

medicaid
and the uninsured

ENSURING LINGUISTIC ACCESS IN
HEALTH CARE SETTINGS:
AN OVERVIEW OF CURRENT LEGAL
RIGHTS AND RESPONSIBILITIES

Prepared by
Jane Perkins, J.D., M.P.H.
National Health Law Program

kaiser commission medicaid on and the uninsured

The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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Executive Summary

Over 46 million people -- more than 17 percent of the U.S. population -- speak a language other than English at home. These numbers are certain to increase because of the changing demographics of the U.S. population. Between 1990 and 2000, for example, the Hispanic population alone increased almost 58 percent. It is critical that the growing numbers of limited English proficient (LEP) residents be able to communicate with their health care providers. Accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality. Research provides many examples of how the lack of language access negatively affects access to and quality of health care. In order to ensure access to care for LEP residents, there are a number of federal and state laws and policies that compel publicly funded health care programs and activities to provide language access.

This issue brief focuses on the language access responsibilities of federal fund recipients pursuant to the federal civil rights laws. Federal fund recipients include hospitals, nursing homes, managed care organizations, state Medicaid agencies, home health agencies, health service providers, and social service organizations. In recent years, the Departments of Justice (DOJ) and Health and Human Services (DHHS) have provided extensive information and assistance to federal fund recipients and the public regarding language access. As public interest and debate increase, federal policy in this area is being refined. However, the core aspects of the policy have remained consistent:

- Meaningful language access will only be accomplished over time and through the use of flexible approaches.
- Federal fund recipients should: (1) undertake assessment of the language needs of individuals in their service area; (2) consider developing a written plan for responding to those needs; (3) offer competent assistance services; (4) determine the need to translate written documents, particularly “vital” documents; (5) provide notices to LEP communities and individuals informing them of language assistance services; and (6) monitor the effectiveness of language assistance provided.
- Federal fund recipients should seek to recruit and retain staff that reflects community culture and language and to improve cultural awareness and competency through ongoing staff training.

Over the last two years, the federal and state laws and policies that address linguistic access have received a remarkable amount of attention. These laws are being interpreted and clarified at a steady pace. A number of factors are simultaneously coming into play to complicate the policy challenges, including increases in the numbers of LEP persons and of the different languages being spoken; concerns about the costs associated with providing competent language services and, in many areas, a limited pool of competent interpreters; concerns of the effects of LEP patients accessing the health care system without the ability to make informed decisions about their treatment; and a lack of knowledge among federal fund recipients and LEP patients of the legal requirements that affect the provision of services to LEP persons. Attention is warranted to monitor these factors -- along with developments in federal and state laws -- to ensure that persons with limited English proficiency have access to needed health care services.

I. Introduction

For more than thirty years, the federal government has played a critical role in ensuring that underserved racial and ethnic groups have access to timely and adequate health care services. Passage of the federal civil rights laws and the Medicare and Medicaid Acts in the 1960s launched a major effort to protect the civil rights and safeguard the health of millions of elderly people and people with limited income or disabilities. As both enforcer of the civil rights laws and a major purchaser of health care services, the federal government has treated members of national origin groups who are limited English proficient (LEP) as persons who may need protection.

In recent years and through a change in administrations, the Departments of Justice (DOJ) and Health and Human Services (DHHS) have provided extensive information and assistance to the public and to federal fund recipients, such as hospitals, nursing homes, and clinics. As public interest and debate increase, policy in this area is being refined. The core aspects of the policy have remained consistent, however, as the federal authorities have said:

- Meaningful language access will only be accomplished over time and through the use of flexible approaches.
- Federal fund recipients should: (1) undertake assessment of the language needs of individuals in their service area; (2) consider developing a written plan for responding to those needs; (3) offer competent interpreter services at no cost to limited English proficient individuals; (4) determine the need to translate written documents, particularly “vital” documents; (5) provide notices to LEP communities and individuals informing them of language assistance services; and (6) monitor the effectiveness of language assistance provided.
- Federal fund recipients should seek to recruit and retain staff that reflects community culture and language and to improve cultural awareness and competency through ongoing staff training.

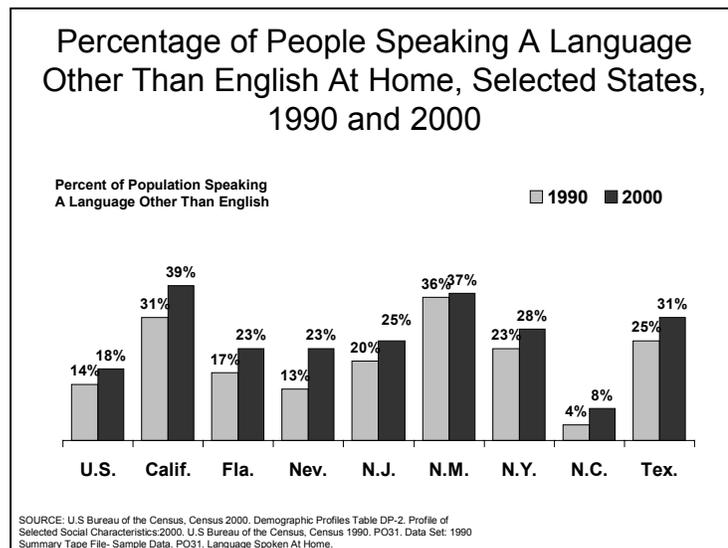
After providing an overview of the need for linguistically appropriate health care services, this policy brief focuses on the recent federal activities to clarify and enforce language access responsibilities under the federal civil rights laws. Policy and program developments in the states are also highlighted.

II. The Need for Language Access

Over 46 million people -- more than 17 percent of the U.S. population -- speak a language other than English at home.¹ While detailed data from the 2000 census are not yet available, data from the 1990 census found 26 percent of all Spanish speakers, 29.9 percent of all Chinese speakers, and 28.2 percent of all Vietnamese speakers reported they spoke English “not well” or “not at all.”² These numbers are certain to increase because of the changing demographics of the U.S. population. Between 1990 and 2000, for example, the Hispanic population alone increased 57.9 percent.³

Excluding English, the 20 most commonly spoken languages in the United States are: Spanish, French, German, Italian, Chinese, Tagalong, Polish, Korean, Vietnamese, Portuguese, Japanese, Greek, Arabic, Hindi, Russian, Yiddish, Thai, Persian, French Creole, and Armenian.⁴ The vast majority of non-English speakers are Spanish-speaking;⁵ all told, however, over 300 different languages are spoken.

Today, hundreds of languages are spoken in both urban and rural areas of the United States. According to 2000 census estimates, over 17 percent of the population speaks a language other than English at home, and some states' populations are significantly above the national average -- 39.5 percent in California; 36.5 percent in New Mexico, 31 percent in Texas, and over 23 percent each in Arizona, Hawaii, Nevada, New Jersey, and New York.⁶ In Los Angeles County alone, more than 80 languages are spoken.⁷ Multilingualism is spreading most rapidly beyond traditional urban areas.⁸ For example, since the mid-1990s immigration to North Carolina has increased by 73 percent, the largest such increase in the country.⁹



It is critical that the growing numbers of LEP residents be able to communicate with their health care providers. Accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality.¹⁰ The literature provides many examples of the how the lack of language access negatively affects access to and quality of health care.

Research has shown that language barriers create significant access issues.

Some research shows that language issues are as significant as the lack of insurance in use of health services.¹¹ In a recent survey, Hispanic children had much lower access to medical care than white children, but the gap became negligible when their parents' English speaking skills were comparable to white parents.¹³ Non-English speaking patients have been found less likely to use primary and preventive care services and more likely to use emergency rooms.¹⁴ Non-English speaking women who did not visit their practitioners for cervical screening cited the inadequacy of translated materials as an influencing factor (one brochure described the screen as the "fat" test).¹⁵ LEP patients in a pediatric emergency department were found to use more medical resources (time and tests) than other patients.¹⁶

Language issues can also create difficulty when communicating with providers. For example, Hispanic respondents who said they did not speak English as their primary language reported having greater problems communicating with their health care providers than those who spoke English as their primary language (43 percent v. 26 percent).¹⁷ In addition, asthmatic patients who did not speak the same language as their physicians were less likely to keep scheduled office appointments and more likely to miss follow up medications and use the emergency room.¹⁸ Health care providers surveyed in Los Angeles, New York City, Houston, and Miami found language difficulties to be a major barrier to immigrants' health care and a serious threat to medical care quality "since clinicians could not get information to make good diagnoses and because patients might not understand the treatment regimens prescribed for them."¹⁹ Over one quarter (27%) of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only two percent of those who either needed and received an interpreter or who did not need an interpreter.²⁰ The use of untrained family members and friends to interpret has been associated with omissions, additions, substitutions, volunteered opinions, and semantic errors that can seriously distort translation.²¹

Language barriers are reflected in how LEP persons perceive their health care encounters. Among Asian and Hispanic parents, for example, those who do not speak English as their primary language gave significantly lower ratings of their children's health care than English speakers.²³ A recent survey across 16 cities found that three of four respondents needing and getting an interpreter said the facility they used was "open and accepting," compared to fewer than half (45%) of the respondents who needed but did not get an interpreter and 57 percent who did not need an interpreter.²⁴ Of equal and disturbing importance are providers' perceptions of language barriers. A March 2002 report by the Kaiser Family Foundation found that the majority of doctors believe disparities in how people are treated within the health care system "rarely" or "never" occur based on factors such as fluency in English or racial and ethnic background.²⁵

In sum, the dramatically growing need for language services is creating a business necessity for health care providers to address the issue. Already, however, there are a number of federal and state laws and policies that compel publicly funded health care programs and activities to provide language access.²⁶ These laws are significant because health care is one of the most heavily government funded endeavors in the United States today. It seems certain that increased demands will be placed on federal fund recipients by the growing numbers of national origin minorities who do not speak English. Publicly financed managed care illustrates this point. A recent study has found that Medicare+Choice plans are popular among Hispanic Medicare beneficiaries who are choosing their insurance, with 51.6 percent of Hispanics enrolled in Medicare+Choice nationally.²⁷ In addition, all but two states (AK and WY) have some form of Medicaid managed care.²⁸ The beneficiaries of these programs are disproportionately underserved racial, ethnic, and national origin groups. As a result, some of the most advanced written policies for providing access to LEP persons are found in Medicaid managed care programs.²⁹

