Language Services

Action Kit

Interpreter Services in Health Care Settings for People with Limited English Proficiency

Updated February 2004

the access project

NHeLP
NATIONAL HEALTH LAW PROGRAM

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We hope that the materials in this kit are used widely. Permission to copy, disseminate, or otherwise use information from the Language Services Action Kit is granted as long as appropriate acknowledgement is given.

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About the Action Kit

The materials in this Language Services Action Kit are designed to support advocates and others working to ensure that people with limited English proficiency in their state receive appropriate language assistance services in health care settings. These materials were developed by the National Health Law Program and The Access Project.

Did You Know...

- Almost 11 million people—4.2 percent of the U.S. population—speak English "not well" or "not at all," and over 21 million—8.1 percent—speak English less than "very well" [1]
- Federal laws and guidelines [2] require that all health care providers who receive federal funding provide meaningful access to services to people with limited English proficiency
- People with limited English proficiency should be provided with trained interpreters in health care settings [3]
- Failure to provide language services can lead to serious medical errors and even liability for malpractice [4]
- Federal funding is available to help states and health care providers pay for language interpreters and other language services for enrollees in Medicaid and the State Children's Health Insurance Program [5]

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Русский Язык Hmoob
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About the Action Kit

In recent history the United States has welcomed more immigrants from more diverse parts of the world than ever before. Immigrants are learning English at a faster rate as well, but mastery of the language—not to mention the specialized jargon of health care—takes time. As the number of people with limited English proficiency in the United States rises, the need for language services in health care settings also grows. Federal laws require health care providers to offer language services, such as oral interpretation and written translation, but many say they do not have the funds to do so. However, providers and others are often unaware that federal funds are available to help states pay for language services for patients covered by Medicaid and the State Children's Health Insurance Program (SCHIP).

Federal funding for interpreter and other language services can benefit everyone: health care providers, state governments, and patients with limited English skills in need of services. This offers an unusual opportunity for these stakeholders and others to come together to advocate for reimbursement for language services in their state Medicaid and SCHIP programs. We hope the materials in this Action Kit will assist you in undertaking such an effort in your state.

The Action Kit includes materials that:

- Explain the federal laws and policies that require health care providers to ensure access to services for people with limited English proficiency
- Explain how states pay for Medicaid and SCHIP services and how they can get federal funding to help pay for language services, such as interpretation, for program enrollees
- Describe models that some states have adopted to reimburse health care providers for language services
- Provide information and describe techniques you can use in advocacy campaigns to demonstrate the need for language services
- List resources where you may find additional information about language services
- Suggest some next steps for getting your advocacy efforts started

Español

About the Action Kit

Endnotes - About the Action Kit

[1] See U.S. Census Bureau, *Ability to Speak English: 2000* available from **http://factfinder.census.gov**. To appreciate the difficulty in calculating the number of LEP individuals, it is important to understand how the census data are collected. The U.S. Census Bureau derives its data on language from a three part question: "Does this person speak a language other than English at home?"; "What is this language?"; and "How well does this person speak English?" There are four possible responses to the 3rd question: 1) "very well"; 2) "well"; 3) "not well"; and 4) "not at all." The form allows persons to self-select their ability to speak English; it does not define what the four categories mean. There are many reasons for supporting the inclusion of those who speak English less than "very well" within the definition of LEP. The Census only questions people's ability to speak English and does not include their ability to read, write or understand English. Moreover, a special need for English skills exists in health care contexts where patients' levels of comprehension must be relatively high when communicating with their providers. Further support arises from the Department of Justice (DOJ) in the voting rights context; the Voting Rights Act covers those members of a single minority language group who have depressed literacy rates and do not speak English "very well."(See **http://www.usdoj.gov/crt/voting/sec_203/203_brochure.htm**; see also § 203 of the Voting Rights Act, 42 U.S.C. § 1973aa-1a, which defines "limited-English proficient" as the inability to "speak or understand English adequately enough to participate in the electoral process.")

[2] See, e.g., Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, 2000d-4a; 45 C.F.R. § 80 et. seq.; Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency,* available at 65 Fed. Reg. 50121 (Aug. 16, 2000).

[3] Office for Civil Rights, *Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency,* available from **http://www.hhs.gov/ocr/lep/ocrlepguidance.htm** or 65 Fed. Reg. 52762 (Aug. 30, 2000).

[4] Harsham, P., *A Misinterpreted Word Worth $71 million,* Med. Econ. (June 1984); Briefings on Patient Safety, *Interpreters Can Protect Your Patients from Harm and Your Facility from Lawsuits,* Vol.3, No.9 (Sept. 2002).

[5] Centers for Medicare and Medicaid Services, *Dear State Medicaid Director* Letter (Aug. 31, 2000), available from **http://www.cms.hhs.gov/states/letters/smd83100.asp**. ■

Federal Laws and Policies

Requiring Access to Services in Health Care Settings for People with Limited English Proficiency

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin by any person or institution receiving federal funding for programs or activities. The federal government and the courts have determined that the prohibition of discrimination based on national origin includes protections for people of different nationalities who do not speak English well.[1]

In health care settings, this means that providers should work to ensure that patients with limited English skills have meaningful access to any program services and benefits that are offered to other patients.

Almost all health care providers today, whether private physicians, hospitals, or other health care facilities, are covered by this law, because almost all providers treat patients enrolled in federally funded programs such as Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP), or receive federal funding for research or other activities. Providers who receive federal funding must work to ensure meaningful access for all of their patients who do not speak English well, even those not covered by federally funded programs.

The material in this section explains the federal laws and policies that address access to services for patients who have limited proficiency in English.

Federal Laws and Policies

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Federal Laws and Policies

To Ensure Access to Health Care Services for People with Limited English Proficiency

Frequently Asked Questions

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.[2] 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.*[3]

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;

> ***"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."***
>
> ***-Title VI***

- Treating an individual differently from others in determining admission, enrollment, eligibility, or other requirement to receive services.[4]

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.[5] 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[6]
- Nursing homes
- Managed care organizations
- State Medicaid agencies
- Home health agencies
- Health service providers
- 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.[7]

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,*[8] 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.[9] 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:[10]

1. The number or proportion of LEP individuals served or encountered.[11]
2. 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.
3. 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).
4. 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.[12]

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.[13]

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.[14] 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,[15] 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 of 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.[16]

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.[17]

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 heath, sufficient patient confidentiality in medical procedures, and true informed consent.[18]

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.[19]

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.[20] 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.

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 heath, sufficient patient confidentiality in medical procedures, and true informed consent.

— Office of Management and Budget

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).[21] 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.

Ελληνικά

Endnotes - Frequently Asked Questions

[1] In addition to federal laws and policies, you may have state laws which affect language access. For a listing of state statutes and regulations, see NHeLP, *Ensuring Linguistic Access: Legal Rights and Responsibilities,* second ed., August 2003.

[2]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).

[3] 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).

[4] 45 C.F.R. § 80.3(b).

[5] *See* 42 U.S.C. § 2000d-4a (defining "program or activity").

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

[7] *See* 42 U.S.C. § 2000d-4a.

[8] *See* 65 Fed. Reg. 50121 (Aug. 16, 2000), see also 67 Fed. Reg. 41455 (June 18, 2002).

[9] *See* 65 Fed. Reg. 80865 (Dec. 22, 2000), *available at* **http://www.omhrc.gov/clas.**

[10] *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.

[11] *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."

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

[13] *See* 67 Fed. Reg. 41460 (June 18, 2002).

[14] 68 Fed. Reg 47311 (August 8, 2003). To review previous versions of this guidance, *see* 65 Fed. Reg. 52762 (Aug. 30, 2000).

[15] 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.

[16] 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.

[17] 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.

[18] 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.**

[19] *Id*

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

[21] *See* 68 Fed. Reg. at 47313. ■

Federal Funding

to Help States Pay for Language Services

While any health care provider who receives federal funds must provide meaningful access to services for individuals with limited English proficiency, states are not required to reimburse providers for these expenses. However, if states choose to reimburse providers for language services for individuals enrolled in Medicaid and the State Children's Insurance Program (SCHIP), federal funding is available to help them cover the costs.

When a patient enrolled in Medicaid or SCHIP receives a service covered by the program (e.g., a doctor's visit or prescription medication), the state government pays for part of the cost of the service and the federal government pays the remainder. The state and federal governments also jointly reimburse providers for some of their administrative costs. Thus state money spent on services to Medicaid and SCHIP patients is "matched" by federal money.

All state Medicaid and SCHIP programs must cover certain federally "mandated" services for their enrollees. However, states can individually choose to cover certain optional services. Reimbursements for optional services are paid in the same way as for mandated services—part comes from the state and part comes from the federal government. In 2000, the federal government reminded states that language services are an optional service that they can choose to cover for Medicaid and SCHIP enrollees. Or states can obtain federal funding for language services provided as part of the state's Medicaid and SCHIP administrative activities.

This section includes materials that explain how states can get federal matching funds for language services for patients in Medicaid and SCHIP. It also provides information about programs in states that have chosen to cover these services.

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Federal Funding

to Help States Pay for Language Services

Frequently Asked Questions

Federal funding to help states and health care providers pay for language services is primarily available through Medicaid and the State Children's Health Insurance Program (SCHIP).[1] This federal funding offers states a valuable opportunity to help providers ensure language access. However, the programs have technical requirements and vary from state to state. This document provides a brief overview to assist you in evaluating the best way for your state to offer language services reimbursement. For specific information on your state, see **http://www.statehealthfacts.kff.org**.

1. What are Medicaid and SCHIP?

Medicaid and the State Children's Health Insurance Program (SCHIP) are health insurance programs for certain low-income individuals, operated jointly by the federal and state governments.[2] Both programs operate as federal-state partnerships: they are jointly administered and jointly funded. Medicaid provides health insurance to over 44 million individuals, SCHIP to over 3 million.

To be eligible for Medicaid or SCHIP, an individual must have low income and fit within an eligible group. Medicaid primarily serves four groups of low-income Americans: the elderly, people with disabilities, parents, and children. Everyone who meets the eligibility requirements must be provided health care and has the right to obtain needed services in a timely manner. SCHIP primarily covers children and sometimes others such as parents and pregnant women. SCHIP's funding is limited to pre-set amounts determined by Congress. Thus, if a state uses up the federal funding for SCHIP that it receives from Congress, it may stop enrolling people in the program who would otherwise be eligible.

