

A Recommendation By
**THE MEDI-CAL LANGUAGE ACCESS
SERVICES (MCLAS) TASKFORCE**

March, 2009

**Providing Language Services for Limited
English Proficient (LEP) Patients in
California
Developing a Service System for the State**

Participants:

Asian Americans for Civil Rights & Equality ■ Asian & Pacific Islander American Health Forum ■ California Academy of Family Physicians ■ California Association of Public Hospitals ■ California Black Health Network ■ California Dental Association ■ California Family Physicians Association ■ California Healthcare Interpreting Association ■ California Hospital Association ■ California Medical Association ■ California Pan-Ethnic Health Network ■ California Primary Care Association ■ Community Health Group ■ Fresno Health Consumer Center, Central California Legal Services ■ Latino Coalition for a Healthy California ■ National Health Law Program

With Assistance from:

California Department of Health Care Services, Medical Care Services ■ California Department of Health Care Services, Medi-Cal Managed Care ■ California Department of Public Health, Office of Multicultural Health ■ California Department of Mental Health ■ California Health & Human Services Agency ■ Los Angeles County Department of Health Services – Diversity Program

April 6, 2009

David Maxwell Jolly, Director
Department of Health Care Services,
State of California
1501 Capitol Avenue
Sacramento, CA 95814

Dear Director Maxwell Jolly:

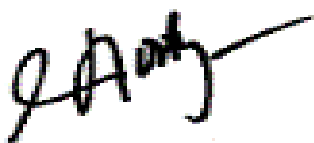
On behalf of the Medi-Cal Language Access Services (MCLAS) Taskforce, we are pleased to submit this report to you.

In December 2006, various stakeholders convened the Medi-Cal Language Access Services (MCLAS) Taskforce and the Department of Health Care Services (DHCS) was charged to assist us in developing a system of delivery and reimbursement for language services in Medi-Cal. Over the past sixteen months, MCLAS members have embarked on a consensus-oriented process to ensure widespread support from state representatives, providers and consumers organizations.

We recognize that recommending a uniform, quality system for delivering language services in Medi-Cal is an investment with immediate funding implications. While we recognize the state's current fiscal situation, we believe that providing adequate language services increases patient satisfaction, improves health outcomes and will demonstrate a cost-savings over the long term.

In the following pages, we submit a recommendation that outlines the delivery of language services in order to leverage available match funds. To be clear, the implementation of such a delivery system would position California as a leader in improving the quality of our state's healthcare system. We thank DHCS and the Office of Multicultural Health for their participation in the Taskforce and for providing key information. Finally, we thank you personally for your support of the Taskforce as well as quality language services in Medi-Cal.

Sincerely,



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Table of Contents

| | |
|--|-----------|
| About the Taskforce | 5 |
| Executive Summary | 6 |
| Section 1: California Today | 7 |
| California’s Current Problem | |
| California’s Diversity in its Healthcare System | |
| Medi-Cal in California and the Provision of Language Services | |
| Section 2: Understanding Language Services | 12 |
| Reimbursement of Language Services | |
| Legal basis for the Provision of Language Services | |
| Federal Laws and Statutes on Language Services | |
| California Laws and Statutes on Language Services | |
| Section 3: Alternatives – What Other States Are Doing | 19 |
| Section 4: Recommendation | 25 |
| Broker System | |
| Direct Provider Reimbursement | |
| Section 5: Implementation Issues | 28 |
| Reimbursement in the Safety Net | |
| Quality and Standards | |
| Other Issues to Consider – | |
| Managed Care and its impact on the Recommendation | |
| Mental Health and its impact on the Recommendation | |
| Translation | |
| Uninsured | |
| Workforce | |
| Estimated Cost | |
| Section 6: Pilot Project | 40 |
| Section 7: Appendix | 42 |

About the Taskforce

In December 2006, the Department of Health Care Services (DHCS) met with interested stakeholders of language services in response to Senate Bill 1405, authored by Senator Nell Soto in 2006. The stakeholders agreed to create a task force charged with developing recommendations for a system to provide language services for California Medi-Cal enrollees, which evolved into the Medi-Cal Language Access Services (MCLAS) Taskforce. The ultimate vision of this effort was to design a system that could accommodate large numbers of persons whose primary language was other than English and to generate federal financial participation for reimbursement of State expenditures. The Latino Coalition for a Healthy California (LCHC) presided over the Taskforce with assistance from DHCS's Office of Multicultural Health (OMH), who provided key information on Medi-Cal Services.

Twenty-two (22) members of the MCLAS Taskforce included internal and external stakeholders representing the OMH Council, state government, Medi-Cal providers and practitioners, and Medi-Cal limited-English proficient (LEP) consumers, and language access experts and advocates. Over 15 meetings, conference calls and workshops were conducted and three workgroups (the Delivery System, Cost & Finance, Quality & Standards and Administration) conducted review of various issues. The following principles were established to guide the work of this Taskforce:

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

Executive Summary

Medi-Cal Fee-for-Service Hybrid Model

The Taskforce recommends a hybrid Brokerage/Direct Provider Reimbursement model to finance the provision of language services within the Medi-Cal fee-for-service program. Reimbursement for languages services in the Medi-Cal Managed Care program is already negotiated between the State and the Managed Care plans. Federal funds are still available for the provision of language services for those beneficiaries not in managed care, such as those in fee-for-service.

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

Under the brokerage feature, the State will be able to contract with regional brokers for interpreter services. The broker can contract with individual interpreters, for-profit interpreting agencies, telephonic interpreting companies, community-based providers of interpreting services, and other entities to provide the actual services and assure service quality. These services will include in-person interpreter services, telephonic interpretation or video/telephone conferencing medical interpreter services. In addition, the broker can also be contacted directly by LEP beneficiaries for assistance in setting up appointments.

Under the Direct Provider Reimbursement Model, providers preferring to use their own employees to interpreter will be able to bill the state for services rendered. As with the Broker model, providers in the Direct Reimbursement model will be required to ensure that their interpreters are trained and qualified to provide healthcare interpretation.

The quality of interpreting services will be ascertained through a Quality Assurance Board of experts and advocates, to be selected by the DHCS. DHCS will also establish a 1-800 centralized complaint line into an ombudsmen's office, available in multiple languages to handle individuals concerns and complaints of LEP beneficiaries.

Pilot Project

The Taskforce is proposing that the State conduct a two-year pilot project to begin this initiative with one additional year for preparation prior to the implementation. The Taskforce is also recommending a group of 10 counties among which a hybrid model will be sufficiently tested. The pilot will explore the delivery and financing of Medi-Cal interpreter services in each model, the level of patient and provider satisfaction, and return on investment.

The State has agreed to convene a Pilot Project Workgroup that will propose a course of action.

Section 1: California Today

As one of the nation's most diverse states, California as a whole has long been recognized as being one of the most racially and linguistically represented states, home to over 200 languages. Geographically large, California's total statewide population is twice the size of the second most populous state, New York, and began its official majority minority status in 2000¹. Forty percent of people in California speak languages other than English at home with Spanish as the second most common language spoken, after English (26 percent), followed by Chinese, spoken by 2 percent of the population². Given the state's "majority minority" status, it is not surprising that approximately four out of five people who are Asian, Latino, or of another race or ethnicity in California speak non-English languages at home³. Approximately 20 percent, or one of every five Californians, is limited English proficient (LEP), identified as speaking English less than "very well"⁵.

California's Current Problem

Despite the state's existing language mix in its Medi-Cal beneficiary population, California currently does not have a comprehensive delivery or reimbursement system for language services. This particularly impacts California's fee-for-

service population who seek services from a wide range of providers with no consistent approach to the provision of language access services. As a result, the state is unable to draw down federal matching funds available for language services in Medicaid. Therefore, the Task Force's recommendations disclosed in this report focuses on the needs of Medi-Cal's FFS beneficiary population.

Research amply documents that language barriers impede access to health care, compromise quality of health care, and increase the risk of adverse health outcomes among patients with limited English proficiency. Language barriers can lead to inefficient care because clinicians are unable to elicit LEP patients' symptoms and thus, use more diagnostic resources or invasive procedures. LEP patients provided with language services make more outpatient visits, and receive and fill more prescriptions. In addition, they do not differ from non-LEP patients in test costs, have outcomes among those that have diabetes that are superior to non-LEPs, and have high level of satisfaction with their care.⁶

California's changing demographics, quality of care, cost of care, patient satisfaction as well as state and federal laws are some of the reasons for recommending a system of delivery and reimbursement of language services in Medi-Cal.

¹ 2000 U.S. Census. www.census.gov

² 2000 U.S. Census. www.census.gov

³ The term, 'majority-minority' refers to a state in which a majority of people in an area who belong to a minority group overall.

⁴ 2000 U.S. Census. Summary. www.census.gov

⁵ Language Use and English-Speaking Ability: 2000. Census 2000 Brief. October 2003. U.S. Census. www.census.gov

⁶ L. Ku and G Flores. (date) Pay Now or Pay Later: Providing Interpreter Services in Health Care

California's Diversity in its Healthcare System

Not surprisingly, this diversity is reflected both in the state's overall patient population and in Medi-Cal, the nation's largest Medicaid program. Of the more than 6.7 million Medi-Cal beneficiaries, more than 25 languages are recorded as beneficiaries' preferred language. In fact, almost half (45.2%) speak a language other than English. The top five non-English languages in Medi-Cal are Spanish (36.9%), Vietnamese (1.9%), Cantonese (1.2%), Armenian (0.9%), and Russian (0.6%).

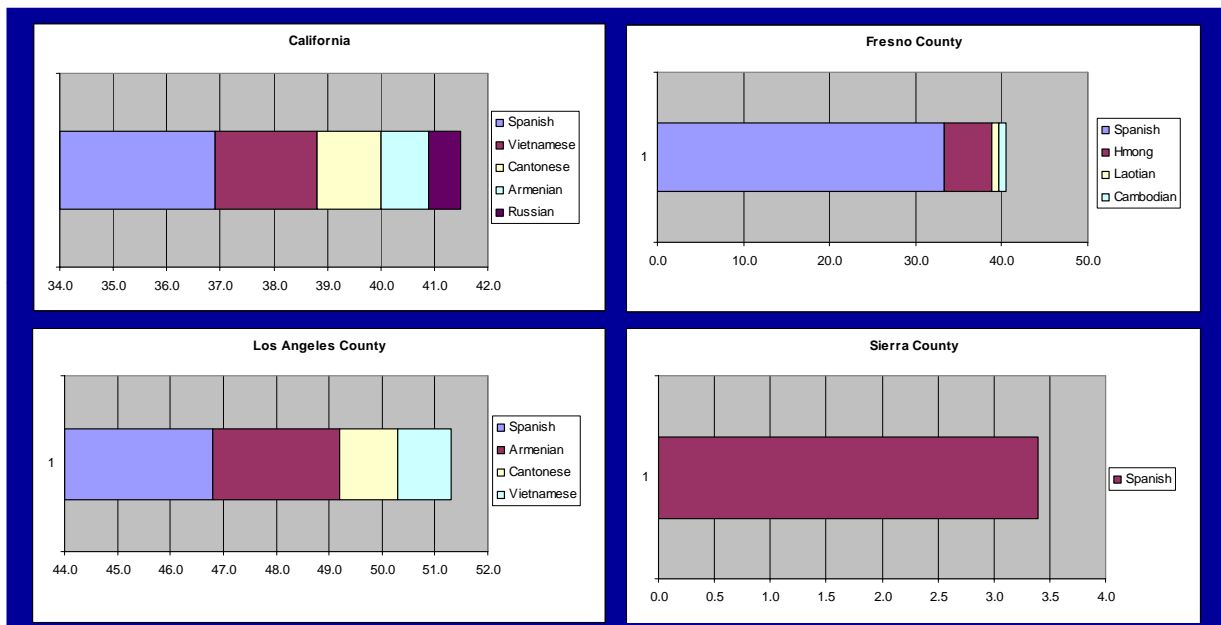
In southern California's Los Angeles County, there were 2,368,363 enrolled in Medi-Cal. 55.4% of those Medi-Cal beneficiaries spoke a language other than English. Languages spoken included Spanish (46.8%), Armenian (2.4%), Cantonese (1.1%) and Vietnamese (1.0%).

spoken included Spanish (33.3%), Hmong (5.5%), Laotian (0.9%) and Cambodian (0.8%).