III. Language Access Responsibilities under the Federal Civil Rights Laws

Congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin.³⁰ Title VI says:

No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.³¹

The United States Supreme Court has treated discrimination based on language as national origin discrimination.³² Regulations issued by the U.S. Department of Health and Human Services in 1964 prohibit federal fund recipients from:

- Using criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color or national origin;
- Restricting an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
- Providing services or benefits to an individual that are different, or provided in a different manner, from those provided to others;
- Treating an individual different from others in determining whether he satisfies an admission, enrollment, eligibility, or other requirement for a service.³³

The obligations under Title VI and implementing regulations apply broadly to any “program or activity” that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.³⁴ Covered entities include hospitals, nursing homes, managed care organizations, state Medicaid agencies, home health agencies, health service providers, and social service organizations. Notably, the Title VI protections extend to all of the operations of the organization or individual, not just that portion that received the federal funds.³⁵

The federal government has long recognized that Title VI requires language access. In fact, the first Title VI regulations, directed at vocational education programs, provided that federal fund recipients “may not restrict an applicant’s admission to vocational education programs because the applicant, is a member of a national origin minority with limited English language skills.”³⁶ In the decades following, the federal government has repeatedly recognized the need for federal fund recipients to offer meaningful language access.³⁷

Within the U.S. Department of Health and Human Services, the Office for Civil Rights (OCR) is the agency that is charged with enforcing Title VI. OCR can decide to initiate investigations on its own, but it must respond to complaints filed by an individual.³⁸ When investigating complaints, the federal regulations require OCR to attempt resolution of the matter through settlement. If settlement is not reached, OCR can terminate federal funding to the program that is out of compliance or ask the Department of Justice to sue for compliance.³⁹

The Alexander v. Sandoval Decision

Title VI does not specify how private citizens can enforce it. However, since enactment of the law in 1964 -- courts, Congress, federal agencies, federal funds recipients and private individuals have assumed that victims of Title VI violations had two independent remedies: an administrative complaint filed with OCR or a lawsuit to challenge either intentional discrimination or actions which reflect disparate treatment or have a disparate impact under the Title VI regulations.

In a recent 5-4 decision, the United States Supreme Court upset these long-standing assumptions and severely curbed lawsuits to enforce the Title VI disparate impact regulations. The case, *Alexander v. Sandoval*,⁴⁰ involved a challenge to the Alabama Department of Safety's refusal to administer its driver's examination in a language other than English. The plaintiff, a Mexican immigrant, could read road signs but did not have the English skills necessary to take a written exam. She filed a lawsuit, arguing that the driver's license rule violated the Title VI regulations because it had the effect of subjecting limited-English speakers to discrimination based upon their national origin.⁴¹

Justice Scalia, writing for the majority, renounced the long-standing assumptions and refused to imply a private right of action to enforce the Title VI regulations. The decision is based on three main findings. First, while presuming the regulations to be valid, the Court said that they prohibit what the statute permits.⁴² Specifically, the Court found the Title VI statute to prohibit only intentional discrimination, not discrimination based on the disparate impact of a federal fund recipient's actions. Thus, the Court found that Congress could not have intended to allow private citizens to enforce actions the statute did not proscribe.⁴³ Second, the Court found its reasoning reinforced by the regulations themselves, which are directed to actions by federal agencies, not entitlements or protections for individuals.⁴⁴ Finally, the Court found that Congress could not have intended to create a private right of action to enforce the regulations where the statute already contained a comprehensive enforcement mechanism that authorized federal agencies to enforce the rules by terminating funding to violators or by other means authorized by law.⁴⁵

The effects of *Sandoval* are only beginning to be felt, but it is already clear that it has altered the legal landscape. First, private enforcement of Title VI against organizations and individuals will be limited to situations where intentional discrimination can be shown. It is more difficult to make the case for intentional discrimination than it is for disparate impact discrimination because the individual must establish that the organization or individual knew that it was engaging in a discriminatory act and, in fact, intended to do so. Second, *Sandoval* has called into question private individuals' rights to enforce the Title VI regulations against state actors through another federal civil rights law, 42 U.S.C. § 1983. Section 1983 provides a cause of action to individuals when the state deprives them of rights that are guaranteed by the U.S. Constitution or federal laws.⁴⁶ The four dissenting members of the Court assumed that this type of action remains an option,⁴⁷ however, the *Sandoval* majority did not address the question. But recently, a federal circuit court of appeals held that individuals could not enforce the regulations through Section 1983.⁴⁸ Relying on the reasoning of *Sandoval*, the court decided that the plaintiffs could not enforce the disparate impact regulations because they impose an obligation "distinct" from that of the statute. On June 24, 2002, the Supreme Court denied a petition asking it to review the circuit court ruling.⁴⁹

Third, *Sandoval* raises questions about the continued viability of the Title VI regulations. The majority assumed for purposes of the case that the regulations were valid. However, it noted “considerable tension” between the statute, which it said prohibits only intentional discrimination, and the disparate impact regulations, which proscribe activities that the statute permits.⁵⁰ This statement from the Court appears to invite a future case on this issue.

The *Sandoval* ruling is also raising questions about whether Title VI’s ban on national origin discrimination includes protections for LEP persons. Before *Sandoval*, the most prominent case in this area was *Lau v. Nichols*.⁵¹ In *Lau*, the Court held that the San Francisco school district violated Title VI when it failed to provide adequate instruction for children of Chinese ancestry who did not speak English.⁵² The Court concluded that “there is no equality of treatment merely by providing students with the same facilities, textbooks, teachers and curriculum; for students who do not understand English are effectively foreclosed from any meaningful education.”⁵³ The Court found it “obvious that the Chinese-speaking minority receives fewer benefits than the English-speaking majority . . . which denies them a meaningful opportunity to participate in the educational program – all earmarks of the discrimination banned by the regulations.”⁵⁴ Notably, the *Sandoval* majority acknowledged *Lau*’s interpretation of the statute to prohibit disparate impact discrimination against LEP persons but it gave this portion of *Lau* no weight.⁵⁵ And while the majority did not question *Lau*’s conclusion that Title VI prohibited discrimination on the basis of language, this premise was called into question in a case that was recently dismissed by the Fourth Circuit Court of Appeals.⁵⁶

Finally, the curbing of citizen suits places added responsibility on the U.S. Department of Justice and the DHHS Office for Civil Rights to enforce the Title VI statute and regulations. However, OCR is persistently underfunded and understaffed.⁵⁷

Federal Guidance and Initiatives

The last two years have seen an increased volume of federal guidance on how entities can comply with the civil rights laws. The White House, Department of Justice, DHHS Office for Civil Rights, and DHHS Office of Minority Health have issued guidelines. Taken together, these guidelines represent the federal government’s strong encouragement of federally funded entities to become acquainted with the LEP populations in their service areas and to develop and implement plans for improving access of these populations. However, these guidelines also recognize the need for flexibility -- that the approach developed by a large public hospitals serving large numbers of LEP patients will differ from that used by private practice physician who sees few LEP patients.

Executive Order 13166

On August 11, 2000, President Clinton issued Executive Order (EO) 13166, entitled *Improving Access to Services for Persons with Limited English Proficiency*.⁵⁸ The reach of EO 13166 is extensive, affecting all “federally conducted and federally assisted programs and activities.” This includes the Department of Health and Human Services and programs and activities that receive federal assistance such as Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP) funding.

EO 13166 contains two major initiatives. First, each federal agency providing federal funding must draft a Title VI guidance specially tailored to its recipients. The agency-specific

guidance is to take into account the types of services provided by fund recipients, the individuals served by the recipients, and other factors that may be designated by the U.S. Department of Justice (DOJ). Second, EO 13166 requires all federal agencies to meet the same standards as federal fund recipients in providing meaningful access to LEP persons.⁵⁹ All federal agencies (whether or not they provide federal financial assistance) must develop and implement their own plans to improve access to their federally conducted programs.⁶⁰ In carrying out the Order, “agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input.”⁶¹

EO 13166 designates the Department of Justice as the lead agency with the responsibility for providing LEP guidance to other federal agencies. It incorporates by reference contemporaneously issued DOJ general guidance and instructs all federal agencies to issue LEP guidance consistent with DOJ policies. The Order requires each agency to have developed and begun to implement its plan by December 11, 2000. Also by that date, each agency that provides federal financial assistance was required to submit to DOJ a draft of its guidance document for fund recipients.⁶²

General Policy Guidance from DOJ

Simultaneous with the issuance of EO 13166, the DOJ provided General Policy Guidance to federal agencies announcing four factors for determining the extent of their Title VI obligations to assist LEP persons:⁶³

1. Number or proportion of LEP individuals who will be excluded from the services absent efforts to remove language barriers. “Programs that serve a few or even one LEP person are still subject to the Title VI obligation to take reasonable steps to provide meaningful opportunities for access.”⁶⁴ However, the numbers of LEP persons expected to be encountered will determine the reasonableness of efforts.
2. Frequency of contact with the program. If LEP individuals access the program on a daily basis, a recipient has greater duties than if contact is infrequent.
3. Nature and importance of the program to beneficiaries. More affirmative steps must be taken if a denial or delay of services may have critical implications for daily life (e.g. hospitals, schools) than in programs that are not as crucial (e.g. theaters, zoos).
4. Resources available and cost considerations. A small fund recipient with limited resources may not have to take the same steps as a larger recipient in programs where the numbers of LEP persons are limited. Costs are a legitimate consideration in identifying the reasonableness of particular language assistance measures.⁶⁵

In balancing these factors, the appropriate mix of written and oral assistance must be addressed, including which documents must be translated, when oral interpretation is needed, and whether such services must be immediately available.⁶⁶

The federal government has recently launched an Internet gateway to EO 13166, called “Let Everyone Participate,” <http://www.lep.gov>. The website contains information about the EO and federal agency guidance. It also offers direct assistance to federal fund recipients. For example, fund recipients can download “I Speak” cards that allow LEP persons to designate their primary language.

