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How California Can Pay For Language Assistance Services

Recommendations from the Medi-Cal Language Access Services (MCLAS) Task Force

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PREPARED BY
Doreena Wong, Senior Attorney

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Asian and Pacific Islander American Health Forum: Marguerite Ro, Deputy Director.

Lambda Legal: Jennifer Pizer, Senior Counsel

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I. Need for Language Assistance Services in California

California is one of the nation's most linguistically diverse states, with over 40 percent of its population speaking a language other than English at home, encompassing over 200 languages.[1] Despite the rich diversity of its residents, the lack of both available language services and payments for language services in Medi-Cal's fee-for-service (FFS) program makes it difficult to assess the level or quality of such services.[2] Language assistance services often are not provided or compensated appropriately.

Providing adequate language services improves health outcomes and patient satisfaction, comports with existing federal and state requirements, and achieves long-term cost savings.[3] Language services facilitate effective communication between health care providers and patients, thereby reducing medical errors, ensuring better health outcomes and lessening health disparities. In contrast, language barriers impede access and quality of care and also result in costly, unnecessary testing due to the lack of a thorough patient interview.[4]

All federal fund recipients, including all Medi-Cal providers, must comply with Title VI of the Civil Rights Act of 1964. Title VI prohibits discrimination based on national origin, which federal agencies and the Supreme Court have defined to include language.[5] The Office for Civil Rights of the U.S. Department of Health and Human Services (DHHS) has issued policy guidance that requires all of its recipients of federal funds to provide meaningful access for limited-English proficient (LEP) persons.[6] Since Medi-Cal is federally funded, Medi-Cal providers should assess the needs of its LEP population; provide competent interpreter and translation services (such as translation of readily understandable print materials); provide notice of the availability of free language-assistance services; train staff; and adopt, monitor and update an adequate language services plan.[7]

Additionally, state contracts and policy letters apply to the Medi-Cal Managed Care (MMC) Program that outline the language access requirements in more detail. The policy letters assist managed care plans provide high-quality, culturally and linguistically appropriate services, including interpreter services and translated materials.[8]

Additional state requirements to ensure language access are included in the following laws:

- California Government Code §§ 11135–11139—an anti-discrimination statute analogous to Title VI that applies to state agencies and state-funded entities;
- Dymally-Alatorre Bilingual Services Act of 1973—requires that all state agencies that provide services to a population that is 5 percent or more non-English speaking employ a sufficient number of qualified bilingual persons to provide interpreter and translation services;[9] and
- Kopp Act of 1983—requires that where linguistic barriers exist in general acute hospitals, interpreters or bilingual staff must be available using a 5 percent threshold.[10]

As a result of federal and state requirements, some states have opted to obtain federal matching funds to reimburse language services using various reimbursement models discussed below.[11]

Formation of MCLAS Task Force

In December 2006, the California Department of Health Care Services (DHCS) met with interested language access stakeholders about proposed Senate Bill 1405.[12] The Medi-Cal Language Access Services (MCLAS) Task Force was subsequently created to develop recommendations for an economical and effective state delivery system and reimbursement mechanism to provide language services for California's Medi-Cal LEP beneficiaries.

The 22 members of the MCLAS Task Force included approximately one-third government officials, one-third providers and practitioners, and one-third consumer representatives and advocates.[13] Many other interested stakeholders attended the MCLAS Task Force meetings and provided input to the final report.[14] The work of the MCLAS Task force was guided by the following principles:[15]

1. Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans.
2. Competent health care language services are essential to an effective public health and health care delivery system in a pluralistic society.
3. The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be assigned to any one segment of the public health or health care community.
4. Federal and state governments should establish and fund mechanisms through which appropriate language services are available where and when they are needed by Medi-Cal beneficiaries.
5. Because it is important for providing all patients the environment most conducive to positive health outcomes, linguistic diversity in the health care workforce should be encouraged, especially for individuals in direct patient contact positions.
6. Quality improvement processes should assess the adequacy of language services provided when evaluating the care of LEP patients, particularly with respect to outcome disparities and medical errors.
7. Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators, and bilingual staff/clinicians.
8. Continued efforts to improve primary language data collection protocols are essential to enhance both services for, and research identifying the needs of, the LEP population.

II. Paying for Language Assistance Services: What Are Other States Doing?

In 2000, state Medicaid directors were reminded that federal Medicaid and State Children's Health Insurance Program funds could pay for language assistance activities and services.[16] To date, however, only 13 states and the District of Columbia have taken advantage of the federal matching funds available and directly pay the costs of language services; two others are exploring or developing federal mechanisms to pay for language services in their Medicaid programs.[17] States can draw down federal funds through expensing these services as:[18]

- "Covered services" provided to Medicaid beneficiaries
- Costs for program administration
- Payments made to "disproportionate share hospitals"

States are using four methods to provide and pay for language assistance services:

- Pay the costs of a telephonic language line used by Medicaid providers (Kan.)
- Directly reimburse interpreters (Mont., N.H., Wyo.)
- Directly reimburse providers who hire and pay for interpreters (Iowa, Idaho, Maine, Minn.)[19]
- Contract with language services agencies to reimburse language service providers directly (D.C., Hawaii, Utah, Vt.) or with brokers who arrange services and submit billing to the state agencies (Wash.)