2. How does the federal government pay its share of Medicaid and SCHIP costs to the states?

The federal government pays states in three ways for their Medicaid and SCHIP expenses:

- Covered Service - States get federal reimbursement for "covered services" provided to enrollees, such as a visit to a doctor or an in-patient hospital stay. States must cover certain "mandatory" services, but they also have the option of covering certain additional services, such as language services.
- Administrative Costs - States also get federal funds to assist with the administrative costs of the program (e.g., costs of staff to determine eligibility and oversee contracts, and computer costs).
- Disproportionate Share Hospitals - States get federal funding for payments made to "disproportionate share hospitals," hospitals that serve a disproportionate share of Medicaid and uninsured patients.[3]

3. Why can states get (draw down) federal reimbursement for language services?

In 2000, the Centers for Medicare & Medicaid Services (CMS), a part of the federal Department of Health and Human Services and the agency overseeing Medicaid and SCHIP, reminded states that they could obtain federal "matching" funds for language services provided to Medicaid and SCHIP enrollees. In a letter to state health officials, CMS reminded states that "federal matching funds are available for states' expenditures related to the provision of oral interpretation and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available for state expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service."[4]

Federal Funding

to Help States Pay for Language Services

4. Why don't all states cover language services for Medicaid/SCHIP enrollees?

While each healthcare provider who receives federal funds must provide meaningful language access, states do not have to reimburse providers for these expenses. Each state determines if and how it will provide reimbursement for interpreters. Individual providers cannot seek reimbursement *unless* their state has set up a mechanism to do so. Only ten states directly reimburse providers for language services.[5] States have an obligation, however, to ensure language access at Medicaid and SCHIP eligibility offices.

The reasons states do not offer direct reimbursement vary, and you may need to take different steps to educate policymakers depending on the reason in your state. For example, some state officials do not know that federal funding is available. Informing them may be sufficient to build their interest in offering reimbursement. Faced with tight budgets, some states may not designate state funds to pay their share of the Medicaid/SCHIP match. In these states, you may want to educate policy makers about the costs of non-compliance with federal requirements (such as Title VI), and the indirect costs of not providing language assistance to LEP patients (such as increased medical errors, reduced quality of care, and unnecessary diagnostic testing). Finally, some states view language services as part of providers' costs of doing business, and bundle the cost of language services into the providers' general reimbursement rates, regardless of providers' actual costs. In these states, changing state policies may require providing information about the utilization of language services, the actual costs of interpreters, and why a bundled payment rate is insufficient to cover these costs.

States directly reimbursing providers for language services

- Hawaii
- Idaho
- Kansas
- Maine
- Massachusetts
- Minnesota
- Montana
- New Hampshire
- Utah
- Washington

Tiếng Việt

5. How much would my state get from the federal government for language services?

This depends on the state, the program, and how the state chooses to be reimbursed.

Covered Services - For covered services, the state pays part of the costs and the federal government pays the remainder. Each state has a different federal "matching" rate, that is, the percentage of costs for which the federal government is responsible. The federal contribution varies from 50 percent to 83 percent, depending upon a state's per capita income (states with higher per capita income receive less federal funding). States also have different matching rates for Medicaid and SCHIP; SCHIP services are reimbursed at a higher rate. For example, Iowa receives a 63.50 percent federal match for Medicaid services and 74.45 percent for SCHIP services. For information on your state, see Kaiser Family Foundation's State Health Facts Online at **http://www.statehealthfacts.kff.org**.

Administrative Costs - Some states may choose to cover the costs of language services as an administrative expense, rather than as a covered service. For administrative expenses, all states receive a 50 percent federal match for both Medicaid and SCHIP.[6] In SCHIP, however, states can only spend 10 percent of their total federal allotment on administrative expenses. For states that are at or near their 10 percent administrative cap, it may thus be preferable to consider language services as a "covered service" rather than as an administrative expense.

6. How does my state start drawing down federal reimbursement for language services?

Covered Services - States that wish to get federal funding as a "covered service" must add language services to their Medicaid "state plan." The state plan is the document that outlines how each state's Medicaid program works, including what services it covers. The state must submit this request, a "state plan amendment" or "SPA," to CMS. Until a service is added to the "state plan" and approved by CMS, the state cannot receive federal reimbursement. In many states, because of the financial costs of covering a new service, the state legislature must approve the SPA prior to submission to CMS.

Administrative Costs - States that seek reimbursement for language services as an administrative expense do not need prior CMS approval. Thus, while the federal matching rate for administrative expenses may not be as high as the rate for covered services, a state may choose this option because it is easier to implement. However, this decision is also affected by the differing matching rates for Medicaid and SCHIP. In some states, the federal matching rate for Medicaid covered services is 50 percent, the same as for administrative expenses. In these cases, the state does not have a financial incentive to add a covered service to its Medicaid state plan. But while a state's Medicaid matching rate might be 50 percent, its SCHIP rate is always higher, at least 65 percent. In addition, states are not allowed to spend more than 10 percent of their SCHIP allotment on administrative expenses.

Federal Funding

to Help States Pay for Language Services

So deciding to cover language services as an administrative expense in SCHIP may produce fewer federal dollars, and also create conflicts with other administrative priorities.

Disproportionate Share Hospital Costs - States can also use federal funding available for "disproportionate share hospitals" (DSH), that is, hospitals that serve a disproportionate share of Medicaid and uninsured patients, to help pay for language services. States determine which hospitals are considered DSH and how much funding to distribute to them. States could consider a hospital's language services expenses in determining the allocations of DSH money.

7. Which providers can get reimbursed for language services?

Each state determines which Medicaid and SCHIP providers can obtain reimbursement. States may choose to reimburse all providers or only some—for example, only "fee-for-service"[7] providers, or hospitals, or managed care organizations. Most states that provide reimbursement do so for fee-for-service providers. Two states reimburse hospitals. One state has added money to the "capitation rate" (fixed per patient rate) it pays to managed care organizations for each enrolled patient to cover the costs of providing interpreter services.[8]

The decision of which providers to reimburse will vary state by state. Factors to consider include whether a provider uses a staff member or contract interpreter, whether staff interpreters interpret full-time or have other job responsibilities, and whether bilingual providers are competent to provide services in a non-English language and should be compensated for their language skills.

To encourage the use of interpreters, it is important that states set a rate that will cover at least the interpreter's actual costs. The state should also set an adequate reimbursement rate to ensure that a sufficient number of interpreters to meet the needs of its LEP population are willing to participate in the program.

8. How can my state reimburse providers who receive pre-set rates for services?

Some states set payment rates that "bundle" all of the costs of providing services to a patient into a single fee. The fee includes the costs of medical tests or procedures, as well as of other services and items, such as consultation, medical supplies and medications. The payment rate also includes reimbursement for a share of the facility's overhead costs: salaries, utilities, maintenance of physical plant, etc. Such bundling is particularly common for inpatient hospital services. The federal Medicare program bundles fees into "diagnosis related groups," or DRGs. Some states pay for inpatient hospital stays based on DRGs, while others pay on a per-case or per-diem basis. The cost of language services is implicitly included in whatever bundling method a state employs. For other health care providers, such as doctors operating small group practices, many states include all administrative and overhead costs—including language services—in the provider's payment rate.

Federal Funding

to Help States Pay for Language Services

Federally qualified health centers receive bundled payments through a "prospective payment system," an advance payment that estimates the health centers' costs.

Since states set the Medicaid/SCHIP payment rates for each service, states can modify the rates to add on direct reimbursement for interpreters when they are used.[9] States can have a separate "billing code" with a payment rate specifically for interpreters—each time a provider uses an interpreter, the provider receives both the payment rates for the covered service and for the interpreter. States can also add a "modifier" to an existing rate—each time a provider uses an interpreter, the modifier increases the payment rate by either a percentage or a specific amount. The rates or modifiers can vary by language (frequently encountered versus less frequently encountered), type of interpreter (staff interpreter, contract interpreter, bilingual provider, telephone language line), or other factors.

Many states include requirements to provide access to language services in their contracts with managed care organizations. If a state chooses to directly pay managed care organizations for the costs of these language services, they have two options—pay for language services separately from the managed care capitation rate[10] (i.e., "carve out" language services from the set of services the managed care organization must provide) or increase the capitation rate to include language services.

> ***The difference between "translating" and "interpreting" languages is often a source of confusion. The difference is this: interpretation applies to spoken words and translation to written ones. Interpretation is as accurate as translation when properly done. Language interpreters should not take liberties, embellish or otherwise modify the words that are being interpreted from one language to another.***
>
> *-The Access Project*

9. How much should the state pay for interpreters?

When a state decides to reimburse providers for language services, it determines the payment rate. Those currently in use vary from $7 to $50 per hour. The rates should reflect labor costs in the state as well as training or certification requirements. When setting the payment rate, the state should also consider travel time, waiting time, and other activities associated with providing interpretation; these circumstances vary by state and often by region. For example, in rural areas where travel times can be lengthy, a state should evaluate whether the interpreter can receive reimbursement for travel time. A state also needs to determine if and what to pay in a variety of circumstances, for example, when the interpreter arrives but the provider or patient cancels the appointment. To encourage the use of interpreters, it is important that states set a rate that will cover at least the interpreter's actual costs. The state should also set an adequate reimbursement rate to ensure that a sufficient number of interpreters to meet the needs of its LEP population are willing to participate in the program.

10. How can states offer reimbursement?

Currently, states that provide reimbursement for language services use three payment models:

- Require providers to hire interpreters and submit for reimbursement
- Pay interpreters directly
- Use "brokers" or language agencies that providers can call to schedule an interpreter visit; the state reimburses the broker/agency which in turn pays the interpreter

[For more information on these models, see "Medicaid and SCHIP Reimbursement Models for Language Services" on page 22.]

11. What about language services for individuals not *enrolled in Medicaid/SCHIP?*

Federal funding is only available for language services for Medicaid and SCHIP enrollees (or to parents and guardians of Medicaid/SCHIP enrolled children). It is also available for patients who receive Medicaid-covered emergency services.

Health care providers who receive federal funds, however, must ensure language access for all of their patients, not just Medicaid and SCHIP enrollees. Thus, a gap exists between existing federal funding and the need for services. States could use state funds to provide language services for other individuals. Once a state has established a language assistance program for its Medicaid and SCHIP beneficiaries and invested the initial resources necessary to implement it, the additional costs to expand the program to other LEP patients would probably be minimal.

Endnotes - Frequently Asked Questions

[1] The recently enacted Community Health Centers Reauthorization Act includes language services demonstration programs but funding has not yet been appropriated.

[2] For more information on these programs, see **http://www.healthlaw.org, www.kff.org/medicaid/2248-index.cfm** *(Medicaid: A Primer)* or **http://cms.hhs.gov/medicaid/mover.asp** *(Medicaid: An Overview).*

[3] Currently, hospitals that serve a "disproportionate share" of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the Disproportionate Share Hospital (DSH) program. In many states the DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. More than 10 percent of all Medicaid funding is through DSH, amounting to more than $15.8 billion combined federal and state spending in 2001.