In northern California's Sierra County, there were 441 enrollees and only two recorded languages among Medi-Cal beneficiaries, English (91.2%) and Spanish (3.4%).⁷ See Appendix C for additional information.

Unfortunately, the state lacks a mechanism to both track and identify whether these Medi-Cal enrollees are LEP, identified as speaking a language other than English. As a result, non-English speaking Medi-Cal enrollees, for the purposes of this report, are used as a proxy for Medi-Cal LEP beneficiaries.

Figure 1: Non-English Languages



Medi-Cal in California and the Provision of Language Services

California counties administer the Medi-Cal program through two separate systems: traditional fee-for-service (FFS) and increasingly, through Medi-Cal Managed Care (MMC). Roughly 52 percent of Medi-Cal beneficiaries (3.4 million people) receive benefits under FFS, while 48 percent (3.2 million) receive care as MMC enrollees. The state's current expansion of managed care plans in 14 counties is due to be completed in 2009 although some populations of Medi-Cal enrollees can voluntarily exempt out of managed care coverage, including the elderly, blind, and disabled. Federal Title VI (see Appendix E for more information on Title VI) applies equally to providers in both fee-for-service and managed care.

Medi-Cal Fee-for-Service

California's FFS system relies on reimbursement system where direct health services are reimbursed to Medi-Cal eligible providers who must first apply to become a Medi-Cal provider and must then bill the state once accepted by the program for services provided.

California does not currently have a mechanism for the reimbursement of language services under the fee-for-service component of Medi-Cal, with a couple of notable exceptions. In general, since there is no billing code for language services in FFS, providers are not reimbursed for the cost of providing language services.

The exceptions are safety net providers who, by virtue of their missions and patient populations, tailor their services to meet the needs of LEP

patients. These include Federally Qualified Health Centers (FQHC), which theoretically can have language services costs included in their prospective payment rate (see pages 29-30). In addition, public hospitals can receive partial reimbursement for language services by drawing down the federal portion (roughly half) of the Medicaid reimbursement (see pages 29-30).

Across the range of providers, from safety-net providers with a large proportion of Medi-Cal patients to private providers, language services are currently provided in a number of ways⁸. They range in adequacy and quality, depending on such factors as timeliness, consistency and competence. These practices include:

- Use of trained (or untrained) staff interpreters
- Use of trained (or untrained) bilingual medical or non-medical staff. This ranges, for example, from a bilingual physician (whose language competence has not likely been assessed) communicating directly with an LEP patient, to deploying clinical or non-clinical bilingual employees from other areas and departments of a hospital or clinic
- Contract interpreters, trained or untrained, either individually or through agency contract
- Contract telephonic interpreting services
- Video/telephone conferencing interpreting networks
- Use of trained or untrained volunteer interpreters

⁸ Language Access Resources, from the Proceedings of the Medical Leadership Council on Language Access. Meetings 2002-2004.

- Using a patients’ family member or friend.

A Medi-Cal provider office, clinic or hospital may utilize a variety of methods to meet both the patient and provider needs and to maximize efficiency and cost-effectiveness of language services. Reasons for such a wide range of language service delivery methods include: not having a language services system to access, wide ranges in costs and language provider availability, number and proportion of LEP patients, the mix of languages spoken, institutional culture and linguistic competence awareness, lack of standardization around training and assessment of interpreters, and, given the lack of reimbursement, the financial incentive to settle for a low-cost and perhaps lower-quality solution. Despite the obstacles, a number of facilities, either alone or in affiliation, have pursued effective, innovative approaches to delivering adequate language services to Medi-Cal patients even with the absence of financial support.

In general, it is difficult to assess the level and quality of language services being provided to Medi-Cal patients in both MMC and FFS. This is due in part to the lack of a language access services system, lack of direct reimbursement in FFS and potential lack of sufficient reimbursement in MMC, limited data on the actual number of LEP Medi-Cal beneficiaries and lack of a tracking mechanism in the state’s healthcare delivery system.

Medi-Cal Managed Care

Under MMC, the Department of Health Care Services’ Medi-Cal contracts require all participating health plans to ensure compliance with Title VI of the Civil Right Act of 1964, which

prohibits federal fund recipients from discriminating against persons based on race, color, or national origin.⁹ Medi-Cal managed care contractors must also follow cultural and linguistic competency requirements outlined in the contract and a series of policy letters issued by the department. All Medi-Cal Managed Care “plans must develop and implement policies and procedures for ensuring access to interpreter services for all LEP members.”¹⁰

The contract specifically requires Medi-Cal Managed Care plans to:

- Ensure equal access to health care services for LEP Medi-Cal members through the provision of high quality interpreter and linguistic services
- Provide no cost, twenty-four hour access to interpreter services for all monolingual, non-English-speaking, or LEP Medi-Cal beneficiaries at all key points of contact either through interpreters or telephone language services
- Provide that oral interpreters or bilingual providers or provider staff in all languages spoken by Medi-Cal beneficiaries are made available and not limited to those languages that meet the numeric threshold or concentration standards which only apply to written translations
- Provide referrals to culturally and linguistically (C&L) appropriate community service programs
- Monitor, evaluate, and take effective action to address any needed improvement

⁹ Medi-Cal Managed Care Division (MMCD), Boilerplate Agreement Between DHCS and Contractor, Exhibit A, Attachment 9, *Access & Availability*, at §11 (June 2003).

¹⁰ MMCD Policy Letter 99-03

in the delivery of C&L appropriate services and implement a written description of its Cultural and Linguistic Services Program

- Conduct a group needs assessment of its members every three years, and review and update their cultural and linguistic services
- Assess, identify and report the language capability of interpreters or staff (clinical and non-clinical)
- Implement and maintain standards and performance requirements for the delivery of C&L appropriate health care services

The Department of Health Care Services has affirmed that the administrative cost portion of rates will reflect those costs within reason. The Taskforce members acknowledge that there may be a perceived question as to whether adequate payment flows downstream to a plan's contracted providers or the degree to which downstream providers are actually providing language services or utilizing health plan-provided language services to ensure language access for LEP enrollees.

Section 2: Understanding Language Services

On August 31, 2000, shortly after Executive Order #13166 was released, the Centers for Medicare and Medicaid (CMS) sent a letter to state Medicaid directors to remind states that federal Medicaid and State Children's Health Insurance Program funds could be used to pay for language assistance activities and services.¹¹ It further explained that federal reimbursement was available for expenditures of language services, including oral and written translation services, whether provided by staff interpreters, contract interpreters or a telephone interpretation service.

Reimbursement of Language Services

There are only a handful of states – 13 and the District of Columbia – that are taking advantage of these federal dollars and have established mechanisms to obtain partial reimbursement for language services in their Medicaid programs (See Appendix H)¹². They include: District of Columbia, Hawaii, Idaho, Kansas, Maine, Massachusetts,¹³ Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Wyoming and Washington. There are currently several

states across the country that have pilot projects or are developing federal reimbursement mechanisms to pay for language services in their Medicaid programs. Connecticut recently passed legislation requiring the Commissioner of Social Services to amend its State Plan amendment to include foreign language services as a covered service under its Medicaid program, but has not yet developed its reimbursement system.¹⁴ Texas has established a pilot project involving five hospital districts but has not yet implemented actual reimbursement to the providers and is negotiating terms with the CMS.¹⁵ North Carolina is planning to seek federal reimbursement to pay for language services after it establishes a credentialing program for its interpreters.¹⁶ New York also re-introduced legislation in 2008 to provide funding for a reimbursement system for providers, similar to a bill that almost passed the state Legislature in 2007.¹⁷

Based on existing reimbursement models, states can draw down the federal match in the following ways:¹⁸

¹¹ CMS letter available at: <http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf>.

¹² Chart current as of March 2007.

¹³ Although Massachusetts (MA) has established a reimbursement mechanism and has sought federal matching funds in the past, it currently does not reimburse providers due to budget constraints. See *Action Kit Update* at 15-16. (Because MA is not receiving federal matching funds, it has been taken off the NHeLP *Current Reimbursement Chart*).

¹⁴ SB 1484, CT Public Act No. 07-185 (July 1, 2007).

¹⁵ Texas Human Resources Code Ann. § 32.068; SB 376 (March 17, 2005 (Senate) & May 9, 2005(House)).

¹⁶ *Action Kit Update* at 13-14.

¹⁷ SB 7059 (March 5, 2008)

¹⁸ See National Health Law Program & the Access Project, *Language Services Action Kit* (2003)(hereinafter “*Action Kit*”), available at: <http://www.healthlaw.org/library/folder.71337>; see also March 2007 Reimbursement Update (hereinafter “*Action Kit Update*”) available at: <http://www.healthlaw.org/library/item.142454>.

There are advantages and disadvantages to each method. For example, some states seek reimbursement as a “covered service” to

- States can get federal reimbursement for “covered services” provided to Medicaid beneficiaries and get paid for the cost of the service; possibly by billing for language services as part of another medical service or raising the base rate accordingly.
- States can obtain federal funds to pay for the costs associated with the administration of the program and bill the costs as an administrative expense.
- States can get federal funding for payments made to “disproportionate share hospitals,” those that serve a disproportionate share of Medicaid and uninsured patients.

Under these models, states can determine which providers it will reimburse, such as hospitals, community health centers, managed care plans, physicians, etc. Most states have focused reimbursement to fee-for-service providers, though some also cover managed care plans. Some states currently set their reimbursement rates for hospitals, clinics, and managed care organizations to include the costs of language services as part of these entities’ overhead costs or capitated rate. But a state could also choose to

obtain a higher federal “matching” rate because states have different matching rates, ranging from 50-83%. However, in order to obtain reimbursement as a covered service, the state must seek CMS approval and submit a state plan amendment to CMS. On the other hand, it is easier to seek reimbursement for language services as an administrative expense because it does not require CMS approval and can be implemented by establishing a billing code for language assistance services. As noted in the NHeLP chart, those states claiming reimbursement as a service expense receive a higher federal match (Hawaii, Idaho, Maine, and Utah). For California, the rate for a covered service is the same reimbursement rate as an administrative expense, 50%. Finally, reimbursement for DSH providers is limited to certain hospitals. *Action Kit* at 15-18.

allow all providers to be reimbursed for most language services.