A summary of how states pay for language services in Medicaid and CHIP is included in the chart on the next page.

State	For which Medicaid and SCHIP enrollees?	Which Medicaid and SCHIP providers can submit for reimbursement?	Who does the state reimburse?	How much does the state pay for language services provided to Medicaid/SCHIP enrollees?	How does the state claim its federal share—as a service or administrative expense?	What percentage of the state's costs does the federal government pay (FY 2009)?
D.C.	Fee-for-service (FFS)[20]	FFS practice < 15 employees	language agencies[21]	$135–$190/hour (in-person) $1.60/min. (telephonic)	Admin	Medicaid adults (MA-A)—50% Medicaid kids (MA-K)—75% CHIP—84%
Hawaii	FFS	FFS	language agencies	$36/hour (in 15 min. increments)	Service	MA-A—54.24% MA-K/CHIP—75%
Iowa	FFS	FFS who do not submit cost reports	providers	$60/hour (in 15 min. increments, in-person) $1.70/min. (telephonic)	Service	MA-A—63.51% MA-K—75% CHIP—79.46%
Idaho	FFS	FFS	providers	$12.16/hour	Service	MA-A—69.40% MA-K—75% CHIP—83.58%
Kan.	Managed care	not applicable (state pays for language line)	EDS (fiscal agent)	Spanish—$1.10/min.; other languages—$2.04/min.	Admin	MA-A—50% MA-K—75% CHIP—77.27%
Maine	FFS	FFS	providers	Lesser of $20/15 min or usual and customary fee	Service	MA-A—64.99% MA-K—75% CHIP—80.49%
Minn.	FFS	FFS	providers	Lesser of $12.50/15 min or usual and customary fee	Admin	MA-A—50% MA-K/CHIP—75%
Mont.	all Medicaid	all[22]	interpreters	Lesser of $6.25/15 minutes or usual and customary fee	Admin	MA-A—50% MA-K—75% CHIP—82.19%
N.H.	FFS	FFS	interpreters (who are Medicaid providers)	$15/hour $2.25/15 min. after first hour	Admin	MA-A—50% MA-K/CHIP—75%
Utah	FFS	FFS	language agencies	$28–35/hour (in-person) $1.10/minute (telephonic)	Service	MA-A—71.68% MA-K—76.68% CHIP—85.18%
Va.	FFS	FFS	Area Health Education Center & three public health departments	Reasonable costs reimbursed	Admin	MA-A—50% MA-K/CHIP—75%
Vt.	All	All	language agency	$15/15 min. increments (in-person)	Admin	MA-A—50% MA-K—75% CHIP—76.11%
Wash.	All	public entities	public entities	50% allowable expenses	Admin	MA-A—50% MA-K/CHIP—75%
Wash.	All	non-public entities	brokers; language agencies	brokers receive administrative fee language agencies receive $34/hour	Admin	MA-A—50% MA-K/CHIP—75%
WY	FFS	FFS	interpreters	$11.25/15 min.	Admin	MA-A—50% MA-K/CHIP—75%

The MCLAS Task Force discussed the advantages and disadvantages in each system to determine which model(s) would be appropriate for California.[23]

III. A Proposal for California: What Should California's Model Look Like?

California does not currently have a mechanism for the reimbursement of language services for its Medi-Cal program. Due to continuing budget deficits, it does not seek federal funds to pay for language assistance services because such funds require the state to match some of the costs. Public hospitals and Federally Qualified Health Centers (FQHCs) are exceptions and do receive some funding for such services, although not enough to cover all of their costs (the costs of language services are included as part of these entities' overall rates).

The MCLAS Task Force sought to create a system providing reimbursement for as many types of providers as possible, including hospitals, physicians' offices, and clinics, and for all of the different modes of interpreter services—in-person, via the telephone, or through video-conferencing.

After studying the states that provide reimbursement, the MCLAS Task Force focused on Washington state's broker model, one of the most promising reimbursement models because it has a single point of contact and ease of access for providers, decreased administrative overhead, improved oversight of interpreter quality and reductions in Medicaid fraud.[24] Washington's language services delivery system is the oldest and largest in the country, although its broker system was initiated more recently.[25] Although the state-administered broker system allows increased control over quality standards for interpreter services, it does not incentivize health care institutions to increase their own language services. The MCLAS Task Force report examined the relative benefits of brokerage models, as compared with other approaches.[26]

A. Medi-Cal Fee-for-Service (FFS) Hybrid Model

As a result of its deliberations, the MCLAS Task Force recommended a hybrid Brokerage/ Direct Provider Reimbursement model for California to provide and finance language services within the Medi-Cal fee-for-service program. Reimbursement for language services in the Medi-Cal Managed Care program is already negotiated between the state and the managed care plans.

