

Strategies For Reimbursement of Language Assistance Services

CPEHN Convening

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Making the Case for Language Assistance Services Based on...

- Legal Mandates
- Business Case
- Quality Improvement/Assurance
- Public Health Objectives



FEDERAL LEGAL MANDATES

- Title VI of the 1964 Civil Rights Act
- E.O. 13166-8/11/00
 - prepare a plan to improve LEP access
 - draft a title VI LEP guidance for its recipients
- DOJ LEP Guidance- 6/18/02
 - take reasonable steps to provide meaningful access
 - take into account the #/, % & freq. Of LEP persons; importance of the service; and available resources



STATE LEGAL MANDATES

- CAL. GOVT. CODE §§ 11135,11139; 22 C.C.R. §§ 982100 et seq.
- DYMALLY-ALATORRE BILINGUAL SERVICES ACT (CAL. GOVT. CODE §§ 7290 et seq.
- KOPP ACT (CAL. HEALTH & SAFETY CODE § 1259)
- MEDI-CAL MANAGED CARE CONTRACT REQUIREMENTS
- HEALTHY FAMILIES MANAGED CARE CONTRACT REQUIREMENTS
- SENATE BILL 853 (CAL. HEALTH & SAFETY CODE §§ 1367, 1367.04, & 1367.07 and CAL. INS. CODE §§ 10133.8 & 10133.9)



Business Case

- Changing demographics of consumers/ members
- Need to meet consumer needs, increase consumer satisfaction
- Marketing strategy: attract new consumers
- Risk management: indirect costs - increase patient compliance, reduce errors/malpractice
- Cost reductions: measure cost effectiveness



Quality Improvement/Assurance

- Language access questions now included on Consumer Assessment of Health Plans Survey (CAHPS)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reviewing its accreditation standards
- National Committee for Quality Assurance (NCQA) includes language access standards in HEDIS performance measures
- Monitoring by State Agencies – California example: CA DHS & Managed Risk Medical Insurance Board (MRMIB) in Medi-Cal managed care and Healthy Families; Department of Managed Health Care (California HMO Report Card at: http://wp.dmlnc.ca.gov/report_card/)



Public Health Objectives

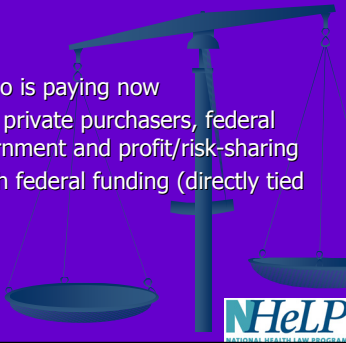
- Acknowledge continuing health disparities based on racial/ethnic and other socioeconomic factors, including linguistic access
- Institute of Medicine (2002) health disparities report cited language access as challenge
[www.nap.edu/books/030908265X/html/]



How to Address Cost Issues

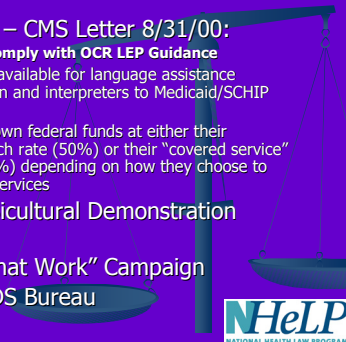
■ Who Pays?

- Depends on who is paying now
- Combination of private purchasers, federal and state government and profit/risk-sharing
- Most clarity with federal funding (directly tied to Title VI)



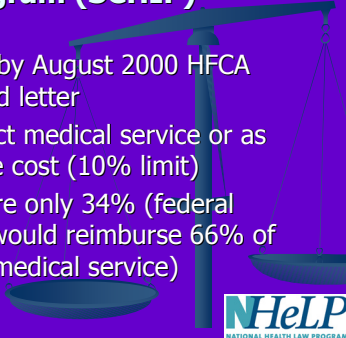
What Funding Is Available – Federal Sources?

- Medicaid/SCHIP – CMS Letter 8/31/00:
 - **Recipients must comply with OCR LEP Guidance**
 - Reimbursement is available for language assistance including translation and interpreters to Medicaid/SCHIP enrollees
 - States can draw down federal funds at either their administrative match rate (50%) or their “covered service” match rate (50-85%) depending on how they choose to provide language services
- OMH Bilingual/Bicultural Demonstration Program
- HRSA “Models that Work” Campaign
- HRSA – HIV/AIDS Bureau



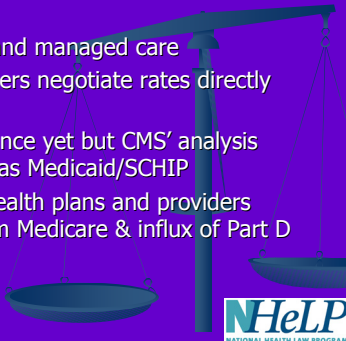
State Children's Health Insurance Program (SCHIP)

- Also covered by August 2000 HFCA State Medicaid letter
- Either as direct medical service or as administrative cost (10% limit)
- But state share only 34% (federal government would reimburse 66% of cost if direct medical service)