The Legal Basis for Provision of Language Services

The provision of language services in healthcare settings is overseen by both federal and state laws, regulations and statutes. Federal laws related to language services include Title VI under the Title VI of the Civil Rights Act of 1964, as well as federal Executive Order #13166 issued in 2000, Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the U.S. Department Office of Minority Health. Additionally, the U.S. Department of Health and Human Services (HHS) regulations¹⁹ requires all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons.

State laws on language services include CA Government Code §11135-11139, the Dymally-Alatorre Bilingual Services Act of 1973 as well as the Kopp Act of 1983. As a result of federal laws, some states have opted to reimburse language services using various types of reimbursement models.

Federal and State Laws and Statutes and its Impact on Existing Law

While relevant federal and state laws are disclosed below, it should be clear that the establishment of the proposed reimbursement mechanism for the state to receive federal matching funds to pay for language services

¹⁹ [45 CFR 80.3\(b\)\(2\)](#).

provided to Medi-Cal beneficiaries will not have any effect on existing law.

Although the reimbursement mechanism would only allow for payment to Medi-Cal fee-for-service providers under the current recommendations, it is hoped that payment for language services by DHCS will encourage third party payers to pay for such services in the future, especially given that all health care services plans and health insurers in the state must establish “Language Assistance Programs” pursuant to SB 853.²⁰

Federal Laws and Statutes on Language Services

Title VI, Civil Rights Act of 1964:

Title VI states that, “No person in the United States shall, on the 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.”²¹

Passed by Congress in order to ensure that federal assistance programs did not discriminate on the basis of race, color, or national origin,²² Title VI has been consistently interpreted by the Courts and the agencies charged with its enforcement to require the provision of language services. In 1974, for example, the United States Supreme Court in Lau v. Nichols held that the

²⁰ See Cal. Code Regs. tit. 28, §§ 1300.67.04 & 1300.67.8 (health care service plans) ; Cal. Ins. Code § 10133.8 & Cal. Code Regs. tit. 10, §§ 2538.1-2538.8 (health insurers).

²¹ 42 U.S.C. § 2000d.

²² 110 Cong. Rec. 1658 (1964).

San Francisco School District violated Title VI by failing to take affirmative steps to assist LEP Chinese students.²³ The Supreme Court found:

“[T]here is no equality of treatment merely by providing students with the same facilities, textbooks, teachers and curriculum; for students who do not understand English are effectively foreclosed from any meaningful education.

[It is] obvious that the Chinese-speaking minority receive fewer benefits than the English speaking majority . . . which denies them a meaningful opportunity to participate in the educational program – all earmarks of the discrimination banned by the [Title VI] regulations.²⁴

Executive Order #13166:

On August 11, 2000, Executive Order 13166 titled "Improving Access to Services for Persons with Limited English Proficiency" was issued.²⁵ Executive Order 13166 requires Federal agencies to examine the services they provide, identify any need or services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so that LEP persons can have meaningful access to them.²⁶ Under that order, every federal agency that provides financial assistance to non-federal entities must publish guidance on how their recipients can provide meaningful access to LEP persons and thus

²³ Lau v. Nichols, 414 U.S. 563 (1974).

²⁴ Id. at pp. 566-568.

²⁵ 65 Fed. Reg. 50121 (August 16, 2000).

²⁶ See <http://www.lep.gov/13166/eo13166.html>.

comply with Title VI regulations. The order forbids funding recipients from "restrict[ing] an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program" or from "utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect [to] individuals of a particular race, color, or national origin."²⁷

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons:

As the lead Title VI enforcement agency within the U.S Department of Health and Human Services, the Office for Civil Rights (“OCR”) has issued a series of guidelines to assist federal fund recipients with complying with the law.²⁸ Its most recent revised guidance, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (“Revised OCR LEP Guidance”) was published on August 8, 2003. OCR is responsible for investigating and resolving complaints, conducting compliance reviews, and providing technical assistance. The Revised OCR LEP Guidance made clear that it

²⁷ 45 C.F.R. 80.3(b)(2).

²⁸ 68 Fed. Reg. 47311-23. OCR became the first federal agency to issue guidance for its federal fund recipients but later issued a revised guidance to comply with the Department of Justice’s General Policy Guidance. (65 Fed. Reg. 50123 (Aug. 16, 2000).

did not create new obligations but, rather, clarified existing Title VI responsibilities. The Guidance states the following:

As mentioned previously, the U.S. Department of Health and Human Services regulations²⁹ require all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. 45 CFR 80.3(b)(2).

Recipients of HHS assistance may include, for example:

- Hospitals, nursing homes, home health agencies, and managed care organizations.
- Universities and other entities with health or social service research programs.
- State, county, and local health agencies.
- State Medicaid agencies.
- State, county and local welfare agencies.
- Programs for families, youth, and children.
- Head Start programs.
- Public and private contractors, subcontractors and vendors.
- Physicians and other providers who receive Federal financial assistance from HHS.

The Revised OCR LEP Guidance explains that federal fund recipients take reasonable steps to ensure that LEP persons have meaningful access to programs and activities. However, what

²⁹ [45 CFR 80.3\(b\)\(2\)](#).

constitutes appropriate language services depends on the factual situation or the totality of the circumstances.³⁰ The factors that OCR weighs include:

- The number or proportion of LEP persons eligible or likely to be served, directly affected, or encountered by the program, using program-specific data along with census, school, state and local, and community-based data from the relevant service area
- The frequency with which LEP persons come into contact with the program, activity or service
- The nature and importance of the program or service to beneficiaries
- The resources available to the fund recipients and costs³¹

Federal Medicaid Managed Care:

Each contract must comply with Title VI of the Civil Rights Act, requiring oral interpretation for all and written translation for all “prevalent” languages.³²

CLAS Standards, U.S. Office of Minority Health:

On December 22, 2000, following a lengthy period of public comment and collaboration, the Office of Minority Health of the U.S. Department of Health and Human Services

released its National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.³³ The standards are “proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers.”³⁴ CLAS is comprised of a total of 14 standards that include mandates, guidelines and recommendations based on Title VI, such as: culturally competent care, language services, (including bilingual staff and interpreter services) and organizational support for cultural competence. The following four mandates relate to language services and are based on Title VI Healthcare organizations:

- Must offer and provide assistance with language services at no cost to the LEP patient at all points of contact in a timely manner during all hours of operation
- Must provide verbal offers and written notice to LEP patients in their preferred language of their right to receive language services
- Must assure the competence of interpreters—no family or members or friends should be used as interpreters
- Must make available easily understood patient-related materials and post signage in the most common languages of groups in the service area.³⁵

³⁰ 68 Fed. Reg. at 47315.

³¹ 68 Fed. Reg. at 47314-15.

³² 42 code of Federal Regulations Part 438.109(c), 67 Federal Register 40989 (2002)

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

³⁴ 65 Fed. Reg. at 80873.

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

California Laws and Statutes on Language Services

California Civil Rights Statute, CA Government Code §11135-11139:

The statute prohibits discrimination based on race, national origin, ethnic group identification or color, religion, age, sex, or disability by “any program or activity that is conducted, operated or administered by the state or any state agency directly or receives any financial assistance from the state.”³⁶ The regulations define the term, “ethnic group identification” to mean “the possession of the racial, cultural or linguistic characteristics common to a racial, cultural, or ethnic group or the country or ethnic group from which the person or his or her forebears originated.”³⁷ Federal regulations also state that it is a prohibited discriminatory practice “to fail to take appropriate steps to ensure that alternative communication services are available to ultimate beneficiaries, except where the State agency determines that such a requirement would place an undue hardship on the recipient.”

Dymally-Alatorre Bilingual Services Act of 1973:

California Government Code § 7290, known as the Dymally-Alatorre Bilingual Services Act (Dymally), requires that state and local agencies provide bilingual services to non-English-speaking persons. It recognized that “[t]he effective maintenance and development of a free and democratic society depends on the right and ability of citizens and residents to communicate

³⁶ CA Govt. Code § 11135, 11139; 22 CCR § 98000 et seq

³⁷ Cal. Code Regs. Tit. 22 § 98210(b).

with their government.”³⁸ Dymally-Alatorre specifically states that every state and local agency which is directly involved in providing services to a “substantial number” of non-English-speaking people must employ a sufficient number of qualified bilingual persons in public contact positions to ensure that information and services are provided in the language of the non-English-speaking individuals.³⁹ For a state agency, a “substantial number” is defined as five percent or more of the population served by the state and for local agencies they may determine what constitutes a “substantial number” of non-English-speaking people.⁴⁰ It also mandates the translation of any materials that explain state and local services and any notices about translated materials into any language that triggers the five per cent threshold and distribution of those materials.⁴¹

Kopp Act of 1983:

The Kopp Act provides that where communication barriers exist, interpreters or bilingual staff must be provided to ensure “adequate and speedy communication between

³⁸ CA Gov’t Code § 7291.

³⁹ A “sufficient number” of qualified bilingual persons is defined as the number required to provide the same level of services for non-English-speaking persons as is available for English-speaking individuals. Cal. Gov’t. Code § 7296.4

⁴⁰ 40 65 Fed. Reg. at 80873.

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

⁴⁰ CA Govt. Code § 11135, 11139; 22 CCR § 98000 et seq

⁴⁰ Cal. Code Regs. Tit. 22 § 98210(b).

⁴⁰ CA Gov’t Code § 7291.

⁴⁰ A “sufficient number” of qualified bilingual persons is defined as the number required to provide the same level of services for non-English-speaking persons as is available for English-speaking individuals. Cal. Gov’t. Code § 7296.4

Cal. Gov’t. Code §§ 7296.2 & 7293.

⁴¹ Cal. Gov’t. Code § 7295.2 & *Id.* § 7295.4

patients and staff.”⁴² This law affects all general acute care hospitals.⁴³ In order to assure access to health care information and services for LEP residents, all acute care hospitals must:

- Provide, to the extent possible, language services 24 hours a day for language groups that comprise five percent or more of the facility’s geographic service area or actual patient population
- Develop policies on the provision of interpreter services to LEP patients and review these policies annually
- Post multilingual notices that advise patients and their families of the availability of interpreters, how to obtain an interpreter, and how to make complaints to state authorities
- Notify their employees of their commitment to provide interpreters to all patients who request them
- Prepare and maintain a list of qualified interpreters
- Identify and record their patients’ primary languages in hospital records⁴⁴
- Consider providing non-bilingual staff with picture and phrase sheets to facilitate communication with LEP patients
- Consider establishing community liaison groups to enable LEP communities to ensure the adequacy of interpreter services.⁴⁵

⁴² Cal. Health & Safety Code § 1259(a)

⁴³ California Health & Safety Code § 1259.

⁴⁴ See also Cal. Health & Safety Code § 123147 (requires all health care facilities and all primary care clinics to include the patient’s principal spoken language on his/her health records)(2005).