Under the FFS hybrid model, a Medi-Cal provider will have the option of either choosing to: 1) use a broker to provide the language assistance service, 2) provide the language assistance service and bill for it directly, or 3) a combination of the two. For example, a hospital will be able to bill the state directly for the cost of providing interpreter services for its inpatient encounters but can use a broker for interpreter services in its outpatient clinics.

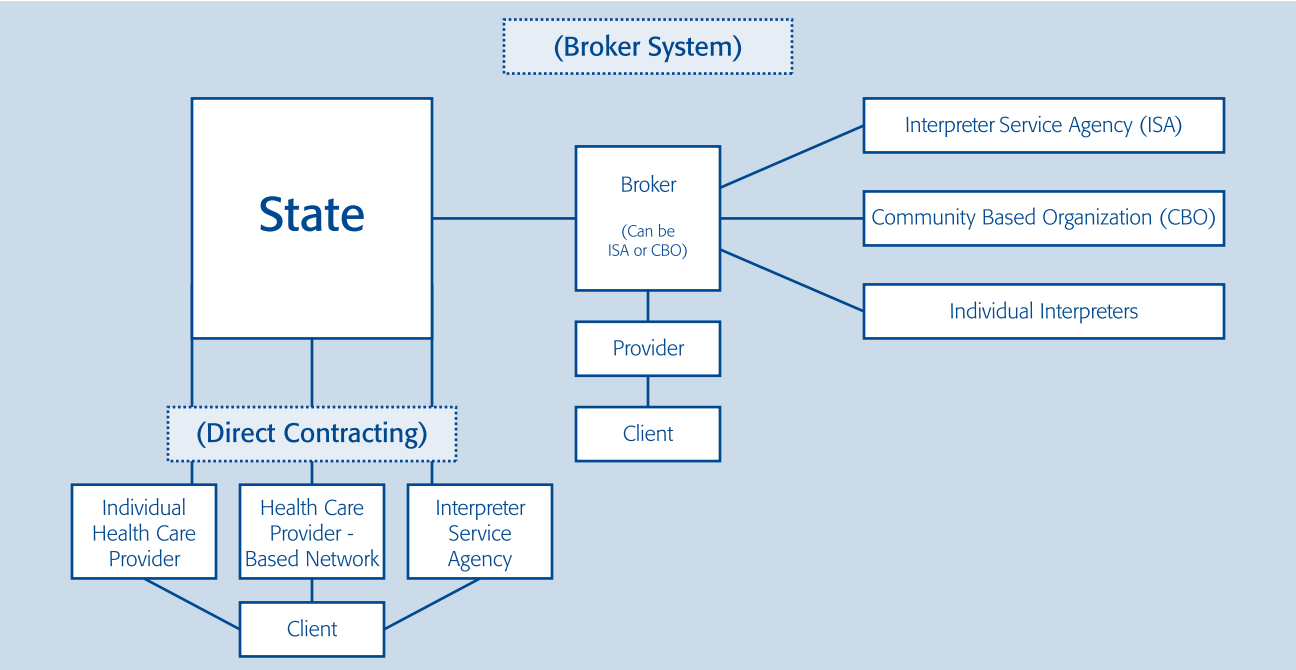
Using the broker feature, the state will contract with regional brokers for language assistance services and will define the geographic

regions for broker coverage. The broker must demonstrate capacity to fulfill services and responsibilities for a particular region. Brokers would be paid directly by the state for language services, and would be responsible for coordinating, paying and managing a network of language agencies, as well as verifying the eligibility of Medi-Cal beneficiaries.[27] The regional broker would receive a predetermined administrative fee to manage its overall service, as well as a fee-per-interpreter encounter.[28]

Under the Direct Provider Reimbursement Model, Medi-Cal providers who currently provide language assistance services and/or prefer to use their own employees, including bilingual providers and staff, and/or contracted interpreters will be able to bill the state for services rendered. As with the Broker model, providers in the Direct Reimbursement model will be required to ensure that their interpreters are trained and qualified to provide health care interpreting. The MCLAS Task Force report explains how providers could be paid using the existing Medi-Cal fee-for-service system through the introduction of new billing codes.[29] It is important to include the Direct Provider Reimbursement Model so that health care providers who already have established interpreting programs can maintain those and still obtain payment. Otherwise, with only a broker model, providers would likely be at a disadvantage if they maintained interpreters on-site and/or on-staff if they could not access reimbursement directly.