Detailed DOJ Recipient Guidance

While asking federal agencies to expedite their issuance of guidance documents, the DOJ has worked to address concerns raised since EO 13166 was issued.⁶⁷ In particular, the DOJ has received complaints from federal fund recipients (to the Departments of Health and Human Services and Labor) that the guidance documents could be confusing and impose unnecessary requirements.⁶⁸ There have also been questions regarding the requirements of the Executive Order in light of the Supreme Court's decision in *Alexander v. Sandoval*, which some commentators have read to impliedly strike down the Title VI regulations that form the basis for that part of the EO that applies to federally assisted programs and activities.⁶⁹

The DOJ first addressed these issues in an October 26, 2001 memorandum. In this memorandum, it required all federal agencies to obtain public comment on agency-specific guidance documents and asked them to decide whether their guidelines needed to be subjected to more strenuous rule making procedures and Office of Management and Budget review.⁷⁰ The memorandum also disagreed with the *Sandoval* commentators, finding that because the Supreme Court did not address the validity of the regulations or EO 13166, both remain in effect.⁷¹

The final DOJ Recipient Guidance was adopted on June 18, 2002.⁷² This document is important because it represents the views of the lead federal agency responsible for enforcing Title VI and EO 13166, and it states: "Consistency among Departments of the Federal government is particularly important. Inconsistency or contradictory guidance could confuse recipients of Federal funds and needlessly increase costs without rendering" meaningful access.⁷³ Therefore, the June 18, 2002 Guidance document is likely to become a benchmark against which other agencies' LEP guidance policies are measured. It makes the following major points:

- State and local "English-only" laws do not excuse a federal fund recipient from complying with the federal Title VI obligations and agency guidance.⁷⁴
- While designed to be a "flexible and fact-dependent standard," the starting point for determining meaningful access remains an individualized assessment that balances the four factors originally announced in the DOJ General Guidance: (1) the number or proportion of LEP persons in the service population;⁷⁵ (2) the frequency with which LEP persons come in contact with the program; (3) the importance of the program; and (4) the resources available to the recipient and costs.⁷⁶ Analysis of these four factors will allow fund recipient to determine what language assistance services need to be offered.
- Oral language services –interpretation -- may be needed. Competency to provide oral interpretation does not mean that an individual must be formally certified; however, it does require more than self-identification as bilingual.⁷⁷ When using interpreters, fund recipients should make sure they demonstrate proficiency to communicate information in both English and the other language, have knowledge in both languages of specialized terms, understand and follow confidentiality and impartiality rules, and understand and adhere to their role as interpreters without deviating to another rule such as counselor.⁷⁸

- “When oral language services are necessary, recipients should generally offer competent interpreter services free of cost to the LEP person.”⁷⁹ However, after receiving this offer, the LEP person should generally be permitted to use family members or friends to interpret if this arrangement is appropriate.
- Written language services –translation -- may also be needed for “vital” documents. The fund recipient should decide which documents are vital, and this determination may depend on many factors, including the importance of the program, encounters with LEP persons, services involved, and consequences to the LEP person if the information is not provided accurately.⁸⁰
- The extent of the recipient’s obligation to translate written documents should be determined by the recipient on a case-by-case basis, looking at the totality of the circumstances in light of the four factor analysis. However, taking the following steps will provide the recipient a “safe harbor,” or strong evidence of compliance with written translation obligations: (1) The recipient provides written translations of vital documents for each LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons served or likely to be served. Translation of other documents, if needed, can be provided orally; or (2) If there are fewer than 50 persons in a language group that reaches the five percent trigger in (1), the recipient does not translate vital documents but provides written notice in the primary language of the LEP group of the right to receive competent oral interpretation of those documents, free of cost.⁸¹
- After completing the four factor analysis and deciding what language assistance services are appropriate, recipients should develop an implementation plan. There is “considerable flexibility” in developing this plan. It does not have to be written; however, a written plan is viewed by the DOJ as likely to be the most appropriate and cost-effective means of documenting compliance. Five elements for an LEP policy and effective implementation plan are suggested: (1) identifying LEP individuals who need assistance; (2) deciding on the ways in which language assistance will be provided; (3) training staff; (4) providing notice to LEP persons; and (5) monitoring and updating the policy.⁸²
- The DOJ recognizes that compliance will take time and will look favorably on the intermediate steps recipients take that are consistent with federal guidance and move their service delivery toward providing full access to LEP persons.⁸³

DHHS Recipient Guidance

On August 30, 2000, the DHHS Office for Civil Rights became the first federal agency to issue guidance for recipients of federal funds.⁸⁴ Following a DOJ instruction to agencies to obtain additional public comment, the guidance was re-issued on February 1, 2002.⁸⁵ Then, on July 8, 2002, the DOJ asked all federal agencies to republish their proposed guidance yet again, stressing the need for uniformity among the various federal agencies’ documents.⁸⁶ Tracking the DOJ guidance, DHHS issued its revised guidance document on August 8, 2003.⁸⁷

As required by EO 13166 and DOJ instruction, the August 2003 DHHS Recipient Guidance clarifies current obligations for federal fund recipients under Title VI. This includes

hospitals, nursing homes, state Medicaid agencies, managed care organizations, home health agencies, health service providers, human services organizations, and any other health or human services federal fund recipient, as well as subcontractors, vendors, and subrecipients.⁸⁸

The Guidance states DHHS' intent that federal fund recipients take reasonable steps to ensure that LEP persons have meaningful access to programs and activities as well as the agency's reluctance to impose undue burdens on small business, small local governments, or small nonprofits. Adopting the "flexible and fact-dependent" approach of the DOJ, the Guidance asks all fund recipients to assess: (1) the number or proportion of LEP persons eligible or likely to be served, directly affected, or encountered by the program, using program-specific data along with census, school, state and local, and community-based data from the relevant service area; (2) the frequency with which LEP individuals have or should have contact with the program, activity, or service; (3) the nature and importance of the program or service to people's lives; and (4) the resources available to the fund recipient and costs.⁸⁹

DHHS notes that the four-factor analysis necessarily implicates the "mix" of language services, that is, whether oral interpretation and/or written translation services will be offered.⁹⁰ The correct mix should be based on what is both necessary and reasonable in light of the four factors. The agency notes that, depending on the circumstances, the assistance may need to be expedited while in other situations, "pursuant to an agreement, where there is no discriminatory intent, the purpose is beneficial and will result in better access for LEP persons, it may be appropriate for a recipient to refer the LEP beneficiary to another recipient."⁹¹ For example, if a physician knows that a nearby physician's office can provide linguistically appropriate services to an LEP patient and the offices have a custom/practice of referring patients between each other, it may be appropriate to refer the patient to the other physician.

The Guidance provides specific information about oral interpretation. It describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,⁹² and using community volunteers. It notes that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters but clearly states that an LEP person may not be required to use a family member or friend to interpret. DHHS says recipients should make the LEP person aware that he or she has the "option" of having the recipient provide an interpreter for him/her without charge. "Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence and appropriateness of using the family member or friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual. Moreover, if the fund recipient determines that the family member or friend is not competent or appropriate, the recipient should provide competent interpreter services in place of or, if appropriate, as a supplement to the LEP person's interpreter.⁹³

With respect to written translation, DHHS says it will determine compliance on a case-by-case basis, taking into account the totality of the circumstances in light of the four-factor test.⁹⁴ However, like the DOJ guidance, the DHHS guidance designates "safe harbors" that, if met, will provide strong evidence of compliance with the recipient's written-translation obligations:

- The recipient provides written translations of “vital” documents (e.g. intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally; or
- If there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost.⁹⁵

According to DHHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written implementation plan as a means of documenting compliance with Title VI.⁹⁶ If so, the following five elements are suggested for designing such a plan:

1. Identifying LEP individuals who need language assistance, using for example, language identification cards.
2. Describing language assistance measures such as: the types of language services available, how staff can obtain these services and respond to LEP persons, and how competency of services can be ensured.
3. Training staff to know about LEP policies and procedures and how to work effectively with in-person and telephone interpreters.
4. Providing notice to LEP persons about available language assistance services through, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings.
5. Monitoring and updating the plan, considering changes in demographics, types of services, and other factors.⁹⁷

DHHS also notes that an effective plan will set clear goals and establish management accountability. Recipients may want to provide opportunities for community input and planning throughout the process.⁹⁸

The August 2003 Recipient Guidance notes that systems will evolve over time, and DHHS will look favorably on intermediate steps that recipients take that are consistent with the Guidance. DHHS repeatedly states its interest in working with fund recipients to disseminate examples of model plans, best practices, and cost saving approaches.⁹⁹

OCR Complaint Resolution

As noted above, the HHS Office for Civil Rights is the federal agency charged with enforcing Title VI and implementing regulations. Over the last 30 years, OCR has

undertaken thousands of investigations and reviews involving language differences in health care and social services settings.¹⁰⁰ The National Health Law Program has docketed the formal complaints that were resolved between 1988 and 1998. The overwhelming majority of these reviews involved hospitals. NHeLP is currently updating this docket and has noted that, over the last few years, the subject matter of OCR reviews has broadened, to include investigations regarding:

- *Renal dialysis*: for failing to provide qualified interpreters (Cook County Hospital Renal Dialysis Center);
- *Managed care*: for failing to ensure that Medicaid health maintenance organizations did not engage in marketing practices which deny information or enrollment opportunities to LEP persons (Illinois Department of Public Aid)
- *Subsequent compliance review*: for failing to adhere to a previous voluntary hospital compliance agreement (Maine Medical Center);
- *Behavioral health*: for failing to have a policy concerning language assistance and effective communication with LEP persons (Northcoast Behavioral Health Care System);
- *Children's rehabilitation*: for requiring LEP patients to provide their own interpreters (Rancho Los Amigos Rehabilitation Hospital, Los Angeles);
- *Home health*: for refusing to accept patients for home care services who did not speak English (Visiting Nurse Services of Western Massachusetts);¹⁰¹
- *State Department of Health*: A preliminary assessment has found that the North Carolina Department of Health and Human Services has turned LEP clients away because no interpreters were available; required LEP clients to use family members and friends as interpreters; and failed to assess language needs of national origin groups, evaluate interpreter competency, have procedures to determine when written materials need translation, train staff on language access requirements, and notify LEP persons that interpreter services are available to them at no cost.¹⁰²

Although they involve a range of federal fund recipients and situations, the OCR findings share a number of common features. Specifically, they require federal fund recipients to:

- Develop a written plan for providing LEP services;
- Designate a staff person to coordinate Title VI activities;
- Provide information and training to staff on these policies;
- Post translated notices that contain information on the availability of no cost interpreters;
- Maintain effective interpreter services by emphasizing in-person interpretation and, to the extent possible, minimize telephone interpretation;

- Provide translation of important forms and documents;
- Collect, analyze, and maintain data to determine if interpreter services are adequately provided;
- Monitor subcontractors and include a nondiscrimination clause in all contracts for services.