⁴⁵ Cal. Health & Safety Code § 1259(c)(1)-(9). Interpreter is defined as “a person fluent in English and in the necessary second

language, who can accurately speak, read, and readily interpret the necessary second language,” but who has “the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages.” Cal. Health & Safety Code § 1259(b)(1).

Section 3: What Other States Are Doing

There are four reimbursement models that 13 states and the District of Columbia use to deliver language services and receive reimbursement for those services, with some overlap among them, including:

- Use of telephonic language lines: Kansas⁴⁶
- Direct reimbursement of interpreters: Montana, New Hampshire, and Wyoming
- Direct reimbursement of providers for hiring interpreters: Idaho, Massachusetts, Maine, and Minnesota
- Contracting with language services brokers and/or agencies: DC, Hawaii, Utah & Vermont reimburse language or interpreter agencies directly.⁴⁷ Other states, such as Virginia & Washington use brokers to arrange services and submit billing information to the state Medicaid agency for reimbursement

⁴⁶ Although other states also reimburse for telephone interpreter services, Kansas is the only state that limits its reimbursement to telephonic interpreter services.

⁴⁷ Vermont actually allows providers to hire any interpreter but services are primarily provided by one language agency, which has a contract with the state Agency for Health Services. However, the provider must make its own arrangements with the language services agency. Although the language agency has a statewide telephonic interpretation contract to provide interpreters in rural areas, providers who use the telephonic interpreters cannot submit claims for reimbursement. *Action Kit Update* at 10.

Telephonic Interpreter Reimbursement Model

As noted above, some states allow reimbursement for both telephone and in-person interpreter services but Kansas is the only state that reimburses solely for telephonic interpreter services provided by its two telephonic interpreter organizations.⁴⁸ Under this type of delivery system, the state contracts directly with telephonic language services that are reimbursed on a per-minute rate. This reimbursement model only allows use for telephonic interpretation and does not include any other type of reimbursement. Kansas currently is the only state that uses a purely telephonic-interpretation reimbursement model.

Some of the recognized positive aspects of telephonic-only interpretation model include:

- Requires the least amount of infrastructure of the four reimbursement models
- Minimal wait times to access interpreter

Some of the challenging aspects of a telephonic-only interpretation model include:

- Lack of facial and physical patient cues may lead to further miscommunication
- ‘Less satisfaction’ factor perceived by patients

⁴⁸ Providers are given the 1-800 number to call the Managed Care Enrollment Center, which connects the provider with the telephone interpreter. The state uses two language companies, one for Spanish and one for the other languages, and contracts with EDS to administer the program. *Action Kit Update* at 5-6.

- Limitations experienced in one person speaking at one time
- Can potentially prove more expensive than other forms of interpretation if the medical encounter is extensive, given the per-minute rate payment
- Telephonic interpreters may often be employed by national companies and may not necessarily be medically trained for proper interpretation
- While individual companies may provide training for telephonic interpreter, it is unclear how consistent the level of quality standards may be across companies

While use of telephonic interpretation may be of particular benefit to rural areas or areas where language services may be infrequently used, reimbursement of language services should not be restricted to the sole use of telephone interpreters as in-person interpreters can often be more effective and may be more cost-efficient in instances of medically-complex encounters, particularly if the use of an interpreter requires more than a few minutes.⁴⁹

Direct Interpreter Reimbursement Model

Three states, Montana, New Hampshire, and Wyoming provide direct reimbursement to interpreters. In this model, the state contracts directly with interpreters who must invoice the state for payment once language services are rendered.

⁴⁹ Rural areas, largely due to the geographic size or the lack of available local healthcare interpreters who might be able to conduct in-person interpretation impacts both time and cost.

Some of the recognized positive aspects of a direct interpreter reimbursement model include:

- Eligible Medicaid beneficiaries and eligible interpreters may work together to ensure that services are provided
- Allows an informal method of assuring quality as beneficiaries can continue to ask specific interpreters for their assistance

Some of the challenging aspects of a direct interpreter reimbursement model include:

- Requires an active part of the state in both developing and maintaining a system of interpreters that are accepted and eligible for reimbursement
- Requires a separate billing and reimbursement system for interpreters, in addition to those reimbursements given to providers already in the Medicaid program
- Often recognized as burdensome for interpreters in both applying to become eligible, maintaining that eligibility and invoicing for services already provided
- May create little to no incentive(s) for interpreters, due to administrative burdens
- Lack of formal mechanism to assure the quality of interpretation if no quality standards are required

Due to the administrative burdens placed on interpreters both by requiring them to become Medicaid providers and to process paperwork for reimbursement, the direct contracting reimbursement model may not be ideal for California. For example, New Hampshire requires each interpreter (whether he or she works for an organization that coordinates

services or not), to submit paperwork for reimbursement and to wait for reimbursement of services, often for substantial periods of time. Although Montana requires that the interpreter and provider attest that the interpreter is qualified to provide medical interpretation, none of the states have any certification requirement, and therefore lack an adequate mechanism to assure the quality of interpreters.

Direct Provider Reimbursement Model

In a few states, including Idaho, Maine, Massachusetts,⁵⁰ and Minnesota, the state directly reimburses the provider for the provision of interpretation services. Providers, including physicians, are responsible for identifying and arranging appropriate services, paying for the interpretation services, and submitting claims for reimbursement.⁵¹ Providers bill the state for the service in the same way they would bill for a medical visit, but can then utilize a state-established billing code to receive reimbursement for the service.⁵² California also has a limited example where the state has a billing code for Medi-Cal providers with 15 or fewer employees to receive reimbursement for sign language interpreters.

⁵⁰ Discussion of Massachusetts is excluded because it does not currently reimburse for language assistance services.

⁵¹ In Minnesota, the physician can only bill for interpreter services offered in conjunction with an otherwise covered service. For example, the physician can bill for the entire time the LEP patient spends with the physician or provider but not for appointment scheduling or translation of materials. *Action Kit Update* at 7.

⁵² Maine's providers are encouraged to use local and more cost-effective resources first, and telephone services only as a last resort. They are also required to include a statement of verification in the patient's record of documenting the date and time of services, its duration, and cost. *Action Kit Update* at 6-7.

Some of the recognized positive aspects of direct provider reimbursement include:

- Continued support of provider models already in place and easy implementation by building upon existing reimbursement models
- Medi-Cal providers who have proactively taken steps to recruit and hire bilingual staff, create relationships with interpreters, etc should be allowed to continue using the method that works for their practice
- Medi-Cal beneficiaries would benefit from having a regular interpreter at their provider's office with whom they could develop a relationship
- The California Department of Health Care Services would be able to reimburse providers using existing methods that have been established for other health care services

Some of the challenges associated with direct provider reimbursement includes:

- Providers who do not have the capacity or infrastructure to provide interpreter services and do not serve enough LEP patients cannot sustain a staff interpreter
- Some providers may serve such a wide diversity of languages and will have difficulty securing qualified interpreters for all the languages, especially those languages which are less widely spoken
- Providers may access language assistance services that are easiest to obtain with no assurance of the quality of the interpretation.

Language Services Agency/Broker Reimbursement Model

One of the models adopted by several states involves a system where the state contracts with language service agencies to arrange interpretation services for LEP Medicaid beneficiaries requested by Medi-Cal providers. In some instances, such as Hawaii and Utah, these language agencies are non-profit organizations whose missions focus on providing language services to LEP patients. The states that contract with language agencies are; Hawaii, Utah, Vermont as well as the city of Washington D.C. Language agencies, under this model, both schedule and provide the interpreter services.⁵³ One state, Washington, originally utilized language agencies for the provision of its language services but has since transitioned to a broker system. The broker system continues to utilize contracted language agencies but it is now the broker that contracts with the state in lieu of individual language agencies.

The State of Washington's Model

The state of Washington has one of the longest histories of providing language services for Medicaid recipients. A broker under this reimbursement model acts as a third-party responsible for the oversight and coordination of language service encounters. Washington decided to require its eight (originally nine)

⁵³ DC contracts with one language agency for in-person interpretation and pays for a telephone language line for FFS providers with less than 15 employees. Hawaii contracts with two language service organizations to provide interpreters for FFS Medicaid and SCHIP beneficiaries. Utah contracts with four language service organizations that provide both in-person and telephonic interpreter services. *Action Kit Update* at 4-5, 9-10.

regional transportation brokers to assume responsibility for providing interpreter services based on maintaining their transportation contracts. The state pays an administrative fee to the broker who in turn pays the language agencies, based on a negotiated amount included in their contract.⁵⁴ The regional brokers are responsible for filling interpretation requests from Medicaid providers, billing the state for the services, and paying the interpreters who are utilized.⁵⁵ The state of Washington is the only state nationally that utilizes a regional broker model.

Both language agencies and brokers provide the state with increased control over quality standards for interpreter services by ensuring the quality of their interpreters over that of other reimbursement models.

Some challenges associated with the language services agency/broker system over the language agency model are the following:

⁵⁴ For non-public entities, the providers call the broker to schedule interpreters. Once the services are provided, the language agency bills the broker for the services rendered and the broker submits the claim to the state agency. The language services must be provided in conjunction with a covered medical service and the claim form requires the name of the physician, and the diagnosis or nature of the injury. The administrative fee is set at 10% of total costs. For public hospitals and health departments, there is a separate reimbursement system that allows the local facilities to act as the state for purposes of meeting the state 50% match through the use of inter-local or intergovernmental agreements (IGA). The local facilities receive reimbursement for both direct and indirect interpreter expenses. *Action Kit Update* at 11-12

⁵⁵ Virginia established a pilot project with Virginia Commonwealth University and The Northern Virginia Area Health Education Centers program (AHEC) and three health departments. AHEC acts as the broker and receives calls from recipients requesting language services, schedules services, and submits claims to the state Medicaid agency. *Action Kit Update* at 10-11.

- The broker model is not designed to support the development of on-site interpreter services in health care institutions. Using a broker does not encourage health care institutions to increase their ability to provide interpreter services through increased numbers of bilingual staff and bilingual providers
- Unlike Washington State, a broker system currently does not already exist in California and would need to be created with a certain level of funding to cover costs associated with this new infrastructure
- Adding an additional layer of administrative bureaucracy may increase costs and create an additional barrier to language assistance services for LEP Medi-Cal beneficiaries

Although it is unclear whether the language services agency model or the broker model provides better access to language services, some of the recognized positive aspects of the broker system over the language agency model include:

- Having a single point of contact for providers, increased coordination, and potential for higher quality at lower cost
- Medi-Cal providers can utilize the brokers if they are not in the position to hire staff or arrange for interpreter services on their own and do not want additional administrative burdens
- It may be easier for health care providers to access interpretation in a wide variety of languages according to their geographic region if they can

simply call one entity rather than locate a language agency in their area

- The California Department of Health Care Services (DHCS) would be able to provide this benefit without the need for direct involvement in actual services provided through direct contract with a few major entities responsible for delivery of language services in the Medi-Cal fee-for-service network, rather than contacting with many language agencies across the state. These efficiencies and negotiation leverage could produce cost savings.
- Brokers may reduce Medicaid fraud by language agencies and/or interpreters by ensuring that multiple payment are not processed for one encounter and by ensuring that interpreters do not directly solicit beneficiaries for arrangement of language services
- A broker system may provide the state with a consolidated method to ensure oversight in the quality of language services provided

Washington State and Language Certification

The state of Washington is also the only state that has a developed system for certifying interpreters to provide service in the state's Medicaid program. The Language Testing and Certification (LTC) program under the Division of Administrative Services certifies interpreters in the eight most prevalent non-English languages: Cambodian, Chinese-Cantonese, Chinese-Mandarin, Korean, Laotian, Russian, Spanish and Vietnamese. Interpreters who work in rarer languages can be "qualified" for the Medicaid program through a less comprehensive

assessment process. Currently there are 83 of these ‘non-certificated’ language interpreters.