B. Pilot Project

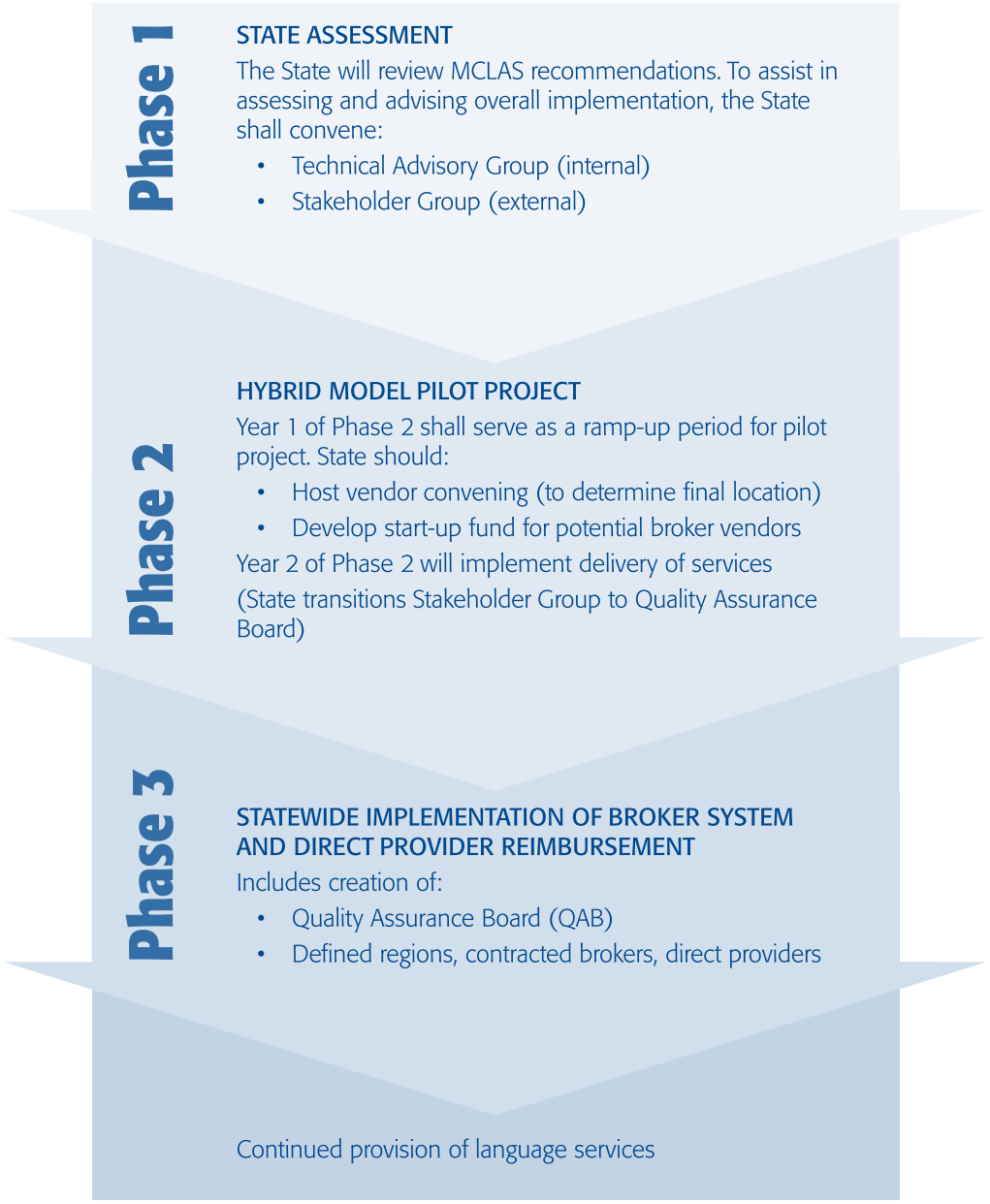
Given California's budget constraints, the MCLAS Task Force proposes that the state conduct a two-year pilot project, initially covering a single California county, to test both a broker and direct provider billing system.[30] The first year includes the state hosting a vendor meeting for potential regional brokers, developing a start-up fund for potential brokers and reviewing data about LEP encounters in the Medi-Cal FFS program. Actual delivery of services and evaluation of the system



is projected to begin in Year 2. The pilot project would allow the state to determine statewide implementation costs as well as to assess the feasibility of the hybrid system statewide.

During the pilot project period, the MCLAS Task Force recommends forming an external stakeholder group to assess and advise the state on overall implementation of the pilot project, as well as to address contingencies that may arise. In order to assure the continued viability of the broker, the state should allow for a one-year extension if standards are met.

Pilot Project Timeline



IV. Other Implementation Issues

The MCLAS Task Force identified many related issues when considering potential language services models for the state. Given the short time allowed to develop its proposals, the report only highlights some of the key issues that should be more thoroughly addressed when the chosen model is implemented. The remainder of this Issue Brief addresses some of the more relevant sections of the Task Force's report.