Letter to State Medicaid/SCHIP Directors Regarding Federal Funding

On August 31, 2000, the Health Care Financing Administration (now Centers for Medicare and Medicaid Services (CMS)) issued a letter to all state Medicaid and SCHIP directors that clarifies that federal Medicaid and SCHIP matching funds are available for state expenditures related to the provision of oral and written translation activities and services.¹⁰³ The letter also informs the states of the DHHS Recipient Guidance.¹⁰⁴

The National Health Law Program surveyed the states to determine the extent to which federal funding is being used specifically to reimburse the costs associated with the provision of language services to Medicaid beneficiaries. A handful of states report obtaining these federal matching funds, including Hawaii, Idaho, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, and Washington. States can receive reimbursement for language services as an administrative expense (equal to 50 percent of the costs). Idaho, Hawaii, Maine and Utah receive reimbursement as a covered service, thus obtaining reimbursement at a higher rate. Different payment models are being used. Hawaii, Washington, and Utah contract with language interpretation agencies, to which the states pay directly for services. In New Hampshire, interpreters contract with the state Medicaid agency and become participating Medicaid providers who are then reimbursed directly by the state. Idaho, Maine, and Minnesota require providers to pay interpreters and then receive reimbursement from the state.¹⁰⁵ The Washington Department of Health and Social Services has recently announced plans to move to a contract broker system for interpreter services. State officials expect the change to result in reduced rates, lower administrative fees, and enhanced contract oversight. The agency plans to implement the system effective January 1, 2003.¹⁰⁶

Office of Minority Health Cultural and Linguistic Access Standards

On December 22, 2000, following a lengthy period of public comment and collaboration, the HHS Office of Minority Health issued National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.¹⁰⁷ The standards are “proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers.”¹⁰⁸

The CLAS standards are independent of DOJ and OCR guidance documents. However, because they address many of the same issues in great detail and are aimed at health care providers, these standards are proving helpful to providers as they devise and implement language access plans. Already, the CLAS standards are being used widely. For instance, the George Washington University Center for Health Services Research and Policy has released and widely circulated model cultural competence purchasing specifications for Medicaid managed care that are based on the CLAS standards.¹⁰⁹ HHS has also made cultural and linguistic competence the focus of Medicare+Choice quality

improvement projects for its Quality Assessment and Performance Improvement (QAPI) initiative for FY 2003 and is encouraging health plans to use the CLAS standards in developing their projects.¹¹⁰ While aimed at health care organizations, the standards are also presented as guidelines for accreditation and credentialing agencies, such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, and Peer Review Organizations.¹¹¹

There are 14 standards, organized into three themes: culturally competent care, language access services, and organizational supports for cultural competence. The 14 standards can also be categorized by their stringency as mandates, guidelines, and recommendations. All of the standards apply to language access to some degree. For example, the standards call on health care organizations to conduct needs assessments, develop a written strategic plan to obtain CLAS, recruit and retain diverse staff, provide ongoing education to staff on culture and language, and monitor and track activities. Five of the 14 standards (4,5,6,7, and 10) deal specifically with language access and are mandates upon recipients of federal funds:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.
- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- Health care organizations should ensure that data on the individual patient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.¹¹²

Office of Management and Budget Report on EO 13166

Congress asked the Office of Management and Budget (OMB) to prepare a report on the costs and benefits of implementing EO 13166. For the report, the OMB issued a general request for cost-benefit information.¹¹³ A number of comments were received, including from community-based and interpreter organizations and advocates, which provided examples of the benefits and actual costs of language access, and the American Medical Association, which expressed concern that the burden of funding language services could fall disproportionately on physicians.¹¹⁴

The OMB report was issued on March 14, 2002.¹¹⁵ It examines “case studies” from four areas—transportation, immigration, food stamps, and health care. With respect to health care, the OMB stated,

Almost all individuals, LEP and non-LEP, need to access the health care system at multiple points in their lives. Making these interactions more effective and more accessible for LEP persons may result in a multitude of benefits, including: increased patient satisfaction, decreased medical costs, improved health, sufficient patient confidentiality in medical procedures, and true informed consent.¹¹⁶

The OMB was unable to evaluate the actual costs of implementing the Executive Order due to insufficient information about the cost of providing language services. However, using data from emergency room and inpatient hospital visits and outpatient physician and dental visits, it estimated that language services would cost an extra 0.5 percent of the average cost per visit.¹¹⁷

IV. Policy and Program Developments in the States¹¹⁸

State laws provide another source of potential protection for LEP patients. In recent years, state legislatures and administrative agencies have begun to recognize the growing need for linguistically appropriate health care and to adopt measures that require or encourage health care providers to take steps to overcome language barriers. In a survey of state laws, the National Health Law Program has identified forty states with laws that address language access in health care settings.¹¹⁹ Some states, such as California and New York, detail specific guidance to providers on what they must do to meet language needs.¹²⁰ Other states, such as Illinois, have passed legislation that notes the importance of translation services but leaves it to the health care provider to decide on the service it will offer.¹²¹

Rhode Island and Massachusetts also have enacted statutes aimed at improving meaningful access in health care settings. These laws take varying approaches, conditioning licensure on the availability of qualified interpreter services in Rhode Island and requiring interpreter services in emergency settings in Massachusetts.

Rhode Island Licensing Law

As of January 1, 2002, a Rhode Island law addresses the provision of interpreter services through its licensing statutes.¹²² The law requires hospitals, as a condition of initial or continued licensure, to provide a qualified interpreter, if an appropriate bilingual clinician is not available, for all services provided to every non-English speaker who seeks treatment and is not accompanied by a qualified interpreter. The statute does not allow any persons under age sixteen to be qualified interpreters.¹²³ It also makes clear that the receipt of interpreter services will not be deemed the receipt of a benefit under any provision of law restricting benefits or assistance on the basis of immigrant status.¹²⁴

Each hospital must post a multi-lingual notice in conspicuous places that describes the interpreter services requirements in English and, at minimum, the three most common foreign languages used at the hospital, as determined by the hospital.¹²⁵

Regulations require each hospital to develop, establish and maintain a formal plan for the provision of language interpretation no later than July 1, 2002.¹²⁶ In addition to parroting the statute, the rules assist hospitals with deciding who is a “qualified interpreter.” While each hospital is to establish its own criteria for the qualification of interpreters, minimum qualifications are provided. In addition to fluency in a language other than English, interpreters must have demonstrated competency in the following topics: (i) appropriate role of a medical interpreter; (ii) confidentiality of health care information; (iii) ethical issues involved in serving as a medical interpreter; (iv) common medical terminology; and (v) relevant hospital policies and procedures.¹²⁷ Hospitals are encouraged to use bilingual clinicians.¹²⁸ They may also contract with off-site interpreter service providers *if* the hospital has received the prior written approval of such arrangements from the State Department of Health.¹²⁹ Hospitals are required to document their reviews and designations of individuals as interpreters.¹³⁰

Massachusetts Emergency Services Interpreter Law

As of July 1, 2001, “every acute care hospital [in Massachusetts] ... 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.”¹³¹ The law also applies to hospitals providing acute psychiatric services. The state Attorney General is authorized to enforce the law, and individuals can file a legal action if they are denied emergency services because of the lack of interpreters.

The Department of Public Health (DPH) has initiated a wide range of activities to assist with implementing the law. Regulations have been issued to provide hospitals with detailed guidance.¹³² The regulations clarify that language services should be made available at no charge and that these services can be provided through bilingual staff, staff interpreters, or contract interpreters. Regardless of the method of delivery, hospitals must provide assurances that interpreters have received appropriate training. Notably, the regulations discourage contracts with telephone interpreter services and the use of family members as interpreters, and they prohibit using minor children to interpret. Further, the regulations require hospitals to designate a coordinator of interpreter services, conduct an annual needs assessment, and ensure that interpreter services are competent. Hospitals must determine the primary language (as well as self-identified race and ethnicity) of all emergency room patients and record this information in the hospital’s management information system, as well as any patient records used by hospital staff. The hospital must make available written translations of important materials, including discharge instructions, consent forms, and advance directives.

The regulations also discuss notification of individuals of their right to interpreter services in the emergency room, orally or in writing, in their primary language. Signs describing the law are to be posted in the emergency department. The DPH has developed multi-lingual drafts of the signs and made them available to hospitals.¹³³

The Department of Public Health has followed promulgation of the regulations with a best practice manual and extensive website postings.¹³⁴ The manual, *Best Practice Recommendations for Hospital-Based Interpreter Services*, is extensive and practical. For example, hospitals are provided a list of the items and policies that, if addressed, will result in a thorough, patient-oriented needs assessment and a written compliance plan. There are suggested procedures for identifying and assessing the language needs of patients. The

Recommendations also discuss ways to ensure trained and competent interpreters and clinical staff working with patients and interpreters.