Tests for languages are given 10 times per year in 6 established testing sites throughout the state. Interpreter examinations are given in both written and oral formats with a separate test (written) given to translators. Under this system, certified status is granted to state bilingual employees, interpreters, and translators once they pass the required examinations. The state also requires that all staff serving in a bilingual capacity and interpreters and translators providing bilingual services to state clients under contract, are required to obtain certification status by successfully passing a bilingual fluency test. No bilingual duties are assigned to any staff and no interpreter service is assigned under the regional broker system, to any contractor that does not exhibit proper certification or authorization.⁵⁶

More recently, other states have begun developing their own healthcare interpreter certification standards. In 2006, in response to a legislative mandate, the Oregon Office of Multicultural Health released Standards for Registration, Qualification and Certification of Health Care Interpreters. Similarly, the Indiana legislature has charged an independent commission with developing standards for training and practice for health interpreters and translators. North Carolina’s Department of Health and Human Services is working with the Center for New North Carolinians to develop

credentialing for interpreters as a pre-condition for initiating Medicaid reimbursement.⁵⁷

Assessing the Various Reimbursement Models

As presented in the above section, implementation of any of the above described reimbursement models have both positive aspects and challenges to either the delivery or implementation of that type of reimbursement model. While the Taskforce recognized the need to review and assess the various reimbursement models, it was also acknowledged that little-to-no information currently exists to document why certain states adopted the use of one particular reimbursement model over other types of reimbursement models.

In some instances, such as the state of Washington, the adoption of a reimbursement model for the provision of language services resulted from a complaint filed with the U.S. Office of Civil Rights (OCR). In fact, Washington State’s initial provision of language services resulted from an OCR complaint originally filed in 1981. Other states having provided language services as a result of OCR complaints include the state of Hawaii and Montana. North Carolina, however, entered into a ‘voluntary compliance agreement’ with the U.S Department of Health and Human Services and the North Carolina Department of Health and Human Services.

⁵⁶ Professional Language Certification, Examination Manual. State of Washington, Department of Social and Health Services (DSHS). Update November 2007. <http://www1.dshs.wa.gov/word/MS/ltc/200711ExamManualWebVersion.doc>

⁵⁷ The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond. Alice Hm Chen, Mara K. Youdelman and Jamie Brooks. Journal of General Internal Medicine. Available: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2150609>. Accessed May 22, 2008.

Section 4: Recommendations

Based on the diversity and geography of California's provider and patient population, and consideration of various state models of language services provision, the Taskforce recommends a combination of two delivery systems as previously denoted resulting in a new hybrid delivery system. As such, the Taskforce recommends a delivery system that focuses on providing services to Medi-Cal fee-for-service population using two different service reimbursement models, the Language Services Broker System and the Direct Provider Reimbursement models. Under this recommended hybrid delivery system, Medi-Cal providers may choose to use either or both of these options. For example, a hospital may bill the state directly for the cost of providing interpreter services on the inpatient side, but utilize a broker for interpreter services in its outpatient clinics.

Hybrid Model

1) Language Services Broker System

The Taskforce proposes that California establish contracts with various qualified brokers (for review of criteria for qualified broker, see Appendix I.1) who would be responsible for arranging interpretation services for any Medi-Cal fee-for-service beneficiary in a specified geographic service area. The Medi-Cal provider would contact the broker to schedule an interpreter for a Medi-Cal beneficiary visit, and the broker would make the arrangements for getting a face-to-face, phone, or video/telephone conferencing interpreter to the visit. See Appendix I.1 for a visual interpretation.

Although Medi-Cal providers would have primary contact with the broker for requesting an interpreter through the broker system, Medi-Cal beneficiaries would be allowed to contact the broker to request assistance with scheduling appointments. The recommendation would also authorize Medi-Cal beneficiaries to contact brokers and request language services in instances where they have experienced barriers to either requesting or scheduling appointment due to the lack of the Medi-Cal provider's ability to communicate with them.

MCLAS members cited anecdotal situations where LEP Medi-Cal beneficiaries have faced barriers to scheduling appointments because of the lack of Medi-Cal provider bilingual staff who could communicate with them. Therefore, the Taskforce felt it was critical for LEP Medi-Cal beneficiaries to interact with the broker in these types of situations.

Defining Regions under California's Broker System

The Taskforce recommends that the California Department of Health Care Services (DHCS) shall define the geographic regions for broker coverage and develop a Request for Proposals (RFP) process for selecting brokers. As part of the development of this process, DHCS shall strive to utilize the criteria outlined by the Taskforce in Appendix I.1. As recommended by the Taskforce, brokers will be responsible for the coordination of language service and for verifying the eligibility of Medi-Cal beneficiaries by incoming requests from the provider or patients. Additionally, brokers must

demonstrate the capacity to fulfill services and responsibilities for a particular region, in areas such as language availability, quality, timeliness, and administration (Please see Appendix I.1 for more information). Any entity meeting the criteria set by the state to be a broker shall be eligible to apply.

Additionally, as one of its primary principles, the Taskforce recognizes that effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans. This includes the provision of services for all patients regardless of their geographic location. The goal of this principle is to provide the same level of service to all Medi-Cal beneficiaries and would also encourage the state to take all the geographic areas into consideration when designating the state's regions under the broker system.

The regional broker would receive a predetermined administrative fee to manage its overall services, to be negotiated with DHCS, as well as a per encounter fee for administering the interpreter encounters.⁵⁸ Under the broker system, neither providers nor interpreters would be reimbursed directly by the state. Instead, brokers would be paid directly by the state for these services and, in turn, the broker would be

⁵⁸ States can draw down federal funds at either their administrative match rate (50%), paying for the costs of administering the program or as a "covered service" match rate (50-77% for Medicaid, 65-84% for SCHIP), paying for the cost of a service, such as a doctor's office visit or a hospital stay. The final type of funding depends on the method in which language services are provided. Language Services Action Kit. NHeLP. <http://www.healthlaw.org/langaccess/resources.html#nhelp>.

responsible for payments to its network of language agencies. In-person, telephone and video/telephone conferencing medical interpretation (VMI) services provided by the broker would be reimbursed. See Appendix I.2 for additional information.

2) Direct Provider Reimbursement

The Taskforce also proposes that direct provider reimbursement be made available to Medi-Cal providers who use bilingual providers, bilingual staff, interpreter staff or other types of arrangements to provide language services for Medi-Cal fee-for-service beneficiaries. Under this component of the reimbursement model, Medi-Cal providers would receive reimbursement from the state for the provision of these services, using an existing framework that has been established for other health care services.

All Medi-Cal providers could be eligible for direct reimbursement for the language services provided through their own arrangements to a Medi-Cal fee-for-service patient. However, given the complexity of the Medi-Cal financing system, Medi-Cal providers may be paid using different approaches. The following are suggested approaches (rather than a comprehensive list) and does not preclude a Medi-Cal provider from utilizing other approaches:

Providers Using Billing Code Method

There are a variety of provider types that use a billing code method for getting reimbursed in the Medi-Cal fee-for-service program. While not an exhaustive list, examples include physicians, dentists, pharmacists, chiropractors, optometrists, podiatrists, physical therapists,

family therapists, and nurse practitioners. For the provider types that use a billing code method, a mechanism for reimbursement could be modeled after existing methods for reimbursing a physician office visit. Currently, there are 6 different billing codes for a Medi-Cal physician office visit based on the severity of the health condition. Similarly, the state could establish several different language services billing codes, based on the complexity of the case, and develop a mechanism for certifying eligible expenses. Providers would then use their existing method of billing to bill for language services that are provided through their arrangements.⁵⁹

Although technical approval by CMS would be required, DHCS can add the billing code and estimated expenses as part of its annual Medicaid application submitted to CMS each November. California would also have to demonstrate to CMS that it has budgeted for the non-federal share of the new language services expenses. No state legislation or other state regulatory authorization is required.⁶⁰

Contracted interpreters, staff interpreters, bilingual providers, bilingual personnel, telephone and video/telephone conferencing medical interpretation (VMI) services would be reimbursed.⁶¹ See Appendix I.2 for additional information.

⁵⁹ Note: California currently has created a billing code for American Sign Language (ASL) interpretation services provided to Medi-Cal beneficiaries for certain types of Medi-Cal providers.

⁶⁰ The California Endowment. (2003) Improving Access to Health Care for Limited English Proficient Health Care Consumers: Options for Federal Funding for Language Assistance Services. Volume 2, Issue 1.

⁶¹ There are different methods to provide language services including contracted interpreters, staff interpreters, bilingual

Hospitals in the Hybrid Delivery Model

Hospitals should also be able to receive reimbursement directly from the state for their provision of language services in the Medi-Cal fee-for-service program. Hospitals could directly bill the State using either an enhanced encounter rate (T-code) or Medi-Cal Administrative Claiming. Additionally, some have their own call center-type systems and networks to connect their providers, staff, and patients with interpreters in a timely fashion. To create efficiencies, these network systems, if separate and apart from the hospital, should be able to serve as the billing entity for Medi-Cal reimbursement for language services. Finally, some hospitals may not have adequate internal systems to meet language needs and may need to access the broker system.

Provider-Based Interpreter Networks

Identified provider-based interpreter networks, such as those consisting of hospitals and primary care clinics, may be able to utilize a billing number and act as the billing agent for individual provider entities. This model recognizes that this type of network already exists in California and “best practice” efforts such as this model should be preserved, to the extent possible, in any new efforts to provide language access services to California’s LEP Medi-Cal beneficiaries. Such networks shall also have the option of applying to become brokers if they meet the criteria to be set by the State, as suggested in Appendix I.1.

providers, bilingual personnel, as well as telephone and video/telephone conferencing medical interpretation (VMI) services. Although the Taskforce discussed the different methods, no decision was made as to which service would be preferred.

Section 5: Implementation Issues

The following section reviews the impact that the recommended reimbursement model will have on California's safety net through our public hospitals and community clinics. Additionally, the following section reviews what components of quality and standards must be taken into consideration during the implementation of a reimbursement system. Lastly, this section reviews other issues to consider such as the interaction of the Hybrid Reimbursement Model with existing managed care, mental health, the state's healthcare interpreter workforce and covering the uninsured.

Reimbursement in the Safety Net

Much of the medical care provided to Medi-Cal enrollees is concentrated in the safety net, for example, in public hospitals, public clinics, and non-profit community health centers. Public hospitals and their clinic systems provide approximately one-third of the state's inpatient and outpatient care to the Medi-Cal population.⁶² California's community health centers and public hospital systems share a common mission to serve all in the need regardless of ability to pay, immigration status or insurance. They serve patient populations that are comprised of more than two-thirds ethnic and racial minorities and more than half of their patients are LEP.