A. Reimbursement of Safety Net Providers

Many safety net health institutions—such as public hospitals; public clinics; and non-profit community health centers, including Federally Qualified Health Centers (FQHCs)—receive some reimbursement for the language services they provide, but significant costs remain unreimbursed. Although the state's public hospitals do not receive any state reimbursement, they receive some federal payment for the cost of language services;[31] yet more than half of their costs are unreimbursed. If the state would cover 50 percent of the costs of interpreter services, this would bring reimbursement levels closer to actual costs, and provide opportunities to sustain and expand language services to LEP beneficiaries. The MCLAS Task Force recommends that all hospitals, not just public hospitals, have two options for providing language services and obtaining reimbursement from the state for services provided to Medi-Cal patients: 1) direct billing to the state using either an enhanced encounter rate (T-code) or expensing the claims as an administrative expense, and/or 2) using the broker service.

FQHCs also are federally required to provide language assistance services to their LEP patients, and the cost of such services is included in an all-inclusive prospective payment rate (PPS). However, not all FQHCs include the costs of providing interpreter services in their PPS rate, so their costs are understated. Therefore, the MCLAS Task Force recommends allowing FQHCs to continue to secure reimbursement through the PPS rate and having the state facilitate a change of the scope of service for FQHCs that do not include the costs of language assistance services included in their PPS rate. The MCLAS Task Force also recommends that FQHC providers be allowed to use the broker for those languages that are unavailable at the FQHC.

B. Quality and Standards for Interpreters

The MCLAS Task Force recommends a system to ensure that Medi-Cal beneficiaries have access to competent, trained and tested interpreters. An accrediting organization would be responsible for accrediting agencies, programs and/or schools—called "Interpreter Training Programs" (ITPs)—that conduct interpreter training and testing. The accredited program will conduct training and administer a competency test. Interpreters who have a certificate of completion from an accredited ITP will be eligible to receive reimbursement

for language services through Medi-Cal. Additionally, because there are interpreters providing services in California today, the MCLAS Task Force recommends that they be "grandfathered" into the system and be eligible for reimbursement.[32] DHCS would develop a system to track and maintain records identifying interpreters who are eligible for Medi-Cal reimbursement. In addition to the proposed accreditation process, the state could accept a certification process as a prerequisite or alternative process for reimbursement to ensure interpreter competency. For example, the Certification Commission for Healthcare Interpreters (CCHI), launched in 2009 after the MCLAS Task Force had completed its report, is developing a national, valid, credible, vendor-neutral certification program that the state could adopt.[33]

A Quality Assurance Board (QAB) of experts and advocates would be established by DHCS to assure the quality of interpreting and development of an effective Medi-Cal language-services program. The QAB would provide advisory and technical assistance to DHCS, and help develop, implement and monitor the Medi-Cal language-services program. The final set of core competencies for health care interpreters would be determined by the state working with the QAB.[34] The state and the QAB should consider adopting nationally recognized standards on training that are currently being developed by the National Council on Interpreting in Health Care (NCIHC), which is a multidisciplinary organization whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency.[35]

The MCLAS Task Force also recommends the state undertake the following language access responsibilities: monitor compliance; identify and resolve complaints related to language services; oversee implementation of the language-services program; establish a free, well-publicized, centralized complaint line to handle concerns and complaints of LEP beneficiaries;[36] issue Medi-Cal eligibility cards identifying the beneficiary's oral and written language needs;[37] educate Medi-Cal populations about their rights to free interpreter and translation services and how to secure interpreter services; educate Medi-Cal providers about language assistance services available through the new system; and conduct audits of brokers to ensure contract compliance, including maintaining an adequate network of interpreters.

C. Managed Care

Medi-Cal managed care plans are obligated to provide cultural and linguistic services to their enrollees. The MCLAS Task Force recommends that the plans have an option retain the services of a broker for a fee and inform contracted providers about this option. The MCLAS Task Force also recommends that DHCS review with managed care plans the following information: the number of LEPs in each plan, the range of language services provided to LEPs, LEP language service utilization rates, annual cost of providing language services, and the relative cost and effectiveness of different types of language services. The MCLAS Task Force should also inform managed care plans that they can receive an enhanced match rate for the portion of the capitated rate that is related to language services under guidance issued by the Centers and Medicare and Medicaid Services in 2010.[38]

Existing auditing and enforcement mechanisms could be strengthened through a survey of LEP enrollees about the use of language services, and education of Medi-Cal beneficiaries about the language services available and of the Ombudsman Toll-Free 1-888-452-8609 line. Managed care plans also should educate providers on their available language services.

D. Mental Health

The state's mental health system operates under a county-operated Mental Health Medi-Cal Managed Care Plan (MHP) program that includes oversight by the state. Similar to other managed care programs, the mental health "carve out" of Specialty Mental Health services should include interpreter services, but specific costs for interpreter services are not available. Because each MHP must develop and implement a Cultural Competence Plan and develop strategies for providing language services for persons served through the managed care contracts, the MCLAS Task Force recommends improved documentation to make an informed assessment of language needs of Medi-Cal beneficiaries with mental health needs and further studies to identify language services costs.