The Emergency Services Interpreter Law is little more than a year old, so the extent of hospitals' progress in implementing the law is not clear and has not been assessed. Some hospitals are beginning to work together to develop a system that will allow them to exchange information about available interpreters and to develop interpreter pools for unusual languages.¹³⁵ Concerns have also been expressed about how hospitals will pay for the activities required by the law. The federal disproportionate share hospital (DSH) adjustment is providing hospitals serving a disproportionate number of Medicaid and uninsured persons with rate add-ons to compensate them somewhat for these patients. However, it is not clear whether this adjustment is adequate to cover the costs associated with the interpreter law. The law requires the state Medicaid program to reimburse hospitals for the costs of interpreter services associated with enrollees in the State's Medicaid managed care program.¹³⁶ The fiscal year 2002 state budget included an appropriation for these costs; however, many non-English speakers who use emergency rooms are not covered by Medicaid and, at any rate, a state budget crisis makes significant Medicaid funding uncertain.

V. Conclusion

Over 46 million people --over 17 percent of the U.S. population -- speak a language other than English at home. These numbers are certain to increase because of the changing demographics of the U.S. population. It is critical that LEP residents be able to communicate with their health care providers. Accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality.

Numerous federal and state laws address linguistic access in health care settings. Title VI and its regulations offer LEP persons broad protections. Moreover, federal agencies, including the Department of Justice and DHHS, have consistently interpreted Title VI to require federal fund recipients to take reasonable steps to provide meaningful access to LEP persons.

Over the last two years, the federal and state laws and policies that address linguistic access have received a remarkable amount of attention. These laws are being interpreted and clarified at a steady pace. A number of factors are simultaneously coming into play to complicate the policy challenges, including increases in the numbers of LEP persons and of the different languages being spoken; concerns about the costs associated with providing competent language services and, in many areas, a limited pool of competent interpreters; concerns of the effects of LEP patients accessing the health care system without the ability to make informed decisions about their treatment; and a lack of knowledge among federal fund recipients and LEP patients of the legal requirements that affect the provision of services to LEP persons. Attention is warranted to monitor these factors -- along with developments in federal and state laws -- to ensure that persons with limited English proficiency have access to needed health care services.

¹ U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), available at <http://factfinder.census.gov>. See also INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 70-71 (2002) (reporting more than one in four Hispanic individuals in the U.S. live in language-isolated households where no person over age 14 speaks English “very well,” over half of Laotian, Cambodian, and Hmong families are in language isolated households, and 26-42 percent of Thai, Chinese, Korean, and Vietnamese are in such households).

² See 67 Fed. Reg. 41455, 41457 (June 18, 2002).

³ Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* at 2 (May 2001) (finding from 1990 to 2000, the Hispanic population increased by 57.9 percent, from 22.4 million to 35.3 million, compared with an increase of 13.2 percent for the total population in the United States).

⁴ Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No.13166: Improving Access to Services for Persons with Limited English Proficiency* at 4 (Mar. 14, 2002), available at <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>.

⁵ United States Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table QT-02), available at <http://factfinder.census.gov>.

⁶ U.S. Bureau of the Census, Census 2000, Table DP-2: Profile of Selected Social Characteristics 2000. According to the 1990 census, 13.8 percent of the population spoke a language other than English at home. U.S. Bureau of the Census, Census 1990, Table PO31: Language Spoken at Home. For discussion of the 1990 census information, see DiversityRx, *Why Language and Culture Are Important* (1997), at <http://www.diversityrx.org/HTML/ESLANG.htm>.

⁷ See Southern California Association of Governments, *The State of the Region 2001* (2001) (on file with National Health Law Program, Los Angeles, CA).

⁸ See Peter T. Kilborn and Lynette Clemetson, *Gains of 90's Did Not Lift All, Census Shows*, NEW YORK TIMES, A20 (June 5, 2002) (finding the immigrant population from 1990-2000 increased 57 percent, surpassing the century's great wave of immigration from 1900-1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).

⁹ See Joel Kotkin, *Immigration Spreads Throughout Nation*, WSJ.com Real Estate Journal (undated), at <http://www.newgeography.com/WSJ-Reis2.htm>. See also North Carolina State Data Center, Office of State Budget, Planning, and Management, *North Carolina Growing Rapidly and Becoming More Diverse* (Mar. 21, 2001), available at http://www.census.state.nc.us.static_cen00_pl_highlights.pdf (reporting 393.9 percent increase in Hispanic population between 1990 and 2000); Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* at 5 (May 2001) (reporting that in some counties in North Carolina, Georgia, Iowa, Arkansas, Minnesota, and Nebraska, Hispanics now represent as much as 24.9 percent of the total population).

¹⁰ See NATIONAL HEALTH LAW PROGRAM, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES* at 3-5 (published by The Henry J. Kaiser Family Foundation Jan. 1998) (update forthcoming Winter 2003).

¹¹ See Kathryn P. Derosé and David W. Baker, *Limited English proficiency and Latinos' use of physician services*, 57 MED. CARE RESEARCH AND REV. 76 (2000).

¹² Karen Scott Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Findings from The Commonwealth Fund 2001 Health Care Quality Survey* at vii (Mar. 2002) (noting also that Hispanics who spoke primarily English still reported more problems than did whites). See also Glenn Flores et al., *The Health of Latino Children*, 288 JAMA 82, 87-88 (July 3, 2002).

¹³ See Robin M. Weinick and Nancy A. Krauss, *Racial and Ethnic Differences in Children's Access to Care*, 90 AMERICAN J. OF PUBLIC HEALTH 1771 (Nov. 2000).

¹⁴ E.g. Judith Bernstein et al., *The Use of Trained Medical Interpreters Affects Emergency Department Services, Reduces Charges and Improves Follow-Up, Boston Medical Center* (2001) (on file with National Health Law Program, Los Angeles, CA); IS Watt et al., *The health care experience and health behavior of the Chinese: a survey based in Hull*, 15 J. PUBLIC HEALTH MED. 129 (1993);

Sarah A. Fox and J.A. Stein, *The effect of physician-patient communication on mammography utilization by different ethnic groups*, 29 MED. CARE 1065 (1991).

¹⁵ See Jeannette Naish et al., *Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening*, 309 BMJ 1126 (Oct. 29, 1994).

¹⁶ See Louis Hampers et al., *Language Barriers and Resource Utilization in a Pediatric Emergency Department*, 103 PEDIATRICS 1253 (June 1999).

¹⁷ Karen Scott Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Findings from The Commonwealth Fund 2001 Health Care Quality Survey* at vii (Mar. 2002) (noting also that Hispanics who spoke primarily English still reported more problems than did whites). See also Glenn Flores et al., *The Health of Latino Children*, 288 JAMA 82, 87-88 (July 3, 2002).

¹⁸ See Aaron Manson, *Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma*, 26 MEDICAL CARE 1119 (Dec. 1988).

¹⁹ Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). See also INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH* 71-72 (2002) (describing recent survey finding 51 percent of providers believed patients did not adhere to treatment because of culture or language but 56 percent reported no cultural competency training).

²⁰ See Dennis P. Andrulis, PH.D., Nanette Goodman, M.A., and Carol Pryor, M.P.H., The Access Project, *What a Difference an Interpreter Can Make* at 7 (Apr. 2002).

²¹ See David W. Baker et al., *Use and Effectiveness of Interpreters in an Emergency Department*, 275 JAMA 783 (Mar. 13, 1996); Bruce T. Downing, *Quality in Interlingual Provider-Patient Communication and Quality of Care* 7-9 (Sept. 1995) (manuscript available from Kaiser Family Foundation Forum, *Responding to Language Barriers to Health Care*) (finding 28 percent of words and phrases incorrectly translated by a son for his Russian-speaking father); Steven Woloshin et al., *Language Barriers in Medicine in the United States*, 273 JAMA 724 (Mar. 1, 1995).

²² Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). See also INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH* 71-72 (2002) (describing recent survey finding 51 percent of providers believed patients did not adhere to treatment because of culture or language but 56 percent reported no cultural competency training).

²³ Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook* at 122 (Apr. 2002) (available from The Commonwealth Fund, New York, NY) (citing Robert Weech-Maldonado et al., *Racial and Ethnic Difference in Parents' Assessments of Pediatric Care in Medicaid Managed Care*, 36 HEALTH SERVICES RESEARCH 575 (July 2001)).

²⁴ See Dennis P. Andrulis, PH.D., Nanette Goodman, M.A., and Carol Pryor, M.P.H., The Access Project, *What a Difference an Interpreter Can Make* at 1 (Apr. 2002).

²⁵ Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care, Highlights and Charts* 3-4 (Mar. 2002), available at http://www.kff.org/content/2002/20020321a/Physician_SurveyPartI_disparities.pdf.

²⁶ A number of federal laws have been cited to improve language access, including the civil rights laws, provisions of the Medicare and Medicaid Acts, the Hill-Burton Act, federal categorical grant requirements, the Emergency Medical Treatment and Active Labor Act, and the United States Constitution. See, e.g., NATIONAL HEALTH LAW PROGRAM, *ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES* (published by The Henry J. Kaiser Family Foundation Jan. 1998) (update forthcoming Winter 2003).

²⁷ See Kenneth E. Thorpe et al., *Medicare+Choice: Who Enrolls? A Study Commissioned by Blue Cross and Blue Shield of America* (Apr. 25, 2002), available at <http://bcbshealthissues.com/relatives/19526.pdf>.

²⁸ See Centers for Medicare and Medicaid Services, *Medicaid Managed Care State Enrollment* (Dec. 31, 2001), at <http://www.cms.gov/medicaid/managedcare/mmcp01.pdf>.

²⁹ For additional information on Medicaid managed care contract provisions, *see, e.g.*, GEORGE WASHINGTON UNIVERSITY CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, NEGOTIATING THE NEW HEALTH SYSTEM (4th Ed.) (Table 3.6: Translation Services and Cultural Competence), *available at* http://www.gwu.edu/~chsrf/Fourth_Edition/GSA/Tables/Table3_6.html; NATIONAL HEALTH LAW PROGRAM, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES at 70-76 (published by The Henry J. Kaiser Family Foundation Jan. 1998) (update forthcoming Winter 2003).