[4] This letter is available from **http://cms.hhs.gov/states/letters/smd83100.asp**.

[5] These ten are Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, and Washington. For more information on the models these states are using, see "Medicaid and SCHIP Reimbursement Models for Language Services" on page 22.

[6] Limited exceptions exist to the administrative matching rate. For example, states can receive 90 percent federal funding for upgrading computer systems or providing family planning services and supplies; 75 percent federal funding to cover the costs of medical and utilization review; and 100 percent for expenses in implementing and operating an immigration status verification system.

[7] "Fee-for-service" generally refers to services not provided through a hospital, managed care organization, or community health center. Providers agree to accept a state-set fee for the specific service provided to a Medicaid/SCHIP enrollee.

[8] For more information, see "Medicaid and SCHIP Reimbursement Models for Language Services" on page 22.

[9] States cannot, however, increase their Medicaid/SCHIP reimbursement rates above Medicare reimbursement rates.

[10] The "capitation rate" is the amount a state pays the managed care organization for each enrollee per month, which compensates the managed care organization for all the services covered by the contract. It is a set amount that does not vary depending on how many or few services the enrollee utilizes. ■

Federal Funding

to Help States Pay for Language Services

In 2000, the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration) reminded states that they can include language services as an optional service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet only a handful of states are directly reimbursing providers for language services. Instead, most states consider the costs of language services as part of providers' overhead or administrative costs, and include the costs in providers' payment rates. This piece outlines existing state mechanisms for directly reimbursing providers for language services for Medicaid and SCHIP enrollees as of February 21, 2003.

Medicaid and SCHIP Reimbursement Models for Language Services

State	For which enrollees does the state pay for language services—all, FFS,[a] managed care?	Which providers can submit for reimbursement—all,[b] FFS, managed care, hospitals?	Who does the State reimburse—providers, language agencies,[c] interpreters, hospitals, brokers?	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? [d]	What percentage of the state's costs does the federal government pay (FY 2002)? [e]
HI	FFS	FFS	Language agencies	$36/hour (in 15 min. increments)	Service	Medicaid (MA)—58.77 SCHIP—71.14
ID	FFS	FFS	Providers	$7/hour	Service	MA—70.96 SCHIP—79.67
KS	FFS	FFS	EDS (fiscal agent)	Spanish – $1.10/minute; other languages – $2.04/minute	Admin	50
MA	FFS	Hospitals & psychiatric facilities	Hospitals & psychiatric facilities	Determined by Medicaid agency [f]	Unknown	50
ME	FFS	FFS	Providers	$30/hour (business hours) $40/hour (non-business hours) $7.50/15 min. after first hour	Service	MA—66.22 SCHIP—76.35
MN	FFS	FFS	Providers	$12.50/15 min., lesser of $50/hour or usual and customary fee	Admin	50
MT	All	All	Interpreters	Lesser of $6.25/15 min. or usual and customary fee	Admin	50
NH	FFS	FFS	Interpreters (who are Medicaid providers)	$15/hour $2.25/15 min. after first hour	Admin	50
UT	FFS	FFS	Language agencies	$22/hour (phone) $39/hour (in-person)	Service	MA—71.24 SCHIP—79.87
WA	All	Public entities	Public entities	50% allowable expenses	Admin	50
	All	Non-public entities	Brokers; interpreters & language agencies	Brokers receive an administrative fee Interpreters/language agencies receive up to $28/hour	Admin	50

[a] "Fee-for-service" generally refers to services not provided through a hospital, managed care organization, or community health center. Providers agree to accept a state-set "fee" for the specific "service" provided.

[b] Providers who have staff interpreters cannot submit for reimbursement.

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

[d] 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).

[e] For "covered services," the federal reimbursement rate varies from 50-85 percent, based on the state's per capita income. For "administrative" expenses, every state receives 50 percent of its costs from the federal government.

[f] Each hospital or psychiatric facility's amount is based on a percentage of the difference between the qualifying entity's total Medicaid costs and total Medicaid payments from any source.

Hawaii

The state contracts with two language service organizations to provide interpreters. The eligible enrollees are Medicaid fee-for-service patients or SCHIP-enrolled children with disabilities. The state pays the language service agency a rate of $9 per 15 minutes. If an interpreter is needed for more than 1.5 hours, a report must be submitted stating the reason for the extended time. Interpreters who are staff or bilingual providers are not reimbursed.

Interpreters are allowed to charge for travel, waiting time, and parking. The state has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire. The state spends approximately $144,000 per year on interpreter services for approximately 2570 visits (about $56 per visit). Hawaii receives reimbursement for the interpreter services as a "covered service" (similar to an office visit or other service covered by the state's Medicaid plan). The state receives federal reimbursement of approximately 59 percent for Medicaid patients and 71 percent for SCHIP patients.

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

Idaho

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

Idaho reimburses the costs of language interpretation at a rate of $7.01 per hour (the state reimburses certified sign language interpreters at $12.13/hour and partially certified sign language interpreters at $9.56/hour).

Kansas

In 2003, Kansas began offering healthcare providers serving Medicaid fee-for-service enrollees access to a telephone interpreter/language line. The state began providing this service in response to results from a provider survey. The survey results—collected from 87 responses—identified that Spanish is the most frequently spoken language requiring interpretation services. Other languages are less frequently encountered. Nineteen providers reported that they never needed access to an interpreter. Twenty-five providers reported needing an interpreter 1-10 times per month and seven providers responded they needed an interpreter over 100 times per month.

The language line is administered by the state's Medicaid fiscal agent, EDS. Medicaid fee-for-service providers receive an access telephone number and a passcode. Two language lines are used—a Kansas-based organization for Spanish interpretation (charging $1.10 per minute) and a national organization providing interpretation for other languages (charging $2.04 per minute).

The state has budgeted $275,000 for the first year of operation. The amount was based on past history.

Maine

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

The provider must include a statement of verification in the patient's record documenting the date and time of interpretation, its duration, and the cost of providing the service. The state reimburses the provider for an hour at a minimum, and for 15-minute increments thereafter. The reimbursement includes travel time to and from the location, but not waiting time. The maximum hourly rate is $30 for business hours and $40 for non-business hours. After the first hour, providers may bill in increments of 15 minutes at $7.50 per increment. The provider must ensure that interpreters protect patient confidentiality and have read and signed a code of ethics. The state provides a sample code of ethics as an appendix to its Medical Assistance Manual.

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

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

Massachusetts

Massachusetts has been a leader in the development and provision of language services in clinical health settings. As part of the state's Determination of Need process, whenever a provider seeks to add or expand services or transfer ownership, it must reassess health care needs in the community and respond accordingly. Since 1989, most hospitals have submitted plans for providing interpreter services as part of this process. Through this process, over 50 of the state's 80 hospitals have addressed the provision of interpreter services, training for staff, and tracking of services.

In April 2000, the legislature addressed the need for competent emergency room interpreter services by passing Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services."

This law mandates that "every acute care hospital shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment."

The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights.

The FY 2002 state budget included an appropriation of $1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The Division of Medical Assistance is making "supplemental payments" to "qualifying" hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute hospitals, and private psychiatric hospitals. The distribution is based on an "equity formula" comparing expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals. Massachusetts recently received approval of three State Plan Amendments (one each for psychiatric hospitals, and in-patient and out-patient acute-care hospital care) to obtain federal reimbursement for these language services.

In addition, the state's Medicaid agency considers interpreter costs in its DSH (Disproportionate Share Hospital) distribution formula. Medical interpreter costs are identified by the hospitals on their cost reports, which are used to determine unreimbursed costs for DSH purposes. Distribution of DSH funds are then based on these unreimbursed costs. For its Uncompensated Care Pool (UCP), Massachusetts allows hospitals to include the costs of language services in the base costs used to develop Medicaid rates and the UCP cost-to-charge ratio.

Website: **http://www.state.ma.us/dph/omh/interp/interpreter.htm**

Minnesota

In 2001, Minnesota began drawing down federal matching funds for language interpreter services for Medicaid and SCHIP fee-for-service and managed care enrollees. All providers can submit for reimbursement except for services provided in an in-patient hospital setting (for which interpreter services are bundled in the hospital payment rate). Hospitals may obtain reimbursement for interpreter costs provided for outpatient care.

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

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

The state budgeted $4.3 million over two years for interpreter services,[1] expecting $1.9 million to be reimbursed by the federal government.

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

Montana

Montana began reimbursing interpreters in 1999 following an investigation by the Office for Civil Rights. Montana pays for interpreter services provided to eligible Medicaid recipients (both fee-for-service and those participating in the Primary Care Case Management program), in conjunction with medically necessary and covered services. The interpretation must be face-to-face; no reimbursement is available for telephone interpretation services. The interpreter must submit an invoice/verification form signed by the interpreter and provider; Montana then reimburses the interpreter directly. Reimbursement is not available if the interpreter is a paid employee of the provider and provides interpretation services in the employer's place of business, or is a member of the patient's family.

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

The state does not have any interpreter certification requirements. Thus, it is the responsibility of the provider to determine the interpreter's competence. While a state referral service exists for sign language interpreters, no equivalent exists for foreign language interpreters.

New Hampshire

New Hampshire has had policies to reimburse sign language and foreign language interpreters since the 1980s. While the state initially reimbursed for interpreters as a covered service, it currently reimburses interpreters as an administrative expense.[2]

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

Interpreters can bill directly or can work for an organization that coordinates interpreter services. Each interpreter, however, must individually enroll as a Medicaid provider regardless of who bills for reimbursement. Interpreters (or language services organizations) can submit claims for reimbursement for language services only for clients of fee-for-service providers; interpreters cannot submit claims for hospital and community health center clients. At the present time, the state has 60 interpreters enrolled as Medicaid providers; recent training programs funded in part by the state may increase this number. The state is also examining ways to lessen the administrative burdens on interpreters and increase the availability of Medicaid interpreters.

In FY 2002, the state spent $6,255 on interpreters. Fifty-two Medicaid enrollees received interpreter services from seven interpreters for a total of 158 encounters. In FY 2001, the state spent $3,081 for 85 encounters for 35 recipients from five interpreters. While FY 2003 data may not be complete, state expenditures thus far total $8,212.50. There were 241 encounters in FY 2003 from seven interpreters for 83 recipients.

Utah

Utah covers medical interpreter services as a covered service; in FY 2002, the state received a 70 percent federal matching rate for interpretation. The state pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP), 2) the client receives services from a fee-for-service provider, and 3) the health care service needed is covered by the medical program for which the client is eligible.