The Taskforce recognizes that public hospital systems and public and non-profit FQHC clinics may already receive some Medicaid reimbursement for language services, but significant costs remain unreimbursed.

Public Hospitals

Currently, public hospital systems in California receive partial federal reimbursement for language services provided to Medi-Cal patients, which is claimed in cost-finding reports. Public hospitals do not receive any state reimbursement, and more than half of their language services costs remain unreimbursed. If state Medi-Cal reimbursement was available to cover 50% of the costs of interpreter services, this would bring the Medi-Cal payments to public hospitals for interpreter services closer to the actual costs and provide opportunities to sustain and expand language services to LEP beneficiaries. Public hospital systems receive federal payments for some of the costs of language services if they are included in their cost-finding for inpatient, outpatient non-FQHC clinics and outpatient FQHC services, as follows:

Inpatient Language Services: On the inpatient side under the current hospital financing waiver, public hospitals are reimbursed based on costs. On an annual basis, hospitals undergo cost-finding and should be including staff and contracted interpreter services as overhead costs. This draws down the federal payment to cover 50% of the costs.

⁶² "Fast Facts," www.caph.org.

Outpatient Non-FQHC Language Services: In public hospital non-FQHC outpatient clinics, because of AB 915 (2002) (See Appendix F.6) and the subsequent AB 959 (2006) (See Appendix F.7), public hospital non-FQHC clinics can claim costs and receive 50% of those expenses in federal payments. If the State were to pay the non-federal share, public clinics would have more payment to offset against cost.

Outpatient FQHC Services: See section on FQHCs below.

Including Public Hospitals in the Hybrid Model

The Taskforce recommends that all hospitals, not just public hospitals, have two options for providing language services and obtaining reimbursement from the state for services provided to Medi-Cal patients. The first option would be for hospitals to directly bill the state using either an enhanced encounter rate (T-code) or Medi-Cal Administrative Claiming. The second option involves using an approved broker service where the hospital would obtain interpreter services through a certified regional broker and the broker would be responsible for billing the State for services provided to Medi-Cal patients. Because of the extensive, 24-hour/day language services required in hospitals, one hospital should be allowed to use both options concurrently. For example, a hospital could access a broker for in-person interpreting but bill Medi-Cal directly for the costs of providing telephonic interpreting after hours. In both options, the hospital retains the overall Title VI responsibility and Joint Commission for Accreditation of Hospitals requirement for ensuring that patients have sufficient and timely access to interpreter services.

Federally Qualified Health Centers (FQHCs):

In addition to the many free standing non-profit FQHCs, many public hospital system clinics also have FQHC designation. Many of California's FQHCs also receive Section 330 funding (See Appendix E.7 for additional information on Section 330). Section 330 health centers are required to provide interpreter services appropriate to the language needs of the FQHCs target population as feasible.⁶³ Because FQHCs are required to provide language services necessary for the adequate support of primary health services and other services provided by the health center, language services are a necessary and proper expense incurred in furnishing services to Medi-Cal beneficiaries who are FQHC patients.

In Medi-Cal, FQHC services are reimbursed on an all-inclusive prospective payment rate (PPS) per visit in accordance with the definition of visit set forth in the Medi-Cal statute.⁶⁴ An FQHC visit is defined as a face-to face encounter with a specified licensed provider.⁶⁵ A visit may be billed when the FQHC service involves a face-to-face encounter with a core

⁶³ See 42 U.S.C. § 254b(b)(1)(A)(iv) and 42 Code Fed. Regs. § 51c.102 subdivisions (c) and (j)(14).

⁶⁴ Cal. Welfare & Institutions Code § 14132.100(c).

⁶⁵ 1) a physician; 2) a dentist; 3) a chiropractor; 4) an osteopath; 5) a podiatrist; 6) an optometrist; 7) a licensed clinical social worker; 8) a licensed clinical psychologist; 9) a physician's assistant; 10) a certified nurse midwife; 11) a nurse practitioner; 12) a visiting nurse; 13) a comprehensive perinatal services practitioner; 14) a four-hour day of attendance at a federally qualified health center, and 15) any other provider identified in the state plan's definition of an FQHC visit. (For the purposes of this recommendation, these provider types will be referred to as core providers.) SB 238 was enrolled to the Governor on September 20, 2007. SB 238 would also include dental hygienists and dental hygienist in alternative practice as core FQHC providers.

provider during which language services are provided- either by the person who is also providing clinical services to his or her own patients or through the use of an interpreter who provides the language services.

Services provided “incident to” the services of a core provider are a reimbursable cost if they are provided only as allowed under the Medicaid and Medicare regulations. Medicaid agencies are directed to follow the Medicare cost reimbursement principles set forth in 42 CFR Part 413 (See Appendix E.8). In Medicare, services and supplies incident to a physician’s services provided by an FQHC must meet the following criteria:

- That they are furnished as an incidental, although integral, part of a physician’s professional services
- Be of a type commonly furnished in physicians’ offices
- Be of a type commonly rendered without charge or included in the FQHC bill
- Be provided by a clinic employee other than a non physician practitioner under the direct, personal supervision of a physician.⁶⁶

Currently, language services are reimbursed as a service provided “incident to” the services of a core provider if an interpreter, other than the core provider, is necessary to furnish patient services. Language services provided “incident to” a core provider should be provided during or following a face-to-face encounter with a core

provider. When provided in this manner, language services can be included as an allowable cost for the purpose of determining an FQHC’s per-visit rate.

The FQHC’s per-visit rate is set based on costs from a base year(s). Rate adjustments are permitted under the following circumstances: 1) where adjustments are made on annually based Medicare Economic Index (MEI), and 2) if the scope of the FQHC’s services change and specific requirements of the scope of service change process are met. If during the base year(s) a FQHC either did not provide interpreter services or did not realize these costs were allowable, the costs of providing interpreter services may not be in the current FQHC’s per-visit rate. It is likely that some FQHCs currently do not include these allowable costs in their rate. For example, with the adoption of video/telephone conferencing interpreting, many public FQHC clinics have significantly increased utilization of health care interpreters, and have borne the costs. For those FQHCs that do include these costs in their FQHC per-visit rate, it is also likely that the costs are currently understated. As mentioned previously, rates are adjusted annually based on the MEI. The costs of providing health care services including the associated costs of providing interpreter services are growing at a faster rate than is covered by the MEI annual increase.

Including FQHCs in the Hybrid Model

FQHCs are able to secure reimbursement for language services provided incident to the services of a core provider through the all-inclusive PPS rate, and should continue to do so

⁶⁶ 42 Code Fed. Regs. § 410.26; *also see* CMS Pub. 100-02, *Medicare Benefit Policy Manual*, Chpt. 13, §60.3

under any new system for the provision of these services. Because of California’s diversity, it is not feasible for each FQHC to meet the language needs of LEP Medi-Cal patients who seek FQHC services. If the Medi-Cal program adopts a broker model for language services, FQHC providers must be able to access this assistance for unique languages unavailable at the FQHC.

The Medi-Cal Language Access Services Taskforce recommends that the Department of Health Care Services (DHCS) continue to treat all costs related to language services provided by FQHCs—whether provided by a core provider or “incident to” the services of a core provider—as “allowable costs” for the purpose of determining an FQHC’s prospective per-visit rate. The Taskforce also recommends that the State facilitate scope of service change for FQHCs providing language services that do not have these costs included in the PPS rate.

If California adopts language services as a Medi-Cal covered benefit, the Taskforce recommends that the state recognize FQHCs making changes to their language services program based on this regulatory or statutory change as a potential scope of service change or consider the development of a “recalculation” process similar to that created under SB 238 (Aanestad) (See Appendix F.8) in order to allow FQHCs to adequately account for the costs of providing interpreter services. Once a system to certify interpreters is established, the Taskforce recommends that Department of Health Care Services (DHCS) should convene FQHC representatives to determine how certification may be applied to interpreters utilized by FQHCs.

Quality and Standards

Recommendations on Quality

The Taskforce recommends the development of a system to ensure that Medi-Cal beneficiaries have access to competent, trained, and tested interpreters. The recommended pathway includes an accrediting organization that will be responsible for the accrediting of agencies, programs and/or schools—Interpreter Training Programs (ITP)—that conduct interpreter training and testing. The accredited program will conduct their training and administer a competency test. Students who have a certificate of completion from an accredited ITP will be eligible to receive reimbursement for language services through Medi-Cal. Medi-Cal reimbursement may only be claimed for services provided by an interpreter with a certificate of completion from an accredited ITP. For more information on the certification process, please see Appendix I.3. Additionally, the Taskforce recognizes that there are existing interpreters already providing services in California today. For these interpreters, the Taskforce recommends that they be granted a grandfather clause. For more information on this issue, please see Appendix I.3.

Developing a Quality Assurance Board (QAB)

The mechanism for the state to assure the development of an effective Medi-Cal language services program will be a Quality Assurance Board (QAB). Established by DHCS, QAB will provide advisory and technical assistance. DHCS will work with the QAB on matters

relevant to the development, implementation, and monitoring of Medi-Cal language services. In Appendix I of this report, the Taskforce offers recommendations related to the standard competencies (see Appendix I.3) which should determine the appropriateness of interpreter training to be eligible for Medi-Cal reimbursement. The final set of core competencies will be determined by the state working in conjunction with the QAB.

Compliance Monitoring

In order to ensure meaningful access to healthcare services in its Medi-Cal program, the Taskforce recommends that the state shall monitor compliance, identify and resolve complaints related to language services and oversee the implementation of the state's language services program.

Use of an Ombudsman's Office

With regard to the responsibilities of the state, the Taskforce recommends that the state place primary responsibility for monitoring all complaints into the existing Medi-Cal Managed Care Ombudsman's (MMCO's) office or any similar ombudsmen's office designated by DHCS and approved by the Quality Assurance Board (QAB). If DHCS selects the MMCO as the compliance office, it would require an expansion of its current role and capacity of the MMCO to encompass complaints from both the fee-for-service and managed care providers, as well as an ability to handle complaints against brokers. The complaint number must also be well publicized in multiple languages so that all stakeholders are aware of the appropriate office to contact when problems arise. For FFS Medi-

Cal, upon receiving a complaint from either a patient or provider, the MMCO shall contact the relevant broker and arrange for the dispatchment of emergency interpreter services within 30 minutes. For managed care, if a provider complains that a managed care plan is not providing an interpreter as they are obligated to under its contract with DHCS, the MMCO will first contact the plan and allow it the opportunity to provide an interpreter. However, if the plan refuses or cannot provide emergency interpreter services within 30 minutes, the MMCO will follow the procedure for fee-for-service providers: contact the relevant broker, arrange for the dispatchment of emergency interpreter services within 30 minutes, and subsequently bill the plan. The MMCO will report all (fee-for service and managed care) complaints to the state and QAB, along with the resolution of the problem. If a broker, provider or health plan consistently fails to provide interpreters, or has a significant number of complaints, the MMCO and/or state will develop a corrective action plan to resolve the problem.