³⁰ 100 Cong. Rec. 1658 (1964).

³¹ 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

³² *See* *Lau v. Nichols*, 414 U.S. 563 (1974), *but see* notes 49-54, *infra*, discussing *Alexander v. Sandoval*, 121 S.Ct. 1511 (2001), and its effect on *Lau*.

³³ 45 C.F.R. § 80.3(b).

³⁴ *See* 42 U.S.C. § 2000d-4a (defining “program or activity”).

³⁵ *See* 42 U.S.C. § 2000d-4a.

³⁶ 45 C.F.R. Pt. 80, App. B. *See also* 44 Fed. Reg. 17162-75 (Mar. 21, 1979).

³⁷ *See, e.g.* 45 Fed. Reg. 82972 (Dec. 17, 1980) (Notice) (“No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.”); Memorandum from the Secretary of Health and Human Services to OPDV and STAFFDIV Heads Re: HHS Civil Rights Strategic Plan (Jan. 20, 1995) (developing guidelines and remedial standards for the provision of interpreter and translation services is a “short term strategy”); U.S. Department of Health and Human Services Office for Civil Rights, *Guidance Memorandum Title VI Prohibition Against National Origin Discrimination—Persons with Limited-English Proficiency* (Jan. 1998) (on file with National Health Law Program, Los Angeles, CA).

³⁸ 45 C.F.R. § 80.8.

³⁹ *Id.* *See* 42 U.S.C. § 2000d-1.

⁴⁰ 121 S.Ct. 1511 (2001).

⁴¹ 42 U.S.C. § 2000d.

⁴² 121 S.Ct. at 1517. The Court noted reservations with its presumption that the regulations were valid. *Id.*

⁴³ 121 S.Ct. at 1520-21.

⁴⁴ *Id.* at 1521. (“Statutes that focus on the person regulated rather than the individuals protected create ‘no implication of an intent to confer rights on a particular class of persons.’”) (citation omitted). *But see* 121 S.Ct. at 1536 (“But, of course, there was no reason to put that language in § 602 because it is perfectly obvious that the regulations authorized by § 602 must be designed to protect precisely the same people protected by § 601.”) (Stevens, J., dissenting).

⁴⁵ 121 S.Ct. at 1521 (quoting 42 U.S.C. § 2000d-1).

⁴⁶ 42 U.S.C. § 1983.

⁴⁷ 121 S.Ct. at 1527 (“Litigants who in the future wish to enforce the Title VI regulations against state actors in all likelihood must only reference § 1983 to obtain relief....”) (Stevens, J., dissenting).

⁴⁸ *South Camden Citizens in Action (SCCIA) v. N.J. Dept. of Environmental Protection*, 274 F.3d 771 (3rd Cir. 2001), *cert. denied*, 70 U.S.L.W. 3788, 2002 U.S. LEXIS 4706 (U.S. Jun. 24, 2002). *See also* *Pennsylvania Pharmacists Assoc. v. Houstoun*, 283 F.3d 531, 541 (3rd Cir. 2002); *Cesar v. Pataki*, 2002 WL 472271 (S.D.N.Y. Mar. 26, 2002); *Bonnie L. v. Bush*, 180 F. Supp. 2d 1321, 1341-43 (S.D. Fla. 2001). Other courts have accepted Justice Stevens’s analysis, *e.g.*, *Frederick L. v. Dep’t of Public Welfare*, 157 F. Supp. 2d 509, 533-34 (E.D. Pa. 2001); *Lucero v. Detroit Public Schools*, 160 F. Supp. 2d 767 (E.D. Mich. 2001).

⁴⁹ *South Camden Citizens in Action*, 274 F.3d 771 (3rd Cir. 2001), *cert. denied*, 70 U.S.L.W. 3788, 2002 U.S. LEXIS 4706 (U.S. Jun. 24, 2002).

⁵⁰ 121 S.Ct. at 1517.

⁵¹ 414 U.S. 563 (1974).

⁵² *Id.*

⁵³ 414 U.S. at 565.

⁵⁴ 414 U.S. 568.

⁵⁵ 121 S.Ct. at 1519.

⁵⁶ See *ProEnglish v. Bush*, Civ. No. 02-CV-356-A (E.D. Va.) (Complaint filed March 12, 2002). ProEnglish, an organization which advocates for state “official English” laws, joined with four physicians in this lawsuit against President Bush, Attorney General Ashcroft, and DHHS Secretary Thompson. The plaintiffs argued that EO 13166 and federal agency guidance issued pursuant to the EO, discussed *infra*, violate the First Amendment, claiming that the policies will result in “forced speech” (a language other than English) and chill the plaintiffs’ speech in support of the English language. They claimed the policies are beyond the government’s authority because they equate language with national origin when Title VI does not and that the policies are illegal because they need to be formally promulgated pursuant to the Administrative Procedures Act. The Fourth Circuit Court of Appeals dismissed the case on May 15, 2003, noting that the issues were not “ripe” for review.

⁵⁷ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS, *THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY—VOL. II, THE ROLE OF FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORTS* at Ch. 4 (Sept. 1999). See also INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE*, Exec. Summ. at 12-13 (2002) (finding that DHHS “has suffered from insufficient resources to investigate complaints of possible violations” and recommends greater resources be provided to DHHS to enforce civil rights laws).

⁵⁸ See 65 Fed. Reg. 50121 (Aug. 16, 2000).

⁵⁹ Prior to EO 13166, federal agencies were not subject to requirements to ensure meaningful access for LEP persons.

⁶⁰ The Department of Health and Human Services released its plan on December 14, 2001. See U.S. Department of Health and Human Services, *Strategic Plan to Improve Access to HHS Programs and Activities by Limited English Proficient (LEP) Persons* (Dec. 14, 2001), available at <http://www.hhs.gov/gateway/language/languageplan.html>.

⁶¹ *Id.*

⁶² Most agencies have not complied with these requirements. For a listing of the agencies that have issued LEP guidance, see <http://www.usdoj.gov/crt/cor/13166.htm>. The timeframes for compliance have been extended by the DOJ. See, e.g., Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Divisions, to Heads of Federal Agencies, General Counsels and Civil Rights Directors (July 8, 2002) (requesting all agencies to submit drafts of LEP guidance as soon as possible, but no later than July 29, 2002).

⁶³ See 65 Fed. Reg. 50123 (Aug. 16, 2000). In addition to EO 13166, this Guidance is authorized by 28 C.F.R. § 42.404(a), directing agencies to “publish title VI guidelines for each type of program to which they extend financial assistance, where such guidelines would be appropriate to provide detailed information on the requirements of Title VI.” According to DOJ, the Guidance does not create new obligations beyond those already mandated by law. *Id.* at 50121-22.

⁶⁴ 65 Fed. Reg. at 50124.

⁶⁵ *Id.* at 50124-25. See also, e.g., 67 Fed. Reg. 41455, 41457 (June 18, 2002).

⁶⁶ 65 Fed. Reg. at 50125.

⁶⁷ See Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Division, to Heads of Federal Agencies, General Counsels and Civil Rights Directors (July 8, 2002); Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Division, to Heads of Departments and Agencies, General Counsels and Civil Rights Directors (Oct. 26, 2001), at <http://www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm>; U.S. Department of Justice, Background and Questions and Answers Re: October 26, 2001 DOJ Clarifying Memorandum (Oct. 31, 2001), available at <http://www.usdoj.gov/crt/cor/lep/Oct26BackgroundQ&A.htm>; U.S. Department of Justice Coordination and Review Section, *Commonly Asked Questions and Answers Regarding Executive Order 13166* (Jan. 8, 2001), available at <http://www.doj.gov/crt/cor/Pubs/lepqa.htm>; Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Divisions, to Heads of Federal Grant Agencies, General Counsels and Civil Rights Directors (Jan. 11, 2002), available at <http://www.usdoj.gov/crt/cor/lep/BoydJan112002.htm> (encouraging agencies to expedite their work on

LEP guidance documents). See 66 Fed. Reg. 3833 (Jan. 16, 2001) (effective immediately), *republished for additional comment*, 67 Fed. Reg. 2671 (Jan. 18, 2002), *supplanted by*, 67 Fed. Reg. 19237 (Apr. 18, 2002), *supplanted by*, 67 Fed. Reg. 41455 (June 18, 2002).

⁶⁸ See U.S. Department of Justice, Background and Questions and Answers Re: October 26, 2001 DOJ Clarifying Memorandum (Oct. 31, 2001), at <http://www.usdoj.gov/crt/cor/lep/Oct26BackgroundQ&A.htm>.

⁶⁹ See 67 Fed. Reg. 19237, 19237-28 (Apr. 18, 2002).

⁷⁰ See Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Division, to Heads of Departments and Agencies, General Counsels and Civil Rights Directors (Oct. 26, 2001), at <http://www.usdoj.gov/crt/cor/lep/Oct26Memorandum.htm> (requiring federal agencies that have issued LEP guidance to obtain public comment and, based on this comment, to clarify or modify the guidance and noting, “Reasonable steps may cease to be reasonable where the costs imposed substantially exceed the benefits in light of the factors outlined in the DOJ LEP Guidance”).

⁷¹ *Id.* See also, e.g., 67 Fed. Reg. 19237, 19238 (Apr. 18, 2002) (DOJ Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons) (stating DOJ will “strive to ensure that federally assisted programs and activities work in a way that is effective for all eligible beneficiaries, including those with limited English proficiency”).

⁷² See 67 Fed. Reg. 41455 (June 18, 2002). Since 2001, the DOJ has published detailed guidance for DOJ federal fund recipients on four occasions. See 66 Fed. Reg. 3833 (Jan. 16, 2001) (effective immediately), *republished for additional comment*, 67 Fed. Reg. 2671 (Jan. 18, 2002), *supplanted by*, 67 Fed. Reg. 19237 (Apr. 18, 2002), *supplanted by*, 67 Fed. Reg. 41455 (June 18, 2002).