The state contracts with five language service organizations (covering 27 languages) to provide in-person and telephone interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients. The health care provider must call the language service organization to arrange for the service. The language service organizations are reimbursed by the state an average of $22 per visit for phone interpretation and $35 per hour for in-person interpretation, with a one-hour minimum. Providers cannot bill Medicaid directly, and they do not receive any rate enhancements for being bilingual or having interpreters on staff.

In 2000, the Centers for Medicare & Medicaid Services (CMS) reminded states that they can include language services as an optional service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet, only a handful of states are directly reimbursing providers for language services.

-National Health Law Program

For enrollees in managed care, Utah requires health plans to provide language interpretation services for their patients as part of the contract agreements. For services covered by Medicaid but not the health plan,[3] the state will pay for interpreters. The costs of interpreter services for hospitals are included in their payment rates.

If the language agencies do not provide the needed language, the provider may use a telephone interpretation service.

Website: **http://health.utah.gov/medicaid/html/interpreter.html**

Washington

Providers that are not public entities:[4]
In 1998, the Department of Social and Health Services (DSHS) Language Interpreter Services and Translation (LIST) program began contracting with "language agencies" through a competitive procurement process. Beginning in 2003, the state changed its system to contract with nine regional brokers for administrative scheduling of appointments. The brokers contract with language agencies and interpreters.[5] In previous years, interpreters provided services for over 26,000 encounters per month.[6] Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 30 miles.

Rather than require clients to schedule interpreters, providers—including fee-for-service providers, managed care organizations, and private hospitals—call a regional broker to arrange for an interpreter. While the brokers primarily use language agencies, the state will allow brokers to contract with individual interpreters. The state requires providers to schedule interpreters in order to avoid having interpreters independently solicit work and/or act as advocates rather than interpreters. Once services are provided, the language agency bills the broker for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician, as well as the diagnosis or nature of illness or injury.

The state pays the brokers an administrative fee; the brokers then pay the language agencies. For Medicaid and SCHIP enrollees, the state obtains federal reimbursement for these costs. For 2003, payments to language agencies are capped at $28 per hour (previously, the rates ranged from $33 to $39 per hour, but the new broker system caps payments). The state expects to spend $36 million over two years for all DSHS interpreter services, including approximately $24 million for Medicaid and SCHIP enrollees.

Soomaali

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

Website: **http://www.wa.gov/dshs/msa/ltc/index.html**

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

- Provide local match funds (locally generated private funds)
- Ensure that the local match funds are not also used as matching funds for other federal programs
- Ensure that the local match funds meet federal funding requirements
- Ensure that the local match funds are within the facilities' control
- Use only certified interpreters (as certified by Washington's LIST program)
- Coordinate and deliver the interpreter services as specified by the state
- Collect, submit and retain client data as required
- Accept all disallowances that may occur

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

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

Conclusion

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

Endnotes - Medicaid and SCHIP Reimbursement Models for Language Services

[1] These services include oral interpretation; written translation; technical assistance and training for state and county staff; and updating data systems to track clients' language needs, identify barriers, and measure outcomes.

[2] New Hampshire changed from a covered service to an administrative reimbursement because of a change in CMS policy; subsequently CMS clarified that states can get reimbursed at the covered service rate. Since New Hampshire's FMAP for medical services, 50 percent, is the same as for administrative expenses, no practical difference exists in New Hampshire. For SCHIP, considering language services as a covered service would increase the federal share of costs.

[3] For example, pharmacy, dental and chiropractic services.

[4] Washington has two reimbursement mechanisms. The first is for non-public entities—this includes most fee-for-service providers, managed care providers, and non-public hospitals.

[5] For the first six months of 2003, while the contract broker system is being implemented, the state has advised the brokers only to contract with language agencies. After that time, brokers may choose to contract with individual interpreters.

[6] DSHS' program provides language interpretation to all programs within the Department, not just Medicaid and SCHIP. ■

Making the Case for Language Services

The materials in Sections 2 and 3 of the Action Kit explain federal laws and policies that relate to the provision and reimbursement of language services in health care settings. The information in this section is designed to help you raise awareness of the need for such services among policy makers, health care providers, government officials, and the public at large. It includes materials that will help you explain why language services are needed, and suggests additional information you may want to gather and people you may want to contact in order to strengthen your advocacy effort. The information includes:

- The number of people with limited English proficiency by state, and the growth of this population, which indicate that demand for language services will increase
- The consequences of lack of language services for patients and providers, in terms of access to care, compliance with treatment regimens, and costs of medical services
- The reasons why using family members, friends, or children as interpreters, as opposed to trained professionals, is dangerous and should be discouraged
- Ideas for local data that may provide additional evidence for the need for language services in your community and partners who may be able to help you make your case more effectively
- Advice on how to collect stories on the consequences of not providing language services, for use in public awareness campaigns
- Tips for writing op-ed pieces or letters to the editor on the need for language services

Español ไทย Tagalog
Русский Язык Hmoob
Srpsko-Hrvatski 日本語
عربي Kreyòl Ayisyen
Shqip Ελληνικά 中文
Kriolu di Kabu Verdi
עברית Tagalog 한국말
Tiếng Việt Español ไท
Soomaali Русский Язык
한국말 Srpsko-Hrvatsk
Français Hmoob عربي
Shqip Ελληνικά 中文

Making the Case for Language Services

The Growing Need for Language Services

Nearly 47 million people—18 percent of the U.S. population—speak a language other than English at home.[1] Some states have percentages 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.[2] Data from the 2000 census documented that over 28 percent of all Spanish speakers, 22.5 percent of Asian and Pacific Islander speakers, and 13 percent of Indo-European speakers speak English "not well" or "not at all."[3]

Estimates of the number of people with limited English proficiency (LEP) range from almost 11 million people, or 4.2 percent of the U.S. population—those who speak English "not well" or "not at all"—to more than 21 million, or 8.1 percent, of the U.S. population who speak English less than "very well."[4] Furthermore, more than 11 million households in the U.S., 4.7 percent of the population, are linguistically isolated, that is, living in households where all members who are 14 years of age or older have at least some difficulty with English.[5] 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 in the U.S. increased by 57.9 percent.[6] (The charts and tables at the end of this document provide data for each state on the percentage of its population that is LEP and the rate of growth of this population between 1990 and 2000.)

Today, hundreds of languages are spoken in both urban and rural areas of the United States.[7] The vast majority of non-English speakers are Spanish-speaking;[8] all told, however, more than 300 different languages are spoken. In Los Angeles County alone, more than 80 languages are spoken.[9] Multilingualism is spreading most rapidly beyond traditional urban areas.[10] For example, since the mid-1990s immigration to North Carolina has increased by 73 percent, the largest increase in the country.[11]

It is critical that the growing numbers of LEP residents be able to communicate with their health care providers. As complicated as it may be for English speakers to navigate the complex health care system, the difficulties are exacerbated for LEP individuals. Yet accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality.[12] The literature provides many examples of how the lack of language services negatively affects access to and quality of health care. [See Action Kit pages 40-41.]

Not surprisingly, 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 rated their children's health care significantly lower than did English speakers.[13] 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 percent) of the respondents who needed but did not get an interpreter, and 57 percent who did not need an interpreter.[14] Unfortunately, providers are often not aware of the existence 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.[15]

Making the Case for Language Services

In sum, the dramatic growth in the number of people who need language services is making it a business necessity for health care providers to address the issue. In addition, a number of federal and state laws and policies require providers who treat people enrolled in federally funded health care programs and activities to work to ensure meaningful access to services for people with limited English proficiency.[16] These laws are significant because health care is one of the most heavily federally-funded endeavors in the United States today, and providers who receive federal funds will inevitably see an increased demand for language services from consumers who do not speak English well or at all.

Publicly-financed managed care illustrates this point. A recent study found that Medicare and managed care plans are popular among Hispanic Medicare beneficiaries, with 51.6 percent of Hispanics enrolled in Medicare and managed care nationally.[17] Moreover, managed care has become an increasingly popular method of delivering health care to Medicaid and State Children's Health Insurance Programs beneficiaries—all but two states (Alaska and Wyoming) have some form of Medicaid managed care.[18] Enrollees in these programs are disproportionately underserved racial, ethnic, and national origin minority groups. As a result, some of the most advanced policies for providing access to LEP persons are found in Medicaid managed care regulations and contracts.[19] States may also have civil rights or patients' rights statutes that address national origin discrimination.[20] These policies may prove to be models for other providers who are working to ensure access for their LEP patients.

Русский Язык

State	% of Population with LEP, 2000	% Change in LEP Population, 1990-2000
Alabama	1.5	77.5
Alaska	5.3	37.2
Arizona	11.4	95.7
Arkansas	2.3	169.9
California	20.0	41.9
Colorado	6.7	143.4
Connecticut	7.4	27.6
Delaware	3.9	94.8
District of Columbia	7.1	31.3
Florida	10.3	61.7
Georgia	4.9	243.2
Hawaii	12.7	15.3
Idaho	3.9	108.7
Illinois	9.1	60.3
Indiana	2.5	64.9
Iowa	2.5	92.4
Kansas	3.9	103.2
Kentucky	1.6	100.1
Louisiana	2.8	-8.9
Maine	2.0	-13.3
Maryland	5.0	65.9
Massachusetts	7.7	31.6
Michigan	3.2	56.2
Minnesota	3.6	111.1
Mississippi	1.4	47.1
Missouri	2.0	63.7
Montana	1.5	10.5
Nebraska	3.6	159.6
Nevada	11.2	234.1
New Hampshire	2.4	13.2
New Jersey	11.1	43.4
New Mexico	11.9	26.0
New York	13.0	30.9
North Carolina	4.0	243.1
North Dakota	1.8	-5.7
Ohio	2.2	23.5
Oklahoma	3.1	90.8
Oregon	5.9	141.8
Pennsylvania	3.2	25.7
Rhode Island	8.5	26.8
South Carolina	2.2	117.9
South Dakota	2.3	31.0
Tennessee	2.0	137.8
Texas	13.9	51.2
Utah	5.2	158.9
Vermont	1.6	28.4
Virginia	4.6	88.4
Washington	6.4	112.4
West Virginia	0.8	-0.3
Wisconsin	3.0	59.6
Wyoming	1.9	22.7
US Total *	8.1	52.5

United States (numbers in millions)	*1990*	*2000*
Total Population (age 5+)	230.4	262.4
LEP Population	14.0	21.3
% LEP	6.1%	8.1%