Educating Consumer and Keeping Track of their Language Needs

In order for the provider to identify the language needs of the Medi-Cal beneficiary, the Medi-Cal eligibility cards should clearly identify required language services by printing the primary oral and written language needs of the Medi-Cal beneficiary on his or her eligibility card. If the Medi-Cal card does include the needed oral and written language information, and it is apparent that the LEP patient needs an interpreter, the provider should ask the Medi-Cal beneficiary about his or her language needs. If the LEP patient asks for an interpreter, the provider

should contact the broker to arrange for interpreter services.

The state shall educate: a) the Medi-Cal eligible population about their rights under the Medi-Cal program, as well as under federal and state law, including their right to free interpreter and translation services; and b) Medi-Cal providers, including health plans, hospitals, and physicians, about new language services procedures in the Medi-Cal Program. DHCS shall conduct audits of brokers to ensure contract compliance, such as maintaining an adequate network of interpreters.

With regard to the responsibilities of the broker, they shall instruct the interpreter to confirm with the patient and provider that the interpreter will be present 48 hours in advance of an appointment. Brokers will compile data on interpreter usage and timing, which will be reported to the state & QAB, and will conduct annual satisfaction surveys of patients and providers, and report their findings to the state & QAB.

Providers are strongly encouraged to identify and record language needs of the patient in their medical records. Providers should also publicize information on the right to free interpreters and the Ombudsman complaint line in visible points of contact where Medi-Cal patients can see and read such notices. This information will be provided free of charge by DHCS. See Appendix I.4 for additional information.

Other Issues to Consider

Managed Care and its impact on the Recommendation

Although the managed care plans currently provide cultural and linguistic services, as mentioned previously in this report, the MCLAS Taskforce recommends that managed care plans be provided the option to avail themselves of the broker's services for a fee. Under this recommendation, the managed care plans that opt to utilize the broker system will advise their contracted providers accordingly. The Taskforce additionally recommends that the department should work with managed care plans to review the following information: the number of LEPs in each plan, the range of language services provided to LEPs, LEP language service utilization rates, annual cost of providing language services, and the relative cost and effectiveness of different types of language services.

Existing auditing and enforcement mechanisms include joint audits conducted by DHCS and DMHC. Additionally, the Medi-Cal Managed Care Division has a Member Rights & Program Integrity Unit that monitors managed care plans for the provision of language services. These auditing and enforcement mechanisms can be strengthened through a survey of LEP members on utilization of language services as well as increased efforts to educate Medi-Cal beneficiaries of the language services available and of the Ombudsman Toll-Free 1-888-452-8609 line. The managed care plans can contribute by educating their providers on their available language services.

Mental Health and its impact on the Recommended Hybrid Model

Currently, the California Department of Mental Health (DMH) is the responsible entity for the implementation of managed mental health care consolidated Specialty Mental Health services for Medi-Cal beneficiaries. The state's mental health system operates under a county operated Mental Health Medi-Cal Managed Care Plan (MHP) program that includes oversight by the state. Under this system, the MHP's payment for Medi-Cal Specialty Mental Health Services ensures Medicaid matching funds for these services and County MHP's are required to submit implementation plans to the state's DMH. Similar to other managed care programs, the mental health carve out of Specialty Mental Health services, should include interpreter services as included in the Mental Health Managed Care Plans current State Maximum Allowable (SMA) rates. Similarly, Medi-Cal Managed Care plans cannot extract language services cost from the SMA rates. As a result, MHP's fund interpreter services but specific costs for interpreter services are not available.

Additionally, the CA Code of Regulations (CCR), Title 9, Division 1 Article 4 Standards, Sections: 1810.405 and 1810.410, states that each MHP shall develop and implement a Cultural Competence Plan and are required to submit the plan to the DMH for both review and approval. MHP's are also required to develop strategies to provide language services for persons with serious mental illness (SMI) and children and youth who are seriously emotionally disturbed (SED) and their families through the managed care contracts. As a result, the Taskforce recognizes that the recommendations

included under the report may be of use to MHP as a method to provide language services.

The Taskforce recommends that further studies should be undertaken to identify MHP's language costs. Additionally, the Taskforce recommends that improved documentation should occur in order to make an informed assessment of mental health language needs of Medi-Cal beneficiaries with mental health needs.

Mental Health Services Act

Passed in November 2004, the Mental Health Services Act (MHSA), referred to as Proposition 63, was designed to expand mental health care for children, youth, adults, and seniors using programs proven to be effective. The MHSA allows counties to use funds to continue to provide services and programs for Community Services and Supports, a program that targets services for adults and older adults with SMI and children with SED. The new MHSA allocated resources that can be used as matching funds to support programs under the Medi-Cal Managed Care Mental Health Plans.

Additionally, the Cultural and Linguistic Competence Technical Resource Group was developed by the MHSOAC as an advisory group on cultural and linguistic competent services. With the creation of the MHSOAC's Cultural and Linguistic Competence Technical Resource Group, the mental health community has a forum to identify linguistic barriers for accessing mental health services. The Taskforce recommends aligning services between the recommendations found in this report and those

of MHSOAC's Cultural and Linguistic Competence Technical Resource Group.

Translation under the Recommended Hybrid Model

Current Requirements in Medi-Cal on Written Translation

Currently, Medi-Cal uses a numeric threshold of 3000 mandatory Medi-Cal eligible individuals residing in the proposed service area whose primary language is not English, or a *concentration* standard of 1000 in a single zip code or 1500 in two contiguous zip codes that provides DHCS the ability to protect a significant portion of the LEP population that would not otherwise benefit from a percentage threshold.⁶⁷ Using this definition, effective September 30, 2002, there are currently thirteen threshold languages statewide for all Medi-Cal Managed Care plans that require translated materials.⁶⁸

In May 1996, DHS convened a Cultural and Linguistic Competency Taskforce to develop further requirements and standards for the provision of culturally and linguistically appropriate health care services in its Medi-Cal Managed Care program.⁶⁹ After three years, on

April 2, 1999, the Medi-Cal Managed Care Division (MMCD) released Policy Letters 99-01 to 99-04 and an All Plan Letter 99005 clarifying requirements of Medi-Cal Managed Care Plans. These five policy letters issued by MMCD contain detailed guidelines to assist plans in building systems that meet the needs of the diverse Medi-Cal population.⁷⁰

Requesting Translation

The Taskforce recognizes the importance of having written information in order to support the provision of language services such as interpretation. As a result, the Taskforce recommends that services for the translation of documents should be handled in a manner similar to that for oral interpreters, as it is the understanding of the Taskforce that CMS will match state funds used for translation services provided by contract regional brokers. For documents that can be translated by the state, the state shall assume the responsibility for translating documents for fee-for-service beneficiaries.

Conversely, any Medi-Cal provider who can access a regional broker may also request for the translation of a vital document from that broker. As part of their contracting process with the

⁶⁷ Medi-Cal Contract §13(C).

⁶⁸ MMCD, All Plan Letter 02003, *Cultural and Linguistic Contractual Requirements: Threshold and Concentration Standard Languages Update* (6/7/02). The thirteen threshold languages statewide are Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese.

⁶⁹ Department of Health Services, Medi-Cal Managed Care Division (MMCD), *Release of the Cultural and Linguistic Letters* (Apr. 3, 1999). The Taskforce solicited public comments on its draft policy recommendations in July 1997 and finalized its

recommendations in January 1998. From these recommendations, MMCD prepared policy letters that also went through a public process where health plans, medical directors, community advocates, Taskforce members, and experts had an opportunity to review and comment on the letters.

⁷⁰ See MMCD 99-01 (Community Advisory Committee); MMCD 99-02 (Health Education and Cultural and Linguistic Group Needs Assessment), MMCD 99-03 (Linguistic Services); MMCD 99-04 (Translation of Written Informing Materials); and MMCD 99005 (Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population).

state, brokers will be assessed for their capacity to translate vital documents into all Medi-Cal Managed Care threshold languages, either through staff or through contract with other vendors.⁷¹ For more information on what types of documents are defined as vital documents, please see Appendix G.4. The ability to translate or arrange for the translation of documents shall be considered in the awarding of contracts for vendors. If it is reasonable after the start-up period to expect brokers to have the capacity for translation services or to contract for those services, the provision of translation services should be required in future contracts with brokers. For providers that are directly reimbursed by the state for interpreter services, these systems can request from the state reimbursement for the translation of documents as well as interpreters services.

Any provider who requests the translation of a vital document can receive that translated document from the broker in a reasonable time frame, which should be specified in the contract. The definition of vital documents, and the quality processes needed to ensure adequate and competent translation, shall be the same as those specified and required in the Medi-Cal Managed

Care program as delineated in the programs policy letters (See Appendix G).

The Health Care Interpreter Workforce

There is very limited data on the numbers of health interpreters in California. A 2003 report by The Center for the Health Professions at UCSF indicated that there less than 500 health care interpreters and 1,890 interpreters overall (that includes but is not limited to health care interpreters) in California. That said, bilingual and bicultural healthcare providers are a critical component of meeting the language services needs of the Medi-Cal population.

As indicated in the 2004 reports by the Institute of Medicine and The Sullivan Commission on Diversity in the Healthcare Workforce, assuring the diversity of the health care workforce is a critical component towards culturally competent and linguistically appropriate health care. California's health care professionals currently do not reflect the changing demographics and diversity of its patients. While Latinos constitute one-third of all Californians and one-half of all children born in the state, they represent about 4% of nurses, less than 5% of all licensed physicians, less than 8% of dentistry degree recipients and approximately 10% of medical school degree recipients. The lack of ethnic representation in health professions is also reflected in other ethnic minorities including certain Asian and Pacific Islander subgroups. Therefore, having a racial/ethnically concordant health care workforce would not, in and of itself, ensure a culturally or linguistically competent healthcare workforce. For those certified, bilingual providers, the Taskforce recommends that they be reimbursed with a T code and

⁷¹ The U.S. Department of Health and Human Services defines vital documents as what documents are "vital" to the meaningful access of the LEP populations they serve. Thus, vital documents could include, for instance, consent and complaint forms, intake forms with potential for important health consequences, written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings, notices advising LEP persons of free language assistance, written tests that do not assess English language competency, but test competency for a particular license, job or skill for which knowing English is not required, or applications to participate in a recipient's program or activity or to receive recipient benefits or services. For more information, see Appendix G.4.

recommends that the Department of Health Care Services pursue this option.

Uninsured

Recent health care reform efforts have focused on increasing access for the 6.5 million people, representing one in five Californians, who were uninsured for all or some of 2005 (UCLA, Health Policy Research Brief, October 2006). In addition to lacking health care coverage, 65 % of the uninsured population speaks a language other than English at home and would benefit from access to language services. Despite the great need of the uninsured population, the Taskforce focuses on already covered individuals. Proposing recommendations to address the challenges faced by LEP uninsured individuals are not within the Taskforce's scope. However, the Taskforce believes that the implementation of the recommendations for Medi-Cal will greatly expand provider use and access to interpreter services, positively impacting the uninsured patients seen by these providers. The Taskforce encourages the administration to continue looking toward health care access and access to language services for all individuals, although this report only speaks to currently enrolled Medi-Cal beneficiaries.