Proposition 63 (Prop 63) funds can be used to support programs under the MHPs. The creation of Prop 63's Cultural and Linguistic Competence Technical Resource Group gives the mental health community a forum to identify linguistic barriers for accessing mental health services. The MCLAS Task Force recommends aligning services between the recommendations found in its report and those of the Cultural and Linguistic Competence Technical Resource Group.

E. Translation of Written Documents

The MCLAS Task Force recognizes the importance of having written information available in non-English languages as well as interpretation services, and recommends that document translation be handled in a manner similar to that for oral interpreters, since both are reimbursable services under Medicaid. For state documents, DHCS should assume the responsibility for translating documents for FFS beneficiaries.

Any Medi-Cal provider should be able to request the translation of a vital document from the broker.[39] As part of their contracting process with the state, brokers will be assessed for their capacity to translate vital documents

into all Medi-Cal Managed Care threshold languages, either through the broker's staff or contracts with other vendors.[40] The ability to translate or arrange for the translation of documents should be considered in the awarding of vendor contracts. Any provider who requests translation of a vital document should be able to receive that translated document from the broker in a reasonable time frame.

V. Next Steps: Where Do We Go From Here?

The MCLAS Task Force Report issued the final report in 2009 and has continued to discuss its findings with DHCS. However, the final recommendations and the proposed pilot project to test the hybrid broker/direct reimbursement mechanism have not been adopted by DHCS due to budget deficits. When the pilot project and final recommendations are implemented, an internal work group and an external stakeholder work group should be created to implement other provisions of the recommendations, including a Quality Assurance Board to address the quality of language services, standards for interpreters and translators, and other patient-safety issues.

Until the recommendations are adopted and implemented, MCLAS Task Force members will continue educating providers; consumers; community-based agencies; public officials, including legislators; and other stakeholders about the need to adopt the Task Force recommendations to establish an effective funding mechanism to pay for language services in California's Medi-Cal program. Advocates and other stakeholders will also seek increased support for the proposed reimbursement mechanism when funds are available. MCLAS Task Force members are optimistic that language service and funding recommendations will be implemented to accommodate the needs of LEP beneficiaries in the state's Medi-Cal FFS Program. By creating an effective and efficient language assistance delivery system, California will again be able to lead the way for improved, egalitarian healthcare for an increasingly multicultural society.

Endnotes

1 2000 U.S. Census. www.census.gov. Of these residents, 47% report that they do not speak English "very well" and thus could be considered LEP (representing just over 20% of all Californians). *Id.* Among the state's 6.7 million Medi-Cal beneficiaries, almost half speak a primary language other than English at home. Medi-Cal Language Access Services (MCLAS) Task Force., *Providing Language Services for Limited-English Proficient (LEP) Patients in California: Developing a Service System for the State*, (hereinafter MCLAS Report), at 7–8.

2 In California, the state administers the Medi-Cal program through two separate systems: traditional Fee-for-Service (FFS), which covers approximately 52 percent of Medi-Cal beneficiaries, and Medi-Cal Managed Care, which covers the other 48 percent. "Fee-for-service" generally refers to services *not* provided through a managed care organization, community health center or in-patient hospital settings. Providers agree to accept a state-set "fee" for the specific "service" provided. Under Medi-Cal Managed Care, the managed care plans agree to a set capitated rate per enrollee, rather than a set fee per service provided.

3 Although the MCLAS Task Force explored estimating the costs of providing language assistance services, it did not have enough time to consider many of the factors that needed to be resolved prior to determining the state's overall costs. Therefore, the MCLAS Task Force recommends that the state perform a quantitative analysis of potential costs, incorporating the information it derives when planning and conducting one or more pilot projects. MCLAS Report at 37–38.

4 *See e.g.*, L. Ku and G. Flores. Pay Now or Pay Later: Providing Interpreter Services in Health Care; *see* MCLAS Report at 7.

5 *See Lau v. Nichols*, 414 U.S. 563 (court found national origin discrimination included discrimination based on language.; 68 Fed. Reg. 47311, 47312 (Aug. 8, 2003); *see* MCLAS Report at 14–16 and Appendix E; *see also* National Health Law Program, *Ensuring Language Access in Health Care Settings; Legal Rights and Responsibilities*, (2003) for a fuller discussion of the federal language access requirements.

6 68 Fed. Reg. at 47311; *see* MCLAS Report at Appendix E.4.

7 The DHHS LEP guidance sets out procedures for federal fund recipients to ensure meaningful access and compliance with Title VI by balancing four factors to determine the level of language assistance services the federal fund recipient must provide. The following four factors must be balanced on a case-by-case basis: 1) the number or proportion of LEP persons served or encountered in the eligible service population; 2) the frequency with which the LEP individuals come in contact with the program, activity or service; 3) the nature and importance of the program, activity or service, and 4) the resources available to the recipient and costs. *Id.* at 68 Fed. Reg. 47311, 47314–15 (Aug. 8, 2003); *see* MCLAS Report at 65–66, Appendix E.4. For further explanation of the elements of an effective plan on language assistance for LEP persons, *see id.* at 68 Fed. Reg. 47319–21, MCLAS Report at 70–72.