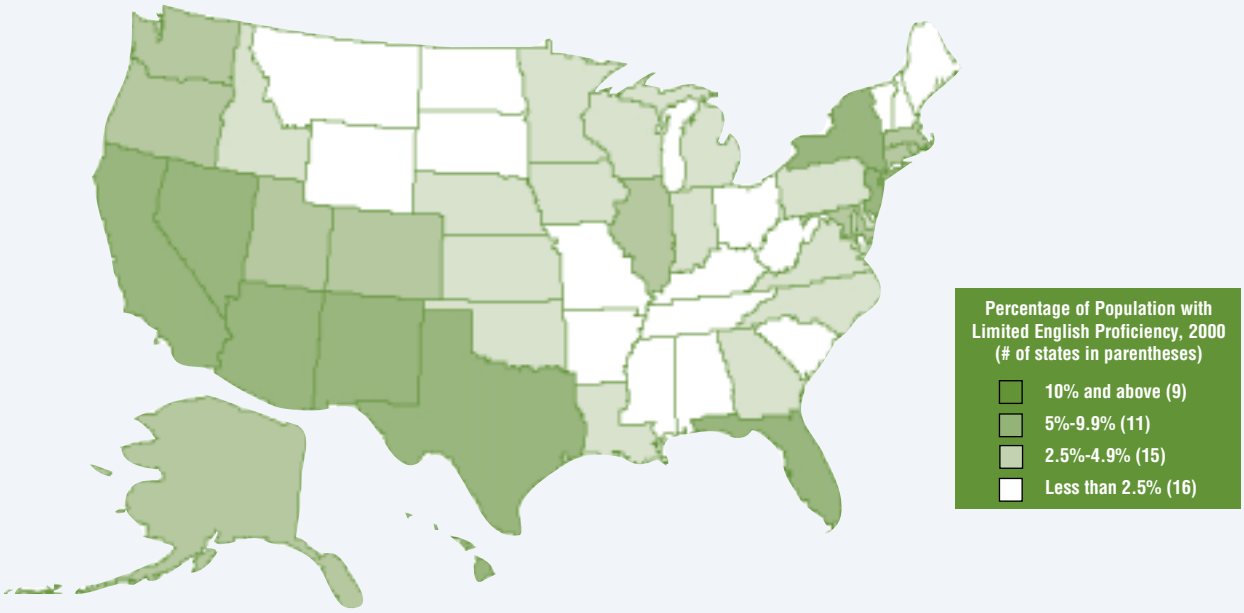
Limited English Proficiency refers to people ages 5 and older who report speaking English less than "very well."

Top 10 languages spoken in the U.S. (excluding English)	
Spanish	10.7%
Chinese	.8%
French	.6%
German	.5%
Tagalog	.5%
Italian	.4%
Vietnamese	.4%
Korean	.3%
Polish	.3%
Russian	.3%

Sources: U.S. Census Bureau. The Bureau provides data from the 1990 and 2000 Census at **http://factfinder.census.gov**. Census data include information on the primary language spoken at home and ability to speak English, and may be accessed at the national level or in smaller geographical groupings, including state, county, city, town, ZIP code, congressional district, and census tract, among others.

People with Limited English Proficiency

A Look at the Numbers



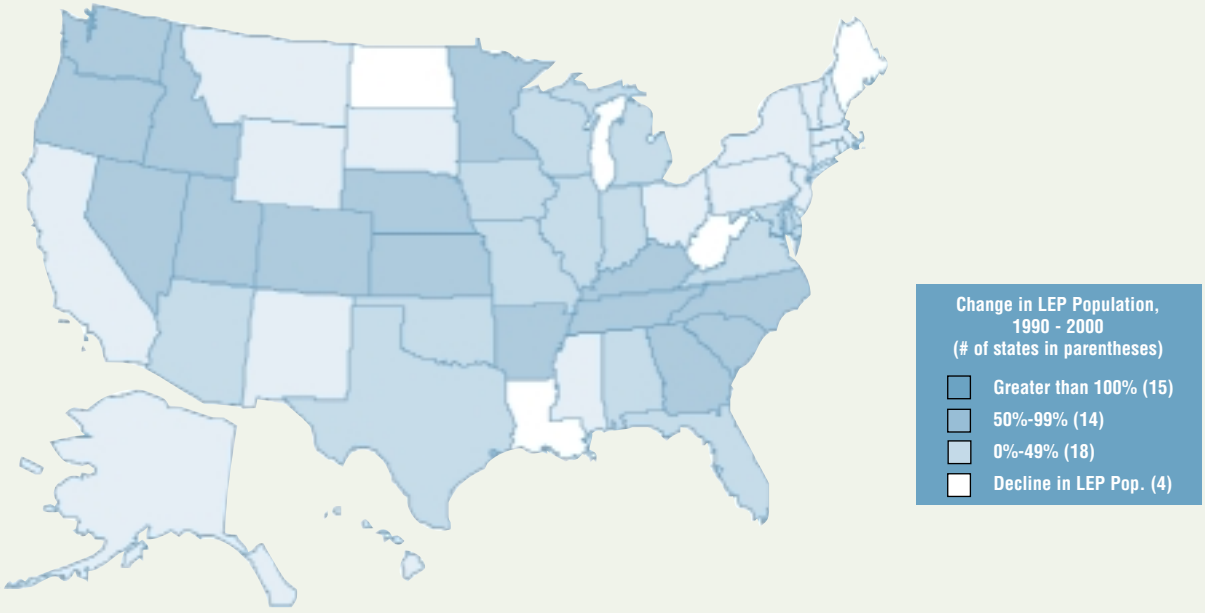
Percentage of Population with Limited English Proficiency, by State, 2000

Source: U.S. Census Bureau.

The proportion of a state's population with limited English proficiency (LEP) varies widely. In general, the Southwestern states plus Florida, New York, New Jersey, and Illinois have the greatest proportion of residents with LEP. Fully one-fifth of California's residents speak English less than "very well."

BUT...

The fastest growth in LEP populations has been in the Southeast and the West, as well as in the center of the country. Georgia, North Carolina and Nevada all saw the number of residents with limited English proficiency grow by over 200 percent between 1990 and 2000. Many of these fast-growth states had small LEP populations in the past, and their institutions may be unprepared for the change.



Change in LEP Population, by State, 1990-2000

Source: 1990 and 2000 Decennial Census. See the full list of states and their percentages on page 35.

Endnotes - The Growing Need for Language Services

[1] U.S. Census Bureau, *Profile of Selected Social Characteristics: 2000* (Table DP-2), available from **http://factfinder.census.gov**. See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70-71 (2002) (reports that 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 individuals are in language isolated households, as well as 26-42 percent of Thai, Chinese, Korean, and Vietnamese).

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

[3] See U.S. Census Bureau, *Ability to Speak English: 2000* (Table QT-P17). Available from **http://factfinder.census.gov**

[4] *Ibid.* To appreciate the difficulty in calculating the number of LEP individuals, it is important to understand how the census data are collected. The U.S. Census Bureau derives its data on language from a three-part question: "Does this person speak a language other than English at home?"; "What is this language?"; and "How well does this person speak English?" There are four possible responses to the third question: 1) "very well"; 2) "well"; 3) "not well"; and 4) "not at all." The form allows people to self-identify their ability to speak English and does not explain what is meant by the four categories. Many reasons support the inclusion of those who speak English less than "very well" within the definition of LEP. The Census only asks about people's ability to speak English and not about their ability to read, write or understand English. Moreover, a special need for well-grounded English exists in health care contexts where patients' levels of comprehension must be relatively high when communicating with their providers. Further support arises from the Department of Justice (DOJ) in the voting rights context—the Voting Rights Act covers those members of a single minority language group who have depressed literacy rates and do not speak English "very well." (See **http://www.usdoj.gov/crt/voting/sec_203/203_brochure.htm**; see also Section 203 of the Voting Rights Act, 42 U.S.C. 1973aa-1a, which defines "limited-English proficient" as the inability to "speak or understand English adequately enough to participate in the electoral process.")

[5] U.S. Census Bureau, *Ability to Speak English: 2000* (Table QT-P17) available at **http://factfinder.census.gov**. According to the Census Bureau, a household in which all members 14 years or older speak a non-English language and also speak English less than "very well" is linguistically isolated.

[6] Guzman, Betsy, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* (May 2001). Finding that 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.

[7] U.S. Census Bureau, *Language Spoken at Home: 2000* (Table QT-P16). Available from **http://factfinder.census.gov**.

[8] U.S. Census Bureau, *Profile of Selected Social Characteristics: 2000* (Table DP-2). Available from **http://factfinder.census.gov**.

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

[10] Kilborn, Peter T. and Lynette Clemetson, *Gains of 90's Did Not Lift All, Census Shows,* New York Times, A20 (June 5, 2002). Finding that the immigrant population between 1990 and 2000 increased 57 percent, surpassing

the century's great wave of immigration between 1900 and 1910 and moving beyond larger coastal cities into the Great Plains, the South, and Appalachia.

[11] Kotkin, Joel, *Immigration Spreads Throughout Nation,* WSJ.com Real Estate Journal (undated), from **http://www.joelkotkin.com/Demographics.** 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 from **http://www.census.state.nc.us/static_cen00_pl_highlights.pdf** (reporting a 393.9 percent increase in the Hispanic population between 1990 and 2000); Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* (May 2001) (reporting that in some counties in North Carolina, Georgia, Iowa, Arkansas, Minnesota, and Nebraska, Hispanics now represent as much as 24.9% of the total population.)

[12] National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* 2nd ed. (August 2003).

[13] Leatherman, Sheila and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook* at 122 (Apr. 2002). Available from The Commonwealth Fund. 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).

[14] See Dennis Andrulis, Nanette Goodman, and Carol Pryor, The Access Project, *What a Difference an Interpreter Can Make* (Apr. 2002). Available from **http://www.accessproject.org**.

[15] Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care,* Highlights and Charts 3-4 (Mar. 2002). Available from **www.kff.org/minorityhealth/20020321a-index.cfm**.

[16] 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 (EMTALA), and the United States Constitution. See, e.g., National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* 2nd ed. (August 2003); National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities,* Kaiser Family Foundation (2003).

[17] 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 from **http://bcbshealthissues.com/relatives/19526.pdf**.

[18] See Centers for Medicare & Medicaid Services, Medicaid Managed Care State Enrollment (Dec. 31, 2001). Available from **http://www.cms.gov/medicaid/managedcare/mmcpr01.pdf**.

[19] 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 from **http://www.gwu.edu/~chsrp/Fourth_Edition/GSA/Tables/Table3_6.html**.

[20] For a complete list of relevant state statutes and regulations, see NHeLP, *Ensuring Linguistic Access: Legal Rights and Responsibilities,* 2nd ed. (August 2003). ■

Making the Case for Language Services

The Consequences of Not Providing Language Services: Some Facts and Personal Stories

The health services research literature provides many examples of how a lack of interpreters and other language services creates a barrier to and diminishes the quality of health care. Findings from a sampling of these studies are described below.