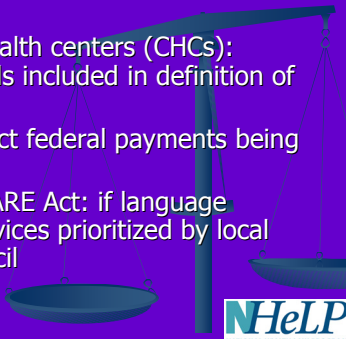
Medicare

- Fee-for-service and managed care
- Plans and providers negotiate rates directly with CMS
- No written guidance yet but CMS' analysis should be same as Medicaid/SCHIP
- But context of health plans and providers withdrawing from Medicare & influx of Part D plans



Other Federal Funding Streams

- Community health centers (CHCs): language needs included in definition of underserved;
- Hospitals: direct federal payments being reduced
- Ryan White CARE Act: if language assistance services prioritized by local planning council



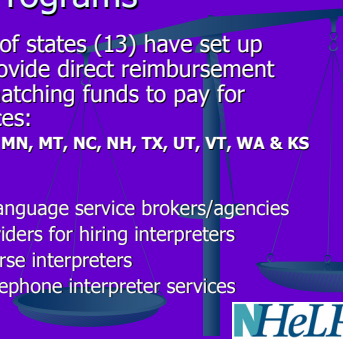
Other Funding Available for Providing Linguistic Access

- Offices of Refugee Resettlement
- State/County Departments of Health/Social Services
- Local foundations
- Non-profit organizations




Statewide Medicaid/SCHIP Programs

- Only a handful of states (13) have set up programs to provide direct reimbursement using federal matching funds to pay for language services:
 - HI, ID, MA, ME, MN, MT, NC, NH, TX, UT, VT, WA & KS
- Four models –
 - contract with language service brokers/agencies
 - reimburse providers for hiring interpreters
 - directly reimburse interpreters
 - contract for telephone interpreter services



Model 1 – Language Service Brokers/Agencies

- HI and UT contract with interpreter organizations; providers schedule interpreters who bill the state
- WA contracts with language “brokers” to schedule interpreters; requires testing – interpreters must be certified (7 prominent languages) or qualified (other languages)
- VT allows providers to hire any interpreter but services primarily provided by one language agency
- HI & UT – reimbursed as “covered service”



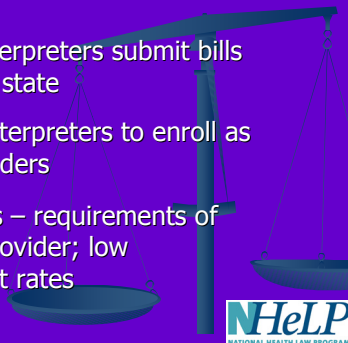
Model 2 – Provider Reimbursement

- ID, MA, ME and MN require providers to pay for interpreters and then reimburse providers
- Providers have discretion on who to hire
- ME – interpreters must sign code of ethics; cannot use family members/friends
- Considerations – state oversight; quality of interpreters; provider concerns



Model 3 – Payments to Interpreters

- NH & MT – interpreters submit bills directly to the state
- NH requires interpreters to enroll as Medicaid providers
- Considerations – requirements of becoming a provider; low reimbursement rates



Model 4 – Telephone Interpreter Services

- Kansas
- Contracting with EDS for telephone interpretation services for all FFS providers
- No cost to provider (1-800 number)
- Began in October 2003



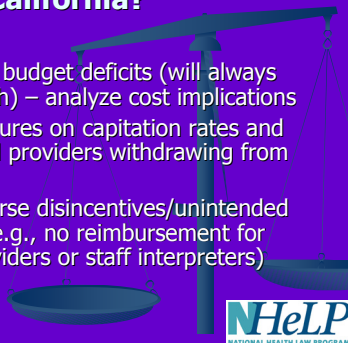
So what are the next steps for California?

- How do we decide on the best/most appropriate model for California?
 - Who is covered? Enrollees; Providers? FFS; Managed Care; Hospitals?
 - What is reimbursement rate?
- Other state models informative but California will be unique in level of utilization and resources available



So what are the next steps for California?

- Context of state budget deficits (will always need state match) – analyze cost implications
- Context of pressures on capitation rates and health plans and providers withdrawing from managed care
- Beware of perverse disincentives/unintended consequences (e.g., no reimbursement for multilingual providers or staff interpreters)



So what are the next steps for California?

- Establish billing code and include in state plan
- Identify related issues – Interpreter certification? Contract amendments?
- Determine whether legislative and/or administrative action is needed
- Formulate an action plan - California governmental and nongovernmental leadership required



How to Get Involved

- Advocacy – state budget, department policies, Medi-Cal and Healthy Families funding
 - Participate in the Language Access Advocacy Coalition's stakeholders meetings to provide input into a reimbursement model for California
 - Develop Medi-Cal and Healthy Families reimbursement mechanism for language services
 - Support SB 1405 to create a task force
 - Work with state administrative agencies and/or legislature to adopt reimbursement mechanism



NHeLP Resources

- The California endowment (Sept. 2003)
 - Complete update of "ensuring linguistic access in health care settings: an overview of current legal rights and responsibilities"
- NHeLP and access project
 - Language services action kit: interpreter services in health care settings for people with limited English proficiency" (August 2003 & December 2005 update)
- Commonwealth fund
 - "Interpretation services in health care settings: examples from the field" (May 2002)
- Commonwealth fund
 - "Providing language services in small health care provider settings: examples from the field" (April 2005)
- Available at: www.healthlaw.org