8 MCLAS Report at 170–197, Appendix G. There are language access requirements for the private health care market, including SB 853, which requires all health care service plans and health insurers in the state to establish Language Assistance Programs and meet similar requirements under Title VI, including conducting an assessment of language needs of enrollees and insureds, a written a language access plan that includes the provision of interpreter and translation services, and notice of the free language assistance services. *See* Cal. Code. Regs. tit. 28, §§ 1300.67.04 & 1300.67.8 (health care service plans); Cal. Ins. Code § 10133.8 & Cal. Code Regs. tit. 10, §§ 2538.1–2538.8 (health insurers).

9 Cal. Gov't Code § 7291

10 Cal. Health & Safety Code § 1259(a).

11 For a fuller discussion of the state legal requirements, *see* MCLAS Report, at 17–18, and Appendix F; *see also* National Health Law Program, *Overview of the Medi-Cal Program*, Chapter 15: "Linguistically Appropriate and Culturally Competent Services,' (2008), *available at*: http://healthconsumer.org/Medi-CalOverview2008Ch15.pdf.

12 The Medi-Cal Language Access Services Task Force (MCLAS Task Force) was originally convened by DHCS to address the challenges faced by health care providers as a result of the increasing linguistic and cultural diversity of their patients.

13 The members of the MCLAS Task Force are: Asian Americans for Civil Rights & Equality, Asian & Pacific Islander American Health Forum, California Academy of Family Physicians, California Association of Public Hospitals, California Black Health Network, California Dental Association, California Family Physicians Association, California Healthcare Interpreting Association, California Hospital Association, California Medical Association, California Pan-Ethnic Health Network, California Primary Care Association, Community Health Group, Fresno Health Consumer Center, Central California Legal Service, Latino Coalition for a Healthy California, and National Health Law Program, with assistance from the California Department of Health Care Services, Medical Care Services, California Department of Health Care Services, Medi-Cal Managed Care, California Department of Public Health, Office of Multicultural Health, California Department of Mental Health , California Health & Human Services Agency, and the Los Angeles County Department of Health Services—Diversity Program. MCLAS Report at 1, 44, Appendix A.1.

14 These included community-based providers, interpreter agencies, and experts in the field of interpreter services, such as Asian Health Services, PALS for Health, and Healthy House, all of whom provided valuable information and resources for the final report.

15 The principles were based on similar principles developed by a broad coalition of national organizations coordinated by the National Health Law program; *see Language Access in Health Care—Statement of Principle: Explanatory Guide* (2007) *available at*: http://www.healthlaw.org/images/stories/issues/explanatory.guide.revised_1107.pdf.

16 Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter*, (Aug. 31, 2003), *available at*: http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf.

17 See National Health Law Program, *Medicaid and CHIP Reimbursement Models for Language Services (2009 Update)* (hereinafter Medicaid/CHIP Models) *available at*: http://www.healthlaw.org.

18 States can draw down Medicaid/SCHIP funding in two ways—as a "covered service" (paying for the cost of a service, such as a doctor's office visit or a hospital stay) or as an "administrative expense" (paying for the costs of administering the program). For adults in Medicaid, "covered services", the federal reimbursement rate varies from 50–83%, based on the state's per capita income while "administrative" expenses receive 50% of the costs from the federal government. For all CHIP enrollees and children in Medicaid, the federal share of payments for language services is the higher of 75% or a state's FMAP plus 5%. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111–3, § 209(b)(amending 42 U.S.C.§ 1396b(a)(2). Some states have decided that the higher federal reimbursement rate for language services as a "covered service" rather than an "administrative expense" warrants the submission of a state plan amendment to the Center for Medicare and Medicaid Services. For more information *see How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees? available at*: http://www.healthlaw.org.

19 Although Massachusetts has established a reimbursement mechanism for some of its hospital emergency rooms and in-patient psychiatric facilities, it has not allocated funding for

language services for the last few years and is not included in this list. *See Medicaid/CHIP Models*.

20 *See* fn.2.

21 Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training.

22 Providers who have staff interpreters cannot submit for reimbursement.

23 *See* MCLAS Report at 19–24.

24 MCLAS Report at 23.

25 The state originally contracted and reimbursed interpreter agencies directly but later changed to a broker system, in which regional language services brokers are responsible for filling interpretation requests, billing the state, and paying language providers.

26 *See* MCLAS Report at 19–24.

27 *See id.* at Appendix I.1 for a fuller explanation of the responsibilities of the broker.