- A language barrier is as significant as the lack of insurance in predicting Latinos' use of health services.[1]
- 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% vs. 26%).[2]
- In a recent survey, Hispanic children had much less access to medical care than white children, but the gap was negligible when their parents' English-speaking skills were comparable to white parents.[3]
- Non-English-speaking patients are less likely to use primary and preventive care services and more likely to use emergency rooms, although they receive far fewer services in the emergency room than English-speaking patients.[4]
- Non-English-speaking women who did not visit their practitioners for screening for cervical cancer cited the inadequacy of translated materials as a contributing factor (one brochure described the screening as the "fat" test).[5]
- LEP patients in a pediatric emergency department were found to use more medical resources (time and tests) than other patients.[6]
- 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 appointments and to use the emergency room than those who spoke the language of their physicians.[7]
- 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 both those who needed and received an interpreter and those who did not need an interpreter.[8]
- The use of untrained family members and friends to interpret for non-English-speaking patients has been associated with omissions, additions, substitutions, volunteered opinions, and semantic errors that can result in serious distortions of the content of physician and patient exchanges.[9]
- Health care providers surveyed in Los Angeles, New York City, Houston, and Miami found language difficulties to be a major barrier to immigrants' access to health care and a serious threat to the quality of the medical care they received, "since clinicians could not get information to make good diagnoses and because patients might not understand the treatment regimens prescribed for them." [10]

Not providing trained interpreters or other language services to patients who need them can result in inconvenience, embarrassment, poor quality of care, and even tragedy. The following personal accounts illustrate some of these consequences.

Making the Case for Language Services

Absence of interpreters may compromise a person's privacy and cause embarrassment or instill confusion, or fear

- A mother on birth control took her 10-year-old daughter to the Public Health Clinic to interpret how to use the birth control pills. The daughter said that she had to help her mother because the clinic did not have an interpreter available.[11]
- A Korean woman with an appointment for a gynecology exam was not provided with an interpreter or language line assistance. The clinician used the 16-year-old son of a complete stranger to interpret.[12]
- A child being treated at a hospital had a feeding tube inserted without anyone explaining the procedure to his Spanish-speaking mother or obtaining her consent. When the child was sent home with an oxygen tank, no one explained to his mother how to operate it.[13]
- A Cambodian woman went to the emergency room at a Fresno hospital, which discharged her to a mental health provider. She was transported to a facility in Modesto, an hour and a half away. No one spoke her language (Hmong). She thought she was being kidnapped.[14]

Preventable deaths may occur

- A pregnant woman lost her baby when her doctor, using an untrained interpreter, failed to communicate adequately that she needed an immediate cesarean section. The woman returned home; her child ultimately was stillborn.[15]
- A Haitian woman in her 70s who spoke Haitian Creole was seen at a health center several times complaining of "gaz." Providers thought she was talking about gas and prescribed Mylanta. They did not perform any tests. In fact, she was describing general stomach pains that moved around (which is the meaning of "gaz" in Creole). By the time she was diagnosed with stomach cancer, it was too late to treat it. The woman died.[16]

Poor communication equals poor care

- A 22-year-old Latino woman was scheduled for a cesarean section at a hospital in Memphis, where she resides and works at a local restaurant. However, when her water broke early, she went to the hospital emergency room. No interpretation was provided. A nurse's assistant assumed she had wet her pants and sent her out of the hospital. Confused and uncertain, the woman left the hospital and contacted her obstetrician. Eight hours later, she was readmitted to the hospital, where her obstetrician performed an emergency cesarean section.[17]
- A Vietnamese refugee suffering from a skin condition requiring laser treatment underwent treatment for over a year. The man endured days of pain after each treatment, but was unable to communicate this because he was never provided with an interpreter. Only after a community organization intervened did the clinic understand the patient's pain and adjust the treatment.[18]

More specifically, patients who do not have the benefit of competent medical interpreters may not understand medication instructions, often with harmful results:

- After going to an Alexandria hospital with a severe stomach ache, a Hispanic man in Virginia was prescribed three medicines. After taking all three medicines at once, he experienced a severe reaction and went to the emergency room. An interpreter was found who explained in Spanish that he was not supposed to take all three at once.[19]

Endnotes - The Consequences of Not Providing Language Services: Some Facts and Personal Stories

[1] Derose, Kathryn P. and David W. Baker, "Limited English Proficiency and Latinos' Use of Physician Services," *Med. Care Research And Rev.* (2000) 57 76.

[2] Collins, Karen Scott, 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 reported more problems than did whites]. See also Glenn Flores et al., "The Health of Latino Children," *JAMA* 288 (July 3, 2002) 82, 87-88.

[3] Weinick, Robin M. and Nancy A. Krauss, "Racial and Ethnic Differences in Children's Access to Care," *American J. of Public Health* (Nov. 2000) 90 1771.

[4] Bernstein, Judith, et al., "Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up," *J. of Immigrant Health,* Vol. 4 No. 4 (October 2002); I.S. Watt, et al, "The Health Care Experience and Health Behavior of the Chinese: A Survey Based in Hull," *J. Public Health Med.* (1993) 15 129; Sarah A. Fox and J.A. Stein, "The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups," *Medical Care* (1991) 29 1065.

[5] Naish, Jeannette, et al., "Intercultural Consultations: Investigation of Factors that Deter Non-English Speaking Women from Attending their General Practitioners for Cervical Screening," 309 *BMJ* (Oct. 29, 1994) 1126.

[6] See Louis Hampers, et al., "Language Barriers and Resource Utilization in a Pediatric Emergency Department," *Pediatrics* (June 1999) 103 1253.

[7] Manson, Aaron, "Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma," *Medical Care* (Dec. 1988) 26 1119.

[8] Andrulis, Dennis P., Nanette Goodman, and Carol Pryor, "What a Difference an Interpreter Can Make," The Access Project (Apr. 2002).

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

[10] 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" (2002) 71–72. [Describing a recent survey that found that 51 percent of providers believed patients did not adhere to treatment because of culture or language but 56 percent reported no cultural competency training].

[11] Maya Ministry Family Literacy Program.

[12] National Health Law Program.

[13] National Health Law Program.

[14] Central California Legal Services, Fresno, CA.

[15] National Health Law Program.

[16] Cambridge Health Alliance, Cambridge, MA

[17] Latino Memphis, Memphis, TN.

[18] National Health Law Program, Washington, D.C.

[19] Tenants & Workers Support Committee, Alexandria, VA. ■

Why Relying on Family Members, Friends, and Children as Interpreters Is Dangerous and Should Be Discouraged

As you begin to discuss the issue of language interpretation in your state, you may hear people say that a patient's family members or friends can—or should—appropriately serve as interpreters. If so, you may need to undertake educational activities to explain the need to use trained interpreters rather than family members and friends. For example, using trained interpreters can ensure confidentiality, prevent conflict of interest, and make sure that medical terms are interpreted correctly. This document is intended to provide some background information so that you can communicate with policymakers, providers and others about the potential pitfalls of using untrained interpreters.

Significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Patients may suffer direct consequences because they do not fully understand a diagnosis or treatment. One study noted that interpreting errors by "ad hoc" interpreters, including family members and friends, are significantly more likely to have potential clinical consequences than interpretation provided by hospital interpreters.[1]

Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be unfamiliar with medical terminology. Furthermore, many patients will not disclose sensitive or private information to family members and friends; providers may thus receive incomplete information that can prevent them from correctly diagnosing a condition. For example, if a battered woman is brought to the hospital by her batterer who is then asked to interpret for her, the battered woman is not likely to reveal the scope and cause of her injuries.

Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead.

Why children should not be used as interpreters: a personal account

The following personal account, written by a 17-year-old junior at Galileo High School in San Francisco, illustrates the emotional toll that interpreting can take on a child.

It's 2:30 in the afternoon and I have to rush out in the middle of my history class. My heart pounds like a drum. Fear and worry overtake me. My head burns with what feels like hot, boiling blood rushing up my head. I'm confused and lost; I don't know what's going on.

Finally, I arrive at the hospital. I sit outside the waiting room with my older sister and I began to weep silently. My sister yells at me with frustration, "Stop crying. Mom's going to be OK. Stay here till the doctor comes. I have to go home and pick up dad."

Dr. Harrison walks down an infinite hallway with his long white coat that nearly reaches down to his feet. He comes with the bad news.

"I'm sorry to tell you this but your mom has cancer. The hemorrhoid we found turned out to be a tumor. I know that your mom doesn't speak English so can you please interpret for her."

I don't like sitting in the hospital, and I feel uncomfortable. I want to tell the doctor that I don't want to be here. But since my mom doesn't speak English, my sister Janice and I are the only ones that can help mom.

The doctor looks at me and he begins to talk about my mom's medical condition. He talks to me as simply as possible, so I can understand the situation, and says my mother's cancer would require surgery and probably radiation and chemotherapy treatments afterward.

I am shocked. Surgery. Radiation. Chemotherapy. Side effects. I can't even begin to think of how I'm going to tell my mom. All this information is new to me; all those big words sound horrible. And the doctor is expecting me to tell mom this in Cantonese.

I begin to translate for my mom. She looks back at me with watery eyes. I search for comforting words in Cantonese that would help calm her, but I am lost. It's hard enough to think of the Cantonese terms for various organs, for surgery and chemotherapy.

Instead, I describe the situation in basic terms, and leave gaps in-between my explanation. Since I don't know how to say "surgery," I tell her that there will be needles, knives, tubes, and cuts into her body.

My mom bursts out crying, pushing me away. She doesn't want to see anyone.

Queena Lu, "Children: Voices for Their Parents" Asian Week (May 18-24, 2001) Reprinted with author's permission.

Guidance from the federal Department of Health and Human Services Office for Civil Rights recognizes the drawbacks of using family members and friends and encourages the use of trained interpreters whenever possible.[2]

While many problems can result from using adult family members and friends as interpreters, additional problems arise when the interpreter is a minor. Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information.[3] Children who act as language brokers often influence the content of the messages they interpret, which in turn affects their parents' decisions.

Other concerns with using children as interpreters include:

- Requiring children to take on additional burdens, such as decision-making responsibilities
- Creating friction and a role reversal within the family structure, which can even lead to child abuse
- Violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services
- Causing children to miss school

The potential for harm is exacerbated when providers use children to interpret in gynecological or reproductive health settings. For example, in one case a provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. The provider only called a trained medical interpreter when the daughter became upset and refused to do the interpretation.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese-American and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3%) used their children to interpret for them.[4] Most used their children for communicating with schools and government agencies and filling out forms. More than half of the women who used their children as interpreters identified problems with this practice. The top four problems were:

- The child interpreted incorrectly
- The child left out information
- The information was too technical for the child
- The child was unable to properly interpret due to limited language skills

Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

The problems associated with using minors, family members and/or friends as interpreters highlight why states should reimburse providers for the costs associated with using trained medical interpreters.