⁷³ *Id.* at 41457.

⁷⁴ *Id.* at 41459. See also Department of Justice, Coordination and Review Section, *Commonly Asked Questions and Answers Regarding Executive Order 13166* (Jan. 8, 2001), available at <http://www.usdoj.gov/crt/cor/Pubs/lepqa.htm> (noting that entities are not required to accept federal funding, but if they do, they must comply with the federal mandates).

⁷⁵ 67 Fed. Reg. at 41459. The eligible service population will be program specific and includes persons who are in the geographic area designated by a federal grant agency as the recipient’s service area, or where there is no such federal designation, the service areas designated by state or local authorities or the recipient itself. *Id.* at 41459-60.

⁷⁶ *Id.* at 41459-61.

⁷⁷ The DOJ discusses ways to provide interpreter services: hiring bilingual staff, hiring staff interpreters, contracting for interpreters, using telephone interpreter lines, using community volunteers, using family members and friends at the LEP person’s own expense (when the LEP person so desires and generally after an offer of free interpreter services is rejected). *Id.* at 41461-62.

⁷⁸ *Id.* at 41461.

⁷⁹ *Id.* at 41462.

⁸⁰ *Id.* at 41463.

⁸¹ *Id.* at 41463-64.

⁸² *Id.* at 41464-65.

⁸³ *Id.* at 41466.

⁸⁴ See 65 Fed. Reg. 52762 (Aug. 30, 2000).

⁸⁵ See 67 Fed. Reg. 4968 (Feb. 1, 2002) (seeking comments by Apr. 2, 2002). This Guidance supplements a prior internal OCR memorandum from January 1998 that instructed OCR regional offices on enforcement of Title VI. See U.S. Department of Health and Human Services, Office for Civil Rights, *Guidance Memorandum: Title VI Prohibition Against National Origin Discrimination—Persons with Limited English Proficiency* (Jan. 1998) (on file with National Health Law Program, Los Angeles, CA).

⁸⁶ Letter from Ralph F. Boyd, Jr., Assistant Attorney General, DOJ Civil Rights Divisions, to Heads of Federal Agencies, General Counsels and Civil Rights Directors (July 8, 2002).

⁸⁷ 67 Fed. Reg. 47311 (Aug. 8, 2003) (effective immediately). DHHS will receive comments on the revised guidance until January 6, 2004, after which it will evaluate whether further revisions are needed.

⁸⁸ *Id.* at 47313. DHHS explicitly states that recipients do not include providers who only receive Medicare Part B payments. *Id.*

⁸⁹ *Id.* at 47314-15.

⁹⁰ *Id.* at 47315.

⁹¹ *Id.*

⁹² Previous guidance cautioned the fund recipient that telephone interpreter lines should not be the sole language assistance option, unless other options were unavailable. See 67 Fed. Reg. at 4975.

⁹³ *Id.* at 47317-18.

⁹⁴ *Id.* at 47319. The previous guidance called for the review to include the nature of the service, the size of the recipient, the size of the LEP language groups in the service area, the nature and length of the document, the objectives of the program, total resources available to the recipient, the frequency with which translated documents are needed, and the cost of translation. See 67 Fed. Reg. at 4973.

⁹⁵ 68 Fed. Reg. at 47319. The guidance makes it clear that the safe harbors only apply to translation of written materials. Previous guidance established different safe harbors, calling for (a) translation of written materials, including vital documents, for each eligible LEP language group that constituted 10 percent or 3,000, whichever is less, of the eligible population to be served; (b) for LEP language groups that did not meet the above threshold, but constituted five percent or 1,000, whichever is less, of the population to be served, the recipient ensured that, at a minimum, vital documents are translated, with oral translation of other documents, if needed; and (c) notwithstanding the above, a recipient with fewer than 100 persons in a language group did not translate written materials but provided written notice in the primary language of the patient of the right to receive competent oral interpretation of written materials. See 67 Fed. Reg. at 4973.

⁹⁶ 68 Fed. Reg. at 47319. The Recipient Guidance recognizes additional benefits that a written plan can provide to recipients in the areas of training, administration, planning, and budgeting. It further notes that absence of a written plan does not obviate the need to comply with Title VI, and the recipient may want to consider alternative ways to articulate how it is providing meaningful access in compliance with Title VI. *Id.*

⁹⁷ *Id.* at 47319-21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. See 67 Fed. Reg. at 4971.

⁹⁸ 68 Fed. Reg. at 47321.

⁹⁹ *Id.* at 47321-22.

¹⁰⁰ See 67 Fed. Reg. at 4970-71.

¹⁰¹ For additional information, see <http://www.hhs.gov/ocr/selectacts/lep.html>.

¹⁰² See Letter from Roosevelt Freeman, Regional Manager, OCR Region IV, to Carmen Hooker Buell, Secretary, NC Department of Health and Human Services (May 24, 2002) (available from NHeLP, Los Angeles, CA).

¹⁰³ See CMS, *Dear State Medicaid Director* (Aug. 31, 2000), available at <http://www.cms.hhs.gov/states/letters/smd83100.asp>.

¹⁰⁴ *Id.*

¹⁰⁵ See Mara Youdelman and Jane Perkins, National Health Law Program, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* 8-12 (available from The Commonwealth Fund May 2002).

¹⁰⁶ See MAA News Release, *MAA plans new system for interpreter services* (May 7, 2002), available at <http://www.wa.gov/dshs/mediareleases/2002/pr02158.shtml>. For detailed information about Washington's Medicaid coverage of interpreter services, see <http://access.wa.gov/dshs/maa/interpreterservices>.

¹⁰⁷ 65 Fed. Reg. 80865-79 (Dec. 22, 2000), reprinted at <http://www.omhrc.gov/clas>.

¹⁰⁸ 65 Fed. Reg. at 80873.

¹⁰⁹ See Center for Health Services Research and Policy, *Purchasing Specifications—Cultural Competence in the Delivery of Services Through Medicaid Managed Care* (Jan. 2001), available at <http://www.gwhealthpolicy.org/newsps/ccs/>.

¹¹⁰ See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare+Choice Organizations' (M+CO) National Quality Assessment and Performance*

Improvement (QAPI) for the Years 2002 and 2003 (July 16, 2001) (#OPL 2001.133), available at <http://www.hcfa.gov/medicare/opl133.pdf>. The Centers for Medicare and Medicaid Services and the University of North Carolina School of Public Health recently sponsored a two-day conference for managed care plans to provide assistance with understanding the CLAS standards and developing cultural and linguistic quality improvement plans. Best Practices for Culturally and Linguistically Appropriate Services in Managed Care (June 3-4, 2002) (Research Triangle Park, North Carolina).

¹¹¹ U.S. Department of Health and Human Services, OPHS Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* at x (Mar. 2001).

¹¹² 65 Fed. Reg. at 80875-76.

¹¹³ See 66 Fed. Reg. 58824 (Nov. 30, 2001).

¹¹⁴ See Letter from Robert W. Gilmore, M.D., American Medical Association, to Brenda Aguilar, Office of Management and Budget (Dec. 21, 2001), available at <http://www.ama.org>.

¹¹⁵ Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* (Mar. 14, 2002), available at <http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf>.

¹¹⁶ *Id.*

¹¹⁷ This was based on the total number and average cost of ER visits, inpatient hospital visits, outpatient physician visits, and dental visits. *Id.*

¹¹⁸ For examples of replicable initiatives by state and local governments, managed care organizations, hospitals, community-based organizations, and educational institutions, see Mara Youdelman and Jane Perkins, National Health Law Program, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (available from The Commonwealth Fund, May 2002).

¹¹⁹ State chart available from National Health Law Program. For an in depth discussion of these statutes, see NATIONAL HEALTH LAW PROGRAM, ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES at App. G (published by The Henry J. Kaiser Family Foundation Jan. 1998) (update forthcoming Spring 2003).

¹²⁰ See, e.g., CAL. HEALTH & SAFETY CODE § 1259; N.Y. COMP. CODES R. & REG., tit. 10, § 4005.7(a)(7).

¹²¹ 210 ILL. COMP. STAT. 87/5 (The Illinois Language Assistance Services Act).

¹²² R.I. GEN. LAWS § 23-17-54; 14 090 CRIR 007 § 20.1 (effective Jan. 1, 2002).

¹²³ *Id.* at § 23-17-54(a).

¹²⁴ *Id.* at § 23-17-54(c).

¹²⁵ *Id.* at § 23-17-54(b); 14 090 CRIR 007 § 20.3.

¹²⁶ 14 090 CRIR 007 § 20.2.

¹²⁷ 14 090 CRIR 007 § 20.2.1.

¹²⁸ *Id.* at § 20.2.3.

¹²⁹ *Id.* at §§ 20.2.5.

¹³⁰ *Id.* at §§ 20.2.2, 20.2.4.

¹³¹ Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services," codified at MASS. GEN. L. CH. 111 § 25J(b) (emergency services), CH. 123 § 23A(b) (acute psychiatric services) (enacted April 2000). "Competent interpreter services" are defined to mean interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting, and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving emergency care. *Id.*

¹³² 105 CODE MASS. REGS. § 130.1101 *et seq.*

¹³³ See <http://www.state.ma.us:80/dph/omh/interp/interpreter.htm>.

¹³⁴ *Id.*

¹³⁵ See Cindy Rodriguez, *Hospitals Eye Language Remedy*, BOSTON GLOBE, Mar. 14, 2002.

¹³⁶ MASS. GEN. L. CH. 118G §§ 7, 11.

VI. APPENDIX
FREQUENTLY ASKED QUESTIONS: WHAT ARE CURRENT FEDERAL LAWS AND POLICIES FOR ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS?

1. Is there a federal requirement that health care providers offer interpreters to individuals who do not speak English well?

Yes. In 1964, Congress passed Title VI of the Civil Rights Act. This is a civil rights law that prohibits discrimination. Its purpose is to ensure that federal money is not used to support health care providers who discriminate on the basis of race, color, or national origin.¹ Title VI says:

No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.²

The federal Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well. Thus, recipients of federal funding must take reasonable steps to ensure that people with limited English proficiency (LEP) have meaningful access to their programs and services.