28 The broker could contract with individual interpreters, for-profit interpreting agencies, telephonic interpreting companies, community-based providers of interpreting services, and other entities to provide the actual services and assure competence and quality. These language assistance services will include in-person interpreter services, telephonic interpretation or video/telephone conferencing medical interpreter services. In addition, the broker can also be contacted directly by LEP beneficiaries for assistance in setting up appointments or in instances where they have experienced barriers to either requesting or scheduling an appointment due to the lack of a Medi-Cal provider's ability to communicate with them. *Id.* at 25–27.

29 *Id.* at 26–27.

30 The MCLAS Task Force included a list of 10 counties in which the hybrid model could be sufficiently tested in a subsequent program. The FFS counties selected have both a significant FFS population (between 50,000 and 300,000 beneficiaries per year) and more than three identified threshold languages in the Medi-Cal program.

31 Under California's Medi-Cal waiver, safety net institutions report their entire operating costs to the state and are reimbursed based on those costs. Since these institutions include their costs for paying language services, there is some limited reimbursement although the reimbursed costs do not meet actual costs.

32 *See id.* at 204–205, Appendix I.3 for additional information about the recommendations regarding quality and standards for interpreters.

33 *See* Certification Commission for Healthcare Interpreters website for more information: http://www.healthcareinterpretercertification.org.

34 *See id.* at 206–208, Appendix I.3, for standard competencies which should determine the appropriateness of interpreter training for health care interpreters.

35 In February 2010, the National Council on Interpreting in Health Care (NCIHC) began its project to develop National Standards for Healthcare Interpreter Training Programs to provide guidance on the development and characteristics of quality interpreter training programs at various levels. NCIHC has published many other national standards for health care interpreters, including a National Code of Ethics and the National Standards of Practice, which can provide valuable guidance to ensure quality interpreter services. *See* NCIHC website for more information: www.ncihc.org.

36 For FFS Medi-Cal, upon receiving a complaint from either a patient or provider, the Medi-Cal Managed Care Ombudsman (MMCO) shall contact the relevant broker and arrange for the dispatchment of emergency interpreter services within 30 minutes. For managed care, if a provider complains that a managed care plan is not providing an interpreter as they are obligated to under its contract with DHCS, the MMCO will first contact the plan and allow it the opportunity to provide an interpreter. However, if the plan refuses or cannot provide emergency interpreter services within 30 minutes, the MMCO will follow the procedure for fee-for-service providers: contact the

relevant broker, arrange for the dispatchment of emergency interpreter services within 30 minutes, and subsequently bill the plan. The MMCO will report all (fee-for-service and managed care) complaints to the state and QAB, along with the resolution of the problem. If a broker, provider or health plan consistently fails to provide interpreters, or has a significant number of complaints, the MMCO and/or state will develop a corrective action plan to resolve the problem. *Id*. at 32

37 If the card does not include the needed language information and it is apparent that the LEP patient needs an interpreter, the provider should ask the Medi-Cal beneficiary about her or his language needs and contact the broker to arrange for interpreter services. *Id*. at 32–33.

38 *See* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director Letter*, (March 2, 2010; Center for Medicaid Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) § 114 & 115.

39 The definition of vital documents, and the quality processes needed to ensure adequate and competent translation, will be the same as those specified and required in the Medi-Cal Managed Care program as delineated in the MMCD policy letters. The U.S. Department of Health and Human Services defines vital documents as those that are "vital" to the meaningful access of the LEP populations they serve. These could include, but are not limited to, consent and complaint forms, intake forms with potential for important health consequences, written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, notices advising LEP persons of free language assistance, or applications to participate in a recipient's program or activity or to receive recipient benefits or services. *See id*. at 36 and Appendix G. 3&4.

40 Medi-Cal uses a numeric threshold of 3,000 mandatory Medi-Cal eligible individuals residing in the proposed service area whose primary language is not English, or a concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes. Dept. of Health Care Services, Medi-Cal Contract §13(C); *see* MCLAS Task Force Report at 213, Appendix J. Using this definition, effective September 30, 2002, there are currently thirteen threshold languages statewide for all Medi-Cal Managed Care plans that require translated materials: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese. Dept. of Health Care services, Medi-Cal Managed Care Division (MMCD), All Plan Letter 02003, *Cultural and Linguistic Contractual Requirements: Threshold and Concentration Standard Languages Update* (6/7/02).

NHeLP
NATIONAL HEALTH LAW PROGRAM

Los Angeles Office (Main Office)

2639 South La Cienega Blvd
Los Angeles, CA 90034
ph: 310-204-6010
fx: 310-204-0891
nhelp@healthlaw.org

Washington, DC Office

1101 14th Street NW, Suite 405
Washington, DC 20005
ph: 202-289-7661
fx: 202-289-7724
nhelpdc@healthlaw.org

North Carolina Office

101 East Weaver Street, Suite G-7
Carrboro, NC 27510
ph: 919-968-6308
fx: 919-968-8855
nhelp@healthlaw.org

Website

www.healthlaw.org