Endnotes - Why Relying on Family Members, Friends, and Children as Interpreters Is Dangerous and Should Be Discouraged

[1] Flores, Glenn, et al., "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters," *Pediatrics,* (January 2003) Vol. 111, No.1.

[2] 65 Fed. Reg. at 52769-80 (August 30, 2000). While OCR is currently reviewing its guidance to comply with a Memorandum from the Department of Justice (July 8, 2002), we anticipate that the substance will remain similar. OCR's existing guidance remains in effect.

[3] See generally, McQuillan & Tse, "Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy," *Language and Education,* (1995) 9(3), 195-215.

[4] Equal Right Advocates, "From War on Poverty to War on Welfare: The Impact of Welfare Reform on the Lives of Immigrant Women" (April 1999). Available from **http://www.equalrights.org/welfare/iwwp/finddisc.htm**.

Making the Case for Language Services

Data: What Is Available and Why We Need It

Bolster your educational efforts about the need for language services by presenting data specific to your state or region. Document the changing demographics of your state or community to help make the case for improving language access. Much national discussion has focused on racial and ethnic disparities in healthcare, which overlaps the lack of access to language services. Using data to document disparities can help educate policy makers and the public about the need for interpreters.

"The Growing Need for Language Services" on page 33 provides national data from the 2000 Census. You can obtain Census information about how many LEP individuals reside in your state or community and how those numbers have increased since the last Census. Census 2000 data for your state, city or town can provide information on residents' places of birth, languages spoken, and language proficiency.[1] Additional data on race, ethnicity and primary language of people using federally and locally supported health programs is essential to identifying, measuring, and eventually eliminating health disparities.

Other sources for data on language diversity are school districts, comprehensive data on students' primary language, and community-based organizations working with immigrants or on healthcare issues, local/regional population surveys (e.g., the California Health Interview Survey), and institutional data sets (e.g., hospital admissions or discharges). This data also can help you:

- Develop and implement effective prevention, intervention, and treatment programs
- Promote the delivery of culturally and linguistically competent health care services
- Empower LEP individuals to make informed decisions about health plan choice
- Identify and track similarities and differences in performance and quality of care provided to various cultural and ethnic communities
- Develop meaningful standards to analyze the efficacy of data collection activities to ensure access to language services

You may also want to encourage broader data collection. By improving the collection of data, you can lay the foundation for ongoing documentation of your efforts to eliminate disparities and improve quality of care for LEP individuals. You can emphasize to health care providers that the collection of racial, ethnic and primary language data is *legal* and, in fact, encouraged by regulations implementing Title VI of the Civil Rights Act of 1964.[2] Just as Title VI offers a basis for collecting racial, ethnic and primary language data in federal programs, state civil rights or other statutes and regulations may support data collection in state programs as well.

Endnotes - Data: What Is Available and Why We Need It

[1] **http://factfinder.census.gov**. You can access this information through the "Summary File 3" data.

[2] 45 C.F.R. § 80.6. No federal statutes prohibit the collection of this data. Only California, Maryland, New Hampshire and New Jersey statutorily regulate what data can be collected. Three other states have stated they would disapprove requests from health plans to collect racial and ethnic data: Connecticut, Minnesota and North Carolina. Often the statutes or policies are limited in scope, e.g., only prohibiting data collection prior to enrollment. Check your state laws to determine if any limits apply to the collection of racial, ethnic and/or primary language data. For additional information on state laws, see National Health Law Program, "Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans" (Draft, July, 2001).

An Introduction to Story Banking

Reporters often begin articles with examples. Legislators are swayed by personal stories from their own constituents. Compelling personal stories help to complement reports. So to change policy, paint a clear picture of the repercussions of not providing interpreters and illustrate the differences interpreters have made.

Developing "story banks" is important to your efforts. Families USA (FUSA), a health care consumer advocacy organization, maintains a database with hundreds of stories it uses to enlighten policy makers and the public about the health care access challenges many consumers face. It has produced guides for creating story banks, "The Art of Story Banking," and "The Story Bank: Using Personal Stories as an Effective Way to Get Your Message Out." Both are available from **www.familiesusa.org/site/PageServer?pagename=Advocates_Impressives**.

According to FUSA, to create and use a story bank:

1. Identify potential sources of stories obtained through networks that work with or serve LEP individuals, such as:

- Community based organizations serving or advocating on behalf of immigrants
- Refugee resettlement agencies
- Health care advocates
- Organizations focusing on civil rights and/or health disparities
- Ethnic media outlets
- Community health centers and/or clinics
- Interpreter associations
- Legal services organizations
- Labor unions

2. Prepare a letter to mail to the organizations requesting personal accounts illustrating the need for language services. The following example may be modified for making contact in person or by telephone:

We [identify the organization, coalition, provider, etc.] are seeking information about problems individuals with limited English proficiency are having in accessing health care. We are looking for stories of individuals from our state to use in public advocacy and educational efforts as we attempt to increase the availability of, and funding for, interpreters and translators in health care settings.

We need your help in collecting information to use in our efforts. For example, stories that have been gathered in other states include:

- A woman who recently gave birth to a still born child because a doctor could not communicate that a cesarean section was necessary to save the baby
- A hospital that used a 16-year-old male child of a stranger to interpret for a woman seeing a gynecologist
- A Russian-speaking patient who complained of "urgina," (sore throat in Russian); his complaint was misinterpreted as "angina," causing him to undergo unnecessary diagnostic testing

All of these examples point to the need for trained medical interpreters to prevent humiliating, serious, and sometimes life-threatening consequences. If you have stories or anecdotal information about the consequences of not having an interpreter, please send them to _____ [name, phone, fax, email] by [insert date]. Please provide a description of the situation, including as many

details as possible. Also, please tell us whether the individual will let us use his/her name and/or is willing to speak to the media.

If you would like more information about our education and advocacy efforts, please let us know. Thank you for your time.

3. Create a simple one-page form in which you can record information about each person who might have a personal story to share.

Follow up with phone calls to people who do not respond to your request. Create a filing system that is cross-referenced by geography and subject criteria (language spoken, type of problem, characteristics of individual, etc.)

4. Include in the file a usable quote from the initial interview stage.

5. Verify the facts. Before sharing any story, try to interview the person yourself to ensure accuracy and determine if she/he will seem credible and sincere to the press.

6. Discuss with potential sources whether they are willing to speak in public (to the press, legislative staff and others) or would prefer you use the story without identifying them by name. Ask if they want their story to appear only in print media or if they are willing to be interviewed on TV or radio.

7. Let the person know that there is no guarantee that the story will be used.

8. Keep the stories (and database) updated. Record any new developments in the stories, and check whether people are still willing to talk about them publicly.

9. Obtaining prior consent is of key importance! Secure permission each time you release a story or share personal contact information. Treat this information as confidential until you get permission to make it public.

10. Have a list of resources, so you can try to refer people to someone who can help them with their problem.

11. Offer to help practice questions or answers if the person is nervous.

12. Develop a trusting and respectful relationship with the contributors to the story bank.

Developing a story bank is important, but it is also time consuming and can be hard to do well. Many consumers are reluctant to tell their stories publicly, particularly people with limited English proficiency who may not be citizens.

Remember that you may also need an interpreter who can explain to potential sources the purpose of collecting their stories, and who can be available, for example, when a reporter wants to interview someone with LEP.

You need to be aware of these difficulties. However, you also should remember that having LEP individuals recount their personal experiences trying to navigate the health care system can be a powerful tool in convincing policy makers and the public of the serious consequences of not providing interpreters, and of the importance of providing language services to all patients who need them.

Making the Case for Language Services

Writing an Op-Ed Piece or a Letter to the Editor about the Need for Language Services

Getting op-ed pieces and letters to the editor printed in your local newspapers may be an effective way to raise public awareness about the need for language services for patients who do not speak English well. You may find the information below useful in making a case for the value of interpreter services for both patients and providers.

Why should health care providers offer interpreter services to non- or limited-English speaking patients?

1. It's necessary for competent, quality care.
Patients' inability to communicate adequately with providers and support staff they encounter when interacting with the healthcare delivery system can have serious consequences. LEP patients have been misdiagnosed, have misunderstood follow-up procedures, and have even left the hospital altogether despite having life threatening conditions. According to a report released by The Access Project,[1] patients who did not have access to language interpretation services were ten times more likely than others to not understand their physician's instructions for taking prescription medications. The report also found that LEP patients are less likely than others to be told about financial assistance programs that can help them pay for care, and that many patients with outstanding bills would be reluctant to return to the facility for care.

2. It reduces costs.
Providing for long-term sustainability of health care institutions. A strong business case can be made for providing interpreters to LEP patients because language barriers can lead to increased use of medical resources. Studies have found that non-English speaking patients are more likely than English-speaking patients to delay treatment and to access care through emergency rooms, rather than use available primary and preventive care services. Offering interpreter service for patients with limited English proficiency may better allow providers to offer cost-effective, quality care, rather than give costly care that can have adverse effects.[2, 3, 4, 5]

Interpreters can protect patients from harm and institutions from lawsuits.[6] The ability to make an accurate diagnosis and get informed consent for medical procedures is severely jeopardized when LEP patients do not have adequate interpretation services. Medical errors are much more likely in the absence of effective communication. Providing interpreter services can thus help health care facilities avoid costly malpractice suits that can result from medical errors, inappropriate care, and failure to gain meaningful consent from patients for treatment.

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3. It's the law.

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on national origin by those who receive federal funding. State and local civil rights or patients' rights statutes may also mandate the need to ensure access to care for those who do not speak English well. Providers who do not offer language services to patients with LEP may thus be in violation of federal, state, and local laws.

[See "Federal Laws and Policies Requiring Access to Services in Health Care Settings for People with Limited English Proficiency" on page 5 for more information about these legal requirements.]

You may also want to include some or all of the following information in your articles or letters to the editor:

- Local demographic data that show an increase in limited English speakers over the past 10 years in your area.
  [See page 33 for more information about state-level data.]
- A story of a patient with limited English proficiency who experienced health or financial consequences because of lack of medical interpretation services.
  [See page 41 for some examples.]
- Information about why using family, friends, or children as interpreters in medical settings is inappropriate and even dangerous.
  [See page 43]
- Availability of public funds to help defray the costs of these services.
  [See page 22 for a description of how states can get funding through the Medicaid and SCHIP programs.]

Endnotes - Writing an Op-Ed Piece or a Letter to the Editor about the Need for Language Services

[1] Andrulis, et al., "What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency," The Access Project, April 2002.