Estimated Cost

Costs of providing healthcare language services vary widely, and projecting overall program costs require modeling beyond the Taskforce's time and expertise. Using existing Medi-Cal data, it may be possible to estimate the number of potentially reimbursable encounters that occur in Medi-Cal fee-for-service, and how many of those would be paid for through a broker or

direct provider billing. Additionally, the Taskforce recognizes that wide variation exists nationally in rates paid to interpreters and state by state spending per beneficiary, partially due to some of the factors listed below. To be clear, the Taskforce and its members did review the issue at length but determined that the recommendation regarding the delivery and provision of services was the Taskforce's primary charge and as a result, identified the following issues that would require resolution prior to determining the state's overall cost in providing language services:

- The exact definition of a reimbursable encounter (e.g., is language assistance for lab visits reimbursable? Pharmacy? In-home Medical Services? What constitutes a discrete encounter in an in-patient setting?);
- The format of the language service (in-person, video/telephone conferencing, or telephonic);
- The service provider (staff interpreter, bilingual office staff, or contract interpreter);
- Geography (e.g., an encounter may be provided by telephone in one setting, and in-person in another, based primarily on the availability of an in-person interpreter);
- Language spoken (As a general rule, Spanish-language encounters often cost less to provide than encounters in less common languages, such as Cambodian).

Additionally, Figure 2 overviews what other states spend for interpreting encounters currently reimburse (for more detailed information, see Appendix H). The lone estimate of what it might

cost to provide language assistance nationwide to all LEP enrollees in federally funded health programs comes from a federal Office of Management and Budget Report from 2002, in which OMB set a cost at \$268 million per year to provide interpretation services in 66.1 million emergency room, inpatient, outpatient, and dental visits. Those broke out to \$4.04 per LEP visit. However, the report assumed that 20 percent of interpreting encounters would be provided by volunteers including family and friends, and further assumed that 95 percent would be provided face-to-face, with the remaining 5 percent provided via commercial telephonic contracted interpreter services at a very expensive rate.

The Taskforce recommends that the state perform a quantitative analysis of potential costs, incorporating the information it derives when planning and conducting one or more pilot projects.

Figure 2: States' Spending

| Language Services Costs in the U.S. | | |
|--|--------------------|-----------------------------|
| ANNUAL COST (FY 2006) | | |
| | Spending | Number of Encounters |
| Washington D.C. | \$7k ¹ | |
| Hawaii | \$144k | 2,570 |
| Idaho | \$88k | 7,438 |
| Kansas | \$46.5k | |
| Maine | n/a | |
| Minnesota | \$1.6m | 42,400 |
| Montana | Under \$2k | |
| New Hampshire | \$18k | 1,763 |
| Utah | \$180k | |
| Vermont | n/a | |
| Washington | \$12m ³ | 217,865 |
| Wyoming | n/a | |

¹ Estimated cost based on first six months of program (03/06-09/06)

Section 6: Pilot Project

Recognizing the current budget year and fiscal situation, the Taskforce recommends the creation of a pilot project to test the rollout of a statewide broker system. Cost to implement the recommended Hybrid Model remains uncertain, so a pilot project will allow the state to determine statewide implementation cost and matching federal draw down as well as assess statewide implementation of Hybrid Model.

Administration of the Pilot Project

MCLAS Taskforce recommends the creation of a 2 year pilot project to test the rollout of a statewide broker system, which should begin no later than one year after the release of the Taskforce's final recommendation. Year 1 of the 2 year pilot project will serve as the ramp-up period while year 2 will be the actual delivery of services period. The pilot project should be financed as an administrative expense to proceed without a formal State Plan Amendment. Prior to actual delivery of service, the State should host a vendor convening for potential regional brokers to inform vendors of report as well as application process and assess individual vendor's capacity to serve as regional broker. During the same time, the state should develop a start-up fund for potential broker vendors and review data to determine frequency of LEP encounters.

Although the broker system is a priority, the pilot project should test the viability of both a broker and direct provider billing system. Pilot project counties should be Fee-for-Service (FFS)

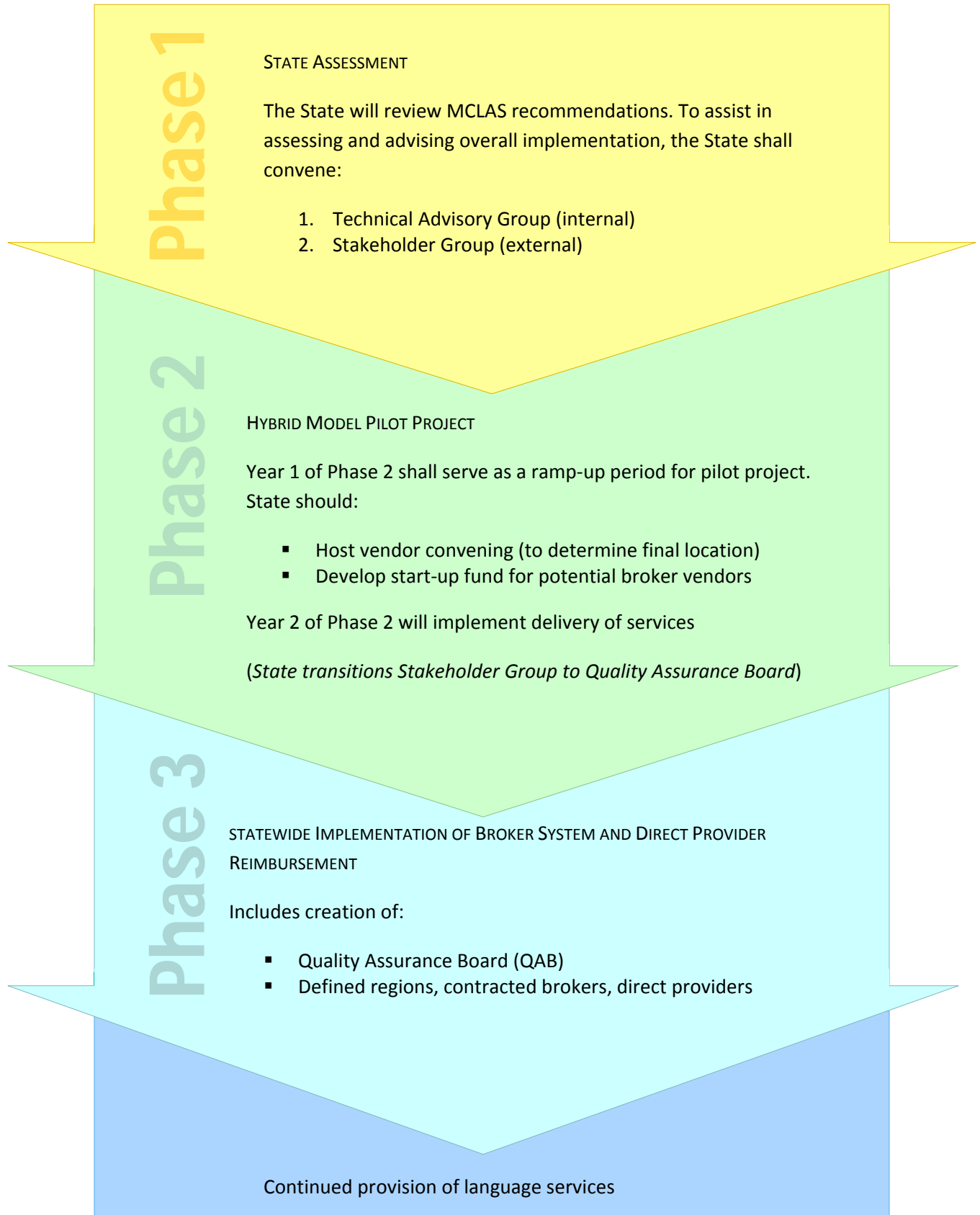
counties or managed care counties with a significant FFS population, have between 50,000 and 300,000 beneficiaries per year, and have more than three identified threshold languages in the Medi-Cal program. The Taskforce recommends the following counties: Alameda, San Francisco, Sacramento, Fresno, Merced, Stanislaus, Contra Costa, Santa Clara, San Joaquin, and Tulare. The Quality Assurance Board will be established during the pilot project to assist in the evaluation of the pilot. Pilot project interpreter standards should align at minimum with SB 853 or include a minimum of 40-hour minimum of training.

Stakeholder Process

The Taskforce recommends forming a stakeholder group in assessing and advising overall implementation of pilot project. Specifically, stakeholders can assist the state in developing contingencies for instances where brokers are unable to fulfill tenure of contract, identify counties if those previously outlined are not viable, and determining whether the federal match should be billed as an administrative or covered service.

The state should allow for flexibility in contract language allowing for a one year extension with broker if standards are met.

Figure 4: Pilot Project Timeline



Appendix: Table of Contents

| | |
|---|-----|
| A. About the Task Force | |
| 1. Medi-Cal Language Access Services Task Force..... | 44 |
| 2. Medi-Cal Language Access Services Task Force Statement of Principals..... | 45 |
| B. MCLAS Work Plan..... | 48 |
| C. Distribution of Languages in Medi-Cal, 2006 MEDS Data..... | 54 |
| D. Managed Care Plans in California..... | 55 |
| E. Existing Federal Laws | |
| 1. Title VI of the Civil Rights Act of 1963..... | 56 |
| 2. Regulation Pursuant to Title VI: 45 CFR 80.3..... | 57 |
| 3. Executive Order 13166..... | 60 |
| 4. Guidance to Federal Fund Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons..... | 62 |
| 5. Office of Minority Health, U.S. Department of Health and Human Services, <i>National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care</i> | 75 |
| 6. Title VI Prohibition Against National Origin Discrimination-Persons with Limited- English Proficiency..... | 90 |
| 7. Public Health Services Act, 42 UCS 254B (Section 330 Funding)..... | 99 |
| 8. 42 CFR Part 413..... | 121 |
| F. Existing State Laws | |
| 1. California Government Code §11135-11139..... | 133 |
| 2. 22 CA Code of Regs § 98211..... | 135 |
| 3. 22 CA Code of Regs § 92810..... | 136 |
| 4. Dymally Alatorre Act Bilingual Services Act..... | 137 |

| | |
|--|------------|
| 5. The Kopp Act..... | 143 |
| 6. Assembly Bill 915..... | 146 |
| 7. Assembly Bill 959..... | 151 |
| 8. Senate Bill 238..... | 157 |
| G. Policy Letters | |
| 1. Community Advisory Committee, MMCD 99-01..... | 170 |
| 2. Health Education and Cultural and Linguistic Group Needs Assessment, MMCD 99-02... | 172 |
| 3. Linguistic Services, MMCD 99-03..... | 173 |
| 4. Translation of Written Informing Materials, MMCD 99-04..... | 184 |
| 5. Cultural Competency in Health Care- Meeting the Needs of a Culturally and Linguistically Diverse Population, MMCD 99005..... | 192 |
| H. NHeLP Reimbursement Charts | |
| 1. States Currently Providing Reimbursement..... | 198 |
| 2. How States Provide Reimbursement..... | 199 |
| I. MCLAS Task Force Recommendations | |
| 1. Broker Selection Process..... | 201 |
| 2. Reimbursable Services..... | 203 |
| 3. Quality & Standards for Interpreters..... | 204 |
| 4. Monitoring and Complaints..... | 209 |
| J. Sample Managed Care Contract..... | 211 |