five hospital districts given preference are Harris County Hospital District; Bexar County Hospital District; El Paso County Hospital District; Tarrant County Hospital District; and Parkland Health and Hospital System.