[2] Gandhi, et al., "Drug Complications in Outpatients," *Journal of General Internal Medicine,* March 2000.

[3] Haish, et al., "Intercultural Consultations: Investigation of Factors that Deter Non-English Speaking Women from Attending Their General Practitioners Cervical Screening," *British Medical Journal,* October 1994.

[4] Hampers, et al., "Language Barriers and Resource Utilization in Pediatric Emergency Dept." *Pediatrics,* June 1999.

[5] Manson A., "Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma," *Medical Care,* December 1988.

[6] "Interpreters Can Protect Your Patients From Harm and Your Facility From Lawsuits," Briefings On Patient Safety, *Opus Communications,* Sept. 2002, Vol.3 No.9.

Some Next Steps

In Advocating for Medicaid/SCHIP Reimbursement for Language Services

Understanding the federal laws that prohibit discrimination against people with LEP and how federal funding for language services is available through the Medicaid and SCHIP programs is an important first step in advocating for reimbursement for language services. However, to effectively advocate for language services in your community, you will probably need to collect additional local information, raise public awareness about the importance of the issue, identify and communicate with potential allies, educate government officials and other key decision makers on the need for language services reimbursement, and consider the best approach for providing reimbursement in your state. Each of these steps requires time and work. This document provides a quick overview of activities you may need or want to undertake to make the case for language services.

- Understand why health care providers are required by law to work to ensure access to services for people with limited English proficiency (LEP).
- Review Section 2 of the Action Kit on federal law and policies that require health care providers to provide language services for people with LEP.
- Research whether your state, county, or city also has laws that prohibit discrimination and require service providers to provide language services.
- Understand why and how your state may be able to access federal funding to help pay for language services for Medicaid and SCHIP enrollees.
- Review Section 3 of the Action Kit that describes how the federal government pays part of the costs for Medicaid and SCHIP services, how these federal funds might also be used to help provide language services, and how states that have implemented this option have structured their language services reimbursement programs.

Some Next Steps

In Advocating for Medicaid/SCHIP Reimbursement for Language Services

Find out whether your state currently reimburses health care providers for language services. See the table on page 22 to see if your state is on the list.

Contact your state Medicaid and Children's Health Insurance Programs and ask if they reimburse providers for language services.

[See the Resource Section on page 55-56 for contact information.]

Find out the reasons why your state has chosen not to pursue Medicaid and SCHIP reimbursement for language services, so you can decide how to address them.

Find others interested in providing language services.

Identify and contact organizations or individuals in your community who need language services, work with people who need them, and/or help to provide them. Ask whether they are interested in learning more about federal and state reimbursement for language services. You may want to include:

- Interpreter organizations
- Immigrant groups
- Public and community health advocates
- Hospital administrators, community health centers, doctors and other health care providers
- State legislators who represent districts with significant numbers of people with LEP, or who have demonstrated an interest in services for immigrants in the past

Gather local information and stories that will help you make the case for the need for language services in your state.

Review the materials on page 33 that describe the growing need for language services; the legal, medical, and financial consequences of not providing these services; and the importance of using trained medical interpreters rather than family and friends.

Systematically document stories about the advantages of providing language services or the negative consequences of not providing them. For example, contact interpreters and see if they have stories about cases in which their services led to better interactions between patients and providers or improved medical outcomes, or where patients experienced serious medical consequences because interpreters were not available. Gather similar stories from patients and providers.

Gather local data on newcomers to your community who may not speak fluent English. State Health Departments and local school districts can often provide data on newcomer groups. Estimates of the number of people in your state or community that have LEP are also available on the U.S. Census Department website, **http://www.census.gov**.

Raise awareness in your community about the importance of providing language services in medical settings.

Review the material on page 49 on writing op-eds and letters to the editor. Using local stories and data, write pieces for local newspapers and encourage others supportive of language services to do the same.

Present Action Kit materials and information gathered in your community to elected officials and state policymakers.

Research the policy environment in your state. Find out if your state Medicaid plan requires legislative action to change benefits and payment mechanisms, or if these changes can be accomplished through administrative action.

Design a reimbursement program appropriate for your state and inform policymakers.

Review the material on page 22 that describes how other states have structured their reimbursement programs, and work with others interested in reimbursement for language services to design policies appropriate to your state. Then, meet with state policymakers to present the program and gather support for implementing it.

Resources

As you begin developing an advocacy campaign for reimbursement for language services, you may find you need to conduct additional research. A wide variety of resources exist that offer information about issues related to the provision of language interpretation and translation services. This resource list includes some key resources, although it is far from comprehensive. Depending on the action steps you decide to take, you may want to look at other sources as well. For information about the organizations that produced this Language Services Action Kit:

- The Access Project

  30 Winter Street, Suite 930
  Boston, MA 02108
  Phone: (617) 654-9911
  Fax: (617) 654-9922
  http://www.accessproject.org

- National Health Law Program

  101 14th Street NW, Suite 405
  Washington, DC 20005
  Phone: (202) 289-7661
  Fax: (202) 289-7724

  2639 S. La Cienega Blvd.
  Los Angeles, CA 90036
  Phone: (310) 204-6010
  Fax: (310) 204-0891
  http://www.healthlaw.org

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עברית Tagalog 한국말
Tiếng Việt Español ไท
Soomaali Русский Язык
한국말 Srpsko-Hrvatsk
Français Hmoob عربي
Shqip Ελληνικά 中文

Resources

Resources

Federal Government Resources

Agency for Healthcare Research and Quality, "Providing Oral Linguistic Services: A Guide for Managed Care Plans" (AHRQ Publication No. 03-R201); "Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care" (AHRQ Pub. No. 03-R202). Available from **http://www.cms.hhs.gov/schip/**.

Department of Health and Human Services, Centers for Medicare & Medicaid Services: "Dear State Medicaid Director," letter explaining the availability of federal matching funds for language services provided to Medicaid/SCHIP enrollees. Available from **http://cms.hhs.gov/states/letters/smd83100.asp**.

Department of Health and Human Services, Office for Civil Rights: information about the agency's enforcement of Title VI, links to its LEP guidance, and other resources. Available from **http://www.hhs.gov/ocr/lep**.

Office for Civil Rights Contact Information

Headquarters: (202) 619-0403

Region I - Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont: (617) 565-1340

Region II - New Jersey, New York, Puerto Rico, Virgin Islands: (212) 264-3313

Region III - Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia: (215) 861-4441

Region IV - Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee: (404) 562-7886

Region V - Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin: (312) 886-2359

Region VI - Arkansas, Louisiana, New Mexico, Oklahoma, Texas: (214) 767-4056

Region VII - Iowa, Kansas, Missouri, Nebraska: (816) 426-7278

Region VIII - Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming: (303) 844-2024

Region IX - Am. Samoa, Arizona, California, Guam, Hawaii, Nevada: (415) 437-8310

Region X - Alaska, Idaho, Oregon, Washington: (206) 615-2290

Department of Health and Human Services, Office of Minority Health: "Culturally and Linguistically Appropriate Services (CLAS) Standards in Health Care." Available from **http://www.omhrc.gov/CLAS**.

Department of Justice (DOJ), Civil Rights Division: LEP guidance, DOJ memorandum to other agencies, and other links. Available from **http://www.usdoj.gov/crt/spectop.html**.

Let Everyone Participate, a gateway to the federal government's activities on language access, includes a link to Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance. Available from **http://www.lep.gov**.

U.S. Bureau of the Census: recent Census data, including languages spoken and English proficiency. Available from **http://www.census.gov**.

State Agencies

Massachusetts Department of Public Health, Office of Multicultural Health: "Best practices" guides, "I Speak" cards, a poster in 30 languages informing patients of their right to an interpreter, and other information on interpreter programs, especially in hospital settings, **http://www.state.ma.us/dph/omh/interp/interpreter.htm**.

Medicaid agencies, National Association of State Medicaid Directors: select "members" to identify your state Medicaid Director and contact information, **http://www.nasmd.org**.

State Children's Health Insurance Program (SCHIP) agencies, **http://cms.hhs.gov/schip/**.

Resources

Interpreter "Standards of Practice" and Certification

California Healthcare Interpreters Association, "California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention." Available from **http://www.chia.ws**.

Massachusetts Medical Interpreter Association, "Medical Interpreters Standards of Practice." Available from **http://www.mmia.org**.

National Council on Interpreting in Health Care, **http://www.ncihc.org.**

Reports from Non-Profit Organizations

The Access Project, "Real Clout: A How-To Manual for Community Activists Trying to Expand Healthcare Access by Changing Public Policy" (1999). Available from **http://www.accessproject.org**.

The Access Project, "What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency" (April 2002). Available from **http://www.accessproject.org**.

The California Endowment, "How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract with Language Agencies" (February 2003). Available from **http://www.calendow.org/pub/frm_pub.htm**.

Hablamos Juntos: rationale, model approaches, tools and data, **http://www.hablamosjuntos.org/index.**

The Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," National Academy Press (2002). Available from **http://www.iom.edu**.

National Council on Interpreting in Health Care, "Research Issues in Medical Interpretation: Bibliography," **http://www.ncihc.org.**

The National Health Law Program, "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities", 2d ed. (August 2003). Available from **http://www.healthlaw.org**.

The National Health Law Program, "Providing Language Interpretation Services in Health Care Settings: Examples from the Field, A Field Report from The Commonwealth Fund" (May 2002). Available from **http://www.healthlaw.org** or **http://www.cmwf.org**.

Studies

A growing number of studies and articles demonstrate that the lack of language services creates a barrier to and diminishes the quality of health care for people with LEP. For a sample of the findings from these studies, see "The Consequences of Not Providing Language Services: Some Facts and Personal Stories" in this Action Kit. For additional studies and articles, see "Research Issues in Medical Interpretation: Bibliography", National Council on Interpreting in Health Care, **http://www.ncihc.org**, and The California Endowment's "Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature" (forthcoming), **http://www.calendow.org/pub/frm_pub.htm.** ■

Kreyòl Ayisyen

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The Access Project

The Access Project (TAP) is affiliated with the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. Initiated through a grant from The Robert Wood Johnson Foundation, it currently receives funding from a variety of public and private sources. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

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Fax: (617) 654-9922
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The National Health Law Program

The National Law Health Program (NHeLP) is a national non-profit public interest law firm working to increase and improve access to quality health care on behalf of America's limited income individuals. For over thirty years, NHeLP has worked on issues affecting the working and unemployed poor; people of color; women, children and their families; immigrants; and individuals with special needs. NHeLP provides legal and policy analysis, advocacy, education and information, training and technical assistance.

If you have any questions or would like to learn more about NHeLP's work, please contact either the Washington, D.C. or Los Angeles, CA office.

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Tiếng Việt Español ไทย
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Language Services

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