2. What if a provider unintentionally discriminates against individuals?

HHS issued regulations to implement Title VI that reiterate the statute and extend Title VI beyond the prohibition of intentional discrimination. They prohibit federal fund recipients from:

- using criteria or methods of administration which have the *effect* of discriminating because of race, color or national origin;
- restricting the enjoyment of any advantage or privilege enjoyed by others receiving services through the same program;
- providing services or benefits to an individual that are different, or provided in a different way, from those provided to others;
- treating an individual differently from others in determining admission, enrollment, eligibility, or other requirement to receive services.³

Through these regulations, the HHS Office for Civil Rights (OCR) can initiate investigations or respond to complaints of discrimination.

3. Who is covered by Title VI?

The obligations under Title VI and HHS' regulations apply broadly to any "program or activity" that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.⁴ This includes payment for services provided to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) enrollees. Thus, in the health care context, this includes virtually all:

- Hospitals;
- Doctor's offices;⁵
- Nursing homes;
- Managed care organizations;
- State Medicaid agencies;
- Home health agencies;
- Health service providers; and
- Social service organizations.

Further, the Title VI protections extend to all of the operations of the organization or individual, not just that part that received the federal funds.⁶

4. Why has so much discussion recently focused on language access?

The number of languages spoken in the United States is increasing significantly. According to the 2000 Census, over 21 million individuals speak English less than “very well.” Many states saw significant increases in their LEP populations. Recent federal activities focusing on improving language access have also increased discussion on the issue. These activities include a presidential “Executive Order” (EO) entitled *Improving Access to Services for Persons with Limited English Proficiency*,⁷ publication of guidance on language access by many federal departments, and release of the “CLAS Standards” (Standards for Culturally and Linguistically Appropriate Services in health care) by the Office of Minority Health.⁸ The Executive Order affects all “federally conducted and federally assisted programs and activities.” This includes health care providers that receive federal funds such as Medicare, Medicaid and SCHIP. The EO asks each federal agency to draft a guidance specially tailored to its federal fund recipients and applies Title VI to the federal departments and agencies themselves so that they have to administer their programs in a non-discriminatory way.

The current Administration has re-affirmed its commitment to the Executive Order and has continued activities to ensure its implementation.

5. How does a health care provider know what it should do to provide language services?

The Department of Justice, which coordinates the federal government’s Title VI oversight, announced four factors for federal fund recipients to use to determine what steps they should take to assist LEP persons:⁹

- The number or proportion of LEP individuals served or encountered.¹⁰
- The frequency of contact with the program. If LEP individuals access the program on a daily basis, a recipient has greater duties than if contact is infrequent.
- The nature and importance of the program to beneficiaries. More steps must be taken if a denial or delay of services may have critical implications for daily life (e.g. hospitals, schools) than in programs that are not as crucial (e.g. theaters, zoos).
- The resources available and cost considerations. A small recipient with limited resources may not have to take the same steps as a larger recipient in programs where the numbers of LEP persons are limited. Costs are a legitimate consideration in identifying the reasonableness of particular language assistance measures.¹¹

In balancing these factors, providers should address the appropriate mix of written and oral language assistance, including which documents must be translated, when oral interpretation is needed, and whether such services must be immediately available.¹²

6. Are there specific guidelines for health care providers?

Yes. On August 8, 2003, the HHS Office for Civil Rights (OCR) issued guidance for its recipients of federal funds, which include health care providers.¹³ This guidance does not impose any new requirements but merely brings together all of OCR’s policies for overseeing Title VI since 1965.

7. How does OCR determine if a health care provider is discriminating?

OCR looks at the totality of the circumstances in each case. Four factors will be assessed: (1) the number or proportion of LEP individuals eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. According to DHHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written implementation plan as a means of documenting compliance with Title VI.

8. How should a provider offer oral interpretation services?

The HHS Guidance describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,¹⁴ and using community volunteers. It stresses that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters but clearly states that an LEP person may not be required to use a family member or friend to interpret. Moreover, DHHS says recipients should make the LEP person aware that he or she has the "option" of having the recipient provide an interpreter for him/her without charge.

"Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence and appropriateness of using the family member or friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual.

9. When should a provider translate written materials?

It depends on the relevant circumstances of each provider based on the factors listed above. After the four factors have been applied, recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Recipients could develop a written implementation plan as a means of documenting compliance with Title VI. If so, the following five elements are suggested when designing such a plan:

- Identifying LEP individuals who need language assistance, using for example, language identification cards.
- Describing language assistance measures, such as the types of language services available, how staff can obtain these services and respond to LEP persons; how competency of language services can be ensured.
- Training staff to know about LEP policies and procedures and how to work effectively with in-person and telephone interpreters.
- Providing notice to LEP person through, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings.
- Monitoring and updating the LEP plan, considering changes in demographics, types of services, and other factors.¹⁵

OCR will evaluate a provider's efforts on a case-by-case basis. For the translation of written materials, the Guidance designates "safe harbors" that, if met, will provide strong evidence of compliance.¹⁶

10. What are the costs and benefits of providing language services?

The federal Office of Management and Budget (OMB) reported to Congress:

Almost all individuals, LEP and non-LEP, need to access the health care system at multiple points in their lives. Making these interactions more effective and more accessible for LEP persons may result in a multitude of benefits, including: increased patient satisfaction, decreased medical costs, improved health, sufficient patient confidentiality in medical procedures, and true informed consent.¹⁷

The OMB was unable to evaluate the actual costs due to insufficient information. However, using data from emergency room and inpatient hospital visits and outpatient physician and dental visits, it estimated that language services would cost an extra 0.5 percent of the average cost per visit.¹⁸

11. How can health care providers pay for language services?

On August 31, 2000, the Health Care Financing Administration (now Centers for Medicare & Medicaid Services (CMS)) stated that federal Medicaid and SCHIP funds can be used for language activities and services.¹⁹ States can thus submit the costs incurred by themselves or health care providers serving Medicaid and SCHIP enrollees to the federal government for partial reimbursement.

12. If my state draws down Medicaid/SCHIP funds, to whom can language services be provided?

States can only receive federal reimbursement for language services provided to Medicaid and SCHIP enrollees (or applicants who need assistance in applying). Depending on how your state structures the reimbursement, it can be available to all providers, including community health centers, managed care organizations and hospitals. Some states have limited the reimbursement to "fee-for-service" providers. Many states currently set their reimbursement rates for hospitals, clinics and managed care organizations to include the costs of language services as part of the entity's overhead or administrative costs. But a state could allow all providers to submit for reimbursement.

13. What if my state has an English-only law – does Title VI still apply?

Yes. As noted by OCR's guidance, the federal law applies regardless of whether your state law makes English its only recognized language (because federal law "preempts" any conflicting state law).²⁰ Since Title VI applies to the receipt of federal funds, a health care provider cannot forego his/her obligations under federal law. In addition, your state's English-only laws may have a specific exemption for health care/social services and/or may only apply to government activities.

14. Where can I get more information?

The federal government has launched a website called "Let Everyone Participate," <http://www.lep.gov>. In addition to tracking federal activities, the website offers direct assistance to federal fund recipients and advocates. For example, fund recipients can download "I Speak" cards that allow LEP persons to identify their primary language.

¹ 100 Cong. Rec. 1658 (1964). The United States Supreme Court has treated discrimination based on language as national origin discrimination. See *Lau v. Nichols*, 414 U.S. 563 (1974).

² 42 U.S.C. § 2000d. See also 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

³ 45 C.F.R. § 80.3(b).

⁴ See 42 U.S.C. § 2000d-4a (defining “program or activity”).

⁵ Title VI has traditionally not applied, however, to doctors who only receive federal payments through Medicare Part B.

⁶ See 42 U.S.C. § 2000d-4a.

⁷ See 65 Fed. Reg. 50121 (Aug. 16, 2000), see also 67 Fed. Reg. 41455 (June 18, 2002).

⁸ See 65 Fed. Reg. 80865 (Dec. 22, 2000), available at <http://www.omhrc.gov/chas>.

⁹ See 65 Fed. Reg. 50123 (Aug. 16, 2000). In addition to EO 13166, this Guidance is authorized by 28 C.F.R. § 42.404(a), directing agencies to “publish title VI guidelines for each type of program to which they extend financial assistance, where such guidelines would be appropriate to provide detailed information on the requirements of Title VI.” According to DOJ, the Guidance does not create new obligations beyond those already mandated by law. *Id.* at 50121-22.

¹⁰ See 67 Fed. Reg. 41459. “But even recipients that serve LEP person on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if an LEP individual seeks services under the program in question.”

¹¹ *Id.* at 50124-25. See also, e.g., 67 Fed. Reg. 41455, 41457 (June 18, 2002).

¹² See 67 Fed. Reg. 41460 (June 18, 2002).

¹³ 68 Fed. Reg. 47311 (August 8, 2003). To review previous versions of this guidance, see 65 Fed. Reg. 52762 (Aug. 30, 2000).

¹⁴ Previous guidance cautioned the fund recipient that telephone interpreter lines should not be the sole language assistance option, unless other options were unavailable. See 67 Fed. Reg. at 4975.

¹⁵ 68 Fed. Reg. at 47319-21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. See 67 Fed. Reg. at 4971.

¹⁶ The safe harbors designate that the recipient provides written translations of “vital” documents (e.g. intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally. Or, if there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost. 68 Fed. Reg. at 47319.

¹⁷ Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No.13166: Improving Access to Services for Persons with Limited English Proficiency* (Mar. 14, 2002), available at <http://www.whitehouse.gov/omb/inforg/lepfinal3-14.pdf>.

¹⁸ *Id.*

¹⁹ See CMS, *Dear State Medicaid Director* (Aug. 31, 2000), available at <http://www.cms.hhs.gov/states/letters/smd83100.asp>.

²⁰ See 68 Fed. Reg. at 47313.

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